STATE OF FLORIDA
BOARD OF MEDICINE

Final Order No. DOH-00-1228-FO-MQA
FILED DATE - 7-13-00
Department of Health
By: Vicki R. Kenon
Deputy Agency Clerk

IN RE: THE PETITION
FOR DECLARATORY
STATEMENT OF
RAYMOND GABB, M.D.,
YOLANDA C. HERNANDEZ, M.D.,
EDUARDO INFANTE, M.D.,
and JAMES YELTON, M.D.
_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (hereinafter Board) pursuant to §120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code, on April 8, 2000, for the purpose of considering the Petition for Declaratory Statement (attached as Exhibit A) filed on behalf of Raymond Gabb, M.D., Yolanda C. Hernandez, M.D., Eduardo Infante, M.D., and James Yelton, M.D., (hereinafter Petitioners). Having consider the petition, documents and arguments filed by Petitioners and the Department of Children and Families (hereinafter DCAF), other correspondence and testimony, and being otherwise fully advised in the premises, the Board makes the following findings and conclusions.

FINDINGS OF FACT

1. The Petitioners, Raymond Gabb, M.D., Yolanda C. Hernandez, M.D., Eduardo Infante, M.D., and James Yelton, M.D., are all medical doctors licensed to practice medicine in Florida. They are all psychiatrists who are employed by the State of Florida Department of Children and Families at the North Florida Evaluation and Treatment Center (NFETC) in Gainesville, Florida.

2. The Petition sets forth the following facts, in pertinent part:

In July, 1999, the administrator of NFETC announced that the petitioning physicians would no longer have final clinical decision-making authority regarding the treatment of patients at the facility. Rather, a new "Shared Responsibility Treatment Model" would be adopted which would shift final decision-making authority to a team of health professionals including physicians, psychologists, and administrators. A copy of this new treatment model is attached hereto as Exhibit [B]. As set forth in this model, in cases which the treatment team cannot reach agreement on treatment, the matter will be referred to a panel or individual chosen by the administration whose decision will be final.

In September, 1999, the NFETC administration distributed a document entitled "Rationale for Determining Assignment of Leadership Responsibilities for Multidisciplinary Treatment Teams" which provided further details regarding how the shared decision-making model was to be implemented. A copy of this document is attached as Exhibit C.

3. At the hearing before the Rules Committee, Petitioners testified that even decisions such as allowance or deprivation of canteen privileges have such potential impact on the medical treatment of psychiatric patients as to constitute medical decisions.

4. At the hearing before the Probation Committee, the parties and DCAF representatives testified that the Health Coordinator referred to in the Matrix and in the proposal is not a physician.

5. Petitioners expressed to the Department and, through their Petition, to the Board their concerns that "lack of final decision-making authority regarding treatment of their patients would conflict with their professional obligations as established by the accepted standards of practice of psychiatry and the obligations imposed by state law, including Chapter 458, Florida Statutes (1999).

6. Specifically, Petitioner asked for the Board's interpretation of Sections 458.331(1)(g), (t), and (w), as applied to the treatment model proposed, insofar as the Board finds that a physician's agreement or acquiescence to the proposal might subject him or her to disciplinary action. Petitioners' concerns were as follows:

> As a result of the above described events, Petitioners are in doubt whether they would be subject to discipline pursuant to Section 458.331, Florida Statutes (1999), or any other state statute regulating physicians, if they followed the shared responsibility treatment model. In particular, Petitioners are concerned that they would be subject to civil liability as well as disciplinary action pursuant to Section 458.331, Florida Statutes (1999), should their professional medical opinion on the treatment of one of their patients be overruled by the multidisciplinary team and harm results to the patient which could have been avoided had the Petitioners' medical judgment been followed.
>
> In particular, but without limitation, Petitioners are in doubt whether they could be disciplined pursuant to Sections 458.331(2)(g), (t), or (w), as a result of complying with the shared treatment responsibility model as described in the proceeding paragraph.
>
> The Petitioners believe that the shared treatment responsibility model violates the ethical standards for psychiatrists set forth by the American Medical Association Council on Ethical and Judicial Affairs stating that "in relationships between psychiatrists and practicing licensing psychologists, the physician should not delegate to the psychologist, or in fact, to any non-medical person any matter requiring the exercise of professional medical judgment." The Principals of Medical Ethics,, 1998 edition, Section 4.

7. DCAF filed a memorandum of law in support of its proposed policy relying on Section 916.107(3)(a), F.S., as authorizing the policy.

