



**ENFORCEMENT COMMITTEE
OCTOBER 21, 2015**

SUBJECT: BOARD OF PODIATRIC MEDICINE (“BPM”) 2015/16 SUNSET REVIEW REPORT

ACTION: CONSIDER AND DISCUSS DRAFT SUNSET REVIEW REPORT COVERING SECTIONS 5, 7 AND 11

6

RECOMMENDATION

Discuss and consider the draft sections of the 2015/2016 Sunset Review Report.

ISSUE

The BPM Sunset Review Report for 2015/2016 must be completed and submitted to the Joint Legislative Sunset Review Committee (“JLSRC”) by December 1, 2015.

DISCUSSION

BPM is scheduled for automatic repeal on January 1, 2017, unless the Legislature extends the date for repeal before conclusion of the 2016 calendar year through the “Sunset Review” process.

The Sunset Review process was created in 1994. The process was an effort by both chambers of the State Legislature (Joint Committee) with oversight responsibilities over licensing and regulatory entities to ensure the proper execution, effectiveness and protection against incompetent practice or illegal activities of state licensed professionals in the several professions and occupations. The Joint Committee prepared and forwarded a series of inquiries to BPM which must be answered as part of the Sunset Review process. There are a total of 62 questions. In addition, BPM must respond to sections querying Board action to prior sunset issues in addition to soliciting information on any new issues facing the Board.

Preliminary draft responses to questions falling under Enforcement Committee jurisdiction are provided for review and consideration by committee. Committee guidance and recommendations are to be incorporated appropriately and forwarded for final BPM Board review at its regularly scheduled meeting. These sections include:

1. Section 5: Enforcement Program
2. Section 7: Online Practice Issues

3. Section 11: New Issues

Once approved by the Board, the Sunset Review Report will be finalized and submitted to the Joint Committee on or before the requested December 1st due date.

NEXT STEPS

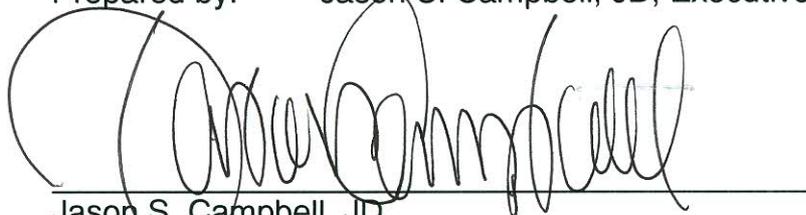
Staff will continue refining and drafting responses to questions as directed which are segregated into appropriate sections and reviewed by the respective BPM committees with subject matter jurisdiction over the particular subject areas.

Committee recommendations will in turn continue to be incorporated and submitted to the full board for consideration, discussion, input and/or approval at its regularly scheduled meeting in November.

ATTACHMENTS

A. Draft Sunset Review Report Sections 5, 7 and 11

Prepared by: Jason S. Campbell, JD, Executive Officer

A handwritten signature in black ink, appearing to read "Jason S. Campbell", written over a horizontal line.

Jason S. Campbell, JD
Executive Officer

California Board of Podiatric Medicine

BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT ENFORCEMENT PROGRAM

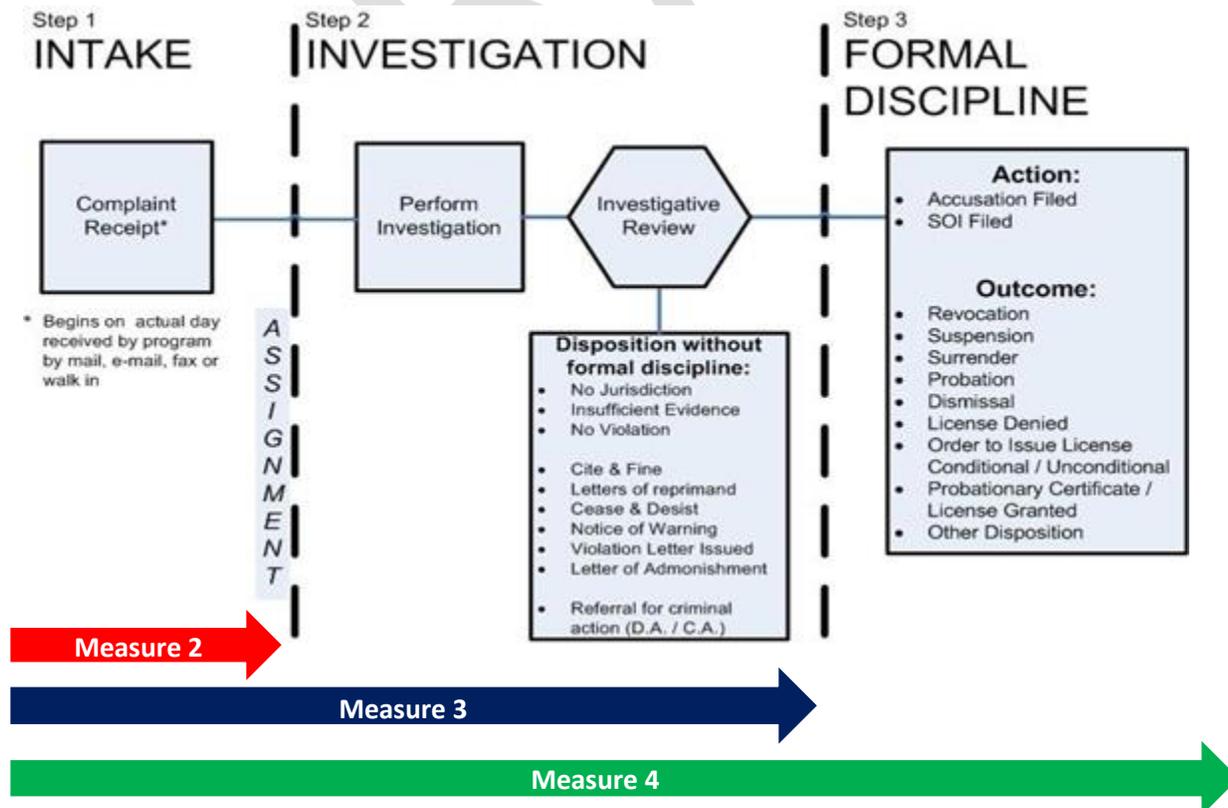
As of October 8, 2015

**Section 5
Enforcement Program**

1. What are the board’s performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

Section 2319 B&P provides in pertinent part that the Medical Board of California—under whose jurisdiction BPM is placed—must set a performance target not exceeding 180 days for the completion of an investigation beginning from the time of receipt of a complaint. Complex fraud, business or financial arrangement investigations or those that involve a measure of medical complexity are permitted to extend the target investigation completion time by an additional 6 months.

