STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF PODIATRIC MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 10-2263PL
KENNETH D. POSS, D.P.M.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on June 23, 2010, by video teleconference, with the parties appearing in Miami, Florida, and in Tallahassee, Florida, before Patricia M. Hart, a duly-designated Administrative Law Judge of the Division of Administrative Hearings, who presided in Tallahassee, Florida.

APPEARANCES

For Petitioner: Monica Rodriguez, Esquire
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Coral Gables, Florida 33134

For Respondent: Mary S. Miller, Esquire
Department of Health
Prosecution Services Unit
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STATEMENT OF THE ISSUE

Whether the Respondent committed the violations alleged in the Administrative Complaint issued February 25, 2010, and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

In a two-count Administrative Complaint issued February 25, 2010, the Department of Health ("Department") charged Kenneth D. Poss, D.P.M., in Count One with having violated section 461.013(1)(s), Florida Statutes (2007 & 2008),[1] by "failing to practice medicine at a level of care, skill and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar conditions and circumstances" in his treatment of patient N.G. The Department specifically charged Dr. Poss with having violated section 461.013(1)(s)

> a. by failing to take routine laboratory tests to identify an infection; and/or
>
> b. by injecting steroids into a previously infected area; and/or
>
> c. by failing to take a confirmation x-ray prior to diagnosis of a bony spur and recommendation of surgery; and/or
>
> d. by failing to properly document routine diabetic care provided.

The Department charged Dr. Poss in Count Two with having violated section 461.013(1)(l), by "failing to keep written

medical records justifying the course of treatment of the patient, including, but not limited to patient histories, examination results, and test results" in his treatment of patient N.G. The Department specifically charged Dr. Poss with having violated section 461.013(1)(l)

> a. by billing for procedures which were not justified or documented in the medical records; and/or
>
> b. by failing to provide sufficient information justifying the level of visit/treatment provided; and/or
>
> c. by failing to take x-rays or do laboratory work; and/or
>
> d. by failing to document recommended in[-] home therapy.

Dr. Poss timely requested an administrative hearing, and the Department transmitted the matter to the Division of Administrative Hearings for assignment of an administrative law judge.

The final hearing was held, pursuant to notice, on June 23, 2010. The Department presented the testimony of patient N.G. and of Stephen Michael Meritt, D.P.M.; the Department did not offer any exhibits into evidence. Dr. Poss presented the testimony of Katherine Michelle Chapiewski and of Thomas Merrill, D.P.M. Respondent's Exhibits 1, 4 through 7, and 9 were offered and received into evidence; Respondent's Exhibit 8 was offered into evidence but was rejected; this exhibit was

proffered by Dr. Poss. The parties offered Joint Exhibits J-1 and J-2, which were received into evidence. Finally, official recognition was taken of the 2007 and 2008 versions of section 461.013(1)(l) and (s) and of Florida Administrative Code Rules 64B18-14.002 and 64B18-14.003.

The two-volume transcript of the record was filed with the Division of Administrative Hearings on July 14, 2010, and the parties timely filed proposed findings of fact and conclusions of law, which have been considered in the preparation of this Recommended Order.[2]

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The Department is the state agency responsible for the investigation and prosecution of complaints involving physicians licensed to practice podiatric medicine in Florida. See § 456.073, Fla. Stat. The Board of Podiatry is an entity created within the Department and is responsible for regulating the practice of podiatric medicine in Florida and for imposing penalties on podiatric physicians found to have violated the provisions of section 461.013(1), Florida Statutes. See §§ 461.004 and 461.013(2), Fla. Stat.

2. At the times material to this proceeding, Dr. Poss was a physician licensed to practice podiatric medicine in Florida, having been issued license number PO 990.

3. At the time of her first visit to Dr. Poss's office on November 19, 2007, patient N.G. was a 72-year-old woman with diabetes, among other ailments, who reported that she healed well.[3]

November 19, 2007, office visit

4. Patient N.G.'s complaint at her first office visit with Dr. Poss, which took place on November 19, 2007, was a nail fungus on the first toe of her right foot that was causing the toe to hurt. Dr. Poss's notes reflect that N.G. reported that she had had the fungus in the first toe of her right foot for approximately two years. Dr. Poss described the fungus as severe, noted that it was pulling the nail into the skin causing an ingrown toenail, and described the area around the toe as "red, incurvated, sore, painful and tender."[4] Dr. Poss also noted that N.G.'s only foot problem at this office visit was the ingrown nail and fungus in the nail of the first toe of the right foot.

5. Dr. Poss's medical records reflect that he cut all of N.G.'s nails and sanded and electronically debrided them. He noted that he spent part of the 25-minute office visit going

over the "treatment regimen," which included "vinegar soaks, Neosporin ointment, Oxistat cream."[5]

6. Dr. Poss also noted in the medical record of the November 19, 2007, office visit that he put N.G. "on the fungus protocol."[6] The nail fungus treatment protocol prescribed by Dr. Poss for N.G. was set out in a written document entitled "Fungus Nail Care." Copies of the protocol were maintained in Dr. Poss's office, and it was Dr. Poss's normal practice to explain the protocol and to provide a written copy of the protocol to all patients that instructed to follow the protocol.[7]

7. The fungus treatment protocol used by Dr. Poss consisted of washing the toenails with Head and Shoulders Dandruff Shampoo, rinsing them with Listerine Whitening Mouthwash, drying them, and applying prescription anti-fungal medication to the affected area. Both the shampoo and the mouthwash contain ingredients with anti-fungal properties.

8. During the November 19, 2007, office visit, Dr. Poss explained the fungus treatment protocol to N.G.[8] Dr. Poss did not include a copy of the written protocol in N.G.'s medical records, but a copy was always available in Dr. Poss's office.

