STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

Final Order No. DOH-99-0538-FOF-MQA Date 5-17-99
FILED
Department of Health
Angela Hall, AGENCY CLERK
By: Stephanie J. Orr
Deputy Agency Clerk

vs.

DOAH CASE NO.: 98-1260
AHCA CASE NO.: 96-17466
LICENSE NO.: ME0056010

CARLOS EUGENIO BERRY, M.D.,

Respondent.

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FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on April 10, 1999, in Ft. Lauderdale, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order and Petitioner's Exceptions to the Recommended Order (copies of which are attached hereto as Exhibits A and B, respectively) in the above-styled cause. Petitioner was represented by Larry G. McPherson, Jr., Chief Attorney. Respondent was present and represented by Donald Weidner, Esquire.

Upon review of the Recommended Order, the argument of the parties, and after a review of the complete record in this case, the Board makes the following findings and conclusions.

RULINGS ON EXCEPTIONS

The Board reviewed and considered the Petitioner's Exceptions to

the Recommended Order and rejected the exceptions.

FINDINGS OF FACT

1. The findings of fact set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

2. There is competent substantial evidence to support the findings of fact.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter pursuant to Section 120.57(1), Florida Statutes, and Chapter 458, Florida Statutes.

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

3. There is competent substantial evidence to support the conclusions of law.

DISPOSITION

Upon a complete review of the record in this case, the Board determines that the disposition recommended by the Administrative Law Judge be accepted. WHEREFORE,

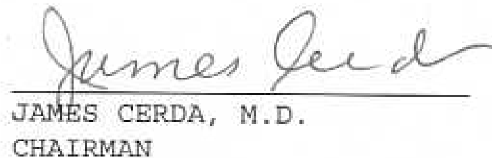
IT IS HEREBY ORDERED AND ADJUDGED that

the Administrative Complaint filed in this cause is hereby DISMISSED.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 11 day of May, 1999.

BOARD OF MEDICINE



JAMES CERDA, M.D.
CHAIRMAN

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. 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 U.S. Mail to Carlos E. Berry, M.D., 636 Turner Street, Clearwater, Florida 33756; to Donald Weidner, Esquire, Weidner & Winicki, P.A., 11265 Alumni Way, Suite 201, Jacksonville, Florida 32246-6685; to Lawrence P. Stevenson, Administrative Law Judge, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060; 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 _________________, 1999.

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STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 98-1260
CARLOS E. BERRY, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on August 20-21, 1998, in Clearwater, Florida, and on November 9, 1998, by videoconference in Tampa, Florida, before Lawrence P. Stevenson, a duly designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: John E. Terrel, Esquire
Department of Health
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: Donald W. Weidner, Esquire
Jeanine H. Coris, Esquire
Weidner & Winicki, P.A.
11265 Alumni Way, Suite 201
Jacksonville, Florida 32246-6685

STATEMENT OF THE ISSUES

The issues for determination in this case are whether Respondent's license to practice medicine should be revoked or otherwise disciplined for the reasons set forth in the Administrative Complaint, specifically for: 1) Respondent's failure to meet the acceptable standard of care for psychiatry by failing to perform a mental status examination on patient G.K. at the time

of the patient's admission to Medfield Hospital in February 1996; 2) Respondent's failure to place patient G.K. under continual close observation and/or in a room where suicide would have been more difficult or impossible; and 3) Respondent's failure to order consultations and staff conferences regarding patient G.K.'s condition during his admission at Medfield Hospital in February 1996.

PRELIMINARY STATEMENT

This case arises from the suicide of G.K., a patient of Respondent, Carlos E. Berry, M.D., a practicing psychiatrist who admitted G.K. to Medfield Hospital on February 20, 1996. G.K. committed suicide on February 22, 1996, in the hospital.

On December 16, 1997, Petitioner, Department of Health, filed an Administrative Complaint alleging that Respondent violated Section 458.331(1)(t), Florida Statutes, in that he failed to practice medicine with an acceptable level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Respondent contested the allegations of the Administrative Complaint, and filed a timely request for formal hearing. The matter was referred to the Division of Administrative Hearings on March 12, 1998. Pursuant to the Prehearing Order, the parties filed a prehearing stipulation on August 11, 1998. Formal hearing was conducted on August 19-21 and November 9, 1998.

At hearing, Petitioner presented the testimony of seven witnesses: Joyce Connolly, administrative assistant to the director of operations at Medfield Hospital; Jenny Schrader, the discharge

planner at Medfield Hospital; Cynthia Young, a registered nurse (R.N.) at Medfield Hospital; James Morello, also an R.N. at Medfield Hospital; P.K., the father of G.K.; F.K., the mother of G.K.; and Dr. Martin Rosenthal, a board certified psychiatrist currently working at the Broward Correctional Institution and qualified as an expert in psychiatry. Petitioner also presented seven exhibits, six of which were received in evidence. Petitioner's Exhibit 1, a procedural manual for Medfield Hospital, was not admitted into evidence because no witness could verify that this version of the manual was in effect at the time of the events at issue in this proceeding.

At hearing Respondent presented the testimony of three witnesses: David Cheshire, M.D., qualified as an expert witness in the field of psychiatry; Daniel Sprehe, M.D., qualified as an expert in psychiatry; and Respondent, Carlos E. Berry, M.D., who testified as a fact witness and was also qualified as an expert in psychiatry. Respondent presented eight exhibits, six of which were received in evidence at the time of hearing. On November 19, 1998, Respondent filed a post-hearing motion to admit the two remaining exhibits into evidence. By order dated December 17, 1998, the motion was granted, and Respondent's Exhibit 3, the curriculum vitae of Dr. Sprehe, and Respondent's Exhibit 4, Dr. Sprehe's written expert opinion, were accepted into evidence, the latter over Petitioner's objection that it was cumulative to Dr. Sprehe's oral testimony.

On November 30, 1998, the transcript of the final portion of the hearing was filed. Pursuant to Petitioner's Motion for Extension of Time, filed December 14, 1998, the parties were

granted without objection additional time in which to file Proposed Recommended Orders. On December 18, 1998, the parties filed Proposed Recommended Orders.

FINDINGS OF FACT

1. Petitioner, Department of Health, is the state agency vested with the statutory authority to enforce the disciplinary standards for the practice of medicine under Chapters 455 and 458, Florida Statutes.

2. Respondent, Carlos E. Berry, M.D., is, and at all material times was, a physician licensed to practice medicine in Florida, having been issued license no. ME 0056010. Respondent has active staff privileges at Charter Medfield Hospital ("Medfield") and at Sun Coast Hospital, both in Largo, Florida. Respondent is board-eligible in adult psychiatry.