Notwithstanding, in an effort to demonstrate efficient and effective use of limited resources, DCA and its stakeholders set out to develop and implement an easy to understand and transparent system of performance targets and expectations for all boards including BPM on or about FY 09/10. The performance criteria—the first attempt DCA wide in over 15 years—established a set of consistent measures and definitions across all DCA program enforcement processes. Specific areas of performance measurement included:



- Time to complete the complaint intake process (Measure 2)
- Time to complete the complaint investigation process (Measure 3)
- Time to complete the complaint enforcement process from beginning to end (Measure 4)

The performance measures additionally included metrics for two additional areas including complaint volume and probation monitoring data not discussed here. Through what has been characterized as a deliberative process of collaboration across line, managerial and executive staff agency wide, performance targets were established. The most relevant target metrics are set forth below as follows:

- 9 days for Measure 2
- 125 days for Measure 3
- 540 days for Measure 4

Each report is published quarterly with the baseline reporting period for BPM released on DCA's website in the first quarter of FY 10/11. Overall, it is believed that the reports more or less represent an accurate portrait of current Board performance and it is the DCA performance targets that the Board strives to meet with an eye toward satisfaction of the statutory timelines mandated by 2319 B&P. Using averages for performance measures obtained using current BreZE reporting configurations currently available to the board for the last three fiscal years yield the following performance figures:

- BPM achieves an average 9 day cycle for Measure 2
- BPM achieves an average 140 day cycle for Measure 3
- BPM achieves an average 797 day cycle for Measure 4

BPM continues to strengthen the intra-agency collaboration between it and the larger Medical Board in order to ensure that DPM cases shepherded through the complaint investigation and enforcement services of the larger Medical Board under the annual Shared Services contract are promptly and efficiently processed. Most recently, the Board's enforcement coordinator has implemented new procedures with the Medical Board's Central Complaint Unit in order to better facilitate and expedite case complaint assignment through increased communication and accountability.

Having said this, it may be noted that the current measures do not capture all timelines involved in case investigations. For example, those that are sent to the Attorney General or the Office of Administrative Hearing are not appropriately accounted. Given that cases meriting formal discipline will by nature take longer to resolve than those that do not, in addition to the fact that these subjects are entitled to due process, there is no current mechanism in place for sorting out legitimate reasons for case delays, such as continuance requests by respondent parties, from those that may be staff and/or casework related.

Finally, the board is advised that the Department of Consumer Affairs is currently re-assessing whether or not current performance expectations are realistic and achievable. Through identification of universal processes that form part of all case life cycles, it is hoped that an improved framework of measurement may be achieved for enhanced reporting processes that will uncover reasonable expectations that serve consumer interests. The board believes that any revision to performance

targets will necessarily have to be program driven to account for operational differences, but BPM very much looks forward to constructive discussion and collaboration with DCA for improving the metric reporting processes overall.

2. Explain trends in enforcement data and the board’s efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

The board’s enforcement statistics for the last three fiscal years generated through current BreEZe reporting configurations currently available continue to reflect an annual sub-130 complaint intake average. As in years past, this reflects a more than 50% longitudinal decline in complaints received since implementation of the board’s continuing competency program in 1999 that continues to hold.

As may be noted from Table 9a below, the greatest source of complaints are received from the public with approximately 72% of total complaints fielded from consumers. Only two complaints were closed without the need for further investigation in FY 13/14. Based on complaint intake averages, approximately 9 actions a year are initiated by the Attorney General which equates to 7.2% of the total complaint volume received. Of cases resulting in disciplinary action, the board enforcement statistics reflect an average 797 day cycle for case completion. After referral to the Attorney General, following conclusion of an investigation, the Board’s enforcement coordinator shifts focus to working with deputy attorneys general and accompanying support staff.

Of cases referred in the last four fiscal years, nearly 25% closed in two years or less. Nearly half or 43% were closed in 3 years with the remaining 33% closing in 4 or more years. It may also be noted that the total the number of cases with the Attorney General in the last four fiscal years represents a 32% decrease in the total number of cases over the last review. Significantly, the last four years saw 21 case closures as opposed to 31 cases closed as reported in the 2011 Sunset Review.

Referencing case aging data shows a tremendous improvement in overall case investigation closures in the last four fiscal years with a full 71% of all investigations closed in 180 days or less whereas only 19% closed in this timeframe as reported in 2011. This period also saw 26.5% or 123 cases closed in two years or less and the remaining 11 cases taking 3 years or longer to complete. By comparison to the last review period, the overall average discipline completion time of 797 days represents a 45-day average improvement since last reported in 2011.

Table 9a. Enforcement Statistics			
	FY 2012/13	FY 2013/14	FY 2014/15
COMPLAINT			
Intake	(BreEZe Report 249)		
Received	123	110	143

Closed	0	2	0
Referred to INV	126	107	137
Average Time to Close	6	9	12
Pending (close of FY)	1	1	7
Source of Complaint (BreEZE Report 249)			
Public	91	80	100
Licensee/Professional Groups	2	5	3
Governmental Agencies	24	18	20
Other	21	19	25
Conviction / Arrest (BreEZe Report 252)			
CONV Received	16	13	10
CONV Closed	16	13	9
Average Time to Close	6	4	16
CONV Pending (close of FY)	0	0	1
LICENSE DENIAL			
License Applications Denied	0	0	0
SOIs Filed	0	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0	0	0
ACCUSATION (BreEZe Report 252)			
Accusations Filed	2	7	7
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	1
Average Days Accusations	?	?	?
Pending (close of FY)	2	5	6

Table 9b. Enforcement Statistics (continued)			
	FY 2012/13	FY 2013/14	FY 2014/15
DISCIPLINE			
Disciplinary Actions (BreEZe Report)			
Proposed/Default Decisions	1	1	1
Stipulations	4	3	4
Average Days to Complete	944	690	758
AG Cases Initiated	7	10	11
AG Cases Pending (close of FY)	5	7	11
Disciplinary Outcomes (BreEZe Reports 249/252)			
Revocation	1	1	0
Voluntary Surrender	0	1	3
Suspension	0	0	2
Probation with Suspension	0	2	1
Probation	4	2	2
Probationary License Issued	0	0	0
Other	2	1	0
PROBATION			
New Probationers	3	3	2
Probations Successfully Completed	1	5	2

