STATE OF FLORIDA
BOARD OF MEDICINE

Final Order No. DOH-99-0332-FOF-MQA Date 3-31-99
FILED
Department of Health
Angela Hall, AGENCY CLERK
By: Ronda L Bryan
Deputy Agency Clerk

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOAH CASE NO.: 98-2036
DOH CASE NO.: 96-17481
LICENSE NO.: ME0066214

ASHOK M. PATEL, M.D.,

Respondent.

_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on February 6, 1999, in Jacksonville, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order (a copy of which is attached hereto as Exhibit A) in the above-styled cause. Petitioner was represented by Larry G. McPherson, Chief Attorney. Respondent was not present but was represented by A.S. Weekly, Jr., 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.

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 26th day of March, 1999.

BOARD OF MEDICINE

James Cerda

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 Ashok M. Patel, M.D., c/o A.S. Weekly, Jr., Esquire, Holland & Knight, 520 Vonderburg Drive, Suite 3005, Brandon, Florida 33511; to Richard A. Hixson, 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.

_____

AMENDED CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Order has been provided by certified mail to Ashok M. Patel, M.D., 13724 – 74th Avenue North, Seminole, FL 33776, A.S. Weekly, Jr., Esquire, Holland & Knight, 520 Vonderburg, Drive, Suite 3005, Brandon, FL 33511, Richard A. Hixson, and interoffice delivery to Larry McPherson, Jr., Chief Attorney, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, at or before 5:00 p.m., this _____ day of _____, 1999.

_____

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. ASHOK M. PATEL, M.D., Respondent.	)	Case No. 98-2036

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on August 19-21, 1998, in Tampa, Florida, before Richard A. Hixson, a duly designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Kristina Sutter, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Post Office Box 14229
Tallahassee, Florida 32317

For Respondent: A. S. Weekley, Jr., M.D., Esquire
Holland & Knight
520 Vonderburg Drive, Suite 3005
Brandon, Florida 33511

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 in not immediately admitting patient J.R. to an intensive in-patient

care facility; 2) Respondent's failure to justify his failure to admit patient J.R. to an intensive in-patient care facility; and 3) Respondent's failure to maintain records which state why patient J.R. was not admitted to an intensive in-patient care facility.

PRELIMINARY STATEMENT

This case arises from the suicide of J.R., a patient of Respondent, Ashok M. Patel, M.D., a practicing psychiatrist whom J.R. saw for one appointment on July 31, 1996.

On February 3, 1998, Petitioner, Department of Health, filed a three-count Administrative Complaint alleging that Respondent, Ashok M. Patel, M.D., committed the following violations: 1) a violation of Section 458.331(1)(t), Florida Statutes, by 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 through Respondent's failure to refer Patient J.R. for intensive in-patient care immediately; 2) a violation of Section 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of J.R. as an out-patient; and 3) violation of Section 458.331(1)(x), Florida Statutes, by violating a rule of the Board of Medicine, specifically Rule 64B8-9.003(2), Florida Administrative Code, failure to maintain records which state why Patient J.R. was not admitted to intensive in-patient treatment.

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 May 1, 1998. Pursuant to the Prehearing Order, the parties filed a prehearing stipulation on August 13, 1998. Formal hearing was conducted on August 19-21, 1998. At the conclusion of the formal hearing the record was left open pending resolution of Respondent's submission of additional expert testimony. On September 28, 1998, Respondent submitted the videotaped deposition of Daniel Sprehe, M.D., without objection.

At hearing, Petitioner presented the testimony of five witnesses: Rosalie Mackay, Medical Records Director of Psychiatric Behavioral Systems; John Llauget, licensed mental health counselor; Mrs. P.R., widow of Patient J.R.; Maurice Lelii, licensed mental health counselor; and Martin Rosenthal, M.D., qualified as an expert witness in the field of psychiatry. Petitioner also presented 15 exhibits which were received in evidence.

At hearing Respondent presented the testimony of 2 witnesses: Arturo G. Gonzalez, M.D., qualified as an expert witness in the field of psychiatry; and Respondent, Ashok M. Patel, M.D. Respondent presented 15 exhibits, 10 of which were received in evidence. Respondent's Exhibit 1 was not offered into evidence, Petitioner's objection to Respondent's Exhibit 4 was sustained, and ruling on Petitioner's objections to Respondent's Exhibits 8, 10, and 12 was reserved. Having

reviewed the submission of the parties, Petitioner's objections are overruled and Respondent's Exhibits 8 and 10 are received over objection. Petitioner's objection to composite Exhibit 12 as irrelevant is sustained.