3. Patient G.K. was a thirty-two year-old male with a long history of mental illness diagnosed as bipolar disorder, commonly called manic depression. G.K. related to staff at Medfield that he had first attempted suicide by hanging himself when he was in the fourth grade. G.K. stated that he had been depressed with suicidal thoughts ever since the incident in the fourth grade. G.K. had been hospitalized numerous times through the subsequent years, and had made several suicide gestures involving overdoses of prescription drugs. G.K. had longstanding problems with alcohol and drug abuse.

4. G.K. had been Dr. Berry's patient intermittently since 1990. G.K. initially came to Dr. Berry on an outpatient basis seeking help with managing his medications.

5. Dr. Berry testified that he saw G.K. from seven to ten times over the next two and a half-year period, all on an outpatient basis. Dr. Berry testified that G.K. was doing relatively well when they met, with some ups and downs.

6. G.K. then stopped regularly seeing Dr. Berry, but would call him every few months to gauge Dr. Berry's willingness to prescribe medication, which Dr. Berry refused to do without seeing the patient. G.K. would then come to see Dr. Berry, get a prescription, then "disappear" for another few months. Dr. Berry testified that this remained G.K.'s pattern until 1994.

7. On May 13, 1994, Dr. Berry admitted G.K. to Medfield. G.K. had been initially admitted to an acute care hospital for an overdose of prescription medicine and alcohol in what he later admitted to Dr. Berry was a suicide attempt. G.K. was cleared medically, then admitted under the Baker Act to Medfield.

8. Dr. Berry performed an initial examination of G.K. within 24 hours of G.K.'s admission and wrote an initial report on May 14, 1994. He diagnosed G.K. with bipolar disorder, and noted that G.K. was depressed and unable to state that he did not want to die, though he was not psychotic and not actively suicidal at the time of the interview.

9. Upon admission, G.K. was placed on "Q15" suicide precautions, meaning that hospital staff would check him every fifteen minutes. Within six hours, G.K. converted his admission to voluntary status and the suicide precautions were discontinued. The initial plan was to assess G.K. for suicidality, reassess his medications, and encourage him to attend and participate in all available modes of group therapy. G.K. was in fact seen by mental

health staff and other allied therapists for individual and group therapy, as well as having individual sessions with Dr. Berry.

10. After 48 hours, G.K. showed marked improvement, being less dysphoric and denying suicidal ideations. On May 15, 1994, G.K. was discharged from Medfield after having agreed to follow up with individual therapy and medication management under the care of another psychiatrist.

11. On August 23, 1994, G.K. was admitted to Pinellas Emergency Mental Health Services, Inc. ("PEMHS"), another inpatient psychiatric facility. The treating psychiatrist's notes indicate that this was a voluntary admission, though other portions of the medical record state that G.K. was admitted under the Baker Act.

12. On admission, G.K. complained of depression and suicidal thoughts, and stated that he had discontinued his medications because they were ineffective. The treating psychiatrist diagnosed bipolar disorder with depression.

13. The psychiatrist noted that G.K.'s affect was "angry and sarcastic," and his mood was dysphoric. G.K. denied hallucinations and did not appear delusional or thought disordered. He admitted to increasing irritability and aggressiveness toward other people over the past year, which had interfered with his employment. He stated that he thought about suicide nearly all the time, but that such feelings had been present for at least twenty years. He admitted to drinking at least a six-pack of beer every day and to smoking marijuana on a daily basis for a period of 15 years.

14. The PEMHS records do not indicate whether G.K. was placed on suicide precautions during his stay, though the physician's

notes indicate G.K. was still "ambivalent" about suicide as late as August 26, 1994.

15. The PEMHS records indicate that G.K. attended group therapy sessions without participating. Both staff and the treating physician noted G.K.'s sarcastic attitude toward his peers and the facility in general.

16. G.K. was discharged from PEMHS on August 30, 1994. The treating physician noted on that date that G.K. denied suicidal ideation, he had shown some improvement during his stay. The physician recommended outpatient treatment and support group therapy along with medication.

17. The events at issue in this proceeding commenced on February 20, 1996, when G.K. was voluntarily admitted to Medfield, four days after overdosing on a prescription medication, Zoloft, while intoxicated with alcohol.

18. G.K.'s admission, while voluntary, was accomplished by way of prodding from his parents, who had become greatly alarmed at his worsening mental state.

19. P.K., G.K.'s father, testified that he convinced G.K. to go to Medfield, and that he drove G.K. to the hospital on the morning of February 20.

20. P.K. further testified that his son was worried because he had no insurance and knew his parents would have to foot the bill for his stay at Medfield. An administrator at Medfield raised the issue of payment method with P.K. while G.K. was present, causing G.K. to flee the facility on foot. The Medfield administrator and P.K. had to go outside and talk G.K. into

returning by assuring him that P.K. would pay for only a three- day stay, then they would decide what to do next.

21. On the afternoon of February 20, Judy McDermott performed an initial needs assessment on G.K. Ms. McDermott was a psychiatric nurse who had worked with Respondent at Medfield since 1991. Dr. Berry testified that he was very familiar with Ms. McDermott's work and trusted her judgment.

22. Ms. McDermott found that G.K. was depressed and anxious. He told her, "I think about suicide all the time." G.K. admitted that four days previous he had overdosed on pills and alcohol, then vomited. G.K. told Ms. McDermott that he had erratic sleep and appetite patterns, and had recently locked himself in his apartment for two weeks in an attempt to quit smoking marijuana. He also admitted that he had been noncompliant in taking his prescription medications. G.K. told Ms. McDermott about his two prior inpatient admissions, including the 1994 Medfield admission when he was treated by Dr. Berry.

23. After performing her assessment, Ms. McDermott called Dr. Berry on the telephone and discussed the case with him. She told Dr. Berry about G.K.'s recent overdose, the circumstances of his admission, including his brief flight, and his unhappiness over being in the hospital. G.K. had told Ms. McDermott that he was unwilling to admit himself unless Dr. Berry was the attending physician.

24. As a result of this briefing from Ms. McDermott, Dr. Berry recommended inpatient treatment for mood stabilization and medication management under his supervision. Dr. Berry testified that he knew his schedule would not permit him to see

G.K. until February 21, but that he went ahead and admitted G.K. in the knowledge that Leslie Webster, an Advanced Registered Nurse Practitioner (ARNP), would be available to perform a psychiatric evaluation and mental status exam within 24 hours of G.K.'s admission.

25. Dr. Berry issued orders to admit G.K. voluntarily to the Adult General Psychiatric unit (AGC) and place him under Q15 suicide and unpredictable behavior precautions. "Q15" meant that the patient would be observed and checked every fifteen minutes. As discussed below, Q15 was the least restrictive of three levels of suicide precautions used at Medfield, but still involved "constant observation" of the patient.