Probationers (close of FY)	17	15	15
Petitions to Revoke Probation	0	0	2
Probations Revoked	0	0	1
Probations Modified	0	2	0
Probations Extended	0	0	1
Probationers Subject to Drug Testing	0	0	1
Drug Tests Ordered	0	0	5
Positive Drug Tests	0	0	4
Petition for Reinstatement Granted	0	0	1
DIVERSION (Inoperative & Repealed July 2009)			
New Participants	-	-	-
Successful Completions	-	-	-
Participants (close of FY)	-	-	-
Terminations	-	-	-
Terminations for Public Threat	-	-	-
Drug Tests Ordered	-	-	-
Positive Drug Tests	-	-	-

Table 9c. Enforcement Statistics (continued)			
	FY 2012/13	FY 2013/14	FY 2014/15
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned			
Closed (BreEZe Report 249 PM3)			
Average days to close (BreEZe Report 249 PM3)			
Pending (close of FY)			
Desk Investigations (Use CAS Report EM 10)			
Closed			
Average days to close			
Pending (close of FY)			
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed			
Average days to close			
Pending (close of FY)			
Sworn Investigation			
Closed (Use CAS Report EM 10)			
Average days to close			
Pending (close of FY)			
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	0	1	1
PC 23 Orders Requested	2	0	1
Other Suspension Orders	0	1	1
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning			
Referred for Diversion (Inoperative/Repealed 2009)	-	-	-
Compel Examination	0	2	2
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued	2	5	6

Average Days to Complete	827	612	354
Amount of Fines Assessed	\$5,000	\$12,500	\$10,660
Reduced, Withdrawn, Dismissed	\$2,500	\$7,500	\$5,000
Amount Collected	0	300	\$3,500
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	0

Table 10. Enforcement Aging						
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	1	1	2	9.5%
2 Years	1	2	0	0	3	14%
3 Years	3	2	1	3	9	43%
4 Years	3	1	0	1	5	24%
Over 4 Years	0	0	2	0	2	9.5%
Total Cases Closed	7	5	4	5	21	100%
Investigations (Average %)						
Closed Within:						
90 Days	56	83	44	48	231	49%
180 Days	32	38	17	17	104	22%
1 Year	14	20	15	24	73	15.5%
2 Years	16	9	4	21	50	11%
3 Years	0	1	5	1	7	1.5%
Over 3 Years	0	3	0	1	4	1%
Total Cases Closed	118	154	85	112	469	100%

3. What do overall statistics show as to increases or decreases in disciplinary action since last review.

The overall statistics show that the board has maintained a steady program of enforcement with no meaningful statistical increases or decreases in disciplinary action since last review. Complaint volumes, Attorney General case referrals, revocations, surrenders and probation all reflect relatively constant levels that may be considered to be within normative operative ranges for the board.

4. How are cases prioritized? What is the board’s compliant prioritization policy? Is it different from DCA’s Complaint Prioritization Guidelines for Health Care Agencies (August 31, 2009)? If so, explain why.

In order to ensure that physicians representing the greatest threat of harm to the public are handled expeditiously, the Legislature has explicitly provided the prioritization schedule for all medical complaints. The governing statute is found under section 2220.05 B&P.

As a unit under the jurisdiction of the Medical Board, BPM uses the complaint investigation and enforcement services of the larger Medical Board by way of an annual Shared Services contract. This has proven to be the most efficient and cost effective process for regulating the Board’s licensee

population of approximately 2000 physicians. Thus, while BPM considers every case to be a priority, BPM medical cases are prioritized identically to Medical Board cases and managed through its Central Complaint Unit (“CCU”) in the same manner.

Accordingly, cases involving gross negligence, incompetence and repeated negligent acts involving death or serious bodily injury are identified as holding the highest priority as mandated by statute. Cases involving physician drug and alcohol use, sexual misconduct with patients, repeated acts of excessive prescribing with or without examination and excessive furnishing or administering of controlled substances are also defined as priorities. Extra-statutory priorities are managed according to protocols as prescribed within DCA’s Guidelines for Health Care Agencies.

5. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?

Yes. There are mandatory reporting requirements statutorily imposed on several entities to alert BPM to possible disciplinary matters for action and investigation. As with complaint prioritization protocols discussed immediately above, mandatory disclosure reports are received and handled through the Medical Board CCU. Codified in section 800 et. seq. of Article 11 of the Business and Professions Code, the mandatory reporting requirements are fully applicable to California DPMs and include the following below listed disclosure reports:

Section 801.01 B&P

Requires settlement agreements exceeding \$30,000 and arbitration awards or civil judgments of any amount to be reported within 30 days by insurer, employer or self-insured public agency acting as the insurer to a doctor of podiatric medicine. There are no problems with receiving the report known to exist and those received are within required timeframes.

Section 802.1 B&P

Requires a doctor of podiatric medicine to report criminal charges within 30 days upon indictment of a felony or conviction of any felony or misdemeanor including a plea of no contest. There are no problems with receiving the report known to exist. Reporting compliance is confirmed through independent verification received separately from Department of Justice subsequent arrest notifications. Within the last four fiscal years, the Board has previously taken action on at least two separate occasions to address a licensee’s failure to report a conviction of crime through citation and fine.

Section 802.5 B&P

Requires a coroner to submit pathologist findings indicating that a patient death may be related to gross negligence by a doctor of podiatric medicine.

Sections 803 and 803.5 B&P

Requires a clerk of the court that renders a criminal judgment or finding of liability for a doctor of podiatric medicine based on negligence or errors and/or omissions resulting in death or personal injury to report to the board within 10 days.

Section 805 B&P

Requires a Chief of Staff, Chief Executive Officer, Medical Director or Administrator of a health care facility or clinic to report a denial or revocation of a doctor of podiatric medicine's health facility privileges within 15 days of effective date of action taken.

Section 805.01 B&P

Requires a Chief of Staff, Chief Executive Officer, Medical Director or Administrator of a health care facility or clinic to report any decision or recommendation for disciplinary action against a doctor of podiatric medicine within 15 days of decision.

Section 2240 B&P

Requires a physician who performs a medical procedure or any person acting under physician supervision or orders that results in a patient death in an outpatient surgery setting to report to the board within 15 days.

Collectively, all mandatory reports are received directly by the Medical Board Central Complaint Unit. It is known that MBC has previously reported some concerns regarding County Coroner and Court Clerk reporting responsibilities and had made several outreach efforts to assist raising awareness and/or compliance levels with these officials. BPM however defers to MBC as to whether it believes there has been improved compliance as a result.

6. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

Yes. The applicable statutes of limitation are found under section 2230.5 B&P. Accordingly, with certain limited exceptions, accusations filed pursuant to Government Code section 11503 must be brought against a licensee within seven (7) years after occurrence of the act or omission serving as the basis for disciplinary action or else within three (3) years after discovery of the act or omission by the Board, whichever occurs first.

Actions involving sexual misconduct extend the time period for filing an accusation from seven (7) to ten (10) years and both 7 year and 10 year statutes of limitation just discussed are tolled until the age of majority is reached in cases involving a minor. Procurement of a license by fraud or misrepresentation and intentional concealment of unprofessional conduct based on incompetence, gross or repeated negligence are not subject to the limitations statute.

To date BPM has not lost the right to pursue an administrative accusation against a licensee due to statute of limitation issues.

7. Describe the board's efforts to address unlicensed activity and the underground economy.

Because the board is a unit of the Medical Board which handles BPM investigation and enforcement cases under its annual Shared Services contract—which has proven to be the most efficient and cost effective process for regulating the board's licensee population of approximately 2000 physicians—the BPM is able to take advantage of the many benefits created by the larger Medical Board enforcement initiatives.

For example, in 2009 the Medical Board reestablished the Operation Safe Medicine (OSM) Unit to assist addressing the unlicensed practice of medicine and/or underground economy. OSM staff are specially trained experts with the necessary skills and abilities to proactively address unlicensed activity within the state which necessarily includes identification, investigation and prosecution of unlicensed individuals.

Historically speaking however, there has not been a large incidence of unlicensed activity either by individuals masquerading as licensed DPMs or by DPMs with invalid licenses. Nevertheless, OSM efforts have resulted in at least one successful action against a doctor of podiatric medicine who continued to practice podiatric medicine notwithstanding an expired and delinquent license.

Cite and Fine

8. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the \$5,000 statutory limit?

The Board's statutory citation and fine authority contained under section 125.9 B&P and codified in regulatory sections 1399.696 and 1399.697 of BPM's Podiatric Medicine Regulations has historically been employed both as an educational and compliance measure. Over the years, while touted and recognized as an effective tool for demonstrating the Board's willingness and ability to enforce the law, the system for issuance of citations has not traditionally been utilized to the extent of needless penalization of licensees for technical statutory violations such as address change oversights.

The Board updated section 1399.696 in 2008 to include qualified language for increasing citation fine amounts to the maximum statutory limit of \$5000 in addition to providing the regulatory authority to issue citations for failure to produce medical records and for failure to comply with a term or condition of probation. There have not been any additional changes to the regulatory framework since the last sunset review and 2008 serves as the last year the Board updated its citation and fine provisions.

9. How is cite and fine used? What types of violations are the basis for citation and fine?

The Board's citation and fine authority is generally directed toward addressing conduct or omissions identified in the course of investigations that do not necessarily rise to the level to support disciplinary action but which nevertheless warrant redress. These issues have included failure to maintain adequate and accurate medical records; failure to produce requested medical records; in addition to

conduct construed as unprofessional under the practice act. Most recently the Board has begun opting to use citation and fine authority as an effective tool for gaining compliance with those owing probation monitoring costs. In this fashion it is expected that compliance may be achieved for minor violations of probation without resort to more costly administrative action and hearing.

10. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

In the last four fiscal years the Board has held a total of six informal office conferences. None of the immediately aforementioned informal office conferences resulted in citation appeals under the Administrative Procedure Act (APA). Finally, the Board does not employ the Disciplinary Review Committee mechanism for resolution of administrative citations.

11. What are the 5 most common violations for which citations are issued?

While fifth place was tied between seven different miscellaneous violations and therefore intentionally left unranked, the Board’s top four most commonly cited violations for the last four fiscal years are compiled below in BPM Table A11.

BPM Table A11. Top Five Violations		
Rank	Number of Citations	Violation
1	4	2266 – Failure to maintain medical records
2	3	2225 – Failure to produce medical records
3	3	2234 – Unprofessional Conduct
4	2	802.1 – Failure to report conviction of crime
5	Tie between 7 different violations	Miscellaneous violations

12. What is average fine pre- and post- appeal?

The average fine amount for all citations issued prior to appeal is \$2,190. As briefly mentioned BPM has not had any citations that resulted in appeals under the APA in the last four fiscal years. Accordingly, the Board does not have a post-appeal average to report.

13. Describe the board’s use of Franchise Tax Board intercepts to collect outstanding fines.

Pursuant to the authority granted for the issuance of citations and assessment of fines under section 125.9 B&P the Board may add fine amounts owed to the fee for licensure renewal if fines remain uncollected. The Board is additionally authorized to pursue administrative disciplinary action for failure to remit fine payments within 30 days of assessment in cases where a citation is not contested.

Both administrative remedies have proven effective such that utilization of Franchise Tax Board (“FTB”) intercepts for the collection of outstanding fines against licensees has proven unnecessary. The FTB intercept program would prove an effective tool in the collection of any unpaid fine in the event of a citation issued to an unlicensed party. However, the Board has not had cause to employ enforcement mechanism against unlicensed individuals to date.

Cost Recovery and Restitution

14. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

The Legislature has explicitly provided BPM with statutory authority for the recovery of costs in administrative disciplinary cases under section 2497.5 B&P. Accordingly, cost recovery is included as a standard condition in the Board's "Manual of Disciplinary Guidelines and Model Disciplinary Orders" for all cases. Second only to settlement provisions aimed at ensuring consumer protection, the recovery of actual and reasonable costs is sought as part and parcel of stipulated settlement agreements by Board staff and the Attorney General and is requested in ALJ proposed disciplinary decisions pending before the Board. It is felt that cost recovery is critical to the Board's continued ability to effectively perform its mission of public protection without which would result in an undue upward strain on Board licensing fees.

Since the Board's last Sunset Review Hearing in 2012, section 2497.5 B&P was successfully amended to permit assessment of additional costs when a proposed ALJ decision was not adopted by the Board and found reasonable grounds for increasing. It was widely believed that ALJs were inconsistent in cost recovery matters across all cases and not in line with recovery of actual and reasonable costs of disciplinary proceedings to the agency. BPM thus recommended amendments to section 2497.5 to permit BPM exercise discretionary cost recovery increases in cases where the Board voted to non-adopt an ALJ proposed decision in order to ensure the recovery of actual and reasonable costs.

15. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

The board has ordered a total of \$170,976 in total cost recovery stemming from 17 disciplinary cases involving final board Decisions and Orders or Stipulated Agreements in the last four fiscal years. Of this amount, the board has collected \$143,082 during the same period reflecting an 83% recovery rate. The board does not believe any outstanding amounts are uncollectable and will continue to ensure cost recovery orders are aggressively pursued.