On September 21, 1998, a transcript of the hearing was filed. Pursuant to Respondent's Motion for Enlargement of Time filed September 28, 1998, the parties were granted without objection additional time in which to file Proposed Recommended Orders. On November 16, 1998, the parties filed Proposed Recommended Orders. Additionally, Respondent filed a Motion to Exclude Irrelevant Material. Having reviewed the motion, and finding that the material meets the evidentiary standards of Section 120.58, Florida Statutes, Respondent's motion is denied.

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, Ashok M. Patel, M.D., is and at all material times was, a physician licensed to practice medicine in Florida, having been issued license number ME 0066214. Respondent practices psychiatry in Largo, Florida. Respondent is board certified in psychiatry.

3. On July 31, 1996, Patient J.R. was referred for an appointment to Respondent by Professional Psychological Services (hereinafter PPS), a mental health care provider with which

Respondent was contractually affiliated. At this time J.R. was a 44-year-old white male who was employed as a paramedic, and later as a firefighter for the City of Clearwater. J.R. had worked in this capacity for over 19 years. J.R. was happily married to P.R. for more than 11 years. The couple had no children.

4. In the weeks preceding his appointment with Respondent, J.R. was experiencing severe depression. The primary basis of J.R.'s depression was chronic health problems. J.R. had a history of back problems which began in 1980. He had back surgery in 1989, and suffered from psoriatic arthritis in his back which adversely affected his ability to function effectively as a paramedic and later as a firefighter. In July of 1996, J.R. had the job of driver of the firetruck.

5. In July of 1996, J.R. was under the care of his primary physician Dr. Mark Smitherman, as well as a rheumatolgist, Dr. Adam Rosen, who prescribed medicine for J.R.'s chronic pain.

6. On July 22, 1996, during an appointment with Dr. Smitherman, J.R. expressed his feelings of depression. Dr. Smitherman suggested that J.R. contact PPS, the psychological services provider of J.R.'s employment insurance plan. An appointment with PPS was thereafter scheduled for July 31, 1996. J.R. also had previously expressed his feelings of depression to Dr. Rosen who had prescribed Serzone, an anti-depressant for J.R.

7. J.R. went to work at the firehouse on Monday, July 29, 1996. At some time during the evening while the other firefighters were asleep, J.R. removed a defibrillator from the

firetruck, went to a private room, and used the defibrillator on himself in an unsuccessful attempt to commit suicide.

8. The following morning of Tuesday, July 30, 1996, J.R. returned home at approximately 8:00 a.m., and telephoned his wife, P.R., who was already at work. J.R. informed his wife of his suicide attempt. P.R. immediately went home and called PPS, explained the circumstances, and requested an earlier appointment. Arrangements were made with PPS to reschedule J.R. from his existing appointment on Wednesday, July 31, 1996, to an appointment July 30, 1996, at 7:00 p.m. Later that day, the appointment was moved up to 5:00 p.m.

9. When J.R. and his wife arrived at PPS they met with Betti Pate, a licensed mental health counselor employed by PPS. During the course of her evaluation, Betti Pate noted that J.R. was severely depressed with a suicide attempt within the previous 24 hours. Ms. Pate in her care plan for J.R. identified three problems, depression, fear of being left alone, and suicidal ideation. Under intervention, she noted, "prevent suicide, daily observation." Betti Pate's note to her supervisor stated that J.R. was fearful, very depressed and negative. She also noted that J.R. was "afraid he'll try again if alone."

10. After Betti Pate's evaluation on July 30, 1996, her supervisors at PPS recommended that J.R. enter a Partial Hospitalization Program (PHP) at Charter Behavioral Health System of Medfield Hospital (Charter). The PHP at Charter was a mental health counseling program which was conducted during the day at

the hospital. The primary focus of the Charter PHP was mental health therapy provided in group settings with licensed mental health counselors. The care plan for J.R. was to provide partial hospitalization at Charter during the day while his wife was at work. J.R. would then return home to his wife in the evening. Under this arrangement J.R. would not be alone for extended periods of time.

11. Admission to the PHP at Charter required the concurrence of an admitting psychiatrist. Because the other psychiatrists employed by PPS were unavailable, an appointment was made for J.R. to be evaluated by Respondent who, although in private practice, had an affiliate agreement with PPS to render mental health services to referred patients. PPS made an appointment for J.R. to see Respondent on Wednesday, July 31, 1996, at 4:00 p.m. It was common and usual practice for PPS to refer patients to Respondent for evaluation prior to admission to PHP, as well as for evaluation of a patient's medications.