26. Medfield had two psychiatric units: AGC, for higher functioning patients able to participate in their own therapy, and the Crisis Stabilization Unit (CSU), for patients admitted under the Baker Act and/or acutely psychotic or very demented.

27. The choice of unit was not based on how suicidal the patient was, but on how well the patient could function, i.e., the patient's ability to participate, to talk, to interact, and to understand what was going on around him. G.K. was properly placed in the AGC unit, as he was voluntarily admitted, alert, and oriented to time, place and person.

28. On the afternoon of February 20, 1996, G.K. was seen by Cynthia Young, a registered nurse who was Medfield's Director of Clinical Services. After reviewing Ms. McDermott's needs assessment, Ms. Young performed the nursing assessment on G.K. She noted that G.K. appeared tense, that his mood was depressed, irritable and anxious, that he made poor eye contact, that he spoke

in limited, unfinished sentences, and that he was withdrawn and defensive.

29. Ms. Young noted in the assessment that G.K. "wants to kill self." In a progress note written later that afternoon, she wrote that G.K. was "thinking about self harm all the time." She testified that she considered such statement to be mere suicidal ideation, because he did not articulate a plan for completing the suicide.

30. Ms. Young testified that the process for putting a patient on line-of-sight or one-to-one observation was triggered when the patient verbalized a definite plan for suicide, or was so confused they constituted a danger to themselves or others. A "definite plan" is a plan that could be accomplished within the confines of the psychiatric unit. She testified that a patient who has voluntarily admitted himself, who has simply expressed suicidal ideation, and who is not psychotic would not generally be placed on line-of-sight or one-to-one precautions.

31. Ms. Young further testified that if she as a nurse believed a patient was a danger to himself, she was empowered to act immediately to place the patient in a safe environment, such as one-to-one observation. After ensuring the patient's safety, the nurse would then call the physician, who would place a time-limited order on the patient restriction. This procedure was confirmed by James Morello, who was the nurse manager of the adult program at Medfield. Ms. Young testified that she saw no need to take such action in regards to G.K., and that she agreed with Dr. Berry's order for Q15 suicide precautions.

32. On the morning of February 21, 1996, G.K. was seen by Jenny Schrader, a case manager and discharge planner at Medfield. Ms. Schrader's job was to arrange after care for patients once they were discharged from Medfield.

33. Ms. Schrader recalled G.K. as angry and a little hostile, and that G.K. had said to her, "I'm pissed because I'm still alive." She did not consider this to be a suicidal statement, in the context of G.K.'s general anger and because his voluntary admission indicated he was seeking help. She testified that it was common for patients to make such statements, and further that G.K. was a sarcastic individual and that she took his statement in that light. Ms. Schrader testified that had she believed G.K. was a serious suicide threat, she would have relayed her concerns to the nursing staff, which in turn had authority immediately to institute greater suicide precautions.

34. Medfield had three levels of suicide precautions: Q15, which required checks on the patient every 15 minutes; line-of-sight, meaning that the patient must be kept in sight of a staff person at all times, including when the patient goes to the bathroom; and one-to-one, meaning that the patient is under constant, arms' length observation by an assigned staff person, even in the bathroom.

35. Medfield's "Precautions Flow Sheet," the document recording the maintenance of suicide precautions, characterized the Q15 level as requiring "constant observation" documented every 15 minutes.

36. Suicidal ideation, i.e., the expression of a wish to be dead or a desire to kill oneself, is not alone considered grounds

for placing a patient in the more restrictive line-of-sight or one-to-one precautions. Ms. Schrader estimated that 65 to 70 percent of the patients admitted to Medfield were there because of some kind of suicidal ideation or attempt. James Morello, who was nurse manager of the adult psychiatric program at Medfield, estimated the number of admissions for suicidal ideation at 70 to 90 percent. Dr. Daniel Sprehe, an expert in forensic psychiatry, estimated that 80 percent of the patients he admits express suicidal ideation. Dr. Berry testified that 50 to 60 percent of the patients he admits have bipolar or severe depression with suicidal ideation.

37. Petitioner's expert, Dr. Martin Rosenthal, testified that it would be practically impossible for Medfield to place 60 percent or more of its patients on line-of-sight or one-to-one observation.

38. An ARNP is a professional nurse who is certified in advanced or specialized nursing practice, and is authorized by rule and statute to perform medical diagnosis and treatment pursuant to a written protocol between the ARNP and a supervising physician. Sections 464.003(3)(c) and 464.012(3), Florida Statutes; Rule 64B9-4.010, Florida Administrative Code.

39. A written protocol between Dr. Berry and Leslie Webster, an ARNP specializing in psychiatric care, authorized Ms. Webster to perform initial psychiatric evaluations and ongoing assessments of Dr. Berry's patients at Medfield, under the general supervision of Dr. Berry.

40. The Rules and Regulations of Medfield provided that patients were required to undergo a mental status examination and that a complete history and psychiatric examination must be written within 24 hours of admission. The Rules and Regulations further

provided that the required psychiatric evaluation could be performed by an ARNP such as Ms. Webster.

41. On the morning of February 21, 1996, less than 24 hours after G.K.'s admission, Ms. Webster performed a comprehensive mental status evaluation of G.K. She noted that he was somewhat guarded in his responses and made no eye contact. His speech was clear, logical and organized. His mood was sad, depressed, and despondent with a flat affect. He complained of constant racing thoughts and an inability to sleep. He was alert and oriented to time, place and person. His thoughts revolved around difficulty in stabilizing his mood disorder and the loss of "visions" that used to guide him. He denied auditory or visual hallucinations. His memory was intact.

42. Ms. Webster's report stated that G.K. admitted to "suicidal thoughts with a plan but states he does not want to be in pain." Her handwritten notes indicated that the referenced "plan" involved buying a gun and killing himself.

43. Ms. Webster concluded that G.K. had poor insight and judgment, and questionable impulse control.

44. Ms. Webster discussed her findings with Dr. Berry via telephone. Dr. Berry signed off on the treatment plan, which included maintaining Q15 suicide precautions and unpredictable behavior precautions, encouragement to participate in group, unit and community activities, and medication management using Klonopin and Ativan.

45. On the afternoon of February 21, 1996, Dr. Berry came to Medfield. After seeing to some administrative matters, he reviewed G.K.'s entire file. He read the various notes relating to G.K.'s

suicidal expressions, but testified that these did not alarm him. Dr. Berry testified that G.K. had often talked about not wanting to live and had often expressed suicidal thoughts.