16. Are there cases for which the board does not seek cost recovery? Why?

No. Once a Board decision and order or stipulated agreement is effective with provisions for the recovery of enforcement costs, the Board makes every effort to ensure that the actual and reasonable costs are obtained. Thus, there are no cases for which the Board does not seek actual and reasonable costs of investigation and prosecution. The recovery of actual and reasonable costs is viewed as an integral component of the administrative enforcement process that permits the Board to continue to provide effective mission critical services for consumer protection.

17. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

Until very recently, the Board had not officially employed FTB intercepts as an agency program for cost recovery collection efforts.

At this time, utilization of the FTB intercept program generally remains unnecessary for cost recovery collection attempts as any failure to pay costs will generally be considered a violation of the terms and conditions of probation upon which additional disciplinary action may be taken. Further, existing probationers will not be released from probation until all outstanding monies including probation monitoring costs have been satisfied. Accordingly, while there are rarely large inordinate sums of unrecovered costs, the FTB intercept program has nevertheless now been employed in those few circumstances where monies remain uncollected.

To date the program has been employed as an attempt to collect outstanding amounts totaling \$19,101.32 for three separate accounts in the last four fiscal years.

18. Describe the board’s efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

The Board has generally not sought restitution against licensees in the superior courts on behalf of individual consumers in the past.

While petition filing authority is extended to the Board under section 125.5 B&P to seek monetary restitution in the superior courts for persons economically harmed as a result of practice act violations, civil proceedings in the superior courts have not traditionally been either the Board’s forum or its focus for redress against licensees. Being principally concerned with seeking protection of consumers from unfit and incompetent doctors, the Board has sought redress against licensees on behalf of individuals for economic harm in the context of administrative proceedings governed by the provisions of the APA. Accordingly, it has been individuals that have historically sought restitution in the superior courts for economic harms.

Thus, pursuant to the Board’s Manual of Disciplinary Guidelines, restitution is always incorporated as a necessary component of probation in all administrative disciplinary proceedings against licensees involving economic exploitation or in cases of Medi-Cal or insurance fraud. In these cases the guidelines specifically recommend ALJs to award no less than the amount that was fraudulently obtained and it is in this fashion—in the administrative forum—that restitution is sought.

Cases involving instances of unlicensed practice by those who are not Board licensees, are easily referred to local District Attorneys’ offices for prosecution where restitution may be ordered as part of a criminal proceeding.

Table 11. Cost Recovery				
	(list dollars in thousands)			
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Total Enforcement Expenditures	392	321	290	324
Potential Cases for Recovery *	7	5	4	5

Cases Recovery Ordered	6	5	3	3
Amount of Cost Recovery Ordered	\$45.4	\$42.2	\$35.7	\$47.6
Amount Collected	\$45.1	\$34.4	\$33.6	\$29.8
* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.				

Table 12. Restitution (list dollars in thousands)				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Amount Ordered	0	0	0	0
Amount Collected	0	0	0	0

Section 7 Online Practice Issues

19. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate internet business practices or believe there is a need to do so?

California can be said to be at the forefront of the development of telehealth. Doctors practicing via telehealth are held to the same standard of care and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information and many other duties normally associated with the practice of medicine.

Notwithstanding, it is known that the practice of prescribing prescription medication via telehealth is not an uncommon source of consternation and confusion among doctors nationally. The common inquiries that BPM has encountered regarding online practice are questions arising out of state prescribing via telehealth and whether an appropriate patient/physician relationship exists; when that relationship develops; whether it may be established through remote interactions alone; and if bona-fide relationship truly exists whether it is permissible to issue a prescription. At this juncture in the national development of telehealth, many states do not permit physicians to issue prescriptions to patients whom they have not met in person.

The Board actively responds—in association with the Medical Board CCU through its existing shared services agreement—to all complaints received. There is currently robust statutory authority to pursue violations for dispensing or furnishing of any dangerous drugs or devices on the internet for delivery to persons in California without a prescription after an appropriate prior examination and medical indication under sections 2242.1 and 4067 B&P. Additional charges may also be warranted for unlicensed practice if committed by an individual without a certificate to practice medicine under sections 2052 and 2474 B&P. Notwithstanding, at this time there is no present evidence to indicate any prevalence of online practice issues existing among either the licensed podiatric community of physicians or with unlicensed populations.

While, it is certainly a subject that comes before the larger Medical Board from time to time, most recently in connection with the prescription of marijuana and the requirement of an appropriate prior

examination meeting the standard of care before prescribing, it has not been an issue that has necessitated Board attention.

Accordingly, there are no plans for BPM to address the subject through additional regulatory authorities at this time.

Section 11 New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, legislative changes) for each of the following:

- 1. Issues that were raised under prior Sunset Review that have not been addressed.**
- 2. New issues that are identified by the board in this report.**
- 3. New issues not previously discussed in this report.**
- 4. New issues raised by the Committees.**

Issue #1: Should reference to ankle certification on and after January 1, 1984 be removed from the B&P code and thereby confirm a single scope of licensure for doctors of podiatric medicine?

BPM Recommendation

Yes. BPM recommends that B&P section 2472(d)(1) be amended to remove reference to "ankle certification by BPM on and after January 1, 1984" thus confirming a single scope of podiatric medical licensure.

Applicable Authority

Business and Professions Code section 2472 provides in pertinent part:

- (a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.
- (b) [...] "podiatric medicine" means the [...] surgical [...] treatment of the human foot, including the ankle and tendons that insert into the foot [...]
- (d)(1) A doctor of podiatric medicine who is ankle certified by the board on and after January 1, 1984, may do the following:
 - (A) Perform surgical treatment of the ankle and tendons at the level of the ankle [...]
 - (B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine.
 - (C) Perform a partial amputation of the foot no further proximal than the Chopart's joint.

[...]

Business and Profession Code section 2473: [Section repealed 1998.]

Repealed Stats 1998 ch 736 § 18 (SB 1981). The repealed section related to the requirement for ankle certification by the board in order to perform surgical treatment of the ankle.

Background

Through passage of legislation (chapter 305, Statutes of 1983) section 2472 B&P was amended in 1983 to include surgical treatment of the ankle in the definition of podiatric medicine. Physicians were therefore authorized to perform ankle surgery as part of their medical practice after gaining “ankle certification” by passing a rigorous oral examination offered and administered by the board. Upon successful passage of the ankle examination, physicians were issued the required ankle license for surgically treating the ankle. Thus, 1984 was the year that a two-tier system of podiatric licensure between ankle and non-ankle certified physicians was codified in the Podiatric Medicine Practice Act (“Article 22”) of the Medical Practice Act.

