

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL
REGULATION,

Petitioner,

v.

Case No. 89-010063

HECTOR R. CORZO, M.D.,

Respondent.

ADMINISTRATIVE COMPLAINT

COMES NOW, the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner", and files this Administrative Complaint before the Board of Medicine against Hector R. Corzo, M.D., hereinafter referred to as "Respondent", and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes, Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0035773. Respondent's last known address is 11200 Seminole Boulevard, Suite 203, Largo, Florida 34648.

3. On or about February 10, 1989, Patient #1, a twenty (20) year old male, was involuntarily committed to a hospital after exhibiting impaired impulse control, physical hostility, religious preoccupation, and delusional thought processes.

4. Upon Patient #1's commitment, Patient #1 had no

previous history available, and was diagnosed by the initial treating physician as suffering from acute psychotic episode and schizophrenia.

5. The initial treating physician provided Patient #1 with psychiatric care and treatment from on or about February 15, 1989 to on or about February 17, 1989.

6. On or about February 18, 1989, Respondent took over the psychiatric care and treatment of Patient #1.

7. Respondent stated that Patient #1 responded well to medication and improved enough to where Patient #1's family could care for him.

8. On or about February 20, 1989, Respondent discharged Patient #1 and prescribed Kadol for Patient #1 with follow up care at a mental health center.

9. On or about February 23, 1989, Patient #1 committed suicide at his parent's home.

10. Respondent failed to appropriately assess Patient #1's condition at the time he took over care of Patient #1 in that Respondent failed to assess Patient #1's premorbid personality, precipitating stress, or psychosocial dynamics as per the admitting hospital's own admitting psychiatric history and evaluation form.

11. Respondent failed to appropriately assess the cause of Patient #1's sudden onset of psychosis in a young physically healthy adult who had no past history of emotional and behavioral problems.

12. Respondent failed to appropriately treat Patient #1 in his overall care of Patient #1 in that there was no

justification as to why Patient #1, with an acute psychotic illness who manifested impaired impulse control, physical hostility, religious preoccupation and delusional thought process, was not evaluated in depth for more than forty-eight (48) hours after his overt psychotic signs and symptoms were under control.

13. Respondent's discharge plan for Patient #1 of Kodal and follow up care at a mental health center did not reflect appropriate transition of care from hospital to home.

14. Respondent failed to adequately document how or why Patient #1's initial diagnosis of schizophrenia was ruled out and why he did not rule out suicide ideation.

15. Respondent failed to keep written medical records justifying the discharge of Patient #1.

COUNT ONE

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

17. The Respondent failed to practice medicine with that level of care, skill, and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances in that: Respondent failed to appropriately assess Patient #1's condition, failed to appropriately treat Patient #1 in his overall care of Patient #1, inappropriately discharged Patient #1, and failed to order an appropriate discharge plan for Patient #1.

18. Based upon the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, by gross or repeated

malpractice or the failure to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

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

20. The Respondent failed to keep written medical records justifying the course of treatment of the patient including, but not limited to the following: the Respondent failed to adequately document as to how or why Patient #1's initial diagnosis of schizophrenia was ruled out, and Respondent failed to keep written medical records justifying the discharge of Patient #1.


21. Based upon the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes, in that the Respondent failed to keep written medical records justifying the course of treatment of the patient, including, but not limited to patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered, and reports of consultations and hospitalizations.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the

Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 28 day of October, 1991.

George Stuart
Secretary

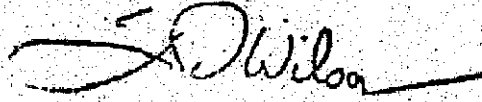

By: Larry G. McPherson, Jr.
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FILED

Department of Professional Regulation
AGENCY CLERK


CLERK _____
DATE 10-28-91

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION

BOARD: Medicine
CASE NUMBER: 89-10063
COMPLAINT MADE BY: P.S.
DATE COMPLAINT RECEIVED: 10-3-89
COMPLAINT MADE AGAINST: Hector Corzo, M.D.
11200 Seminole Blvd., Ste. 203
Largo, Florida 34648
REVIEWED BY: Francesca Plendl, Senior Attorney *FP*
STAFF RECOMMENDATION: Close (PL-82)

CLOSING ORDER AND NOTICE OF DISMISSAL

THE COMPLAINT: Complainant alleges that the Subject failed to practice medicine with an acceptable level of care, skill and treatment by failing to adequately evaluate and treat a psychiatric patient before releasing him from an emergency care facility; and that the Subject failed to maintain adequate medical records.

THE FACTS: On February 16, 1989, Patient P.S. was committed via Baker Act by St. Petersburg police to Pinellas Emergency Mental Health Service (P.E.M.H.S.) on a seventy-two hour admission. On the same day, Patient P.S. was evaluated by a physician, who diagnosed Patient P.S. as suffering from an acute psychotic reaction. The physician petitioned for an involuntary commitment, as the seventy-two hour admission was to expire over the weekend. The same physician saw Patient P.S. the following day and found him to be somewhat improved and responding to medication, but still experiencing psychiatric problems.