9. When used, protocols must be identified in medical records, they must be in writing, and they must be readily available. If these requirements are met, it is not necessary

to include a copy of the protocol in a patient's medical records.

10. Dr. Poss identified the fungus protocol in N.G.'s medical records, the protocol was in writing, and it was readily available in Dr. Poss's office. It was, therefore, not necessary for a copy of the protocol to be placed in N.G.'s medical records.

February 18, 2008, office visit

11. Patient N.G.'s next office visit with Dr. Poss was on February 18, 2008. Dr. Poss noted in N.G.'s medical records that she again presented with severe nail fungus, or onychomycosis, that caused her nails to push into the skin and cause pain, thereby limiting her ambulation. Dr. Poss treated N.G. by cutting her toenails, sanding them, and electronically debriding them. He prescribed Oxistat cream, which is an anti-fungal medication.

August 4, 2008, office visit[9]

12. According to N.G.'s medical records, she was seen by Dr. Poss on August 4, 2008, and presented with a very painful fourth toe on her right foot. Dr. Poss observed that N.G.'s fourth toe was red, hot, sore, painful, inflamed, and tender. Dr. Poss determined that N.G. had a bone spur at the proximal interphalangeal joint ("PIPJ"), on the lateral aspect of the fourth toe, and he diagnosed N.G. as having severe bursitis.

13. Bursitis is an inflammation of the bursa surrounding a joint; a bursa is a soft-tissue envelope that surrounds a joint to protect it. A diagnosis of bursitis is appropriate when an area around or near a joint is red, hot, and swollen but without any ulceration.

14. Dr. Poss treated N.G.'s bursitis by administering a steroid injection between the fourth and fifth toes of N.G.'s right foot. Steroid injections are the appropriate treatment for severe bursitis. Dr. Poss also noted that he debrided the area and applied an 801 dressing, but he did not include in his notation the area that was debrided.

15. Even though the area between N.G.'s fourth and fifth toe on her right foot was red, hot, sore, painful, inflamed, and tender, Dr. Poss did not note any signs of infection in the area of the PIPJ of the fourth toe of N.G.'s right foot.

16. Dr. Poss noted that, at N.G.'s August 4, 2008, office visit, she had dystrophic nails with subungual debris; she had an ingrown toenail on the fourth toe of her left foot that was sore, painful, and tender; and, after she removed the nail polish from her toenails, it became apparent that she had fungus in all of her nails, which was severe and caused her toenails to push into the skin and cause pain.

17. In addition to treating N.G.'s bursitis on her fourth toe of her right foot, Dr. Poss treated the ingrown toenail on

her left foot; he cut, sanded and electronically debrided all of her nails; and he ordered vinegar soaks, Neosporin ointment, and Oxistat cream.

October 10, 2008, office visit[10]

18. N.G.'s office visit to Dr. Poss on October 10, 2008, was an emergency visit because the fourth toe on her right foot was infected. In his medical records, Dr. Poss described the area as red, hot, sore, inflamed, and tender, with an abscess.

19. Dr. Poss performed an incision and drainage procedure on the infected area, and he applied a dry, sterile dressing to the wound. In an incision and drainage procedure, a scalpel is used to cut into the skin and any fluid in the infected area is allowed to drain out of the wound. Dr. Poss prescribed 500 milligram Cipro tablets, Epsom salt soaks, and Garamycin cream, which, together with the incision and drainage procedure, was the appropriate treatment for the infection.

20. Although he treated the abscess by performing an "incision and drainage" procedure, there is no mention in the medical records of N.G.'s October 10, 2008, office visit that the abscess contained purulence, that is, pus or fluid, in a sufficient quantity to take a culture of only the purulence from the infected area. The standard of care in treating an infection between the toes does not require that a culture be taken every time an incision and drainage procedure is

performed. Rather, cultures should be taken only when there is sufficient purulence to ensure an accurate culture.

21. The area between the fourth and fifth toes is a common location of skin breakdown, and this is the most common interspace in which to find an infection such as N.G.'s. Typically, however, there's not enough purulence in this area to justify taking a culture. In addition, there is a very thin layer of fat between the skin and the bones of toes, and many contaminants are normally present on the skin between the toes. It is, therefore, possible that a culture taken in an area where there is not sufficient purulence to ensure that only the infected matter is being cultured would produce incorrect results.

December 1, 2008, office visit[11]

22. At N.G.'s December 1, 2008, office visit, Dr. Poss noted that she presented with "a very painful 4th toe on the R. foot. The area is red, hot, sore, inflamed, and tender with severe bursitis at the PIP joint, lateral aspect. She needs surgery but she doesn't want to do it."[12] Although "red, hot, sore, inflamed, and tender" can describe an infected area, when there is no sign of an ulceration of the skin, such a description is also consistent with a diagnosis of severe soft-tissue bursitis. Dr. Poss did not note any sign of an

ulceration or infection of the area between the fourth and fifth toes of N.G.'s right foot.

23. Dr. Poss noted in the medical records of N.G.'s December 1, 2008, office visit that she had an ingrown toenail on the fifth toe of her left foot, which caused her pain and limited her ambulation. N.G. continued to present with severe fungal nails, which caused the nails to push into the skin and caused N.G. pain, which also limited her ambulation. Dr. Poss did not note any sign of infection in the area between the fourth and fifth toes of N.G.'s right foot.

