



**LICENSING 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 4 AND 11**

**5**

**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 Licensing 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 4: Licensing Program
2. 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 1<sup>st</sup> due date.

**NEXT STEPS**

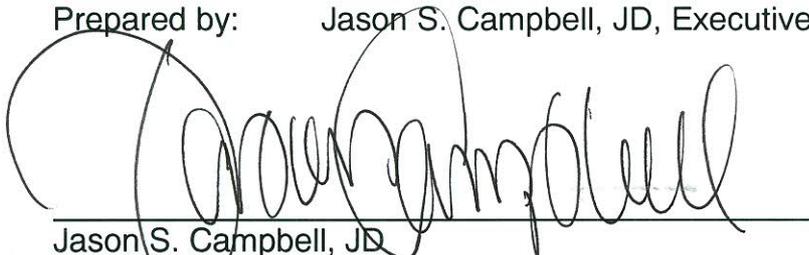
Staff will continue refining and drafting responses to questions as directed which are segregated into appropriate sections and reviewed by the respective BPM committees with subject matter jurisdiction over the particular subject areas.

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 4 and 11

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



Jason S. Campbell, JD  
Executive Officer

# California Board of Podiatric Medicine

## BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT LICENSING PROGRAM

### As of October 8, 2015

#### Section 4 – Licensing Program

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

The Board’s performance target for license processing is to provide same-day issuance of certificates to practice podiatric medicine once all documents satisfying an applicant’s licensure requirements have been received. Applicants are often personally guided through the application process and in some instances are immediately telephoned with their new license number when issued which then appears on the system in real time under the new BreZze system. This internal performance target/expectation is being met with aplomb as it has been for several decades and serves as a matter of personal pride for all board staff. BPM’s focus on customer-centric processes has directly contributed to the creation of a personalized, streamlined and efficient licensing program function that has eliminated delay and backlog for nearly 25 years.

**2. Describe any increase or decrease in the board’s average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?**

Since BPM began primary-source verification of credentials in 2003, the board has relied on the exchange of credentials and verifications from source institutions by postal mail. Accordingly, average license processing times—from the time of receipt of the application and all required supplemental documentation including applicable fees to the time of approval and issuance of a certificate—are wholly predicated on the applicant’s speed, ability and efficiency in contacting source institutions and having them forward all required credentials that affirmatively demonstrate qualification for licensure directly to BPM. This has translated into a 64-day average licensing cycle time for the last four fiscal years as illustrated in Table 7a.

Again, the bulk of this time is directly attributed to the time it takes an applicant to coordinate mail delivery of all licensure materials such as educational transcripts, certificates of approved residency

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<sup>1</sup> The term “license” in this document includes a license certificate or registration.

training, certified examination scores and disciplinary databank reports directly to BPM from source institutions. Notwithstanding, there has not been an appreciable backlog of pending applications nor has there ever been a growth rate that would exceed completed applications. Of the 13 total pending applications handled by BPM in the last four fiscal years; 3 in FY 12/13; 4 in 13/14; and 6 in 14/15; all 13 have been attributed to factors entirely outside of board control.

BPM is gradually beginning to accept and expand its use of electronic source verification from an ever increasing number of institutions. Electronic primary source verification represents a significant advance over the paper verification process. Various security features also ensure that only certain institutional officials are able to send credentials. This process eliminates both transit time and delivery delay normally associated with use of the mails and serves as a benefit to source institutions and the applicant. It is expected that as more and more institutions begin to implement electronic source documents for verification, average BPM licensing cycle times will continue to decline.

### 3. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

The total yearly license issuance data for BPM is contained in Table 7b below. As may be seen, the board issues an average of 106 licenses each year for a grand total of 425 new licenses issued in the past four years. This figure includes a combined average total for both permanent DPM licenses and Resident licenses which may be roughly segregated out along a 60/40 percentage split, respectively. The Board also issues an average of 1106 renewals each year. Table 7a supplies the pertinent figures below. Referencing the data indicates that 1114 renewals were issued FY 11/12; 1032 renewals were issued in FY 12/13; 1126 renewals were issued in FY 13/14; and 1052 renewals issued in FY 14/15.

