STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. MICHAEL BAUERSCHMIDT, M.D., Respondent.	)	Case No. 01-1937PL

RECOMMENDED ORDER

Administrative Law Judge ("ALJ") Daniel Manry conducted the administrative hearing of this proceeding on July 26, 2001, in Ft. Myers, Florida.

APPEARANCES

For Petitioner: Bruce A. Campbell, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: Bruce D. Lamb, Esquire
Ruden, McClosky, Smith, Schuster, and Russell, P.A.
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STATEMENT OF THE ISSUES

The issues for determination are whether Respondent violated Section 458.331(1)(m) and (t), Florida Statutes (2000), respectively, by failing to keep medical records that justify the course of treatment and 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. (All chapter and section references are to Florida Statutes (2000) unless otherwise stated.)

PRELIMINARY STATEMENT

On April 3, 2001, Petitioner filed an Administrative Complaint against Respondent. Respondent timely requested an administrative hearing.

At the hearing, Petitioner presented the testimony of one witness and submitted one exhibit for admission in evidence. Respondent testified in his own behalf, presented the testimony of one witness, and submitted two exhibits for admission in evidence. The parties submitted six joint exhibits for admission in evidence. The identity of the witnesses and exhibits and any attendant rulings are set forth in the Transcript of the hearing filed on August 23, 2001.

Petitioner timely submitted its Proposed Recommended Order ("PRO") on August 27, 2001. Respondent timely submitted his PRO on August 31, 2001. The Transcript was filed August 23, 2001.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for regulating the practice of medicine in Florida pursuant to Sections 20.165 and 20.43 and Chapters 455 and 458. Respondent

is licensed as a medical physician in Florida pursuant to license number ME0057198.

2. Respondent is board certified in emergency medicine and family medicine. The patient at issue is C.L. C.L. is a 65-year-old male with a long history of diabetes and foot problems.

3. On February 22, 1999, a physician at Lee Memorial Hospital ("Lee Memorial") performed a cystoscopy of the urethra on C.L. Lee Memorial discharged C.L. on the same day with a Foley catheter connected to a leg bag. Staff removed the catheter and leg bag on February 23, 1999.

4. C.L. returned to the Lee Memorial emergency room on February 25, 1999. C.L. presented with complaints of swelling in the left ankle, myalgia, cough, and nausea. C.L. indicated that the swelling in his left ankle had been present since the removal of the leg bag he wore after surgery for kidney stones, and that the swelling had not gone down as fast as he expected. The triage nurse noted in the admission notes that the left ankle was swollen, red, and warm to touch. The nurse also noted a scab on the left ankle.

5. Respondent was the emergency room physician at Lee Memorial who examined, diagnosed, and treated C.L. Respondent did not fail to provide adequate medical care to C.L. in violation of Section 458.331(1)(t).

6. Respondent obtained an adequate medical history from C.L. The medical history disclosed that C.L. has a long history of diabetes with neuropathy and skin ulcers. C.L. also suffers from hypertension and gastroparesis and is allergic to sulfa.

7. Respondent performed an adequate general examination of C.L. The general exam showed that C.L. was afebrile with stable vital signs. C.L.'s lungs were clear to auscultation. His heart rate and rhythm were regular. His abdomen was soft without localized tenderness, rebound, or guarding.

8. Respondent performed an adequate focused examination of C.L.'s lower extremities. Respondent checked pulses bilaterally, compared the lower extremities, palpated the swollen area, palpated for tenderness, and observed skin color and temperature.

9. Respondent ordered adequate laboratory tests for C.L. The test results showed a high glucose level but showed normal values of other tested items including white blood cell count ("WBC") and electrolytes.

10. Respondent diagnosed C.L. with viral syndrome and dependent peripheral edema. The diagnosis of viral syndrome was consistent with C.L.'s complaints of cough, nausea, and muscle aches. The diagnosis of dependent peripheral edema attributes the swelling of the lower extremity to venous insufficiency that interfered with return of blood from the swollen area to the

heart. However, such venous insufficiency is common in patients with a long history of diabetes.

11. Respondent correctly prescribed Phenergan for the nausea and recommended that C.L. rest, increase his fluids, elevate his leg, and follow up with his HMO physician. Respondent verbally instructed C.L. to call his doctor the next day for control of the diabetes.

12. Respondent did not violate Section 458.331(1)(t) by failing to conduct a range of motion examination on C.L. There was no history of trauma to the left lower extremity. Respondent did not observe any asymmetry in C.L.'s lower extremities, including redness and warmth. Respondent palpated the left ankle and found the presence of nonpitting edema.