24. Dr. Poss treated N.G.'s severe bursitis with a steroid injection into the PIPJ of the fourth toe of N.G.'s right foot. Steroids are never injected into an area of active infection because steroids inhibit the migration of white blood cells and, thereby, inhibit the body's ability to fight the infection. A steroid injected into an active infection in the foot of a diabetic such as N.G. would present a special danger because a diabetic's ability to heal is compromised by the disease. Dr. Poss did not note any active infection or ulceration in the medical records of N.G.'s December 1, 2008, office visit, and it was not a breach of the standard of care for Dr. Poss to inject steroids into the site.

December 29, 2008, office visit

25. According to Dr. Poss's medical records, N.G. presented at his office on December 29, 2008, with paronychia of the first toe of her right foot, which was causing her a lot of discomfort. Dr. Poss described the area around the margin of the toe nail as "red, hot, sore, inflamed, and tender, with exudate present."[13] ("Exudate" is drainage from infected tissue.) Dr. Poss cut back the nail, performed an incision and drainage, debrided the area, and applied a dry, sterile dressing. He prescribed vinegar soaks and Polysporin ointment. Dr. Poss did not note any sign of infection or ulceration between the between the fourth and fifth toes of N.G.'s right foot on December 29, 2008.

January 19, 2009, office visit

26. At her January 19, 2009, office visit with Dr. Poss, N.G. presented with infected eczematous skin on her left foot, which Dr. Poss described as "inflamed, tender, and sore with ulcerated fissured tissue."[14] Eczematous skin is dry, flaky skin that resembles eczema; the skin can tear and peel and become cracked. Dr. Poss treated the infected eczematous skin on N.G.'s left foot by debriding the area. He prescribed Kenalog with Loprox 50/50, which N.G. was to apply to the affected area twice a day. Dr. Poss also prescribed vinegar soaks for the left foot twice a day for 30 minutes each day.

27. At the January 19, 2009, office visit, N.G. also complained of pain in the fourth toe on her right foot, and Dr. Poss described the fourth toe as "red, hot, sore, inflamed, and tender, with bursitis at the PIPJ of the 4th toe R."[15] Dr. Poss treated the bursitis by administering a steroid injection, debriding the area, and applying a dressing. Dr. Poss's notes reflect that he again advised N.G. to have surgery and that she again refused.

28. It was appropriate for Dr. Poss to administer a steroid injection in the area between the fourth and fifth toes of N.G.'s right foot to treat her severe bursitis. Dr. Poss examined the area between the fourth and fifth toes of N.G.'s right foot and did not note any sign of infection or ulceration in the area on January 19, 2009.

29. Indeed, Dr. Poss last noted an infection between the fourth and fifth toes of N.G.'s right foot in the medical records of her October 10, 2008, office visit, over three months prior to the January 19, 2009, steroid injection. N.G. had three office visits with Dr. Poss between the October 10, 2008, and January 19, 2009, office visits, and he did not note any signs of infection between the fourth and fifth toes of N.G.'s right foot in the medical records he maintained for these three office visits. Dr. Poss did report a small ulceration between the fourth and fifth toes of N.G.'s right foot at her

October 22, 2008, office visit, which he treated, but he did not note any signs of infection in that area.

February 19, 2009, office visit

30. Dr. Poss identified several problems with N.G.'s feet during her February 19, 2009, office visit. He first noted in the medical records that N.G. had an infected fourth toe on her right foot, which Dr. Poss described as an "abscessed spur on the 4th toe R. foot on the lateral aspect" that was "infected, inflamed, tender, and sore."[16] He attributed the abscess to N.G.'s wearing tight shoes and to her refusal to have surgery on the spur on the bone of the toe. Dr. Poss noted that the pain was so severe that it affected N.G.'s ability to walk.

31. Dr. Poss performed an incision and drainage procedure on the lateral aspect of the fourth toe of N.G.'s right foot, at the PIPJ, and applied a dry, sterile dressing to the area. He prescribed 500 milligrams of Levaquin that N.G. was to take once a day, sodium chloride soaks, and Silvadene cream, which is an antibiotic cream. Although Dr. Poss noted that he drained and dressed the wound, he does not record in his medical records any sign of purulence, or pus, associated with the infection, and he did not take a culture when he treated the abscess.

32. N.G. also presented on February 19, 2009, with an ingrown toe nail on the second toe of her right foot, and Dr. Poss noted that the area was "red, hot, sore, painful,

tender, and incurvated."[17] Dr. Poss treated the ingrown toe nail with a partial avulsion.

33. In addition, on February 19, 2009, N.G. presented, as she had a number of times in the past, with "dystrophic nails with subungual debris. Onychauxis, onycholysis present with nail hypertrophy and dystopia with discoloration" and with severely fungal toe nails.[18] Dr. Poss cut N.G.'s nails and sanded and electronically debrided them, and he prescribed vinegar soaks, Polysporin ointment, and Oxistat cream, in addition to the treatment he prescribed for the abscess on the fourth toe of her right foot.

March 12, 2009, office visit[19]

34. At N.G.'s March 12, 2009, office visit with Dr. Poss, she complained of a very painful fourth toe on her right foot. Dr. Poss described the area as inflamed, tender, and sore, and he noted that N.G. had a .25 centimeter by .25 centimeter ulceration between her fourth and fifth toes, which he indicated was caused by the fifth toe rubbing against the fourth toe.[20] He described the ulceration as having "necrotic tissue on the inside and hyperkeratotic tissue on the outside."[21] Necrotic tissue is dead or flaky tissue which is debrided, or scraped off with a blade, so it doesn't produce more pressure in the affected area. The ulceration described by Dr. Poss was essentially a superficial broken blister.