<b>Table 6. Licensee Population</b>					
		FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Doctor of Podiatric Medicine	Active	2144	2155	2288	2249
	Out-of-State	281	308	332	373
	Out-of-Country	6	6	9	9
	Delinquent	120	118	145	218
Resident	Active	116	121	122	117
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	0	0	0	0
Fictitious Name Permit	Active	592	604	337	318
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	322*	325*	390*	424*

\*The Medical Board of California (MBC) handles Fictitious Name Permit (FNP) application processing for the Board of Podiatric Medicine. The delinquency rate for FNPs is attributable to non-renewal. Barring subsequent renewal by a registrant, an FNP will remain in delinquent status for a total of 5 years. All FNPs will automatically cancel following a 5 year period of delinquency. MBC is aware of the high delinquency rate and is making an effort to reach out to delinquent FNP registrants for resolution.

**Table 7a. Licensing Data by Type**

Application Type		Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control	Within Board control	Complete Apps	Incomplete Apps	combined, IF unable to separate out (days)
FY 2011/12	Permanent*	64	64	64	64	0	0	0	-	-	71
	Resident**	36	36	36	36	0	0	0	-	-	
	Renewed	1114				n/a					
FY 2012/13	Permanent	69	66	66	66	3	3	0	-	-	67
	Resident	45	45	45	45	-	-	-	-	-	
	Renewed	1032				n/a					
FY 2013/14	Permanent	60	60	60	60	-	-	-	-	-	55
	Resident	51	47	47	47	4	4	-	-	-	
	Renewed	1226				n/a					
FY 2014/15	Permanent	69	69	69	69	-	-	-	-	-	63
	Resident	44	38	38	38	6	6	-	-	-	
	Renewed	1052				n/a					

\*Permanent DPM License    \*\*Resident/Limited/Temporary DPM License

**Table 7b. Total Licensing Data**

		FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	
<b>Initial Licensing Data:</b>						
Initial License Applications Received		Permanent	64	69	60	69
Initial License Applications Approved			64	66	60	69
Initial License Applications Closed			64	66	60	69
Initial License Applications Received		Resident (Limited/Temporary)	36	45	51	44
Initial License Applications Approved			36	45	47	38
Initial License Applications Closed			36	45	47	38
<i>Total Initial License Issued – Permanent and Resident</i>			100	111	107	107
<b>Initial License Pending Application Data:</b>						
Pending Applications (total at close of FY)			0	3	4	6
Pending Applications (outside of board control)*			0	3	4	6
Pending Applications (within the board control)*			0	0	0	0
<b>Initial License Cycle Time Data (WEIGHTED AVERAGE):</b>						
Average Days to Application Approval (All - Complete/Incomplete)			71	67	55	63
Average Days to Application Approval (incomplete applications)		Combined cycle times (unable to separate)				
Average Days to Application Approval (complete applications)						
<b>License Renewal Data:</b>						
License Renewed – Permanent and Resident			1114	1032	1226	1052

#### **4. How does the board verify information provided by the applicant?**

Since passage of AB1777 [Statutes 2003, Chapter 586], the Board standard has been to require 100% primary source verification for all applicant information. BPM thus requires all applicant information to be supplied directly from original sources alone. This standard ensures qualification and credential authenticity and accuracy and remains a critical tool for combatting document falsification.

##### **a. What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?**

Before any license to participate in a California podiatric residency program or to practice podiatric medicine in California is issued, BPM requires that a criminal record clearance be obtained through both the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

This process is facilitated through DOJ's Live Scan Program; the State's electronic fingerprinting system with automated background check and response. Live Scan is offered as an alternative to the traditional paper and ink fingerprint cards. Out-of-state applicants must contact the Board to request that fingerprint cards be mailed to them and completed with assistance of a local law enforcement office and submitted with the license application. While either option is available to applicants, those residing in California are strongly encouraged to use the Live Scan option as it provides quicker processing times usually taking 48 to 72 hours as opposed to 60 days for traditional fingerprint cards with processing costs being the same.

Applicants must also arrange to have the national disciplinary databank report sent directly to BPM which may disclose information regarding any existing malpractice suits filed or other adverse action taken against the applicant. Additionally, those applicants currently or previously licensed in another state or states are required to have each respective state licensing agency submit a license verification containing current status and any existing disciplinary actions or investigations directly to the Board.

##### **b. Does the board fingerprint all applicants?**

Yes. All applicants for licensure including those applying for a resident's license are fingerprinted.