13. Respondent examined C.L. approximately an hour and a half after the triage nurse observed that the left ankle was red and warm to touch. C.L. was ambulatory when he entered the emergency room and had been walking on the ankle for an undetermined period. After entering the emergency room, the triage nurse took C.L. off of his legs and elevated the left lower extremity. The dissipation of redness and warmth between the examinations by the triage nurse and Respondent is consistent with both the absence of trauma and the long history of diabetes.

14. The redness and scab observed by the triage nurse is consistent with the neuropathy and skin ulceration that accompanied C.L.'s long history of diabetes. Two podiatrists have treated C.L. since 1992 and have intermittently observed the symptoms in C.L.'s lower extremities.

15. Respondent did not observe a scab on the left lower extremity. Nor did Respondent observe any abnormal redness. The discrepancy between the observations by the triage nurse and by Respondent is attributable to Respondent's greater experience and familiarity of symptoms common to patients with a long history of diabetes. Patients with diabetes are one of the most common types of patients seen in emergency rooms. Respondent is board certified in both family and emergency medicine. He has more than 15 years' experience in emergency medicine. The triage nurse had only recently begun as a triage nurse and had previously worked as a labor and delivery nurse. The redness and scab observed by the triage nurse were abnormal in her experience but was normal neuropathy and ulceration for diabetes patients in Respondent's experience.

16. A physician with experience in treating diabetic patients expects to see edema of the legs and feet as well as skin changes, including inflammatory components. Redness and scabbed or abrasive areas are common to patients with a long history of diabetes.

17. Respondent did not violate Section 458.331(1)(t) by failing to conduct further tests to rule out cellulitis. Respondent properly ruled out cellulitis based on his clinical findings. Respondent did not observe any redness or warmth in the left lower extremity. If cellulitis were present in C.L., the redness and warmth observed by the triage nurse would not have dissipated in the period between her examination and that of Respondent. C.L.'s normal WBC was consistent with other clinical findings that cellulitis was not present.

18. Respondent did not violate Section 458.331(1)(t) by failing to conduct a sonogram, or ultra sound, to rule out deep vein thrombosis ("DVT"). Recent medical studies show that pain and swelling in the lower extremities are not associated with any significant medical risk for DVT. A risk for DVT would require a patient who presented with pain behind the knee or in the thigh and with a history of significant immobilization. C.L. did not present any clinical symptoms that justified a sonogram to rule out DVT.

19. C.L. did not present any of the major risk factors for DVT such as cancer, estrogen therapy, and prolonged immobilization after surgery. The same-day surgery on C.L. for kidney stones did not immobilize C.L.

20. Respondent's expert witness is board certified in internal medicine, emergency medicine, forensic medicine, and

quality assurance. He has served on the board of quality assurance in emergency medicine for approximately 20 years. If Respondent were to have ordered a sonogram in the absence of clinical findings, it would have constituted an over-utilization of diagnostic tests and would have been inappropriate under the circumstances.

21. Respondent did not violate Section 458.331(1)(t) by failing to order X-rays. There were no clinical findings to support X-rays. C.L.'s lungs were clear on examination. The absence of an elevated WBC, the absence of a fever, and the absence of any abnormal pulmonary function suggested that C.L. was not suffering from pneumonia, bronchitis, or congestive heart failure. There was no history of trauma to the left ankle, and X-rays would have shown only bony structure or fracture.

22. Respondent did not violate Section 458.331(1)(t) by failing to treat C.L. for his elevated glucose. The laboratory tests showed that C.L. had a glucose level of 317. A person without diabetes and a well-maintained diabetic may have a glucose level of 200.

23. When the body fails to utilize glucose appropriately a condition can develop that is known as diabetic ketoacidosis. The body then attempts to metabolize protein to create energy. This results in the production of acid which lowers the pH of

the body and causes electrolyte abnormalities. Diabetic ketoacidosis can result in cardiac arrhythmias and ultimately lead to death if left untreated.

24. There is no direct correlation between elevated blood sugar levels and diabetic ketoacidosis. C.L.'s electrolyte levels were normal. There was no low carbon dioxide level that would have suggested the presence of acidosis. The normal electrolyte results showed that C.L.'s high glucose level had been present for a number of weeks and was a chronic condition, rather than acute or emergency condition. It was appropriate for Respondent to refer C.L. to his primary physician for treatment of the elevated glucose.

25. Respondent verbally instructed C.L. to see his primary physician the next day. The written instructions given to C.L. upon discharge instructed C.L. to consult his primary physician within five to seven days. Both the verbal and written instructions were appropriate for a patient with a chronic elevated glucose.