35. Dr. Poss noted in the medical records of N.G.'s March 12, 2009, office visit that he again advised her to have surgery to alleviate the chronic problems caused by the bone spur on the lateral aspect of the fourth toe of her right foot; Dr. Poss described her refusal to have surgery as "emphatic."[22] Dr. Poss also noted that he advised N.G. that, if she did not have surgery, the skin between the fourth and fifth toes of her right foot would continue to break down. Dr. Poss considered the problem with the fourth toe of N.G.'s right foot to be a chronic problem that would not be resolved without surgery.

36. Dr. Poss treated the small ulceration between the fourth and fifth toes of N.G.'s right foot with surgical debridement, and he applied a dry, sterile dressing. He told N.G. to continue with "the soaks and cream," which referred to the Silvadene cream and sodium chloride soaks he prescribed on February 26, 2009, and March 5, 2009, to treat the ulceration."[23] He also told N.G. that she was to wear wide shoes and sandals that put no pressure on the area.

37. The March 12, 2009, office visit was the last time N.G. was seen by Dr. Poss. She cancelled her next appointment and failed to keep the re-scheduled appointment.

Treatment by Jay Alter, D.P.M.

38. On March 20, 2009, eight days after her last visit to Dr. Poss's office and one month after Dr. Poss last treated her

for an infection between the fourth and fifth toes of her right foot, N.G. was seen by another podiatric physician, Jay Alter, D.P.M. The medical records maintained by Dr. Alter reflect that N.G. complained on March 20, 2009, that the fourth toe on her right foot was painful when she walked and when she wore closed footwear.

39. Dr. Alter's examination revealed that the interspace of the lateral aspect of the fourth toe, that is, the space between the fourth and fifth toes, was painful when palpated. Dr. Alter noted no drainage or cellulitis in the area, but he did note crusting, that is, scabbing, in the interspace between the fourth and fifth toes; such crusting is the result of the breakdown of superficial layers of skin.

40. Dr. Alter diagnosed N.G. at the March 20, 2009, office visit with "Acute Painful Digital Bursitis 4th Toe Right Foot."[24] Dr. Alter treated the area by applying a protective dressing and antibiotic ointment, and he directed N.G. to use saline soaks as needed and to continue to separate toes with an interdigital pad. Dr. Alter did not note any signs of infection or ulceration in the medical records of N.G.'s March 20, 2009, office visit.

41. On March 23, 2009, N.G. was again seen by Dr. Alter. At this office visit, N.G. complained of increasing pain in the interspace between the fourth and fifth toes of her right foot,

which caused her great difficulty in walking. Dr. Alter noted erythema, or redness of the skin, and a blister between the fourth and fifth toes of N.G.'s right foot, with serous drainage and pain on palpation. Dr. Alter also noted that he did an X-ray and confirmed that N.G. had a bone spur on the middle phalanx of the fourth toe of her right foot.

42. According to Dr. Alter's medical records, he took a sample of the serous drainage from N.G.'s fourth toe on March 23, 2009, and sent the culture to the laboratory for an aerobic bacterial culture and sensitivity organism test. Dr. Alter noted that he cleaned the area with sterile saline solution and applied betadine solution, Bacitracin ointment, and a dry, sterile dressing. He also noted that he prescribed warm saline soaks as needed and 500 milligram tablets of Levaquin.

43. According to Dr. Alter's notes, he received the laboratory results of the culture and sensitivity tests on March 25, 2009. The results showed that N.G. had a heavy growth staphylococcus aureus infection between the fourth and fifth toes of her right foot.

44. Staphylococcus aureus is a very strong, potent infection that spreads quickly and is resistant to many oral antibiotics, including the oral antibiotics Ciprofloxacin and Levofloxacin. When such an infection is located between the toes, it can quickly spread to the bone, and a week's delay in

beginning treatment could be very serious. The treatment for staphylococcus aureus infection includes intravenous antibiotics.

45. Dr. Alter's medical records reflect that he intended to discuss the laboratory results with N.G. at her office visit scheduled for March 26, 2009, but N.G. did not keep the appointment. Dr. Alter's notes also reflect that he called N.G. on March 26, 2009, and that N.G. went to the emergency room for care and the pain. She was referred to the Bethesda wound care center for follow-up.

46. Dr. Alter's notes reflect that N.G. was subsequently seen by a Dr. Jaffe, who hospitalized her on or about April 2, 2009, and treated the infection with, among other things, intravenous antibiotics. According to N.G.'s recollection, the infection resolved in about four-to-six months; the recovery was very difficult, and it was necessary for her to have several skin grafts.

Ultimate facts

A. Malpractice

47. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Poss committed malpractice in the practice of podiatric medicine. The Department presented no evidence to establish that Dr. Poss committed malpractice by failing to take an X-ray

prior to diagnosing a bone spur and recommending surgery, and it presented no evidence to establish that Dr. Poss committed malpractice by failing to document the routine diabetic care he provided.[25]

1. Failure to take culture

48. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Poss committed malpractice because he did not take a culture of drainage from patient N.G.'s infected toe on October 10, 2008, and on February 19, 2009, the two times she presented to Dr. Poss with an infection between the fourth and fifth toes of her right foot. The Department's expert witness testified that, without exception, a culture must be taken every time a podiatric physician does an incision and drainage procedure on a patient with an infection and that Dr. Poss breached the standard of care when he failed to take a culture of the drainage from N.G.'s infected fourth toe of her right foot.[26] On the other hand, the Department's expert witness also opined that Dr. Poss's treatment of N.G.'s infection on October 10, 2008, when Dr. Poss did not take a culture, was appropriate.[27]

49. Dr. Poss's expert witness testified that the standard of care does not require that a culture be taken whenever a podiatric physician performs an incision and drainage procedure.