46. Dr. Berry testified that G.K. had "never, ever had a lethal or near lethal or potentially lethal suicide attempt." Dr. Berry construed some of the notations as being sarcastic, which was typical of G.K. even when he was doing well. Dr. Berry believed that G.K. was in a safe environment, and that the Q15 precautions were sufficient.

47. Dr. Berry reviewed the mental status exam performed by Ms. Webster, determined that she had performed a proper examination of G.K., and signed off on her report.

48. Dr. Berry went onto the AGC unit specifically to see G.K. A staff person told him that G.K. was not available because he was outside playing volleyball. The staff person told Dr. Berry that G.K. was depressed but "doing okay." Dr. Berry testified that upon hearing this, he thought, "Maybe he ain't doing that bad. I'd rather he be outside playing volleyball," particularly since G.K. had already been seen by Ms. Webster. Dr. Berry thus determined there was no pressing need to see G.K. on the afternoon of February 21, 1996.

49. Mr. Morello confirmed discussions with Dr. Berry concerning G.K. on February 21, 1996, though he was unclear whether the conversation was in person or by telephone. Dr. Berry told Mr. Morello that G.K.'s admission would probably be for three to four days, which seemed routine to Mr. Morello for the situation presented by G.K.: the patient would be stabilized,

placed on medications, discharged and then followed-up in outpatient therapy.

50. The nursing progress notes for February 21 describe G.K. as quiet, presenting a flat and sad affect, and attending unit activities. During a goals/assessment group, G.K. stated, "I feel depressed; I've been suicidal for the past fifteen years," and further stated that he hates the way the world is.

51. A note entered at 9:00 p.m. records that G.K. had been observed on the unit during the entire shift, attending all unit activities. G.K. was quiet and nonverbal during most activities. He responded to a question about his visit with his doctor by saying, "He didn't give me anything to kill myself with." Mr. Morello described G.K.'s behavior on February 21 as exhibiting the typical ups and downs of a patient in a psychiatric hospital.

52. As Dr. Berry testified that he did not see G.K. on February 21, it is found that the "doctor" referenced in the 9:00 p.m. note was Dr. Mehul Patel, who performed a physical examination on G.K. on that date.

53. The Precautions Flow Sheet, which records the patient's activities in accordance with the Q15 suicide precautions, notes that during the day and evening of February 21, G.K. participated in group activities, interacted with his peers, engaged in physical activity, took his meals, and sat quietly in his room.

54. Notes from group therapy indicate that G.K. attended three group sessions on February 21, 1996. At a feelings group, he was noted to be quietly attentive with a flat affect and guarded about his thoughts and feelings. At the exercise and socialization group, i.e., the volleyball game, he was noted as being

cooperative, and quiet, having good volleyball skills, having a high participation level, and being attentive to the rules and score of the game. At a psychoeducational group, he was reported as participating in a group calmness exercise, and described as having a flat affect and being withdrawn.

55. The nursing progress notes indicate that G.K. remained in bed throughout the night of February 21 and into the morning of February 22. The Q15 suicide precautions remained in effect throughout the day and night of February 21, though the notes indicate no signs or symptoms of suicidal ideation beyond the 9:00 p.m. note discussed above.

56. On the morning of February 22, Dr. Berry arrived at Medfield between 6:30 and 7:00 a.m. He asked the nursing staff if anything happened during the night that he should know about. Along with two medical students who were accompanying him in connection with his position as a clinical instructor at the University of South Florida, Dr. Berry attended at least a portion of the treatment team meeting regarding G.K.

57. The treatment team for each patient generally comprised a social worker, the utilization review insurance manager, the mental health therapist, and the nursing director. The meetings were held early each morning. Physicians would come in and out of the meetings sporadically, discuss their own patients, then leave. Dr. Berry typically attended two or three such meetings each week, which was normal for physicians at Medfield. The physicians were required to attend treatment team meetings only once a week.

58. After getting information from the nursing staff about his patients, Dr. Berry began making rounds in the company of the

two medical students. They met with G.K. at approximately 8:00 a.m. Dr. Berry testified that he had already decided to try something other than traditional medications with G.K. and intended to discuss that with him.

59. Dr. Berry asked G.K. how he was doing, whether he was still feeling suicidal, and whether he was having hallucinations. G.K. told Dr. Berry that he was feeling safer in the hospital, and even joked about how long it had been since he had seen Dr. Berry. G.K. denied being suicidal and said he was not having hallucinations. He made it clear he was unhappy about being in a locked situation and pressed Dr. Berry to tell him when he would be allowed to leave the hospital. Dr. Berry replied that he wasn't sure, but that G.K. would likely stay through the weekend, another three days.

60. Dr. Berry testified that his estimate of G.K.'s stay was derived from his plan to try G.K. on a new medication, Clozaril. Dr. Berry testified that it takes a few days for a patient to acclimate to Clozaril, and he wanted to see how G.K. was doing with the drug and to see that G.K. was doing better before he released him. He discussed the risks and benefits of Clozaril with G.K., including the need to draw his blood on a weekly basis to monitor his white blood cell count. G.K. agreed to the plan of treatment.

61. Based upon G.K.'s statements that he was feeling safer, his joking with Dr. Berry, his agreement to try the new medication, and his inquiries about discharge planning, Dr. Berry concluded that G.K. was not suicidal at the time he saw him.

62. After his meeting with G.K., Dr. Berry entered an order to discontinue the Q15 suicide precautions. The staff continued to

check on G.K. every 15 minutes because Dr. Berry's order for unpredictable behavior precautions was still in effect.

63. In addition to the factors cited above, Dr. Berry testified that a reason for discontinuing the suicide precautions was the need to make G.K. feel he was making progress. In light of G.K.'s bipolar disorder and his aversion to the inpatient hospital setting, Dr. Berry believed it important to give G.K. signals that he was improving and progressing toward release.

64. Mr. Morello recalled seeing G.K. shortly after his session with Dr. Berry. Mr. Morello released G.K. from the unit to go to breakfast, and testified that G.K. seemed to be doing better, was brighter, more animated, and talking more freely that morning.

65. After breakfast, G.K. attended a 9:00 a.m. goals group meeting run by Dennis Cline, a psychiatric technician. Mr. Cline did not testify at the hearing. Mr. Morello, the nurse manager of the unit, did not attend the meeting but related a hearsay description of what happened. Mr. Morello testified that G.K. was discussing his situation when another patient told him he should "just end his life." G.K. left the group session shortly before it ended.

66. Dr. Berry testified that another physician later told him that one of his patients had related a similar story. G.K. apparently talked at length about his suicidal ideations. The other patients were tired. One patient in particular challenged G.K. vehemently, and commented that G.K. should stop talking about killing himself and just go do it. At this time, G.K. apparently became angry and left the group.

