STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF OSTEOPATHIC MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 01-2594PL
ALEXANDRA KONOWAL, D.O.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its designated Administrative Law Judge, Jeff B. Clark, held a formal hearing in the above-styled case on September 26, 2001, in Fort Myers, Florida.

APPEARANCES

For Petitioner: Bruce A. Campbell, Esquire
Agency for Health Care Administration
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Tallahassee, Florida 32399-0450

For Respondent: Bruce M. Stanley, Jr., Esquire
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STATEMENT OF THE ISSUES

Whether Respondent, Alexandra Konowal, D.O., violated Subsections 459.015(1)(x) and (o), Florida Statutes, and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

On June 6, 2001, the Department of Health ("Petitioner") filed an Administrative Complaint against Alexandra Konowal, D.O. ("Respondent"). The Administrative Complaint alleges that Respondent violated: (1) Subsection 459.015(1)(x), Florida Statutes, by failing to practice osteopathic 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, with regard to a patient known in this record as B. M.; and (2) Subsection 459.015(1)(o), Florida Statutes, by failing to keep medical records including but not limited to: patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultation and hospitalizations to justify the course of treatment of Patient B. M.

Respondent filed an election of rights disputing the allegations of fact contained in the Administrative Complaint and petitioned for a formal administrative hearing. The matter was referred to the Division of Administrative Hearings on July 2, 2001. On July 13, 2001, the case was set for final hearing on September 7, 2001, in Fort Myers, Florida. On August 20, 2001, Petitioner filed an unopposed Motion For Continuance which was granted; the case was rescheduled for September 26, 2001.

The parties filed an extensive Joint Prehearing Stipulation on September 19, 2001, in which they agreed to many of the Findings of Fact set forth herein. The only "live" witness presented at the hearing was Respondent, Alexandra Konowal, D.O. Petitioner presented its expert witness, Douglas R. Leder, D.O., by videotaped deposition. The deposition transcript of September 7, 2001, and videotape were received into evidence as Petitioner's Exhibit 1. At the hearing, the following joint exhibits, J1 through J8 were received into evidence:

J-1. Deposition of Douglas R. Leder, D.O., dated August 29, 2001;

J-2. Medical Records for Patient B. M., Eye Health;

J-3. Medical Records for Patient B. M., St. John’s Surgery Center;

J-4. Sprint Telephone Record dated August 13, 1998;

J-5. Joint Prehearing Stipulation;

J-6. Deposition of Eric Trevor Elmquist, D.O., dated September 4, 2001;

J-7. Deposition of Sandy Fallon, dated September 6, 2001;

J-8. Deposition of James Campbell, D.O., dated September 6, 2001.

A Transcript of Proceedings was filed on November 2, 2001; both parties filed Proposed Recommended Orders which were considered by the undersigned.

FINDINGS OF FACT

1. Respondent is a licensed osteopathic physician in the State of Florida, having been issued license number OS 7169.

2. Petitioner is the state agency charged with regulating the practice of osteopathic medicine pursuant to Section 20.42, Florida Statutes.

3. On July 20, 1998, Respondent first saw Patient B. M., a 75-year-old female, at Eye Health of Fort Myers, for a complaint of poor vision and cataracts. Respondent scheduled cataract surgery for July 30, 1998, at an outpatient surgery center.

4. On Thursday, July 30, 1998, at approximately 10:30 a.m., Respondent performed the surgery, removing the lens of Patient B. M.'s left eye and replacing it with an implant. Patient B. M. was discharged from the surgery center at 11:17 a.m., with instructions to go to Eye Health of Fort Myers for follow-up examination that afternoon. On Saturday, August 1, 1998, Patient B. M. telephoned Eye Health early in the morning complaining of inability to see from the left eye and severe pain in the left eye.

5. At about 9:00 a.m., August 1, 1998, Patient B. M. was examined at Eye Health of Fort Myers by James Campbell, an optometrist with Eye Health. Dr. Campbell found residual cortex in the left eye, with corneal edema, but observed no pus in the

eye. Dr. Campbell changed the antibiotic eye drops for the patient.

6. At approximately 10:00 a.m., on August 1, 1998, Dr. Campbell had a telephone conference with Respondent and Dr. Franz to discuss the symptoms of Patient B. M.

7. At approximately 4:45 p.m., on August 1, 1998, Patient B. M. again called Eye Health complaining of unbearable pain.

8. Dr. Campbell, in turn, called Respondent at approximately 5:00 p.m. to advise her of Patient B. M.'s complaints.

9. During the 5:00 p.m. telephone call from Dr. Campbell to Respondent, Dr. Campbell discussed the possible diagnosis of endophthalmitis.