A mere fifteen years later with enactment of SB 1981 (Greene, Chapter 736, Statutes of 1998) the state legislature completely repealed the requirement for any ankle certification at all. Then existing California doctors of podiatric medicine licensed by the board on and after January 1, 1984 were simply automatically fully authorized to perform ankle surgery. While the board commented at that time that elimination of the two-tier system of licensure was likely premature, the system evolved to distinguish between pre- and post-1984 licensed physicians.

For obvious reasons, the board endeavored to offer those physicians licensed prior to 1984 opportunities to become ankle licensed if certified by the American Board of Podiatric Surgery or through passage of a sophisticated board administered oral examination. Eventually, the board examination was discontinued due to a lack of demand. Nevertheless, the two-tier system of licensure continued.

With passage of AB 932 (Koretz, Chapter 88, Statutes of 2004) the demand for board administered ankle examinations again arose in 2004. At that time many practitioners with conservative practice in the preservation of diabetic foot—which unfortunately sometimes involves digital (toe) amputations critical for the care and treatment of diabetic patients—were being prohibited from performing surgical treatments of the foot that were part and parcel of their existing practices. The compromise measure established “ankle certification” obtained “on and after 1984” as the criteria for authority to perform partial amputations.

While the impetus for passage of AB 932 mainly centered on removing outdated statutory language from the Podiatric Medicine Practice Act that was then being interpreted as a basis to prohibit DPMs from performing minor toe amputations, the law essentially transformed the two-tier licensure system to discriminate not only between pre- and post-1984 licensed physicians but also between ankle and non-ankle certified physicians. This resulted in literally disenfranchising all pre-1984 non-ankle certified physicians from performing even the most basic diabetic toe amputations.

Accordingly, the board again endeavored to offer these newly disenfranchised physicians opportunities to sit for board administered ankle examinations. All those physicians interested in pursuing ankle licensure did so. In total 53 additional doctors of podiatric medicine successfully obtained ankle certification in four separate exam administrations. The last examination was administered in 2010 to the only two known remaining interested examinees. Ankle certification examinations were thus again discontinued due to a lack of demand.

Discussion

California has officially recognized and defined the practice of podiatric medicine to legitimately include surgical treatment of the ankle as part of the scope of podiatric medical practice for over 30 years. As a direct result, the practice of podiatric medicine in California has continued to evolve into a highly complex surgical subspecialty. The advances made by the podiatric medical profession in the state since those times are unquestionable. In the process however a two-tier system of podiatric licensure has been created and permitted to continue in California.

After the board’s Sunset Review report in 2011, Joint Committee staff recommended considering whether a single scope of licensure for doctors of podiatric medicine should be confirmed by removing reference to ankle certification on and after January 1, 1984 from the B&P Code. In support, the board had submitted that over 80% of the podiatric licensee population was ankle certified. Given indications that non-ankle certified physicians comprised a small number of older licensees that neither performed ankle surgeries nor amputations, it was also commented that the percentage was expected to increase over time as greater numbers of pre-1984 licensed physicians retired from practice.

To date, there has not been any further interest expressed by the podiatric medical community for ankle examinations since 2010. As a result, an informal executive study was commissioned by the board on March 6, 2015, for the purpose of analyzing the current state of the podiatric licensee population and determining whether reference to ankle certification in the practice act continues to be necessary. The tables that follow below provide the study’s relevant and significant findings for Joint Committee review and consideration.

BPM Table 5a. Non-Ankle Certified Licensee Populations		
ACTIVE LICENSEES		
TYPE	PRACTICE AUTHORIZATION	COUNT
DPM	Practice Permitted	71
DPM – Military Waiver	Practice Permitted	0
DPM – Disabled	NO PRACTICE PERMITTED	20
DPM - Retired	NO PRACTICE PERMITTED	75
TOTALS PERMITTED TO PRACTICE		71
TOTALS PROHIBITED FROM PRACTICE		95
DELINQUENT/CANCELLED/REVOKED/SURRENDERED/DECEASED LICENSES		
DELINQUENT STATUS		
TYPE	PRACTICE AUTHORIZATION	COUNT

DPM	NO PRACTICE PERMITTED	4
DPM – Military Waiver	NO PRACTICE PERMITTED	0
DPM – Disabled	NO PRACTICE PERMITTED	9
DPM – Retired	NO PRACTICE PERMITTED	38
TOTALS PERMITTED TO PRACTICE		0
TOTALS PROHIBITED FROM PRACTICE		51
CANCELLED STATUS		
TYPE	PRACTICE AUTHORIZATION	COUNT
DPM	NO PRACTICE PERMITTED	37
DPM – Military Waiver	NO PRACTICE PERMITTED	9
DPM – Disabled	NO PRACTICE PERMITTED	21
DPM – Retired	NO PRACTICE PERMITTED	144
TOTALS PERMITTED TO PRACTICE		0
TOTALS PROHIBITED FROM PRACTICE		211
SURRENDERED STATUS		
TYPE	PRACTICE AUTHORIZATION	COUNT
DPM	NO PRACTICE PERMITTED	26
DPM – Military Waiver	NO PRACTICE PERMITTED	0
DPM – Disabled	NO PRACTICE PERMITTED	0
DPM – Retired	NO PRACTICE PERMITTED	0
TOTALS PERMITTED TO PRACTICE		0
TOTALS PROHIBITED FROM PRACTICE		26
REVOKED STATUS		
TYPE	PRACTICE AUTHORIZATION	COUNT
DPM	NO PRACTICE PERMITTED	40
DPM – Military Waiver	NO PRACTICE PERMITTED	0
DPM – Disabled	NO PRACTICE PERMITTED	0
DPM – Retired	NO PRACTICE PERMITTED	0
TOTALS PERMITTED TO PRACTICE		0
TOTALS PROHIBITED FROM PRACTICE		40
DECEASED		
TYPE	PRACTICE AUTHORIZATION	COUNT
DPM	N/A	8
DPM – Military Waiver	N/A	0
DPM – Disabled	N/A	2
DPM – Retired	N/A	31
TOTAL		41
GRAND TOTAL		535
TOTAL NON-ANKLE DPMS AUTHORIZED TO PRACTICE		71

The board has a current active population of 2249 doctor of podiatric medicine licensees for FY 2014/15. The figure may be referenced in Table 6 under section 4 of the present report.