On February 18, 1989, the Subject took over Patient P.S.'s treatment. Patient P.S.'s family wanted the patient released as soon as possible, and the patient expressed a desire to start outpatient treatment with medication. On February 20, 1989, the Subject discharged the patient with a prescription for Haldol and an appointment for follow up care on February 24, 1989 at Mental Health Services. On February 23, 1989, Patient P.S. shot and killed himself at his parent's home.

The physician who initially treated Patient P.S. at the facility has reviewed the applicable records. He

states that in his opinion Patient P.S. had recovered at the time of discharge to the extent that discharge was appropriate.

Neville Marks, M.D., a Board certified psychiatrist, reviewed this case for the Department. He felt that the Subject fell below the standard of care, in that: (1) he failed to take an adequate history of the patient; (2) he failed to rule out suicidal ideation; (3) he failed to address the causation of the sudden onset psychosis; (4) he failed to rule out a diagnosis of major depression or bipolar disorder; and (5) the discharge plan did not reflect appropriate transition of care.

James B. Boorstin, M.D., a Board certified psychiatrist, also reviewed the matter for the Department. He states: "I believe that the subject and the Crisis Stabilization Unit adequately assessed the patient's conditions and complaints. This included appropriate laboratory testing... the patient was adequately prescribed anti-psychotic medications, stabilizing benzodiazepines and anti-Parkinson drugs while in the hospital... The written medical records prepared by the subject and staff are adequate for a Crisis Stabilization Unit of a community mental health center. This justified the course of the treatment of the patient, including history, examination and test results". Dr. Boorstin stated that it was not uncommon for a Social Worker to obtain a history from parents, when the patient is unable to give one. He concluded that "It is my reasonable, medical opinion that the subject did meet the applicable standards of care in his examination, diagnosis and treatment of the patient."

Two experts reviewed the case for the Subject. Daniel Sprehe, M.D., a Board certified psychiatrist, states that in his opinion the Subject did not fall below the standard of care. He states that there was no indication at any time during the patient's stay at P.E.M.H.S. that the patient was suicidal, and that there were no signs of psychosis at the time of discharge. In addition, the patient expressed a desire to obtain outpatient follow-up, and to take medication, expressing realistic plans for the future. The patient was indicating at the time of release that he understood that his beliefs on admission were delusional.

Dr. Sprehe opines that the Subject "...kept good clinical records justifying the course of treatment. He practiced well within the standard of care at all times, both in his diagnosis and his treatment and his decision making regarding discharge of [the patient]. I see no dereliction of duty in [the Subject's] actions in this matter." Dr. Sprehe states that under the Baker Act requirements, the least restrictive alternative must be utilized in dealing with patients, and that in this case, the appropriate course was outpatient treatment.

In response to Dr. Marks' concerns, Dr. Sprehe states that: (1) the lack of history was due to the patient's lack of cooperation; the social history that was obtained was adequate and it was within the standard of care for the Subject to rely on it; (2) suicidal ideation did not need to be specifically ruled out, as there were no presenting suicidal symptoms during the hospitalization; (3) as the cause of schizophrenia is unknown, the standard of care does not require that causation be addressed when treating a schizophrenic patient; (4) there is no documentation to support a diagnosis of bipolar disorder or major depression; and (5) there was an appropriate transition of care, in that the patient expressed interest in outpatient treatment and a follow up appointment was made.

Gisela Garcia-Leyva, M.D., a Board certified psychiatrist, also reviewed the case for the Subject. She states that in her opinion, the Subject did not fall below the standard of care in his treatment of the patient. She states that "The records, by the end of [the patient's] hospitalization, clearly show that the patient had improved remarkably and that the physician felt the patient had reached maximum benefits from hospitalization and there were no contraindication for his discharge".

Dr. Garcia-Leyva reviewed Dr. Marks' written opinion and responded to his concerns. She states that: (1) the standard of care does not require that all possible diagnoses be considered. The most probable diagnoses were addressed and that is all that is required; (2) the patient did not meet the criteria for involuntary hospitalization under the Baker Act.

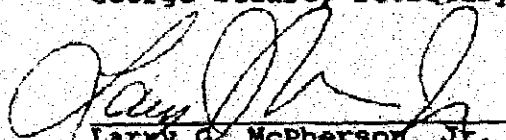
Dr. Garcia-Leyva states "It is my professional opinion that the records reflect positively all of the above and that the patient received an appropriate diagnosis, treatment and discharge date as indicated, all well within the applicable standard of care".

THE LAW: There is sufficient evidence for the panel to have found probable cause in this case. However, based upon the above facts, the Department has determined that there is insufficient evidence to support the prosecution of allegations contained therein. Therefore, pursuant to Section 455.225(2), Florida Statutes and Rule 21-31.00, Florida Administrative Code, this case is DISMISSED.

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

DONE and ORDERED this 16 day of April, 1993

George Stuart, Secretary



Larry G. McPherson, Jr.
Chief Medical Attorney