67. These hearsay accounts cannot form the basis of a finding as to exactly what happened in the group meeting. It is found, however, that something occurred in the group session that caused G.K. to leave the group shortly before the session ended. It is further found that no one on the staff at Medfield informed Dr. Berry of this incident until later in the day, after G.K. committed suicide.

68. Mr. Cline, the psychiatric technician in charge of the group session, continued to check G.K. every 15 minutes as required by the unpredictable behavior precautions. The notations in the Precautions Flow Sheet indicate that G.K. was in his bed at 10:00 a.m. and at 10:15 a.m.

69. At 10:30 a.m., Mr. Cline approached Mr. Morello and asked him if he had seen G.K. Mr. Morello said he had not. Mr. Cline went to look for G.K. in the unit, then called for Mr. Morello to help because he couldn't find G.K.

70. Mr. Morello testified that the door to G.K.'s room was closed. They knocked and entered, but G.K. was not in the room. They saw that the bathroom door was closed. They knocked, then entered. They found G.K. hanging by a luggage strap from an air conditioning vent. Despite efforts by Medfield staff and Emergency Medical Services, G.K. was pronounced dead from asphyxiation at 10:50 a.m.

71. Mr. Morello testified that the luggage strap used by G.K. apparently came from a bag brought to him by his mother on the previous evening. This comports with the testimony of F.K., who stated that she brought clean clothes for her son in what she variously called a "duffel bag," an "overnight bag," or a "gym

bag," on the evening of February 21, 1996. She testified that she left the bag at the nurses' station. The duty nurse apparently gave the bag to G.K.

72. No documents or testimony conclusively established Medfield's policy or protocol regarding what was regarded "contraband" for patients on Q15 suicide and/or unpredictable behavior precautions. Dr. David Cheshire, an expert in psychiatry with more than 30 years in private practice admitting patients to numerous psychiatric facilities, testified that

Dr. Berry was entitled to presume that his patient was in a safe place, and that included presuming that a patient on suicide precautions and/or unpredictable behavior precautions would not be given something with which he could hang himself.

Dr. Cheshire testified that every hospital in which he practices has a contraband list, and he assumed Medfield would have such a list, though it was not produced for the hearing. Dr. Cheshire stated in his written opinion that "[i]t would... be beyond reason to assume that a long strap, capable of being fashioned into a hanging noose, would not be considered a contraband item."

73. Dr. Cheshire's expert opinion accords with common sense on this issue. Staff should not have provided the bag to G.K. on the evening of February 21, 1996, when G.K. was still on Q15 suicide precautions and on unpredictable behavior precautions. Nothing in the record indicates that Dr. Berry knew that G.K. had been given this bag on the evening of February 21.

74. None of the professional staff involved in the treatment and close observation of G.K. throughout his stay at Medfield in 1996 believed that the Q15 precautions ordered by

Dr. Berry were insufficient. None of the professional staff believed that G.K. was actively suicidal during his 1996 stay at Medfield.

75. The Administrative Complaint alleges that Dr. Berry failed to practice medicine with an acceptable level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The Administrative Complaint cites three failures on the part of Dr. Berry: failure to perform a mental status evaluation on G.K. at the time of his admission; failure to order consultations and staff conferencing; and failure to place G.K. under "continual close observation."

76. Three experts testified at the final hearing, in addition to Dr. Berry, who was also qualified as an expert in psychiatry.

77. Petitioner offered the testimony of Dr. Martin Rosenthal, who currently works at the Broward Correctional Institution, a female prison with an active, inpatient acute treatment psychiatric unit. Dr. Rosenthal has not had active staff privileges at a private psychiatric hospital since 1994, but is board-certified and qualified to offer expert testimony on psychiatric treatment issues.

78. Respondent offered the testimony of Dr. David Cheshire, a Life Fellow of the American Psychiatric Association and board certified by the American Board of Quality Assurance and Utilization Review. Dr. Cheshire has been Chief of Psychiatry at Memorial Medical Center in Jacksonville, and has had continuous admitting privileges for thirty years at a number of hospitals in that city, currently including Baptist Hospital and St. Johns River

Hospital, both Baker Act facilities. He has also served as an expert on behalf of the Board of Medicine in the past.

79. Respondent also offered the testimony of Dr. Daniel Sprehe, board certified in psychiatry and forensic psychiatry. Dr. Sprehe has practiced psychiatry for 32 years in the Tampa area, and has active staff privileges at Tampa General Hospital, St. Joseph's Hospital, Memorial Hospital, and University of South Florida Psychiatric Center.

80. Dr. Cheshire, Dr. Sprehe, and Dr. Rosenthal all opined that it is proper to have an ARNP perform the mental status evaluation of a patient, provided the supervising physician reviews, checks, and signs the evaluation within 24 hours of its performance. Thus, the Administrative Complaint accurately recites that Dr. Berry did not personally perform the mental status examination upon G.K.'s admission, but fails to state a violation of the standard of care. Dr. Berry properly used an ARNP to perform the evaluation within 24 hours of G.K.'s admission, and Dr. Berry timely reviewed and approved the ARNP's evaluation, within the standard of care and pursuant to the applicable statute and rule cited above.

81. In his written opinion, Dr. Rosenthal stated: "In view of the seriousness and continuity of G.K.'s depression and preoccupation about suicide, I do think consultation and conjoint staff conferencing would have been in order." At the final hearing, Dr. Rosenthal testified that the written record "well documented" the appropriate information, and modified his written opinion to the extent of agreeing that if Dr. Berry spoke on multiple occasions with the staff people, the psychiatric

technicians and nurses involved in G.K.'s care, and if the information in the written record was fully conveyed to Dr. Berry during these conversations, then it could be concluded that "consultation and conjoint staff conferencing" had taken place.

82. Dr. Cheshire testified that he had no concerns that Dr. Berry failed to carry out appropriate consultations and staff conferencing.

83. Dr. Berry in fact spoke with the staff people, psychiatric technicians and nurses involved in the care of G.K., and was well aware of the contents of the written records. Petitioner failed to establish that Dr. Berry should have done more regarding consultation and conferencing with staff.

84. The most serious allegation, and the one producing serious disagreement among the experts, was that Dr. Berry failed to place G.K. under "continual close observation." It is noted that if the allegation in the Administrative Complaint were read literally, then it is at odds with the facts established at the hearing. The Q15 suicide precautions and unpredictable behavior precautions ordered by Dr. Berry did in fact place G.K. under "continual close observation." G.K. was placed on a locked, secure unit, presumably isolated from any means of inflicting self-harm, and was subject to recorded checks every fifteen minutes.