12. J.R. went alone to his appointment with Respondent. Prior to seeing Respondent, J.R. completed a patient information document. J.R. described his reason for visit as "mental health & coping problem." He circled the following problems which pertained to him: nervousness, anxiety, insomnia, stress, headaches, overwhelmed, obsessive thoughts, compulsive behavior, depression, loneliness, fears, suicidal thoughts, concentration, appetite changes, helpless/hopeless, low energy, sexual problems, impulsive behavior, medical problems, and physical pain. J.R.

listed the medications he was taking as Serzone 150 mg (10 day), Lortab 7.5/500, Robaxin 750 mg. J.R. indicated that he had not received prior psychiatric treatment.

13. After completion of the patient information document, J.R. was seen by Respondent. Respondent observed that J.R. was casually dressed and not dishelveled, was articulate, made eye contact, was appropriately aware of time and place, and able to communicate effectively. Respondent asked J.R. the nature of the problem that had brought J.R. to him. Respondent then conducted a medical history, a family history, and a history of the problems leading to the visit to Respondent. In the course of his evaluation of J.R., Respondent completed a clinical assessment form which included a DSMIV diagnosis.

14. According to Respondent's records J.R. stated as "chief complaint" that "I was referred by PPS." In history of present illness, Respondent notes that: "Patient is 44 year-old white male came in complaining of chronic back pain, decreased sleep agitation, irritability." Patient says he is feeling depressed, says he tried to kill himself using defibrillator on Monday, but says it did not work. Patient had suicidal thoughts for 1-2 weeks, but feels guilty about doing it. Says it was stupid to hurt himself. Weight loss of 14 pounds in two and one-half months, decreased appetite. No SI(suicial ideation)/ No HI(homicidal ideation)/ No AH(auditory hallucinations)/ No VH(visual hallucinations)/ No PI(paranoid ideation) at present.

15. During the course of Respondent's evaluation, J.R. related that he had been seen at PPS on July 30, 1996, that he had an appointment to see Betti Pate the following day, and that arrangements were being made by PPS for him to begin PHP at Charter; however, Respondent did not have J.R.'s PPS evaluation nor Betti Pate's notes at the time of J.R.'s office visit. J.R. also related that he had a supportive wife, although Respondent did not have any personal contact with Mrs. J.R. at this time.

16. Respondent's evaluation of J.R. lasted over one hour. In his diagnosis Respondent determined that J.R. had major severe depression, and that J.R. presented a moderate suicide risk. In his recommendation/plan for J.R. Respondent's notes reflect the following: "Increased Serzone 100mg two Bid; continue out-patient counseling; start Xanax 0.25 mg. 1/2-1 tid prn.; follow up in 2 weeks; and, made aware of 24 hours availability." Respondent also advised rest for 2 weeks. At this time Respondent did not know when J.R. would begin PHP at Charter.

17. After leaving Respondent's office J.R. went home and expressed to his wife some difficulty in understanding Respondent who is a native of India. The next day Thursday, August 1, 1996, Mrs. J.R. contacted PPS to inquire about J.R. seeing a different psychiatrist. Neither J.R. nor Mrs. J.R. contacted Respondent, and PPS did not refer J.R. to another psychiatrist.

18. Because of J.R.'s use of the defibrillator, PPS requested medical clearance from J.R.'s primary care physician Dr. Smitherman prior to admission to PHP at Charter. On

Thursday, August 1, 1996, J.R. telephoned Dr. Smitherman and received medical clearance to begin PHP at Charter.

19. J.R. was scheduled to begin PHP at Charter on Monday August 5, 1996. J.R. received no mental health therapy or counseling from the time he left Respondent's office on Wednesday, July 31, 1996, until Monday, August 5, 1996, when he arrived at Charter. J.R. spent some of this time doing routine shopping, errands and going to the beach where he regularly exercised by swimming. J.R. and his wife also discussed future plans together.

20. On Monday, August 5, 1996, J.R. was admitted to PHP at Charter. At this time Charter telephoned Respondent for admission instructions for J.R., which Respondent as the attending physician gave for J.R. During the course of the day, J.R. attended group therapy sessions at Charter. The Charter records indicate that J.R. presented a flat appearance, and was not actively engaged in the therapy sessions.

21. The following day, Tuesday August 6, 1996, J.R. had a previously scheduled appointment with his rheumotolgist, Dr. Rosen. Because of this previously scheduled appointment J.R. was allowed to miss his therapy sessions at Charter on August 6, 1996, with the understanding that he would return and continue his therapy at Charter on Wednesday August 7, 1996.

22. On Tuesday, August 6, 1996, J.R. went to his appointment with Dr. Rosen. At some time after leaving Dr. Rosen's office J.R. returned home and committed suicide by

hanging himself in the garage where his wife found him later that day.