Rather, Dr. Poss's expert witness testified that the standard of care does not require a culture when there is not sufficient drainage from an infected area to ensure that a culture taken in the area would accurately identify the type of infection. Dr. Poss did not note in N.G.'s medical records for the October 10, 2008, or February 19, 2009, office visits that there was any serous drainage from the infected area.[28] Upon consideration of the testimony of the two expert witnesses and of Dr. Poss's medical records, the undersigned is unable to find, without hesitation, that Dr. Poss breached the standard of care by failing to take a culture when N.G. presented on October 10, 2008, and on February 19, 2009, with infections between the fourth and fifth toes of her right foot.

2. Steroid injections

50. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Poss committed malpractice when he administered injections of a steroid to the area between the fourth and fifth toes of N.G.'s right foot on December 1, 2008, and January 19, 2009, because N.G. had had an infection in that area on October 10, 2008. Both the Department's expert witness and Dr. Poss's expert witness agreed that it is a breach of the standard of care to inject a steroid into an area with an active infection. Dr. Poss is, however, charged with having

administered a steroid on two occasions into an area that was previously infected.[29]

51. The persuasiveness of the testimony of the Department's expert witness regarding the allegation that Dr. Poss breached the standard of care by administering a steroid injection on two occasions into an area where Dr. Poss had diagnosed an infection on October 10, 2008, is significantly diminished because it is confused and inconsistent. Early in his testimony, the Department's expert witness expressed his disagreement with Dr. Poss's having administered a steroid injection on December 1, 2008, in the area between the fourth and fifth toes of N.G.'s right foot that had been "previously infected and previously ulcerated."[30] The Department's expert witness later testified that "you should not inject an area that's been previously infected, previously ulcerated in an at-risk patient that's diabetic."[31] A complete review of the record reveals, however, that the majority of the testimony of the Department's expert witness on this point related to a situation in which a steroid is injected into an area of active infection.[32]

52. The Department's expert witness testified repeatedly and at length that he assumed that the infection between the fourth and fifth toes of N.G.'s right foot diagnosed and treated by Dr. Poss on October 10, 2008, never healed but remained

active throughout the time N.G. was treated by Dr. Poss and that the symptoms of the infection were masked by the steroid injections. The Department's expert witness also testified that he believed that the staphylococcus aureus infection diagnosed from the culture taken by Dr. Alter on March 23, 2009, was the same infection as that treated by Dr. Poss on October 10, 2008. It was primarily in the context of his assumption that N.G. had an ongoing, active infection between the fourth and fifth toes of her right foot that the Department's expert witness testified that he would not, and Dr. Poss should not, have administered a steroid injection into this area.[33]

53. The assumption of the Department's expert witness that the infection diagnosed by Dr. Poss on October 10, 2008, was active throughout the time N.G. was treated by Dr. Poss is based on two faulty premises. First, the sole basis on which the Department's expert witness concluded that the infection between the fourth and fifth toes of N.G.'s right foot never healed was the absence of notations in N.G.'s medical records that the infections diagnosed and treated on October 10, 2008, and on February 19, 2009, had healed. It was not, however, necessary for Dr. Poss to record in the medical records of N.G.'s office visits subsequent to October 10, 2008, and February 19, 2009, the absence of an infection if there was no sign of infection; rather, it was sufficient for Dr. Poss to describe the condition

of the space between the fourth and fifth toes of N.G.'s right foot at each office visit.[34] It is clear from the medical records that Dr. Poss consistently examined between the fourth and fifth toes of N.G.'s right foot,[35] and the absence of a notation in N.G.'s medical records that the infection had healed is not sufficient to support the assumption of the Department's expert witness that the infection had not healed.

54. Secondly, the belief of the Department's expert witness that the staphylococcus aureus infection that was diagnosed from the culture taken by Dr. Alter on March 23, 2009, was a "continuation" of the infection diagnosed by Dr. Poss on October 10, 2008, is, likewise, not supported by the record.[36] As defined by the Department's expert witness, staphylococcus aureus is "a very strong, potent infection that spreads quickly, and it was resistant to a lot of medications that you can take orally. It requires IV medications for adequate treatment. . . . So it's -- they get infected very rapidly. And a week's time, a week's delay in her treatment is bad."[37] Significantly, Dr. Alter did not mention any signs of an infection between the fourth and fifth toes of N.G.'s right foot when he examined her on March 20, 2009, and diagnosed severe bursitis. In addition, Dr. Poss had prescribed the antibiotic Cipro for the infection he diagnosed on October 10, 2008, and Levaquin for the infection he diagnosed on February 19, 2009. If the infections were,

indeed, staphylococcus aureus, they would have been resistant to the antibiotics prescribed by Dr. Poss,[38] and it cannot be reasonably inferred that an essentially untreated, aggressive, and rapidly-advancing infection would have been masked by the steroid injections administered by Dr. Poss on December 1, 2008, and January 19, 2009.

Medical records

55. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Poss failed to keep appropriate medical records justifying the course of treatment of N.G. The Department presented no evidence to establish that Dr. Poss "billed for procedures which were not justified or documented in the medical records."[39] The Department also presented no evidence to establish that Dr. Poss failed to keep appropriate medical records by "failing to take x-rays or do laboratory work."[40]

56. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Poss failed to keep medical records containing sufficient information to justify the level of treatment he provided N.G. or the number of visits she made to his office.[41] Dr. Poss's medical records were thorough and fully justified the treatment he provided N.G. The Department's expert witness, when giving his opinion regarding the sufficiency of Dr. Poss's

medical records, stated only that they were "below standard."[42] The specific deficiencies the Department's expert witness identified to support the conclusion that Dr. Poss's medical records were "below standard" were (1) until March 12, 2009, Dr. Poss failed to include in his medical records notations that he instructed N.G. not to wear tight shoes[43]; (2) on one occasion, Dr. Poss noted in N.G.'s medical records that he did an avulsion, but he failed to say how he did the avulsion or whether he used a local anesthetic to do the avulsion[44]; and (3) Dr. Poss noted in the medical records for N.G.'s office visit on August 4, 2008, that he "debrided the area," but he failed to "define what was debrided or to what level it was debrided."[45] Looking at Dr. Poss's medical records for N.G. as a whole, the three omissions identified by the Department's expert witness are not of sufficient significance to constitute a failure to keep medical records justifying Dr. Poss's treatment of N.G.

57. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Poss's failure to include in N.G.'s medical records a copy of the fungus protocol used in his office constituted a failure to keep medical records justifying the course of treatment Dr. Poss provided to N.G. It was Dr. Poss's practice to keep written copies of the fungus protocol readily available in his office; to provide a copy of the protocol to a patient

that was put on it; and to go over the written protocol with the patient. Dr. Poss did not include a copy of his fungus protocol in N.G.'s medical records because a written copy of the protocol was always available in his office.

58. Although the Department's expert witness identified Dr. Poss's failure to include a copy of the fungus protocol in N.G.'s medical records as a violation of the requirement that a podiatric physician keep medical records justifying the treatment provided a patient, the testimony of the Department's expert witness is not clear on this point. The Department's expert witness testified that "[p]rotocols have to be identified and have to be in writing" and that "[t]here must be something that you can give to a patient that the patient understands, and they must be in the record so that everyone knows what protocol you're using. It's okay to have a protocol, but the protocol must be identified. It must be readily available."[46]

59. N.G. testified that Dr. Poss explained the fungus protocol to her, but she could not recall receiving a copy of the protocol. It is likely, however, that he did give N.G. a copy of the protocol; her memory of the events that took place in 2007 was not precise, and it was Dr. Poss's routine business practice to provide his patients a copy of the protocol they had been told to follow. Nonetheless, N.G. understood the protocol even if she were not provided a copy; the protocol was

identified in the medical records of N.G.'s November 19, 2007, office visit; and a written copy of the protocol was readily available in Dr. Poss's office. Dr. Poss's failure to include a copy of the protocol in the medical records does not constitute a failure to keep medical records justifying the course of treatment of N.G.

CONCLUSIONS OF LAW

60. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to sections 120.569 and 120.57(1), Florida Statutes (2010).

61. Section 461.013(1), Florida Statutes, by reference to section 456.072(2), Florida Statutes, authorizes the Board to impose penalties ranging from the issuance of a letter of concern to revocation of a podiatric physician's license to practice podiatric medicine in Florida if a podiatric physician commits one or more acts specified therein. In its Administrative Complaint, the Department has alleged that Dr. Poss violated section 461.013(1)(l) and (s) which provides that the following acts constitute grounds for disciplinary action by the Board:

> (l) Failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results.

* * *

> (s) Gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the standards for malpractice in s. 766.102 in interpreting this section. . . . As used in this paragraph, "gross malpractice" or "the failure to practice podiatric medicine with the level of care, skill, and treatment which is recognized by a reasonably prudent similar podiatric physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice podiatric medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board must so specify.

62. Section 766.102(1), Florida Statutes, provides in pertinent part: "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."

63. Because the Department seeks in its Administrative Complaint to impose penalties including revocation or suspension

of Dr. Poss's license to practice podiatric medicine and/or the imposition of an administrative fine, the Department has the burden of proving the violations alleged in the Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Dep't of Ins. & Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); and § 120.57(1)(j), Fla. Stat. (2010)("Findings of fact shall be based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute.").

64. "Clear and convincing" evidence was described by the court in Evans Packing Co. v. Dep't of Agric. & Consumer Serv., 550 So. 2d 112, 116, n. 5 (Fla. 1st DCA 1989), as follows:

> . . . [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence 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 the firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

See also In re Graziano, 696 So. 2d 744 (Fla. 1997); In re Davey, 645 So. 2d 398 (Fla. 1994); and Walker v. Florida Dep't

of Bus. & Prof'l Regulation, 705 So. 2d 652 (Fla. 5th DCA 1998)(Sharp, J., dissenting).

65. In Count One of the Administrative Complaint, the Department charged Dr. Poss with having failed to practice podiatric medicine "at that level of care, skill and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar circumstances." The Department specifically charged that Dr. Poss failed to order routine laboratory tests to ascertain the identity of the infection between the fourth and fifth toes of N.G.'s right foot; injected steroids into a previously infected area; failed to take an X-ray to confirm his diagnosis of a bone spur between the fourth and fifth toes of N.G.'s right foot; and failed to document the diabetic care he provided to N.G.

66. Based on the findings of fact herein, the Department failed to prove by clear and convincing evidence that Dr. Poss breached the prevailing standard of care for the practice of podiatric medicine in his treatment of N.G. as alleged in Count One of the Administrative Complaint. The Department, therefore, failed to prove that Dr. Poss violated section 461.013(1)(s) by not practicing "podiatric medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances."

67. In Count Two of the Administrative Complaint, the Department charged Dr. Poss with having failed to keep written medical records justifying the course of treatment for N.G. The Department specifically charged that Dr. Poss billed for procedures which were not justified or documented; failed to provide sufficient information in his medical records to justify the level of treatment of N.G. or the number of office visits by N.G.; failed to take X-rays or do laboratory work; and failed to document the fungus protocol in-home therapy. Based on the findings of fact herein, the Department failed to prove by clear and convincing evidence that Dr. Poss did not keep medical records justifying his treatment of N.G. as alleged in Count Two of the Administrative Complaint. The Department, therefore, failed to prove that Dr. Poss violated section 461.013(1)(l).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Podiatric Medicine enter a final order dismissing the Administrative Complaint filed against Kenneth D. Poss, D.P.M.