8. This petition was noticed by the Board in Vol. 26, No. 2, dated January 14, 2000,

of the Florida Administrative Weekly (p. 159).

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code.

2. The Petition filed in this cause is in substantial compliance with the provisions of Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code, and Chapters 458 and 455, Florida Statutes.

3. Section 458.331, Florida Statutes, cited by Petitioners, provides, in pertinent part, that it is grounds for disciplinary action by the Board if licenses are:

> (g) Failing to perform any statutory or legal obligation placed upon a licensed physician.
>
> (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. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. 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.
>
> (w) Delegating professional responsibilities to a person when the

licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

4. The Board finds that reliance on the multidisciplinary team matrix, if agreed to or acquiesced to by the physicians, would constitute a breach of the standard of care as set forth in Section 458.331(1)(t), F.S., and would constitute improper delegation of professional responsibilities, as prohibited by Section 458.331(1)(w), F.S. Failure to perform any legal obligation is a violation of Section 458.331(1)(g), Florida Statutes. Although the Board supports the use of multidisciplinary teams in patient care, it finds that the Medical Practice Act requires the physician to make or concur with any final medical decision and be held accountable for the decisions made.

5. The provisions of Section 916.107(3)(a), Florida Statutes, are not generally applicable to the questions raised in the Petition. That statutory scheme applies to only the issue of providing treatment to patients in a forensic facility when the patients refuse to consent and DCAF petitions the circuit court to order the treatment the multidisciplinary treatment team deems necessary. That statute is a judicial issue and not one of relevance here.

6. This Final Order responds only to the specific facts set forth and specific questions set forth by the Petitioners in their Petition for Declaratory Statement. In this regard, the Board declines the invitation by Petitioners to identify "any other state statute" that may apply. By the statutory terms, a Declaratory Statement is limited to the facts presented and the laws or rules identified by the Petitioners. Section 120.565, F.S. Similarly, this Board has no authority to determine whether Petitioners may be civilly liable if they practice in conformance

with the matrix. Finally, this Board also has no authority to enforce the ethical standards for psychiatrists published by the AMA Council per se. It does, however, have the authority to interpret the "standard of care" for physicians as set forth in Section 458.331(1)(t), Florida Statutes, and does herein do so by finding that conformance with the proposed multidisciplinary team model would constitute "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." The conclusions of the Board are with regard to the specific statutory provisions addressed and should not be interpreted as commenting on whether the proposed facts may or may not violate other provisions of Chapter 458, Florida Statutes, or other related obligations placed on physicians in Florida.

WHEREFORE, the Board hereby finds that under the specific facts of the petition, as set forth above, the arrangement described by Petitioners is prohibited pursuant to 458.331(1)(g), (t), and (w), Florida Statutes.

DONE AND ORDERED this 23rd day of June, 2000.

BOARD OF MEDICINE

FOR Tanya Williams
GEORGES A. EL-BAHRI, 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 MAY BE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE CLERK OF THE DEPARTMENT OF HEALTH AND A SECOND COPY, ACCOMPANIED BY THE FILING FEES REQUIRED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES OR THE FIRST DISTRICT COURT OF APPEAL. THE NOTICE OF APPEAL MUST BE FILED AS SET FORTH ABOVE AND WITHIN THIRTY (30) DAYS OF RENDITION OF THIS FINAL ORDER.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. Mail to Thomas W. Brooks, Attorney for Petitioners, 2544 Blairstone Pines Drive, Post Office Box 1547, Tallahassee, Florida 32302, this 13th day of July, 2000.

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AMENDED CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Order has been provided by certified mail to Raymond Gabb, M.D., N. Florida Evaluation and Treatment Center, 1200 N.E. 55th Blvd., Gainesville, Florida 32641, Yolanda C. Hernandez, M.D., 2611 NW 29th Place, Gainesville, Florida 32605, Eduardo Infante, M.D., 2611 NW 29th Place, Gainesville, Florida 32605, James Yelton, 7709 NW 50th Street, Gainesville, Florida 32653, Thomas W. Brooks, Attorney for Petitioners, 2544 Blairstone Pines Drive, Post Office Box 1547, Tallahassee, Florida 32302 at or before 5:00 p.m., this 13th day of July, 2000.