23. Respondent had no contact with J.R. subsequent to July 31, 1996.

24. Three expert witnesses in the field of psychiatry presented testimony in this matter: Dr. Martin Rosenthal; Dr. Arturo Gonzalez; and, Dr. Daniel Sprehe. All three expert witnesses concur that Respondent's diagnosis of J.R. was correct and met the appropriate standard of care. Moreover, all three expert witnesses agree that Respondent's prescribed medications for J.R. were correct and met the appropriate standard of care. While Drs. Gonzalez and Sprehe opined that Respondent's treatment plan for J.R. was appropriate, Dr. Rosenthal testified that Respondent's treatment of J.R. in "certain limited ways" did not meet the standard of care. Specifically, Dr. Rosenthal opined that even though J.R. was a moderate suicide risk, he would have hospitalized J.R.

25. The medical literature submitted as part of the record in this case is consistent in stating that suicide in an individual patient is not a predictable event. The factors that are considered by psychiatrists in evaluating the risk of suicide are subjective to the individual patient. In order to be of imminent risk, a patient must have suicidal intent, lethal means, and opportunity. All the experts in this case agree that Respondent made the proper diagnosis of J.R., which included a finding that when Respondent saw J.R., the patient had no

suicidal ideation. At the time J.R. was seen by Respondent the evidence shows not only did J.R. have no present suicidal ideation, but he also expressed regret over having made a suicide attempt, and specifically stated to Respondent that he felt stupid about trying to hurt himself. The expert evidence is supported by the medical literature, that under such circumstances the appropriate standard of care does not require immediate hospitalization.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding, pursuant to Chapter 120, Florida Statutes.

27. Pursuant to Chapter 458, Florida Statutes, the Department of Health is empowered to act against the medical license of a psychiatrist.

28. Disciplinary licensing proceedings are penal in nature. State ex rel. Vining v. Florida Real Estate Commission, 281 So. 2d 487 (Fla. 1973). Therefore, the Petitioner must prove the alleged violations by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 19871); Dept. of Banking and Finance v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996).

29. Clear and convincing evidence was described in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983):

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence 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 the firm belief of conviction, without hesitancy, as to the truth of the allegations sought to be established. Accord, Evans Packing v. Dept. of Agriculture at 116 f.n.5.

30. Agency action that depends upon finding of facts not supported by competent substantial evidence in the record must be set aside, even if the facts raise a suspicion of wrongdoing, speculation, surmise, and suspicion cannot form the basis of disciplinary action against a professional license. Tenbroeck v. Castor, 640 So. 2d 164, 167 (Fla. 1st DCA 1994).

31. The allegations in the present Administrative Complaint are narrowly drawn, and specifically charged Respondent with failure to meet the standard of care by not hospitalizing patient J.R. on July 31, 1997. The evidence is not clear and convincing that Patient J.R. who was appropriately diagnosed as moderate suicidal should have been hospitalized immediately by Respondent on July 31, 1997.

Count I

32. There is substantial competent evidence that the Respondent provided that degree of care which conforms to the prevailing standard of care as required by Section 458.331(1)(t), and therefore is not in violation.

33. In this instance, the evidence is not clear and convincing that Dr. Patel violated Section 458.331(t) by "failing to refer patient J.R. for intensive in-patient care immediately." Therefore, Count I should be dismissed.

Count II

34. There is substantial competent evidence that the Respondent provided that degree of care which conforms to the prevailing standard of care and documented such care as required by Section 458.331(1)(m), and therefore is not in violation.

35. Because the evidence is not clear and convincing that there was a need for Dr. Patel to immediately refer J.R. for intensive in-patient care, there was no showing that Dr. Patel violated Section 458.331(m) by "failing to justify his failure to refer patient J.R. for intensive in-patient care." Therefore, Count II should be dismissed.

Count III

36. There is substantial competent evidence that the Respondent provided that degree of care which conforms to the prevailing standard of care and documented such care as required by Rule 64B8-9.003(2), Florida Administrative Code, and therefore is not in violation of that Rule.

37. Because the evidence is not clear and convincing that Dr. Patel's medical record of patient J.R. did not meet the requirements of Rule 64B8-9.003(2), Florida Administrative Code, there was no showing that Dr. Patel violated Section 458.331(1)(x), Florida Statutes. Therefore, Count III should be dismissed.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a Final Order be entered dismissing the February 3, 1998, Administrative Complaint against the Respondent, Ashok M. Patel, M.D.

DONE AND ENTERED this 30th day of December, 1998, in Tallahassee, Leon County, Florida.