##### **c. Have all current licensees been fingerprinted? If not, explain.**

Yes. All current and existing licensees have been fingerprinted.

##### **d. Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?**

Yes. There is a national disciplinary databank report sent directly to BPM from the Federation of Podiatric Medical Boards that is reviewed for information regarding any existing malpractice suits filed or other adverse actions taken against an applicant as a qualification for licensure before issuance. Applicants must arrange to have the national disciplinary databank report sent directly to BPM for review by the board prior to license issuance.

Licensees renewing their certificates to practice podiatric medicine are required to disclose any convictions for any crimes in any state and/or disciplinary action taken by any government agency or other disciplinary body on their biennial renewal form under penalty of perjury. The board also has mandatory reporting from several entities that are received by the board's Enforcement Program which in turn determines the appropriate action to pursue. Finally, because fingerprinting is a requirement for podiatric medical licensure, the board Enforcement Program also receives automatic DOJ notification of any subsequent arrest of any active licensee pursuant to section 11105.2 of the California Penal Code which are reviewed for a determination if action should be taken.

**e. Does the board require primary source documentation?**

Yes. Having been an early champion and recommending primary source verification as a statutory requirement for licensing DPMs in California, BPM has fully adopted and implemented primary source documentation which remains the national gold standard in licensing and medical credentialing.

**5. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.**

Failure to satisfy any California requirement for podiatric licensure will preclude the issuance of a certificate to practice podiatric medicine by the board. Further, the board does not have reciprocity with any other state. The statute delineating the board's legal requirements for processing out-of-state applicants to obtain licensure is contained in section 2488 B&P. The statutory provision is known as BPM's licensure by credentialing statute and it was codified in 2003. In addition to requiring the absence of acts or crimes that would constitute grounds for denial of a license as for any other license applicant, BPM's credentialing provision calls for out-of-state applicants to have:

- graduated from an approved school or college of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME);
- have passed either Part III of the examination administered by the National Board of Podiatric Medical Examiners or an examination recognized as equivalent by the Board within the last 10 years; and
- satisfactorily completed one year of post-graduate medical education as opposed to two.

To date there are no CPME accredited teaching institutions located abroad. It bears mentioning that podiatric professions internationally on a whole continue to lag behind U.S. standards and California education and training requirements particularly. Accordingly, while there is no current process in place for processing out-of country applicants, it has not presented an issue to date.

**6. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.**

While the board is not currently aware of any existing military medical schools such as the Uniformed Services University that offer a podiatric medical curriculum or equivalent medical training leading to a doctor of podiatric medicine (DPM) degree, existing law and regulation under BPC 2483 and section 1399.666 of Podiatric Medicine Regulations do currently provide for recognition if the military

educational program were to be accredited by the Council on Podiatric Medical Education (CPME). This is also true of post-graduate podiatric medical education training which necessarily includes military podiatric residencies such as those offered by the Department of Veteran’s Affairs that are by all indications already CPME accredited.

However, should a prospective California DPM applicant with experience gained in the U.S. Armed Services as a doctor of podiatric medicine present a non-CPME accredited residency, there would be no currently feasible process in place for evaluating equivalency under existing regulations. Having said this, the Board has recently undertaken efforts to investigate ways to meet the BPC § 35 mandate which is more fully discussed under question 21 subsection c below.

**a. Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?**

Yes. BPM’s Application for a Certificate to Practice Podiatric Medicine has been appropriately amended to include questions regarding an applicant’s past and/or current service in the U.S. Armed Forces. Further, with the recent August 10, 2015 completion of User Acceptance Testing (UAT) for two new System Investigation Requests (SIRs) for implementing BPM § 114.5 enhancements to BreEZe system-wide, veteran data recording features are now in production and functioning as designed. Accordingly, BPM is now able to systematically identify and track veteran applicants through its licensing software database.

**b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?**

The board has not had any applicants offer military training or experience to meet licensing or credentialing requirements for a certificate to practice podiatric medicine in California to date. However, if one considers post-graduate medical training obtained in a U.S. Department of Veterans Affairs podiatric medical residency program as a classification of military related education, the board has had a total of 38 applicants offer such education for meeting licensure requirements; all which were accepted. An annual summary is provided in the table immediately below.