85. More accurately stated, Petitioner's allegation is that the Q15 suicide precautions and unpredictable behavior precautions ordered by Dr. Berry were insufficient, and that G.K. should have been placed on line-of-sight or one-to-one precautions.

86. In his written opinion, Dr. Rosenthal stated that G.K. should have been under "continual close observation and/or in a

'suicide-proof room.'" This opinion was based on "the seriousness and persistence of his suicidal thinking." Dr. Rosenthal wrote that the "brief contact" between Dr. Berry and G.K. on the morning of February 22, 1996, made Dr. Berry "too quick to feel secure" in reducing the suicide precautions.

87. At the final hearing, Dr. Rosenthal elaborated at length on his written opinion. At the outset, he conceded that it is not the standard of care to have a "suicide-proof" room in a hospital, and denied any wish to make an issue of the failure to utilize such a room. On this point, Dr. Cheshire wrote that in thirty years of practice, he had never seen such a room in a hospital.

88. Dr. Rosenthal discussed the various statements made by G.K. as recorded by Medfield staff, and concluded that the Q15 suicide precautions ordered by Dr. Berry were insufficient and below the standard of care. His rationale was as follows:

> This man's suicidal thinking was so consistently expressed through a series of interdisciplinary note entries, from the night he came into the hospital, the next day, into the second morning of his being here with the date of his death, that he had severe depression and such repetitive reference in terms of wanting to die, that I would see this man as obsessing about death and the wish.
>
> This being the case, to observe him every 15 minutes was not sufficient. To look in on him every 15 minutes, as such, to make sure he was okay was not sufficient because between 15 minute checks, there was approximately a 14 minute interval where he was unobserved, this man who was obsessing about suicide and death.
>
> * * *
>
> I realize that if he's in a group session, for example, he's presumably in the presence of somebody for at least 15 minutes for that group session, for example. But throughout a 24-hour day, I would think that there, obviously, would be times when he was not involved in some activity and, thus, under observation because of the activity. When he's sleeping at night,

> or supposed to be sleeping at night, every 15 minutes is not adequate.... I grant that he didn't kill himself during the night, but I'm talking about the principle here, the severity of suicidal risk. Severe. Most severe.

89. Dr. Rosenthal testified that he would have placed G.K. under one-to-one suicide precautions, or at least in the line of sight of a staff person at all times. He also offered the opinion that electric shock therapy should have at least been considered, given G.K.'s history of failure to respond to a plethora of medications.

90. Dr. Rosenthal acknowledged the requirement of Section 394.459(2)(b), Florida Statutes, that a psychiatric patient receive "the least restrictive appropriate available treatment," but testified that what is "appropriate" depends on the condition of the individual patient, and that this was a situation in which it would have been appropriate "to step in protectively to impose a highly restricted situation."

91. Dr. Rosenthal agreed with the general distinction discussed above between suicidal ideation and a definite or active plan to commit suicide. However, he testified that a patient's stating a "plan" that is not immediately workable may still call for heightened precautions in light of the entire case presented by that patient. For example, a patient may tell the nurse or therapist that he keeps thinking about buying a gun and shooting himself. Plainly, he cannot accomplish this "plan" in the hospital. Dr. Rosenthal testified that these statements must nevertheless be taken seriously as they contribute to the "flavor" of the patient's obsessiveness about death and wanting to die.

92. In contrast, Dr. Cheshire concluded:

> From my review of the medical record it appears that Dr. Carlos Berry practiced within acceptable standard of care guidelines and conducted his treatment of this patient in a manner that would be considered prudent by any similar physician under similar circumstances and conditions. Dr. Berry had a relationship with this patient of several year's [sic] duration and appears to have made his decisions regarding the patient's care with a clear understanding of the patient's history and psychiatric condition. I could find no error in judgment or action on the part of Dr. Carlos Berry that in any way contributed to the asphyxiation death by hanging of patient G.K.

93. Dr. Cheshire concluded that, if fault were to be found with anyone other than G.K. himself, that fault must be placed on the hospital for, among other things, failing to provide a safe and secure environment for the treatment of the patient. Dr. Cheshire specifically mentioned the failure of hospital staff to follow standard contraband procedures and the assignment of hospital personnel simultaneously to provide group therapeutic services and to observe at risk patients as contributing causes in the suicide of G.K.

94. Dr. Cheshire strenuously disagreed with Dr. Rosenthal on the question of G.K.'s statements to Medfield staff and the conclusions to be drawn therefrom. Dr. Cheshire noted that the only suicide plan ever mentioned by G.K. during his stay was that he would buy a gun and shoot himself, that he had been admitted after taking an overdose of pills and alcohol, and that these routes for suicide were precluded by his admission to a locked psychiatric unit.

95. Dr. Cheshire noted that suicidal statements such as those made by G.K. are extremely common: "[P]eople say, 'I'm going to

kill myself. I wish I were dead. I can't stand this any longer. You kids are driving me crazy. You'll be sorry when I'm gone,' and all of these things. People think about death. But that doesn't mean they're going to do it."

96. As found above, it would be practically impossible to institute one-to-one suicide precautions for every patient who merely makes such statements without giving some overt indication of a present intent to carry out the suicide.

97. In Dr. Cheshire's opinion, G.K. could not be considered a person with an active suicide plan. Rather, G.K. was a person whose suicidal ideation began in the fourth grade and continued up until he met with Dr. Berry on February 22, 1996. Dr. Berry was familiar with G.K.'s sarcastic method of discourse, his perpetual thoughts of suicide, the nonlethal gestures G.K. had made over the years, and the course of G.K.'s inpatient admission in 1994 under his care, and Dr. Berry properly placed G.K.'s statements in that context.

98. Dr. Cheshire noted that G.K. "wasn't planning suicide whenever he talked with Dr. Berry, unless he was lying to Dr. Berry."

99. At the hearing, Dr. Cheshire testified that a patient is placed in one-to-one precautions when the patient is out of control, unable to control his impulses such that he is dangerous to himself or other people. He testified that a patient such as G.K., who in his opinion was severely depressed but had no suicide plan, was not an appropriate candidate for one-to-one precautions.

100. Dr. Cheshire did not minimize the severity of G.K.'s condition. He agreed that G.K. was very disturbed, very depressed,

with poor insight and minimal judgment, adding that in his opinion G.K. had poor insight and minimal judgment for over twenty years: "He's never had good insight or good judgment, and he's been sick all his life."

101. Dr. Cheshire agreed with Dr. Berry's judgment that a patient displaying G.K.'s symptoms and personality must be given some hope. Dr. Berry discussed changing his medication and talked about positive things. G.K.'s admitting to the fact that he had been doing alcohol and drugs and agreeing to try the new medication were positive steps, and Dr. Berry was correct to identify them as such.