RICHARD A. HIXSON
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847

Filed with the Clerk of the
Division of Administrative Hearings
this _____ day of December, 1998.

COPIES FURNISHED:

Kristina Sutter, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Post Office Box 14229
Tallahassee, Florida 32317

A. S. Weekley, Jr., M.D., Esquire
Holland & Knight
520 Vonderburg Drive, Suite 3005
Brandon, Florida 33511

Angela T. Hall, Agency Clerk
Department of Health
2020 Capital Circle, Southeast
Bin A-02
Tallahassee, Florida 32399-1703

Dr. James Howell, Secretary
Department of Health
Bin A00
2020 Capital Circle, Southeast
Tallahassee, Florida 32399-1701

Pete Peterson, General Counsel
Department of Health
2020 Capital Circle, Southeast
Bin A-02
Tallahassee, Florida 32399-1703

Tanya Williams, Executive Director
Board of Medicine
Department of Health
Northwood Centre
1940 North Monroe Street
Tallahassee, Florida 32399-0750

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH, PETITIONER, v. ASHOK M. PATEL, M.D., RESPONDENT.	)	CASE NO. 96-17481

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 Ashok M. Patel, 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; Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes. Pursuant to the provisions of Section 20.43(3), 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 0066214. Respondent's last known address is 9048 Baywood Park Dr., Seminole, FL 34647.

3. Respondent specializes in Psychiatry and he is board certified.

4. Rule 64B8-9.003(2), Florida Administrative Code, states that a licensed physician shall maintain patient medical records in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken or why an apparently indicated course of treatment was not undertaken.

5. On or about July 30, 1996, Patient J.R., a forty-four (44) year old male, presented to a licensed mental health counselor with complaint of severe depression for approximately two to three weeks. Patient J.R. had attempted suicide that morning by electroshocking himself with CPR equipment. Patient J.R. stated that he feared being left alone because he thought he would try to kill himself again and requested to be admitted to the hospital. Patient J.R. had a family history of depression in Patient J.R.'s mother and sister. The licensed mental health counselor checked off moderate under the category of suicide risk. The counselor recommended outpatient therapy at Charter Hospital but was told that he had to be seen by a psychiatrist first.

6. On or about July 31, 1996, Patient J.R. presented to Respondent who documented that Patient J.R. tried suicide recently, feels helpless and hopeless, has severe depression, and has had suicidal thoughts for approximately one to two weeks. Respondent recommended that Patient J.R. go to outpatient therapy at Charter Hospital starting on or about August 5, 1996. Respondent did not refer Patient J.R. for intensive in-patient treatment, even though Patient J.R. requested to be admitted and feared that he would attempt suicide if left alone.

7. On or about August 5, 1996, Patient J.R. started the outpatient program at Charter but informed his wife that he needed to be in an in-patient program instead.

8. Later that day, on or about August 6, 1996, Patient J.R. committed suicide in his garage by hanging himself.

9. Respondent failed to appropriately treat Patient J.R. in that Respondent failed to refer Patient J.R. for intensive in-patient care immediately. A reasonably prudent similar physician under similar conditions and circumstances would not have proposed outpatient treatment to a suicidal patient such Patient J.R. and would have immediately referred such a patient for intensive in-patient care.

COUNT ONE

10. Petitioner realleges and incorporates paragraphs one (1) through nine (9), as if fully set forth herein this Count One.

11. Respondent is guilty of failing to refer Patient J.R. for intensive in-patient care immediately.

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

COUNT TWO

13. Petitioner realleges and incorporates paragraphs one (1) through nine (9) and paragraph eleven (11) as if fully set forth herein this Count Two.

14. Respondent is guilty of failing to justify his failure to refer Patient J.R. to intensive in-patient care.

15. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient.

COUNT THREE

16. Petitioner realleges and incorporates paragraphs one (1) through nine (9), eleven (11), and fourteen (14) as if fully set forth herein this Count Two.

17. Respondent is guilty of failing to maintain records which state why Patient J.R. was not admitted to intensive in-patient treatment.

18. Based on the foregoing, Respondent violated Section 458.331(1)(x), by violating any provision of this chapter, a rule of the board or department, or a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department by violating 64B8-9.003(2), Florida Administrative Code.

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 3 day of February, 1998.

James T. Howell, M.D., Secretary

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Reva Combs
DATE 2/3/98

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
Agency for Health Care Administration
P. O. Box 14229
Tallahassee, Florida 32317-4229
Florida Bar # 788643
RPC/cab
PCP: January 29, 1998
PCP Members: Skinner, Dauer, and Rodriguez