<b>BPM Table 7c. Department of Veterans Affairs Medical Residents</b>	
<b>Academic FY year</b>	<b>Residents offering VA residencies for licensure</b>
14/15	10
13/14	12
12/13	8
11/12	8

**c. What regulatory changes has the board made to bring it into conformance with BPC § 35?**

With board approval of a motion passed at the June 5, 2015 meeting of the board, BPM is currently in the process of conducting an evaluation of military education, training and experience obtained in the Armed Services for a determination as to how they may possibly be used for satisfying state licensure or credentialing requirements for podiatric medical licensure.

Preliminary findings prove that it is nearly axiomatic that basic qualification requirements for Active Duty employment as a Doctor of Podiatric Medicine in the armed services medical corps mandates, among other things, a doctor of podiatric medicine degree; current licensure in one of the fifty states or the District of Columbia; and successful completion of a surgical residency or an equivalent formal surgical training program. Accordingly, two issues immediately become evident: 1) not all states require two years of podiatric residency and podiatric surgical training; 2) nor are all podiatric and surgical training residencies CPME accredited; both are required criteria for licensure by the board.

It is therefore conceivable that recognition of military medical experience gained in active duty service with the U.S. Armed Forces as a doctor of podiatric medicine for a yet undetermined number of requisite years may serve a possible basis for equivalency licensure under BPM's credentialing statute for those DPM veterans presenting less than two years of podiatric and surgical residency training; or with a non-CPME accredited residency; or alternately presenting no residency training at all. These and other possibilities are currently in the process of research and investigation by the board as required by BPC section 35.

**d. How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?**

The board has not had any section 114.3 requests from active duty members of the armed forces or National Guard for waiver of fees or requirements in the last four fiscal years. Accordingly, BPC section 114.3 has had no impact on board revenues.

**e. How many applications has the board expedited pursuant to BPC § 115.5?**

While the requisite amendments to BPM's Application for a Certificate to Practice Podiatric Medicine have duly incorporated appropriate questions for compliance with BPC § 115.5 mandates in order to expedite the applications for individuals holding active licensure in another state while married to active duty service members assigned to duty in California, the board has not received any applications for expedited licensure to date.

**7. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.**

Yes. Pursuant to Penal Code section 11105.2, the Board continues to send No Longer Interested notifications to DOJ for licensees with canceled, surrendered, revoked or deceased status. While this process is completed through use of the mails or facsimile transmittal rather than electronically there is no backlog to report or address.

## Examinations

<b>Table 8. Examination Data</b>							
<b>California Examination (include multiple language) if any:</b>							
License Type		N/A	N/A	N/A			
Exam Title		BPM Oral Clinical	BPM Oral Clinical	BPM Oral Clinical			
FY 2011/12	# of 1 <sup>st</sup> Time Candidates	Not Applicable to this program (BPM Oral Clinical Exam discontinued in 2002)					
	Pass %						
FY 2012/13	# of 1 <sup>st</sup> Time Candidates						
	Pass %						
FY 2013/14	# of 1 <sup>st</sup> Time Candidates						
	Pass %						
FY 2014/15	# of 1 <sup>st</sup> time Candidates						
	Pass %						
Date of Last OA							
Name of OA Developer							
Target OA Date							
<b>National Examination (include multiple language) if any:</b>							
License Type		Resident	Resident	DPM			
Exam Title		Part I	Part II	Part III			
FY 2011/12	# of 1 <sup>st</sup> Time Candidates	Examinations administered by the National Board of Podiatric Medical Examiners (NBPME)		41			
	Pass %			93%			
FY 2012/13	# of 1 <sup>st</sup> Time Candidates			51			
	Pass %			98%			
FY 2013/14	# of 1 <sup>st</sup> Time Candidates			42			
	Pass %			98%			
FY 2014/15	# of 1 <sup>st</sup> time Candidates			60			
	Pass %			91%			
Date of Last OA				2011	2010		
Name of OA Developer				NBPME			
Target OA Date		Date unavailable					

### 8. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?

The examinations required for podiatric licensure by BPM include Parts I, II and III of the American Podiatric Medical Licensing Examination (“APMLE”). APMLE is a national examination administered by the National Board of Podiatric Medical Examiners (“NBPME”) and its use is mandated by section 2486 B&P.