10. At 5:36 p.m., August 1, 1998, Respondent spoke with Patient B. M. on the telephone for nine minutes.

11. During the 5:36 p.m. telephone call, Patient B. M. reported shooting pains in her eye and that her vision was bad.

12. During the 5:36 p.m. telephone call, Respondent advised Patient B. M. that she needed to be evaluated. When Patient B. M. said she could not come in, Respondent advised of the possible risks including damage to the optic nerve from excessive pressure and infection. Respondent suggested going to the emergency room and offered to provide transportation, but Patient B. M. refused.

13. During the 5:36 p.m. telephone call, Respondent recommended that Patient B. M. take Percocet that the Patient already had for the pain; Respondent would call in a prescription for erythromycin ointment and told the patient to call back if the eye didn’t improve.

14. Following the 5:36 p.m. telephone call, Respondent did phone in a prescription for erythromycin to a Walgreens Pharmacy near Patient B. M.'s residence. It appears the patient did not pick up this prescription.

15. The "standard of care" expert witness offered by Petitioner found it "difficult to answer" a hypothetical question directed to the "standard of care" of Respondent's care of Patient B. M., incorporating all relevant facts set forth hereinabove in these Findings of Facts and, essentially, failed to render an opinion incorporating all relevant facts; therefore, Petitioner has failed to prove by clear and convincing evidence that Respondent failed to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances as alleged in this matter.

16. Respondent prepared an office note dated August 1, 1998, 7:30 p.m., as a record of Respondent’s telephone call to

Patient B. M. This note was, in fact, prepared on the morning of August 3, 1998. The note reads in its entirety:

> 8/1/98 7:30 PM
>
> Spoke with patient. States having pain in left eye. Recommended artificial tears for shooting pain, and continue using Ocuflox and Pred Forte. Patient states she has been taking Percocet every four hours with no relief, but she takes Percocet regularly for neuropathy. Told to use two every four hours and call if no improvement.

17. While the August 1, 1998, office note records a great deal of relevant information, Respondent's testimony revealed it does not reflect Patient B. M.'s refusal to come in for evaluation, Respondent's warnings regarding the risks of not being evaluated, an offer of transportation to an emergency room, or a prescription order for Erythromycin.

18. Petitioner's expert witness testified on deposition that, "I'm not sure what the standard of care is" for charting weekend telephone calls. When he receives a telephone call at home from a patient, he makes notes on "a scrap of paper" and later records the note in the patient's record.

19. Respondent testified that she now keeps a book at home in which she records every conversation when patients call her at home; she then brings the book to her office for reference in recording the entire conversation in the patient's record.

However, she does not believe that anyone in her practice does it the way she now does.

20. There is no standard procedure in the practice of osteopathic medicine for memorializing conversations in the patient's record between a physician and patient which occur outside the office or hospital setting.

21. On August 3, 1998, Patient B. M. returned to Respondent’s office complaining of no vision and sharp pain. Respondent’s examination revealed Patient B. M.’s left eye to be swollen and with hypopyon (internal pus). Respondent diagnosed endophthalmitis and immediately referred Patient B. M. to a retinal specialist.

22. On August 3, 1998, Patient B. M. was seen by the retinal specialist who found near total hypopyon, so that neither the iris nor any posterior detail could be visualized. Ultrasound showed dense mobile vitreal opacities, primarily anteriorly. The specialist recommended a vitrectomy with injection of antibiotics, and discussed at length the possibility of loss of vision, loss of the eye and uncertainty of any visual benefit. He performed the surgery for Patient B. M. the night of August 3, 1998.

23. Endophthalmitis is a recognized complication of cataract surgery that occurs in less than one percent of

patients, but does not presumptively indicate a departure from the standard of care.

24. The standard of care required Respondent see Patient B. M. and treat her for endophthalmitis on August 1, 1998, or to warn Patient B. M. on August 1, 1998, of the serious consequences of endophthalmitis if Patient B. M. did not have an examination. The evidence revealed that Respondent warned Patient B. M. of the serious consequences of her failure to go to the clinic or an emergency room for treatment.

CONCLUSIONS OF LAW

25. The Division of Administrative Hearings has jurisdiction of the parties and the subject matter pursuant to Sections 120.57 and 456.073, Florida Statutes.

26. The Board of Osteopathy is empowered to revoke, suspend or otherwise discipline the license of an osteopathic physician for violation of Section 459.015(1), Florida Statutes.

27. Subsection 459.015(1)(x), Florida Statutes, requires that a licensed osteopathic physician “practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances.”