Carmie Sanderlin

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION
FLORIDA BOARD OF MEDICINE

RAYMOND GABB, M.D., YOLANDA C. HERNANDEZ, M.D., EDUARDO INFANTE, M.D., and JAMES YELTON, M.D.,

Petitioners,
_____/

PETITION FOR DECLARATORY STATEMENT

The Petitioners, Raymond Gabb, M.D., Yolanda C. Hernandez, M.D., Eduardo Infante, M.D., and James Yelton, M.D., petition the Florida Board of Medicine for a declaratory statement pursuant to Section 120.565, Florida Statutes (1999), with regard to the following circumstances:

1. Petitioners are psychiatrists licensed to practice in the State of Florida pursuant to Chapter 458, Florida Statutes (1999), who are employed by the State of Florida Department of Children and Families at the North Florida Evaluation and Treatment Center (NFETC) in Gainesville, Florida.

2. In July, 1999, the administrator of NFETC announced that the petitioning physicians would no longer have final clinical decision-making authority regarding the treatment of patients at the facility. Rather, a new "Shared Responsibility Treatment Model" would be adopted which would shift final decision-making authority to a team of health professionals including physicians, psychologists, and administrators. A copy of this new treatment model is attached hereto as Exhibit A. As set forth in this model, in cases which the treatment team cannot reach agreement on treatment, the matter will be referred to a panel or individual chosen by the administration whose decision will be final.

3. Petitioners responded to the proposed shared responsibility model indicating their concerns that lack of final decision-making authority regarding treatment of their patients would conflict with their professional obligations as established by the accepted standards of practice of psychiatry and the obligations imposed by state law, including Chapter 458, Florida Statutes (1999). A copy of the Petitioners' response is attached as Exhibit B.

4. In September, 1999, the NFETC administration distributed a document entitled "Rationale for Determining Assignment of Leadership Responsibilities for Multidisciplinary Treatment Teams" which provided further details regarding how the shared decision-making model was to be implemented. A copy of this document is attached as Exhibit C.

5. As a result of the above described events, Petitioners are in doubt whether they would be subject to discipline pursuant to Section 458.331, Florida Statutes (1999), or any other state statute regulating physicians, if they followed the shared responsibility treatment model. In particular, Petitioners are concerned that they would be subject to civil liability as well as disciplinary action pursuant to Section 458.331, Florida Statutes (1999), should their professional medical opinion on the treatment of one of their patients be overruled by the multidisciplinary team and harm results to the patient which could have been avoided had the Petitioners' medical judgment been followed.

6. In particular, but without limitation, Petitioners are in doubt whether they could be disciplined pursuant to Sections 458.331(2)(g), (t), or (w), as a result of complying with the shared treatment responsibility model as described in the proceeding paragraph.

7. The Petitioners believe that the shared treatment responsibility model violates the ethical standards for psychiatrists set forth by the American Medical Association Council on Ethical and Judicial Affairs stating that "in relationships between psychiatrists and practicing licensed

psychologists, the physician should not delegate to the psychologist, or in fact, to any non-medical person any matter requiring the exercise of professional medical judgment." The Principals of Medical Ethics, 1998 edition, Section 4.

WHEREFORE, the Petitioners request that the Florida Board of Medicine issue a declaratory statement determining whether following the shared treatment responsibility model could subject them to civil liability or discipline pursuant to Section 458.311, Florida Statutes (1999), or any other state statute regulating physicians.

Respectfully submitted,

MEYER AND BROOKS, P.A.
2544 Blairstone Pines Drive
Post Office Box 1547
Tallahassee, Florida 32302
(850) 878-5212
(850) 656-6750 - Facsimile

By: _____
THOMAS W. BROOKS
Florida Bar No: 0191034

ATTORNEY FOR PETITIONERS

Attachment A

MDT FUNCTIONING

The Center expects the MDT members to practice within the scope of their individual professions and to collaboratively manage the bio psycho-social needs of the residents in accordance with the approved behavioral health care model to help insure the Center's mission is achieved.

MDT MEMBERS

PSYCHIATRIST/ARNP
PSYCHOLOGIST
COUNSELOR
HEALTH COORDINATOR

- The Center adopts an interdisciplinary model with which to conduct the evaluation and treatment of residents.
- The interdisciplinary model is actuated by the MDT.
- The MDT functions in a manner which:
  - + Capitalizes on professional expertise of members
  - + Strives for consensus
- Roles of MDT members will be articulated by each profession.
- In the admittedly rare instances where consensus cannot be achieved the decision will be referred to another Psychiatrist & Psychologist & Senior Human Services Counselor chosen by Administration (Don or his designee). Webster defines consensus as 1) group solidarity in sentiment and belief, 2. a) general agreement; 2. b.) collective opinion. The referring MDT will abide by the referee's decision.