Applicants must sit for and pass APMLE Parts I and II while attending podiatric medical school in order to qualify for a Resident’s License before participating in California based post-graduate medical training as required by section 2475.1 B&P. During post-graduate residency training an

applicant must also sit and pass APMLE Part III, which is the clinical competence component of National Board examination, in order to satisfy the requirements for full licensure to practice podiatric medicine.

With the passage of SB 1955, APMLE Part III replaced the California specific examination as a means for determining entry-level competence of knowledge and clinical skills evaluating, diagnosing, and treating patients consistent with sound medical practice and consumer protection. Use of BPM's oral clinical examination was therefore discontinued and is no longer required for State licensure as recommended by the Joint Committee in 2002.

**9. What are pass rates for first time vs. retakes in the past 4 fiscal years? (Refer to Table 8: Examination Data)**

Referring to the data reflected in Table 8 above, first time examinee passage rates range from a low of 91% in FY 14/15 to a high of 98% in FYs 12/13 & 13/14 for an average pass rate of 95% during the past 4 fiscal years.

**10. Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?**

While the Board does not administer its own examination, all parts of the national examination administered by the NBPME are computer based tests.

Exams are comprised of a set number of questions. NBPME reports that each question is presented only one time. Once an examinee advances to a subsequent question, he or she is precluded from returning to the previous question. Questions are presented to the examinee in four different formats which include: 1) single answer multiple choice; 2) check all applicable choices; 3) drag and drop panels for correct sequencing; and 4) image clicks to the correct area depicted. Credit is received for correctly answered questions alone.

Test center locations for each examination are located and reserved within a fifty miles radius of the nine schools of podiatric medicine. Exam takers may register online and check for exam center locations near them. For the 2015 calendar year, Parts I and III are scheduled to be held twice during the year with Part II being administered three times.

**11. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.**

There are no existing statutes that are believed to hinder the efficient and effective processing of applications at this time.

## School approvals

### **12. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?**

The statutes delineating the Board's legal requirements regarding school approvals are contained within sections 2470 and 2483 B&P. The Board may approve and develop equivalency standards for extending approval to any schools or colleges offering an adequate medical curriculum related to podiatric medicine extended over a period of four years or 32 actual months of instruction representing a minimum of 4,000 course hours of study.

Accordingly, through exercise of its regulatory authority, the Board has required teaching institutions to be accredited by the Council of Podiatric Medical Education ("CPME") pursuant to section 1399.662 of BPM's podiatric medicine regulations. CPME requires a four-year didactic and clinical curriculum nearly identical to that of medical schools with the exception of focused emphasis on the lower extremity of the human body. CPME holds designated accrediting status nationally and has held official recognition as the national authority for accrediting first professional degree programs in podiatric medicine from the United States Department of Education since 1952.

While the Bureau of Private Postsecondary Education ("BPPE") serves an important and vital mission in promoting and protecting the interests of students and consumers through effective oversight of private postsecondary educational institutions, BPPE does not approve medical or podiatric medical schools or colleges as of this writing. Therefore, the Board does not work with BPPE as a result of the BPPE's lack of role in the medical and podiatric school approval process.

### **13. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?**

There are only a total of nine CPME accredited and Board approved podiatric medical schools and colleges in existence within the United States. Periods of accreditation may extend no longer than a maximum of eight years based upon comprehensive on-site visits and continued demonstration of compliance with CPME standards.

If warranted CPME may institute focused evaluations and/or place accredited educational institutions on probationary status in order to address specific concerns. Eight year accreditation cycles may be abbreviated in instances where deterioration or substantial programmatic changes have occurred, a complaint has been filed, or whenever circumstances require review in the discretion of the accrediting agency which may impact existing accreditation periods.

The Board may remove its approval of any school notwithstanding CPME accreditation if it is determined that the school or college does not meet statutory or regulatory requirements pursuant to BPM podiatric medicine regulation section 1399.662(b).

#### **14. What are the board's legal requirements regarding approval of international schools?**

Pursuant to BPM Podiatric Medicine Regulations, podiatric medical schools and colleges are required to be accredited by CPME under sections 1399.662 and 1399.666. There are currently no CPME accredited teaching institutions located abroad in other countries. CPME criteria and guidelines require a four-year didactic and clinical curriculum nearly identical to that of medical schools with the exception of focused emphasis on the lower extremity of the human body.