28. Subsection 459.015(1)(o), Florida Statutes, requires that a licensed osteopathic physician keep "legible, as defined by department rule in consultation with the board, medical

records that identify the licensed osteopathic physician or the osteopathic physician extender and supervising osteopathic 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."

29. Rule 64B15-15.004(1), Florida Administrative Code, states:

> [F]or the purpose of implementing the provisions of Subsection 459.015(1)(o), Florida Statutes, osteopathic physicians shall maintain written, legible records on each patient. Such written records shall contain, at a minimum, the following information about the patient:
> (a) [p]atient histories;
> (b) [e]xamination results;
> (c) [t]est results;
> (d) [r]ecords of drugs prescribed, dispensed, or administered;
> (e) [r]eports of consultations; and
> (f) [r]eports of hospitalizations.

30. While less detailed records are necessary when a physician is treating a patient in a private office setting rather than a hospital, this does not negate the need for a minimum amount of information to conform with the prevailing community medical standards [the Florida statutory standard] so

that "neutral third parties can observe what transpired during the course of treatment of a patient." Robertson v. Dept. of Professional Regulation, Board of Medicine, 574 So. 2d 153, 156 (Fla. 1st DCA 1990).

31. License revocation and discipline procedures are penal in nature. Petitioner's burden in this case is to prove the allegations of the Administrative Complaint by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

32. The "clear and convincing " standard requires:

> [T]hat the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony 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 a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In Re: Davey, 645 So. 2d 398, 404 (Fla. 1994), quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

33. Where the licensee is charged with a violation of professional conduct and the specific acts or conduct required of the professional are explicitly set forth in the statute or valid rule promulgated pursuant thereto, the burden on the agency is to show a deviation from the statutorily-required acts; but where the agency charges negligent violation of

general standards of professional conduct, i.e., the negligent failure to exercise the degree of care reasonably expected of a professional, the agency must present expert testimony that proves the required professional conduct, as well as the deviation therefrom. Purvis v. Department of Professional Regulation, 461 So. 2d 134 (Fla. 1st. DCA 1984).

34. Petitioner failed to establish by clear and convincing evidence that 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 the same conditions and circumstances because of the testimony of Respondent at the final hearing, corroborated by the record of telephone calls, suggests that Respondent met the standard of care; and the absence of expert testimony expressing an opinion, which incorporated all relevant facts, that there had been a deviation from the standard of care.

35. Because Subsection 459.015(1)(o), Florida Statutes, is penal in nature, it, and the administrative rule promulgated to implement it, must be strictly construed in favor of the licensed physician. Breesmen v. Department of Professional Regulation, Board of Medicine, 567 So. 2d 469 (Fla. 1st DCA 1990); Farzad v. Department of Professional Regulation, 443 So. 2d 373 (Fla. 1st DCA 1983); Bowling v. Department of Insurance, 394 So. 2d 165 (Fla. 1st DCA 1981). There was no showing that

Dr. Konowal did not record all medical treatment administered, or that the entries were false or inaccurate.

36. Dr. Konowal's failure to record her request that Patient B. M. appear for evaluation or her warning of the risks incident to her failure to be evaluated, taken in the totality of Patient B. M.'s records, do not fail to justify her course of treatment. The statute should not be so liberally construed as authorizing disciplinary action for a physician's failure to document a small part of an extended conversation, particularly when the physician is at home on a Saturday evening.

37. Petitioner has failed to demonstrate, by clear and convincing evidence, that Respondent failed to "keep legible . . . medical records that identify the licensed osteopathic physician . . . who is . . . responsible 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." The focus of this allegation is the office note entered into the patient's records on Monday, August 3, 1998, which memorialized the nine-minute telephone call between Respondent and Patient B. M. which took place on the evening of Saturday, August 1, 1998. Petitioner's expert witness testified that he was not sure of the standard of

care for charting weekend telephone calls. With the exception of Respondent's failure to record prescribing erythromycin ointment in the patient's office notes, there was no evidence presented that suggests any specific violation of Rule 64B15-15.004(1), Florida Administrative Code, which was promulgated to implement provisions of Subsection 459.015(1)(o), Florida Statutes, the Subsection alleged to have been violated. No other competent evidence was presented which specifically delineated a violation of Subsection 459.015(1)(o), Florida Statutes.

RECOMMENDATION

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

RECOMMENDED, that the Department of Health, Board of Osteopathy, enter a final order finding that Respondent, Alexandra Konowal, D.O., is not guilty of violating Subsections 459.015(1)(x) and (o), Florida Statutes, and dismissing the Administrative Complaint filed in this matter.

DONE AND ENTERED this 18th day of December, 2001, in Tallahassee, Leon County, Florida.

JEFF B. CLARK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 18th day of December, 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.