Counting both active and inactive populations, the board has a grand total of 535 licensees reflected as lacking ankle certification by the board. Unfortunately, 41 of these individuals are deceased. Thus, for obvious reasons, these should not be included in the analysis. Of the remaining 494 licensees in the board database indicating non-ankle certification, a full 66% are legally prohibited from practicing medicine in the state of California. These include revoked, surrendered, cancelled and delinquent status licensees. These may all be considered as having prohibited practice status that present little to no probability of ever returning to the active practice of medicine.

To be sure, while the class of delinquent status licensees does present a chance that some individuals will remedy delinquencies in order to return to the active practice medicine, the likelihood is minor. Further, pursuant to section 2428 B&P, delinquent licenses are cancelled after 3 years of non-renewal. The Table immediately below provides the current timeframe statuses on the 51 delinquent licensees.

DELINQUENT NON ANKLE LICENSEE – STATUS BREAKDOWN			
COUNT	24	< 1 year	Between 5-11 months delinquent – No practice permitted
	22	1st year	No practice permitted
	5	2nd year	No practice permitted
	0	3rd year	Cancelled
TOTAL	51		

Based on these considerations, the board has an active population of 166 doctors of podiatric medicine that do not have ankle certification. Out of this population of licensees, 75 are in retired status and another 20 are unable to practice podiatric medicine due to disability. Both categories are also legally restricted from engaging in the practice of podiatric medicine. As a result there are a total of only 71 active doctors of podiatric medicine that lack ankle certification. 5 of the 71 are listed as residing out of state with no practice in California; thus leaving a total of 66. This represents a mere 2.9% of the active licensee population in the state without ankle certification.

Borrowing retirement analytics originally performed as part of the board fee study, analysis of central tendency indicates that the average age for licensee retirement is 64, with the mode at 62 and the median at 64. Based on the current age distribution of current licensees in the database, a projection of up to 367 licensees may be expected to retire in the next five years. Applying these analytics to the non-ankle certified population of 71 physicians who collectively average 67 years of age, 52 of the expected 367 retirements are non-ankle certified physicians that may be expected to retire from the practice of medicine in the next five years if not sooner. Table 5b provides the relevant age distribution of the active non-ankle certified population for reference below.

BPM Table 5b. Licensees without Ankle Certification permitted to Practice

COUNT	AGE	NOTE
4	60	1 licensee resides out-of-state
4	61	1 licensee resides out-of-state
4	62	
7	63	
11	64	1 licensee resides out-of-state
5	65	
1	66	
4	67	
6	68	
3	69	
5	70	1 licensee resides out-of-state
4	71	
4	72	
3	73	
1	74	
2	76	
1	77	licensee resides out-of-state
1	79	
1	82	
TOTAL COUNT	AVG AGE	
71	67	5 total licensees residing out of state

For purposes of determining whether removing reference to “ankle certification by BPM on and after January 1, 1984” can be done without jeopardizing consumer safety, it is important to note that all physicians are required to limit their medical and surgical practice to the extent of their education, training and experience alone. Hospitals and health facilities also uniformly apply credentialing processes based on a licensee’s affirmative demonstration and satisfaction of required education, training and experience in order to grant facility and surgical privileges. In this case, ankle surgeries may only be performed in peer-reviewed health facilities pursuant section 2472(e) B&P.

As a result, while 97.1% of active BPM licensees may now in fact currently be licensed to perform ankle surgery, many physicians consciously choose not to do so and no health facility would grant ankle surgery privileges to them unless these physicians were able to affirmatively demonstrate the requisite training and experience necessary to perform ankle surgery; even if—legally speaking—they are licensed by the Board to do so.

The important corollary to this principle is that if reference to “ankle certification by BPM on and after January 1, 1984” were to be removed—thereby legally recognizing the remaining 2.9% of licensees authority to perform ankle surgery—health facilities and hospitals would not grant them automatic privileges to do so because these physicians would likely not be able to demonstrate the requisite credentials necessary to satisfy ankle surgery privileging requirements; and it is only in these peer-reviewed facilities where ankle surgeries may be lawfully performed at all. Thus, these physicians

would be required to seek out and receive any additional relevant training and education necessary to pass health facility privileging requirements in order to be granted ankle surgery facility privileges.

It may therefore be reasonably concluded that amending section 2472(d)(1) to remove reference to “ankle certification by BPM on and after January 1, 1984” to confirm a single scope of podiatric medical licensure for the sake of simplifying the statute and its administration can be accomplished without any danger to consumer safety.

Conclusion

At this time, 31 years after section 2472 was amended to include surgical treatment of the ankle in the definition of podiatric medicine, a full 97.1% of the board’s active licensees are ankle-licensed and legally authorized by the board to surgically treat the ankle. While not all current ankle-certified physicians perform ankle surgeries due to the lack of credentials for gaining health facility privileges to do so, any newly recognized physicians authorized through amendment of the law to permit ankle surgery would be required to demonstrate the training and experience necessary to gain privileges to perform ankle surgery at peer reviewed health facilities; the only locations where ankle surgeries are permitted.

With only 66 active status physicians left without ankle certification and currently remaining in the state, representing a mere 2.9% of the total active licensee population, it is believed that continued reference to ankle certification on and after January 1, 1984, has arguably run its course.

Thus, with less than 3% of the active licensee population lacking ankle certification, representing only 71 physicians (5 out of state) who bear an average age 67 years, it is indeed only a very small number of older licensees who are not legally authorized to perform ankle surgeries. These facts coupled with the expectation that a full 75% of them will retire in the next five years or less lend strong support to the contention that continued reference to ankle certification on and after January 1, 1984, has arguably ceased to provide any known continued usefulness and may be confidently amended to remove reference ankle certification by BPM on and after January 1, 1984 without danger to the public or jeopardy to consumer safety.

Issue #2: Should the limitation on post graduate medical education be eliminated for doctors of podiatric medicine?

BPM Recommendation

Yes. BPM recommends that the statutory limitation on post-graduate medical education be eliminated for doctors of podiatric medicine.

Applicable Authority

Business and Professions Code section 2475 provides in pertinent part:

[...] a graduate of an approved college or school of podiatric medicine [...] who is issued a resident's license, which may be renewed annually for up to eight years for [post-graduate medical education training] upon recommendation of the board, and who is enrolled in a postgraduate training program [...] may engage in the practice of podiatric medicine [...] as a part of that [training] program [...] under the following conditions:
(a) [...] in an approved internship, residency or fellowship program [...] under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree [and] *[if the graduate fails to receive a license to practice podiatric medicine [...] within three years from the commencement of the postgraduate training, all privileges and exemptions under this section shall automatically cease. [...]]* (emphasis added.)