RATIONALE

- There has been no documentation nor citations suggesting that the aforementioned model violates any statute, court decision, policy or standards of practice.
- This is consistent with how we direct other teams in that no position or discipline is superordinate.
- This is consistent with the Center's Vision
- Appellate court decisions in FLORIDA support the MDT functioning as indicated.

Response of NFETC Psychiatrists to proposed shared responsibility MDT Model (August 30, 1999)

In the meeting of MDT functions Committee of July 26, 1999, it was announced that the Psychiatrist was no longer the final decision-maker within a given team. The rationale for this decision was based upon our inability to provide any documentation, court decisions or citations suggesting that the proposed model violates any statute, policy or STANDARD OF PRACTICE of our profession (PSYCHIATRY).

Standards of practice of Psychiatry are well established and ours needs to conform to the standards of practice of the community, private and state facilities such as GPW and NEFSH(whose bylaws and operating manuals meet this standard of practice). (See attached). We are not able to accept the decision of any assigned referee, since we treat patients according to our clinical judgment. This judgment is based on our expertise, observations, assessments and the like from a well intentioned team.

We the physicians of NFETC are more than willing to articulate our role as Attendings within the accepted standard of practice of Psychiatry. We work as the chief clinician within a multidisciplinary team. We are responsible for the assessment and formulation of a diagnosis with implication for treatment and patient management. In our role as lead clinician we are responsive to the observation and assessments of other team members that may lead to revisions of diagnosis or treatment. We have the responsibility of coordinating the treatment of other consultants who are involved with a particular patient. Among our duties as lead clinicians within the team, we include:

1. Maintaining current diagnoses, performing psychiatric assessments as regularly required and any special evaluations(all types of competency, risk assessments, etc) that may be needed.
2. Ordering treatments, requesting testing, consultations, and restrictions as clinically indicated based upon the contributions of the team. Per our standard of practice these include, among others, the following:
    a. Medications
    b. Laboratory tests
    c. X-rays (including neuroimaging studies)
    d. EEG
    e. EKG
    f. Psychiatric consultations
    g. Diet and substance restrictions
    h. Homicidal and Suicidal precautions
    i. Seclusion/restraints
    j. Psychological evaluations and testing
    k. Medical consultations (i.e. Neurology, Endocrinology)

EXHIBIT
B

Attachment B

3. We provided the team with updates on the patients progress as it pertains to the following:
   a. Diagnosis
   b. Progress of patient under current drug regimen including need for special monitoring
   c. Rationale for any special orders and continuing need for these orders.

We are willing to provide and have been providing the above-mentioned services to the patients and treatment teams of NFETC. We strongly disagree with the proposed shared responsibility MDT Treatment model in its current form. We have exhaustively expressed that this proposal will change our standard of practice .

Our concerns have been belittled and ignored. We have been asked to provide court cases that show that Psychiatrists have incurred liability based on the proposed model. These court cases probably do not exist since this model is not the accepted standard practice for Mental Health treatment anywhere .

This proposed shared responsibility model violates our medical ethics as defined by the American Medical Association Counsel on Ethical and Judicial Affairs. In *The Principles of Medical Ethics, 1998 edition, prepared* by the AMA Counsel on Ethical and Judicial Affairs Subsection 4 states "In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment."

We strongly recommend that the currently proposed shared responsibility MDT model be changed to reflect the standard of practice and of care that is well established, not only in the community but in similar state facilities. This change would reflect the role of the Psychiatrist as lead clinician within the treatment team, and that rare impasses be resolved to the best of the attending physician's abilities. This request is not extraordinary but STANDARD PRACTICE.

Attachment C.

RATIONALE FOR DETERMINING ASSSIGNMENT OF LEADERSHIP RESPONSIBILITIES FOR MULTIDISCIPLINARY TREATMENT TEAMS

The Center believes in and is strongly committed to the use of teams in accomplishing our mission. The multidisciplinary treatment team is perhaps our best example of this commitment. The full benefit of the MDT approach is realized when there is healthy collegiality and collaboration among the members.

The quality of the decisions made by the team is the product of contributions from each discipline that offers qualified and unique information related to the case/resident. The dialogue in which the team members engage while sharing information and opinions strengthens the quality of the final decisions.