26. Respondent did not violate Section 458.331(1)(t) by prescribing Phenergan for C.L. It was not medically prudent to assume that C.L. was already on a pain medication as a result of the previous surgery for kidney stones. The medical necessity for pain medication passed with the kidney stones, and the Foley catheter and bag are painless after insertion.

27. Respondent did not document in C.L.'s medical records several aspects of the medical history and examination of C.L. Respondent did not document that he checked pulses bilaterally, compared the lower legs, palpated for tenderness in the calf, and observed for skin color and temperature. Respondent did not document a diagnosis of high blood sugar, that the verbal recommendation to increase fluids was in recognition of high blood sugar, or that Respondent recommended that C.L. follow up the next day with the primary care physician. Respondent did not document the duration or nature of C.L.'s complaints of myalgia, cough, and nausea.

28. Respondent did not fail to maintain adequate medical records in violation of Section 458.331(1)(m). Respondent documents only positive, or abnormal, findings and does not document negative, or normal, findings. Respondent's practice is consistent with that of approximately "99 percent" of emergency room physicians. Proper record-keeping required Respondent to document that he observed the peripheral pulses and palpated the left ankle only if Respondent observed any negative findings.

29. The reference to the lower left extremity is an adequate documentation in the medical records. The lower left extremity refers to that portion of the leg from the knee down. The patient complained of swelling in the left ankle, and it is

implicit in the chart that the reference to the lower left extremity means the left ankle. If Respondent made any positive findings in any other area of the left lower extremity, he would have noted those positive findings on the chart.

30. The remaining omissions in the medical records are consistent with the standard applicable to emergency room physicians. Medical records for emergency medicine are characteristically less complete than the records of an office practice. In comparison to the structured environment of an office practice, the environment of a high-volume emergency room, such as that at Lee Memorial, is chaotic. The emergency room physician is constantly called from one problem to the next. As a general rule, approximately 10 percent of the emergency patients are critical, 25 percent are very ill, and fifty percent are fairly minor. There is less time for record-keeping in the emergency room than there is in a typical office practice. The medical records maintained by Respondent for C.L. are quite extensive for an emergency room environment.

31. The medical records maintained by Respondent for C.L. justified the diagnoses of viral syndrome and peripheral edema. The medical records also justified the course of treatment.

CONCLUSION OF LAW

32. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter. The

parties received adequate notice of the administrative hearing. Section 120.57(1).

33. The burden of proof is on Petitioner. Petitioner must show by clear and convincing evidence that Respondent committed the violations alleged in Administrative Complaint and the reasonableness of any proposed penalty. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996); State ex rel. Vining v. Florida Real Estate Commission, 281 So. 2d 487 (Fla. 1973); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987).

34. Petitioner did not satisfy its burden of proof. Disciplinary statutes such as Section 458.331(1)(m) and (t) are penal in nature and must be strictly interpreted against the authorization of discipline and in favor of the person sought to be penalized. Munch v. Department of Business and Professional Regulation, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); Fleischman v. Department of Business and Professional Regulation, 441 So. 2d 1121, 1123 (Fla. 3rd DCA 1983.); Lester v. Department of Professional and Occupational Regulations, State Board of Medical Examiners, 348 So. 2d 923 (Fla. 1st DCA 1977).

35. Petitioner must prove each element required in the statutory definition of the violation by clear and convincing evidence. In order for evidence to be clear and convincing:

> The evidence must be of such weight that it produces in the mind of the trier of fact a firm . . . conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 799 (Fla. 4th DCA 1983).

36. The evidence submitted by Petitioner was less than clear and convincing. It consisted of the testimony of an expert witness who was not present during the examination of C.L. The witness based her testimony concerning the allegation that Respondent failed to provide adequate care to C.L. on a review of the records.

37. The testimony of all three of the witnesses at the hearing was credible and persuasive. However, the burden of proof is on Petitioner. Petitioner must satisfy its burden with clear and convincing evidence. The difference of opinion between equally credible and persuasive experts did not leave the trier of fact a firm conviction, without hesitancy, of the truth of the allegations Petitioner had the burden of proving.

RECOMMENDATION

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

RECOMMENDED that Petitioner enter a Final Order finding that Respondent is not guilty of violating Section 458.331(1)(m) and (t) and dismissing the Administrative Complaint.

DONE AND ENTERED this 28th day of September, 2001, in Tallahassee, Leon County, Florida.

DANIEL MANRY
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 28th day of September, 2001.

COPIES FURNISHED:

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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.