STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2010-19148**

MIGUEL ADAN DE LA GARZA, M.D.

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Miguel Adan de la Garza, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number ME 96073.

3. Respondent's address of record is 2044 Trinity Oaks Boulevard, Suite 220, Trinity, Florida 34655.

4. On or about June 25, 2010, Patient C.D., a 51 year-old female, presented to Respondent for radio frequency ablation treatment for lumbar spine pain.

5. Patient C.D. reported her pain to be aching pain in the lumbar area, with pain intensity ranging from two to eight on a scale of zero to ten, and a current pain intensity level of six.

6. On or about June 25, 2010, Respondent performed left lumbar radiofrequency ablation of dorsal primary ramus blocks at the L3, L4, L5, and S1 levels on Patient C.D.

7. On or about June 27, 2010, Patient C.D. called Respondent's office, and spoke with the on-call physician.

8. Patient C.D. told the on-call physician that she had pain and discomfort unlike her previous procedures.

9. On or about June 28, 2010, Patient C.D. stated that she collapsed on her job.

10. On or about June 29, 2010, Patient C.D. presented to Respondent's office.

11. There are two medical notes for the June 29, 2010, visit.

12. One of the medical notes for the June 29, 2010, visit states that Patient C.D. "almost passed out", provides no vital signs, and does not report that Respondent looked at the procedure site.

13. Respondent considered infection in his evaluation of Patient C.D. by ordering a complete blood count, complete metabolic panel, erythrocyte sedimentation rate (nonspecific test used to help detect conditions associated with acute and chronic inflammation, including infections, cancers, and autoimmune diseases.), and C-protein reactive (a protein found in the blood, the levels of which rise in response to inflammation) tests.

14. Respondent stated that Patient C.D. was to continue Lortab (a combination of acetaminophen and hydrocodone used to relieve moderate to severe pain), ordered a Medrol (a steroid that prevents the release of substances in the body that cause inflammation) dosepak.

15. Respondent ordered that Keflex (part of a group of drugs called cephalosporin antibiotics, which fights bacteria in the body) be started after blood work.

16. Respondent did not inform Patient C.D. when to begin her antibiotics.

17. On or about July 1, 2010, Dr. A.S. ordered blood work for Patient C.D.

18. The blood work revealed that Patient C.D.'s erythrocyte sedimentation rate and C-protein reactive level were elevated.

19. On or about July 8, 2010, Patient C.D. called Respondent's office, stating that she was having problems, it was an emergency and needed to speak with Respondent again.

20. There are two different notes for Patient C.D.'s call on July 8, 2010.

21. One of the notes for Patient C.D.'s July 8, 2010, call states that Skelaxin (Metaxalone--an oral drug that relaxes skeletal muscles that control movement of the body) was prescribed and an office visit was scheduled for the next day.

22. On or about July 9, 2010, Patient C.D. presented to Respondent complaining of pain at her injection site that went across her back.

23. Concerning Patient C.D.'s history, Patient C.D. did not report chills or fever, and there was no mention of antibiotics.

24. In the July 9, 2010, medical note, Respondent noted "Vitals", but aside from pain, none are noted.

25. Respondent did not document a temperature for Patient C.D. during the July 9, 2010, visit.

26. Concerning Patient C.D.'s blood work, Respondent noted that her C-protein reactive level was normal when it was actually elevated.

27. Respondent's physical examination of Patient C.D. revealed side bend to the left is decreased and with pain. The examination further revealed that rotation to the left is decreased, 20 degrees and with pain.

28. Respondent's physical examination of Patient C.D. further revealed severe tenderness at left L5, left S1, and the left SI joint.

29. Respondent's plan for Patient C.D. was to possibly discontinue Lortab, start her on Opana, have her liver function tested by her primary care providers, and to report to the emergency room if she had a change in mental status or fever greater than 101F.

30. Respondent did not reorder a follow up complete blood count, erythrocyte sedimentation rate test, and C-protein test for Patient C.D.

31. On or about July 21, 2010, Patient C.D. presented to the emergency department of Memorial Hospital in Tampa, Florida, with complaints of pain and swelling in her left buttock, with fever.

32. Patient C.D. was ultimately diagnosed with an abscess in her left paraspinal musculature and staphylococcus aureus—methicillin resistant.

COUNT I

33. Petitioner realleges and incorporates paragraphs one (1) through thirty-two (32) as if fully set forth herein.

34. Section 458.331(1)(t), Florida Statutes (2009), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50. Section 456.50, Florida Statutes (2009), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

35. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes (2009), defines the standard of care to mean " . . . The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. . . ."

36. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in one or more of the following ways:

a) By failing to aggressively pursue the cause of Patient C.D.'s pain at the procedure area after the June 25, 2010, left lumbar radiofrequency ablation; or

b) By failing to initiate the appropriate treatment plan when Patient C.D.'s erythrocyte sedimentation rate test and C-protein test results returned elevated; or

c) By failing to inform Patient C.D. to start her antibiotics after the June 29, 2010, visit to Respondent's office; or

d) By failing to order follow up complete blood count, erythrocyte sedimentation rate test, and C-protein test for Patient C.D.; or

e) By failing to document Patient C.D.'s temperatures in her medical records given that Respondent suspected infection.

37. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (2009), 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 II

38. Petitioner realleges and incorporates paragraphs one (1) through three (3), eleven (11), twenty (20), and twenty-four through twenty-six (24-26) as if fully set forth herein.

39. Section 458.331(1)(m), Florida Statutes (2009), provides that failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment

procedure and that justify 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, constitutes grounds for disciplinary action by the Board of Medicine.

40. Respondent failed to keep legible medical records justifying the course of treatment of Patient C.D. in one or more of the following ways:

a) By generating two medical notes for Patient C.D.'s June 29, 2010, office visit; or

b) By generating two medical notes for Patient C.D.'s July 8, 2010, office visit; or

c) By failing to document any vital signs for Patient C.D. aside from pain at her July 9, 2010, visit to Respondent's office; or

d) By failing to document a temperature for Patient C.D. during her July 9, 2010, visit to Respondent's office.

41. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2009), by failing to keep medical records which justify the course of the patient's treatment.

WHEREFORE, Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, corrective action, refund of fees billed or collected, remedial education, and/or any other relief that the Board deems appropriate.

SIGNED this 15th **day of** June, **2012.**

JOHN H. ARMSTRONG, MD
Surgeon General and Secretary of Health
Florida Department of Health

Elana J. Jones by [illegible]

ELANA J. JONES
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, FL 32399-3265
Florida Bar # 0078999
(850) 245-4640
(850) 245-4681 FAX

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EJJ
PCP: June 15, 2012
PCP Members: Avila, M.D., Zachariah, M.D..

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on Notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.