Discussion

Under section 2475(a) of the California Business and Professions Code all post-graduates in California podiatric residencies or fellowships must obtain full podiatric medical licensure within three years of starting their medical training programs or else they will be legally prohibited from continuing their studies. While recognizing that medical education is the very foundation upon which high-quality health care is built, this provision is specifically designed to ensure that all post-graduates progress into full licensure as doctors of podiatric medicine.

In addition to the above, also recognizing that a resident's license authorizes the bearer to participate in full rotations beyond the scope of podiatric medicine, there are a number of additional provisions in the statute to specifically preclude use of a resident's license as a de facto occupational license. First, all residency practice is required to be under the supervision of a licensed physician and surgeon. This also includes explicitly limiting board authorization to learn the practice of medicine in specific board-approved training programs alone.

Accordingly, all post-graduates are required to demonstrate actual enrollment in a specific board approved educational program before a resident's license may issue. A post-graduate is required to submit a Memorandum of Understanding with the board designating the name of the training program where accepted. An accepted resident must certify under penalty of perjury that they will limit training to the designated program alone and will immediately surrender the resident's license if departure from the program before expiration of the term of the one-year license occurs. Verification of continued enrollment occurs annually during the time for renewal.

As part of the annual board residency program approval process, a resident's certification of enrollment is cross-referenced with annual program documentation submitted to the board. Program directors are yearly required to provide the board with the names of all post-graduate residents enrolled in training for the upcoming year. It is also important to note that there are only a finite number of programs in the state. There were only a total of 18 programs approved for the 2015/2016 podiatric medicine residency training year in California.

There is in fact a shortage of residency programs nationally. Because they are specifically intended to train doctors in the clinical practice of podiatric medicine, residency training programs are limited in duration and thus are quite naturally extremely competitive. The likelihood of any individual staying

on with a training program as a sort of “permanent resident” past three years of required residency in an age of limited financial residency program sponsorship and diminishing training opportunities is therefore literally quite nearly non-existent. In sum, medical training practice outside any one of the above mentioned parameters is simply unlawful and a violation that would necessarily result in the unlicensed practice of medicine which would of course be thoroughly pursued.

Nevertheless, as currently codified section 2475 B&P also places an arbitrary and unreasonable obstacle to the acquisition of advanced medical education in formal programmatic settings. Lifelong learning has long been a hallmark in the medical licensing literature and has been fervently advocated by many organizations including the Federation of State Medical Boards, the American Board of Medical Specialties and the Pew Health Professions Committee. The negative corollary of this proposition is that medical educational limitations of any kind are detrimental and preclude advancement and acquisition of evolving medical knowledge and science. This is particularly true in California in two important respects.

One, BPM requires all licensed doctors of podiatric medicine to demonstrate compliance with Board-mandated continuing competency requirements. BPM is the only doctor-licensing board in the country to implement a peer reviewed, performance based assessment program for licensed physicians over and above satisfaction of continuing education units alone. Physicians licensed longer than ten years that lack specialty board certification or that do not have peer-reviewed health facility privileges have fewer options available to them in order to demonstrate competency.

Since use of BPM’s oral clinical examination was discontinued as recommended by the Joint Committee in 2002 and no longer required for state licensure, available pathways for demonstrating competency by such individuals would be limited to just three options: 1) passage of Part III of the national board examination; 2) completion of a board approved extended course of study; or 3) completion of a board approved residency or fellowship program as specified under section 2496 B&P. However, once a physician’s mandated post-graduate educational limit was reached, notwithstanding the fact that the DPM was already the holder of permanent license to practice podiatric medicine, the pathway for demonstrating continuing competency through successful completion a program of post-graduate medical education is essentially foreclosed as an available option.

Accordingly, the board would be legally prohibited from issuing a resident’s license to a licensed doctor of podiatric medicine desiring to satisfy continuing competency requirements through completion of an approved program of post-graduate education. This for no more than the simple reason than the doctor had already reached the limit of permissible education in the eyes of the state. The educational restriction discussed herein is the only statutorily imposed educational prohibition known to exist for any profession in the country.

Two, the state’s leading and most advanced podiatric physicians are ostensibly precluded from advancing in their field through limitations on participation in formal programmatic educational options available for the acquisition of advanced medical knowledge in other fields. A resident’s license represents plenary authorization to learn the entirety of clinical medical practice. This includes full

training rotations normally outside the scope of podiatric medicine under the supervision of medical or osteopathic doctors in a formal programmatic training program. This is incredibly important for the development of expertise in the healing arts as the whole history of western medicine has been built on the foundation of the “see one, do one, teach one” theory of acquisition of medical knowledge. Perhaps equally important in this case because licensed doctors of podiatric medicine, as highly specialized independent medical practitioners, are in high demand to assist other physicians and surgeons in performing nonpodiatric surgeries of any kind anywhere upon the human body as already currently permitted by their scope of practice.

As it stands today, throughout residency training, DPMs stand shoulder to shoulder with MDs and DOs in all medical and surgical rotations and with all physicians having the same level of responsibility and expectations. It is inimical to the very advancement of medical science and state of the art in the medical professions that a leading state licensed doctor of podiatric medicine would be precluded from combining with another foremost physician expert in a formal training program or fellowship simply because the licensed individual wishing to advance in her field may have already completed 8 years of formal post-graduate education.

Conclusion

Education and training are life-long processes for physicians. Accordingly, it is believed that the current medical education limitation placed on the state’s doctors of podiatric medicine places an arbitrary and unreasonable obstacle to the acquisition of advanced medical education.

While a resident’s license does represent the legal authorization to participate in training rotations normally outside the scope of podiatric medicine, there are a number of existing statutory provisions which preclude the training license from being used as a de facto occupational license or that prevent failure to progress to full licensure as doctors of podiatric medicine. These include the obligation of full licensure within 3 years from the start of training in addition to strict parameters requiring that all post-graduate education be undertaken only within formal board approved training programs under direct supervision of a licensed physician and surgeon that is verified by the board annually.

Sound public policy probably dictates that the ability to formally acquire medical education and training should not be limited by statute. As currently codified the post-graduate educational limitation works against the board’s continuing competency program by potentially foreclosing an available pathway to demonstrate competency in a peer-reviewed, performance based assessment in a residency program. The limitation also works to unreasonably interfere with advanced training opportunities for the state’s leading physicians with other leading experts. In truth, it is doubtful that California consumers would prefer to be treated by doctors having less post-graduate education rather than more. Therefore, the board believes that the statutory limitation on post-graduate medical education on doctors of podiatric medicine should be eliminated.

Issue #3: Should the BPM schedule of user service fees be increased?

BPM Recommendation

[pending board discussion and consideration of fee study]

Applicable Authority

Discussion

Conclusion

[...]

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