102. Dr. Sprehe agreed with Dr. Cheshire that one-to-one observation is called for when there is evidence a patient is "imminently suicidal," which he defined as a patient stating he will kill himself if given the chance, or showing he has made plans or "devious manipulations" to line up equipment to kill himself, or doing things such as making out a will or giving away personal items. Dr. Sprehe saw no such indications in G.K.'s record.

103. Dr. Sprehe acknowledged G.K.'s history of severe depression and his several suicide attempts, but did not agree these factors made G.K. such a risk as to warrant one-to-one precautions: "The least restrictive alternative mandate is still in effect, and you don't keep people locked up and eye-balled one-to-one all their life [sic] because they did one or two things in the course of their life." Dr. Sprehe agreed that "close observation" is called for at times with such patients, but he defined the term as fifteen minute checks, similar to the Q15 precautions actually ordered by Dr. Berry.

104. Both Dr. Cheshire and Dr. Sprehe stated that it might have been proper to order one-to-one precautions during the first hour or two of G.K.'s admission, given the frenetic events leading up to it. Interestingly, Dr. Rosenthal opined that the first hour or two of G.K.'s admission was the only time that he would not necessarily have ordered precautions more restrictive than Q15.

105. Dr. Sprehe testified that suicide is a sudden impulse, and that the impulses "all have to do with sudden insults to their personal integrity, whether it's a boss tells them that they're doing terrible in work, or whether someone in group therapy that says, why don't you kill yourself and do the world a favor.... A lot of different things can happen to make a sudden impulse. And that explains why it can happen suddenly on a psychiatric ward with people supposedly watching him."

106. Dr. Cheshire made essentially the same point: "You cannot predict suicide. All the books tell you that you can't predict it. You can just hope that you're right."

107. The weight of the expert testimony establishes that Dr. Berry did practice with an acceptable level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

108. The more restrictive environment recommended by Dr. Rosenthal might have been acceptable. However, the fact that two physicians arrive at different determinations as to the course of treatment for a patient does not necessarily mean that either physician has deviated from the standard of care, as Dr. Rosenthal himself testified.

109. Dr. Berry cannot be deemed responsible for events over which he had no control and of which he had no knowledge. He could not have predicted that hospital staff would allow G.K. to have contraband, and he did not in fact know that G.K. had it. Dr. Berry was not told about the incident in group therapy on the morning of February 22, 1996. It was the unfortunate conjunction of these two events, not anything Dr. Berry did or failed to do, that provided G.K. with the impulse and the means to end his life.

CONCLUSIONS OF LAW

110. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this cause, pursuant to Sections 120.569, 120.57(1), and 455.225, Florida Statutes.

111. License revocation and discipline proceedings are penal in nature. The burden of proof on Petitioner in this proceeding was to demonstrate the truthfulness of the allegations in the Complaint by clear and convincing evidence. Section 458.331(3), Florida Statutes; Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Dept. of Banking and Finance v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996).

112. The "clear and convincing" standard requires:

> that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983). The findings in this case were made based on the Ferris standard.

113. Pursuant to Section 458.331(2), Florida Statutes, the Board of Medicine is authorized to revoke, suspend or otherwise discipline the license of a physician for violating the following relevant provision of Section 458.331, Florida Statutes:

> (1)(t) 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.... As used in this paragraph, "gross 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," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

114. The single count of the Administrative Complaint alleged that Respondent failed to perform the following acts that a reasonably prudent physician in a similar situation would have done: place Patient G.K. under continual close observation; order consultations and staff conferencing; and perform a mental status evaluation on Patient G.K. at the time of Patient G.K.'s admission.

115. Petitioner failed to establish the allegations by clear and convincing evidence.

116. The expert testimony was unanimous that Dr. Berry operated within the standard of care in having an ARNP perform the mental status evaluation, then checking her work within 24 hours.

117. Only Dr. Rosenthal opined that Dr. Berry should have ordered further consultations and conferences, and even he agreed

that such would not have been necessary if Dr. Berry in fact met with the nurses and other staff and was fully apprised of G.K.'s status and condition. The facts established that Dr. Berry had such meetings and was fully conversant with the facts of G.K.'s case.

118. Only Dr. Rosenthal opined that Dr. Berry should have placed G.K. in one-to-one or other more restrictive precautions. There is substantial competent evidence, consisting of both the facts of Dr. Berry's course of treatment and the opinions offered by Dr. Cheshire and Dr. Sprehe, that Dr. Berry provided that degree of care which conforms to the prevailing standard of care as required by Section 458.331(1)(t), Florida Statutes, and therefore committed no violation.

119. Properly applied, the Q15 suicide and unpredictable behavior precautions ordered by Dr. Berry would have been sufficient to protect G.K. from himself. Dr. Berry could not personally control the hospital staff's application of those precautions at every hour of the day. It was the faulty application of the precautions that made it possible for G.K. to end his own life.

RECOMMENDATION

Upon the foregoing findings of fact and conclusions of law, it is recommended that the Department of Health, Board of Medicine, enter a Final Order dismissing the December 16, 1997, Administrative Complaint against the Respondent, Carlos E. Berry, M.D.

DONE AND ENTERED this 5th day of March, 1999, in Tallahassee, Leon County, Florida.

Lawrence P. Stevenson

LAWRENCE P. STEVENSON
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 5th day of March, 1999.

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STATE OF FLORIDA
DEPARTMENT OF HEALTH

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Kelly J. Highsmith
DATE 3-22-99

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOAH CASE NO. 98-1260
DOH CASE NO. 96-17466

CARLOS E. BERRY, M.D.,

Respondent.
_______________________________/

PETITIONER'S EXCEPTIONS TO RECOMMENDED ORDER

COMES NOW the Department of Health, Petitioner, by and through its undersigned attorneys, and submits Exceptions to the Recommended Order, and states:

PRELIMINARY STATEMENT

In the matter before the Board, the Administrative Law Judge concluded that the Respondent practiced medicine with that degree of care which conforms to the prevailing standard of care as required by Section 458.331(1)(t), Florida Statutes and concluded that only the Petitioner's expert opined that suicide precautions more restrictive than 15-minute checks were needed. Because the facts of the case and the ALJ's own findings of facts contradict these conclusions, the Agency is compelled to file exceptions in this matter.