There are some decisions that have a heightened requirement for clarity and timeliness because necessary services and interventions cannot wait. While there is a measure of uncertainty in our practice, in certain instances, firm decisions, made in a timely manner, help provide the confidence necessary for services to be effective.

Accurate clinical documentation underlies all of our work. It is difficult to achieve a record that reflects all team deliberations and conclusions. Therefore we distinguish between matters of speculation, opinion and discussion from those matters on which decisions are made and documented. Speculation, discussion and opinion should be considered by the decision maker while significant collateral or contrary findings and consultative reports should be documented in summaries of the decision process.

Usually responsibilities associated with participation, decisiveness and accurate documentation fall to the role of leadership. Leadership is usually determined in one of several different ways based on the following factors:

1. Pre-existing hierarchy (ies) – one or more members of the team are subordinate to another member by virtue of organizational hierarchy.
2. Distribution of expertise (qualifications) – whether qualifications (education and/or experience) for decisions are evenly or unevenly distributed among members.

EXHIBIT

C

3. Responsibility for decisions -- whether responsibility for the decision, either defending it or taking actions as a result of it, is evenly or unevenly distributed among the members.

For our MDT's a pre-existing organizational hierarchy does not apply. No member is subordinate to another by virtue of the organizational hierarchy. For our teams, we find that qualifications are not evenly distributed. For certain clinical responsibilities, which rely on team involvement, one discipline may or may not be more qualified than others to make a decision. Likewise, responsibilities for certain team-involved decisions are not all equally shared by the team members.

In our opinion, and in view of the above discussion, we have selected a model for MDT functioning that is designed to maximize collaboration while accounting for the role of leadership in the context of evenly and unevenly distributed qualifications and responsibilities. Depending on the particular clinical responsibility the leadership roles are defined as follows:

F = Qualification/responsibility exceed others: final decision making authority after facilitation of discussion, solicitation of input and documentation of outcome.

L = Responsibility evenly distributed, qualification/workload confers leadership which is responsible to lead and facilitate a team decision (unanimous or consensus), facilitate discussion, solicit input, document outcome.

P = Preparation and participation in the discussion is expected and should provide input for documentation.

R = Participation is requested by the final decision maker.

* = Clinical responsibilities for which unanimity is needed for decisions.

The following matrix shows selected clinical responsibilities, which require some degree of team involvement and the distribution of leadership according to the above rationale.

CLINICAL RESPONSIBILITY MATRIX

L E A D E R S H I P

CLINICAL RESPONSIBILITY	PSYCHIATRY	PSYCHOLOGY	COUNSELOR	HEALTH COORDINATOR
1. Assessment of imminent dangerousness to others	F	R	R	F (COD)
2. Assessment of imminent dangerousness to self	F	R	R	F (COD)
3. Assessment of safety of medication therapy	F	R	R	R
4. * Assessment of competence to proceed	P	L	P	R
5. * Assessment of dangerousness for less restrictive (discharge)	L	P	P	R
6. * Determination of malingering	P	L	P	R
7. Determination of diagnosis-does rt. have a mental illness?	F	P	P	R
8. * Assessment of strengths and needs	P	P	L	P
9. Analysis and design of behavior management plan	R	F	P	R
10. Design of medication therapy plan	F	R	R	R
11. Design and delivery of learning modules	R	R	F	R
12. Immediate behavioral crisis intervention-verbal/physical	R	R	F	F (COD)
13. Medical issues affecting behavior	F	R	R	R
14. Intensive Intervention Start / Stop	F / P	P	P	F (COD) / P
15. Individual and group psychotherapy	P	F	R	R
16. Individual and group counseling	R	R	F	R
17. Competence to consent to medication treatment	F	R	R	R
18. Psychological testing	R	F	R	R
19. Status management	R	R	F	R
20. * Furloughs	P	P	L	P
21. Initial treatment plans	F	R	P	R
22. Social history assessment/development	R	R	F	R
23. Family contacts	R	R	F	R
24. Canteen privileges/restrictions	R	R	F	R
25. * Visitation/restrictions	P	P	L	P
26. Conditional release plan	P	P	F	P
27. Service/treatment plan	P	P	L	P
28. Competence for medical legal decisions	F	R	R	R
29. Competence for non-medical legal decisions	R	F	R	R
30. * Intra-facility transfers	P	L	P	P
31. LRD referral	P	P	L	P

* unanimity is needed for the decision

9/17/99