DONE AND ENTERED this 16th day of May, 2011, in Tallahassee, Leon County, Florida.

Patricia M. Hart
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 16th day of May, 2011.

ENDNOTES

[1]/ All references herein to the Florida Statutes are to the 2007 and 2008 editions unless otherwise specified. The pertinent language in the 2007 and 2008 editions of the Florida Statutes is identical.

[2] It is noted that, at the time this case went to final hearing, there was pending in the First District Court of Appeal a Petition for Review of Non-Final Agency Action directed to a discovery order entered by the undersigned on June 9, 2010. The court issued its opinion on September 23, 2010, and its mandate on October 12, 2010. Subsequent to the court ruling, the record in this case was closed.

[3]/ Dr. Poss observed in his notes for the November 19, 2007, office visit that N.G. denied she was diabetic but that she was taking medication for diabetes. Joint Exhibit 1 at page 5.

[4]/ Id.

[5]/ Id.

[6]/ Id.

[7]/ In her testimony, N.G. stated that she did not recall receiving a copy of the Fungus Nail Care protocol. She did, however, recall with specificity the treatment set out in the protocol.

[8]/ Transcript, volume 1 at page 40.

[9]/ Patient N.G.'s medical records reflect that she saw Dr. Poss on March 31, 2008, when he treated her for paronychia, an infection on the edge of the nail margin and in the soft tissue adjacent to the nail, on her the first toe nail of her right foot; on May 12, 2008, when he again treated N.G. for severe fungal nails and noted that the "fungus is coming out"; Joint Exhibit 1 at page 9; and on June 23, 2008, when Dr. Poss treated N.G. for infected eczematous skin on both feet. These office visits were not included in the allegations in the Administrative Complaint, and the details of these office visits are, therefore, not included in the findings of fact.

[10]/ Patient N.G. was also seen by Dr. Poss on September 15, 2008, when she presented with paronychia on the first toes of her right and left feet, which Dr. Poss treated. Dr. Poss noted that N.G.'s fourth toe on her right foot was a "little sore." In addition, the medical records reflect that Dr. Poss advised N.G. to have surgery on the bone spur but that N.G. declined. This office visit was not included in the allegations in the Administrative Complaint, and the details are, therefore, not included in the findings of fact. It is significant, however, that Dr. Poss addressed in his notes the slight soreness of N.G.'s fourth toe on her right foot.

[11]/ Patient N.G. also visited Dr. Poss on October 22, 2008, when she presented with a small ulceration on the lateral aspect of the fourth toe of her right foot. The ulceration was .25 centimeters by .25 centimeters, about the size of a BB, with "necrotic tissue on the inside and hyperkeratotic tissue on the outside." Joint Exhibit 1 at page 14. The area was sore, inflamed, and tender, but Dr. Poss did not note any infection in the area. According to Dr. Poss's notes, N.G. again refused to consider surgery on the bone spur between the fourth and fifth toes of her right foot.

Dr. Poss treated the ulceration by performing a surgical excisional debridement, down to the subcutaneous tissues, which

is the appropriate treatment for an ulceration. Because N.G. continued to have severe fungus in her toenails, Dr. Poss also debrided the nails, cut, and sanded them, and he told her to continue the antifungal treatment. This office visit was not included in the allegations in the Administrative Complaint, and the details are, therefore, not included in the findings of fact. It is, however, significant to note that Dr. Poss examined the area between the fourth and fifth toes of N.G.'s right foot and did not note an infection in that area in the medical records of N.G.'s October 22, 2008, office visit.

[12]/ Joint Exhibit 1 at page 15.

[13]/ Id. at page 16.

[14]/ Id. at page 17.

[15]/ Id.

[16]/ Id. at page 18.

[17]/ Id.

[18]/ Id.

[19]/ Patient N.G. also visited Dr. Poss on February 26, 2009, and on March 5, 2009. In the medical records of the February 26, 2009, office visit, Dr. Poss noted that N.G. had an ulceration on the lateral aspect of the fourth toe of her right foot, at the PIPJ. The ulceration was .25 centimeters by .25 centimeters, the same size as the ulceration recorded by Dr. Poss in the medical records of N.G.'s October 22, 2008, office visit. Dr. Poss described the area as sore, inflamed, and tender, and he noted that he again recommended that N.G. have surgery on the bone spur on the fourth toe of her right foot but that N.G. refused surgery. The medical records reflect that Dr. Poss debrided the ulceration with surgical excisional debridement, down to the subcutaneous tissues, and applied Silvercel cream and a dry, sterile dressing to the area. He prescribed Silvercel cream and sodium chlorine soaks, which he directed N.G. to begin after three days. Dr. Poss noted that N.G. had finished the antibiotic he had prescribed at the February 19, 2009, visit.

N.G. visited Dr. Poss on March 5, 2009, and he recorded in the medical record of that office visit that N.G. had an

ulceration on the outside, or lateral aspect, of the fourth toe of her right foot, at the PIPJ. The size of the ulceration noted by Dr. Poss at this office visit was the same as that recorded at the February 26, 2009, office visit. Dr. Poss again debrided the ulceration with surgical debridement and applied a dry, sterile dressing. Dr. Poss directed N.G. to continue the soaks and cream prescribed at the February 26, 2009, office visit.