CONCLUSIONS OF LAW

1. Petitioner takes exception to paragraph 118 of the Recommended Order. The ALJ concluded "Only Dr. Rosenthal opined that Dr. Berry should have place G.K. in one-to-one or other more restrictive precautions." However, in paragraph 104 of the Recommended Order, the ALJ found that "Both Dr. Cheshire and Dr. Sprehe stated that it might have been proper to order one-to-one precautions during the first hour or two of G.K.'s admission, given the frenetic events leading up to it." Actually, Dr. Cheshire (Respondent's expert) testified in the following manner:

> Q. You could very well tell me that, but I'm persistent. Then on page 74 (of the doctor's prior deposition), I asked, from lines 2-4, question: "Doctor, I'm not talking about 15 minutes. I'm talking about line-of-sight suicide precautions. Do you think that was needed in this case?" And what was your answer?
> A. "He had that."
> Q. And then after that?
> A. "He needed that." That was when he was admitted.
> Q. Okay, so he did need that.
> A. Yes, and he had that. (Tr. 313).

Dr. Cheshire was incorrect in assuming that the patient had line-of-sight suicide precautions. The Respondent never ordered a higher level of suicide precautions than the Q15 or checks every 15 minutes. Dr. Sprehe indicated that the one-to-one was needed in the first hour or two to see how G.K. was doing and then it could be relaxed. (November 9, 1998 Tr. 19). The ALJ's conclusion that only Dr. Rosenthal opined that the Respondent should have placed G.K. in one-to-one or other more restrictive precautions is simply not consistent with the testimony and his own finding of fact.

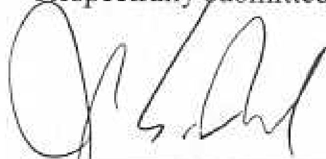
2. Petitioner takes exception to paragraph 119 of the Recommended Order. The ALJ concludes that "Properly applied, the Q15 suicide and unpredictable behavior precautions

ordered by Dr. Berry would have been sufficient to protect G.K. from himself." The ALJ then states that it was the faulty application of the precautions that made it possible for G.K. to end his own life. However, these conclusions are inconsistent with the ALJ's own findings of facts in paragraph 68 of the Recommended Order. The ALJ specifically found that Mr. Cline, the technician, continued to check on G.K. every 15 minutes as required by the unpredictable behavior precautions. The ALJ bolsters this finding with a reference to the Precautions Flow Sheet that indicated that G.K. was checked at 10:00 a.m. and 10:15 a.m. The patient committed suicide shortly before the next 15-minute check at 10:30 a.m. Despite these factual findings by the ALJ, he then concluded that "properly applied, the Q15 suicide and unpredictable behavior precautions ordered by Dr. Berry would have been sufficient to protect G.K. from himself." They clearly were not sufficient.

There is no evidence in the record that there was "faulty application" of the precautions by the staff. Rather, the evidence revealed that they continued to check on the patient every 15 minutes as required by Respondent's order concerning unpredictable behavior. At most, one nurse (Mr. Morello) stated that he failed to pick up the order to discontinue suicide precautions from the Respondent, however, he testified that the patient continued to be checked on every 15-minutes. Therefore, this nurse considered the patient to be under suicide precautions even after Respondent's order. There is no evidence in the record that staff failed to apply the 15-minute checks ordered by Respondent. The evidence simply indicates that these checks, as ordered by the Respondent, did not prevent the suicide.

WHERFORE, Petitioner would respectfully request that this Honorable Board grant Petitioner's exceptions in this case.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Mail to Jeanine H. Coris, at Weidner & Winicki, 11265 Alumni Way, Suite 201, Jacksonville, Florida 32246, this 22nd day of March, 1999.

John E. Terrel
Senior Attorney

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH, PETITIONER,	)	
v.	)	CASE NO. 96-17466
CARLOS EUGENIO BERRY, M.D., RESPONDENT.	)	

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Health, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Carlos Eugenio Berry, M.D., hereinafter referred to as "Respondent," and alleges:

1. Effective July 1, 1997, Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes (Supp. 1996); Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes. Pursuant to the provisions of Section 20.43(3)(f), Florida Statutes, the Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate.

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 0056010. Respondent's last known address is 636 Turner Street, Clearwater, Florida 33615.

3. On or about February 20, 1996, Patient G.K., a thirty-two (32) year old male, was admitted to a hospital after attempting suicide at home about four (4) days earlier. Patient G.K. had a history of mental illness dating back to the fourth grade when he tried to hang himself. Patient G.K. was admitted to a hospital in or about May 1994, in or about August 1994, in or about August 1994, and in or about September 1995 for treatment of severe depression accompanied by suicidal thinking. Respondent had been Patient G.K.'s treating psychiatrist for approximately four (4) years prior.

4. The admitting nurse during Patient G.K.'s February 20, 1996, admission, reported Patient G.K. as being depressed and having suicidal thoughts. Respondent's admission note for Patient G.K. indicated that Patient G.K. felt very sad, hopeless, and helpless, and that Patient G.K. felt no way to go on with his life; however, Respondent failed to perform a current mental status evaluation. Patient G.K. was placed on suicide watch.

5. From on or about February 20, 1996, through on or about February 21, 1996, Patient G.K.'s medical records indicate that he continued to experience depression and expressed anger about being alive. Patient G.K. admitted to having suicidal thoughts and plans during this period.

6. On or about February 22, 1996, Respondent's medical records of Patient G.K. indicate that Patient G.K. admitted to being suicidal, but was feeling safer at the hospital. Respondent's notes indicate a plan to prescribe Clorazil, a legend drug indicated for the management of severely ill schizophrenic patients who fail to respond adequately to standard

antipsychotic drug treatment. Respondent's medical records indicate that at approximately 8:15 in the morning, Respondent discontinued suicidal precautions due in part to the statement made by Patient G.K. that he felt safer at the hospital.

7. On or about February 22, 1996, at 10:15 in the morning, Patient G.K. was found in his bathroom where he had died from asphyxiation due to hanging.

8. A reasonably prudent physician in a similar situation would have placed Patient G.K. under continual close observation and/or in a room where attempted suicide would have been more difficult or impossible; ordered consultations and staff conferencing; and performed a current mental status evaluation on Patient G.K. at the time of Patient G.K.'s admission.

9. Respondent failed to place Patient G.K. under continual close observation; order consultations and staff conferencing; and failed to perform a mental status evaluation on Patient G.K. at the time of Patient G.K.'s admission.

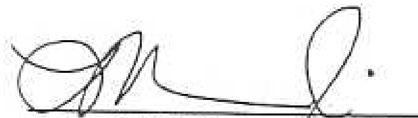
10. Based on the foregoing, Respondent violated Section 458.331 (1)(t), Florida Statutes, in that he failed to practice medicine with an acceptable level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an order imposing one or more of the following penalties: 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 455.624(3), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 16 day of December, 1997.

James T. Howell, M.D., Secretary



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PCP Members: Skinner, Leon

CLERK
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