These office visits were not included in the allegations in the Administrative Complaint, and the details are, therefore, not included in the findings of fact. It is, however, significant to note that Dr. Poss did not note any infection between the fourth and fifth toes of N.G.'s right foot at either of these office visits.

[20]/ As noted in endnote 18, above, the ulceration had been present on both February 26, 2009, and March 5, 2009, but it had not increased in size between the February 26, 2009, and March 12, 2009, office visits.

[21]/ Joint Exhibit 1 at page 21.

[22]/ Id. at page 21.

[23]/ See endnote 19, above.

[24]/ Joint exhibit 2; notes from March 20, 2009, office visit to Dr. Alter.

[25]/ It is noted that the failure to document treatment is not properly categorized as medical malpractice. See Barr v. Department of Health, Board of Dentistry, 954 So. 2d 668 (Fla. 1st DCA 2007)("We believe there is a significant difference between improperly diagnosing a patient . . . and properly diagnosing a patient, yet failing to properly document the actions taken on the patient's chart, which constitutes a subsection (m) [medical records] violation.").

[26]/ See Transcript, volume 2 at pages 148-49.

[27]/ The Department's expert witness testified: "[H]e treated [the infection] appropriately with incision and drainage. He placed the patient on antibiotics, which is correct. He picked a broad-spectrum antibiotic, which is fine, sends the patient home with dressings. Everything is as it should be for that

initial incision and drainage." Transcript, volume 2 at page 158.

[28]/ It is also noteworthy that Dr. Poss included in the medical records of N.G.'s office visits on March 31, 2008, and September 15, 2008, which were not mentioned in the Administrative Complaint, and on December 29, 2008, that there was "exudate" present in the areas in which N.G. had paronychia. It may, therefore, be reasonably inferred that Dr. Poss would have noted any significant drainage or purulence in the infected area between the fourth and fifth toes of N.G.'s right foot.

[29]/ Administrative Complaint at paragraph 32b.

[30]/ The Department's expert witness actually testified as follows: "I have great issues with the second cortisone injection [December 1, 2008] in an area that has been previously infected and previously ulcerated." Transcript, volume 1 at page 105. Shortly after making this statement, the Department's expert witness testified that "I do not and no one should be injecting ulcerative and infected areas with cortisone." Transcript, volume 1 at page 105.

[31]/ Transcript, volume 2 at page 168.

[32]/ Although this was not the allegation in the Administrative Complaint, it bears addressing because it composed a great deal of the testimony of the Department's expert witness, which resulted in a great deal of confusion regarding whether the Department's expert witness was testifying about the standard of care related to an active infection and or to an infection that was previously active.

[33]/ The Department's expert witness summarized his position as follows:

> What I can only tell you is she had an infection [October 10, 2008], was treated with an antibiotic and probably got better. It wasn't addressed. She then got another infection [February 19, 2009], was treated with a similar antibiotic. Again, the issue is not addressed as to what type of infection we're dealing with.

> She gets a third infection with Dr. Alter, which I think is a continuation of the whole line. The difference is Dr. Alter took a culture, and that's when we found out that the medications that she'd had all before were resistant to the infection that she had. That infection could have been harbored there all along, masked by the cortisone injections.

Id. at pages 191-92.

[34]/ The testimony of Dr. Poss's expert witness is accepted as more persuasive on this point than the testimony of the Department's expert witness.

[35]/ It is also noteworthy that the only time Dr. Poss did not address the condition of the space between the fourth and fifth toes of N.G.'s right foot was at the office visit on December 29, 2008, when N.G. presented with only paronychia of the first toe on her right foot.

[36]/ It is also noted that the Department's expert witness is qualified by his education and experience as an expert in podiatric medicine. Although he has treated patients with infected toes and feet, nothing in the record establishes that he is qualified to give an opinion regarding the nature and duration of the infection between the fourth and fifth toes of N.G.'s right foot or whether the steroid injections in fact masked the symptoms of an infection between the fourth and fifth toes of N.G.'s right foot.

[37]/ Transcript, volume 2 at pages 189-90.

[38]/ Joint Exhibit 2.

[39]/ It is questionable, in any event, that this allegation is properly categorized as a violation of the requirement to keep medical records because it does not relate to the treatment Dr. Poss provided N.G. See § 461.013(1)(l).

[40]/ Administrative Complaint at paragraph 36c. In addition, this allegation presents a situation similar to that in Barr, in which the court distinguished between diagnosing a patient and documenting the treatment provided. See endnote 25, above. In this allegation, the Department has reversed the situation

presented in Barr by alleging that the failure to order diagnostic tests constitutes the failure of Dr. Poss's medical records to justify the course of treatment he provided N.G. Such an allegation is not properly categorized as a medical records violation.

[41]/ Although the Department's expert witness testified repeatedly that Dr. Poss failed to note in N.G.'s medical records that the infection between the fourth and fifth toes of her right foot that Dr. Poss diagnosed on October 10, 2008, had healed, these comments were made in the context of his testimony dealing with the allegation that Dr. Poss breached the standard of care by administering a steroid injection into an area that was previously infected. The comments were not related to the allegation that Dr. Poss failed to maintain medical records justifying the course of treatment of N.G.

[42]/ Transcript, volume 1 at page 106. The Department's expert witness also testified that "[l]ooking at the totality of Dr. Poss's medical records, I feel that they are below the standard and do not adequately reflect what he did for the patient." Id. at page 142.

[43]/ Id. at page 127.

[44]/ Id.

[45]/ Transcript, volume 1 at page 118, 162. It is noted that the Department's expert witness was describing his own practice regarding the information he includes in medical records rather than setting forth a standard of care. Id. at page 162.

[46]/ Transcript, volume 1 at page 113.

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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.