While education for podiatrists and chiropodists is available across jurisdictions globally, international programs do not generally award Doctor of Podiatric Medicine degrees. Accordingly, no existing international school yet offers an educational curriculum leading to a doctor of podiatric medicine degree which serves as the recognized basis for licensure in California and the U.S. Rather the international focus has been to continue to award either post-secondary diplomas in chiropody or bachelors of podiatry. Further, the days of licensing chiropodists in the state have long ceased and are the product of a bygone era. The podiatric professions in the United States have advanced significantly while internationally on a whole continue to lag behind U.S. standards and California education and training requirements particularly.

It has been reported that an international four-year program located in Canada is reputed to be substantially patterned on U.S. podiatric medical curriculums that begins to approach CPME standards of accreditation. However, BPM is unaware of any effort on behalf of the Universite de Quebec a Trois-Rivieres in Trois-Rivieres, Quebec to seek CPME certification. Nor has CPME—as the designated national accrediting agency for United States in podiatric medical education—accredited any teaching institution outside of the United States.

#### **Continuing Education/Competency Requirements**

#### **15. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.**

The statute and regulations delineating the requirements for the Board's continuing education (CE) and competency programs are found in section 2496 B&P and section 1399.669 of the Podiatric Medicine Regulations. Continuing education requirements include:

- Completion of 50 hours of approved continuing medical education every two years.

Satisfaction of BPM mandated continuing competency—the only doctor-licensing board in the country to implement such a program over and above continuing education alone—may be affirmatively demonstrated at licensure renewal through satisfaction of one of eight statutory pathways and include:

- Completion of an approved residency or fellowship program within the past 10 years.
- Passage of a board administered exam within the past 10 years.
- Passage of an examination administered by an approved specialty certifying board within the past 10 years.

- Current diplomate, board-eligible or qualified status granted by an approved specialty certifying board within the past 10 years.
- Recertification of current status by an approved specialty certifying board within the past 10 years.
- Passage of Part III of the national board examination with the past 10 years.
- Grant or renewal of staff privileges within the past 5 years by a health care facility recognized by the federal/state government or organization approved by the Medical Board of California.
- Completion of an extended course of study within the past 5 years approved by the board.

**a. How does the board verify CE or other competency requirements?**

The board verifies CE and mandated continuing competency requirements by licensee self-reporting through submission of a signed declaration of compliance to BPM under penalty of perjury during each two-year renewal period for every licensee.

**b. Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.**

Yes. It is the board's policy to conduct CE and continuing competency audits of licensees once each year through a sample of doctors of podiatric medicine who have reported compliance with the requirements pursuant to Podiatric Medicine Regulation sections 1399.669 and 1399.676. Doctors selected for audit through a random sample are required to document their compliance with CE and continuing competency requirements. Those selected for audit may not be audited more than once every two years.

**c. What are consequences for failing a CE audit?**

Any doctor found out of compliance with board mandated CE and continuing competency requirements will be ineligible for renewal of his or her license to practice podiatric medicine unless granted a discretionary waiver under Podiatric Medicine Regulation section 1399.678 which may only be granted once.

Non-compliant physicians granted a waiver will in turn be required to satisfy the identified deficiencies in addition to demonstrating compliance with the hours required for the next renewal period. Those failing to demonstrate compliance prior to the next biennial renewal will not be permitted to practice until such time as all required hours of CE are met in addition to one of the continuing competency pathways.

**d. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?**

The board has conducted 3 CE audits in the past four fiscal years. Out of 114 licensees randomly selected for CME in the past four fiscal years, 9 have not successfully passed for an average 7.8% failure rate overall. BPM Table 8a below provides a summary of the relevant data for each of the last four fiscal years the CME audit was performed.

<b>BPM Table 8a. CME Audits</b>			
<b>FY 2011/12</b>			
<b>Number Audited</b>	<b>Pass</b>	<b>Fail</b>	<b>Percentage Compliance</b>
20	19	1	95%
<b>FY 2012/13</b>			
20	18	2	90%
<b>FY 2013/14</b>			
No audit conducted due to 25% to 50% staff shortage during 2014 year.			
<b>FY 2014/15</b>			
74	68	6	91%

**e. What is the board's course approval policy?**

The board's policy on approved CE courses is contained in Podiatric Medicine Regulation sections 1399.670 and 1399.671. Only scientific courses directly related to patient care may be approved. With the exception of podiatric residency programs and clinical fellowships, all approved institutions, organizations and other CE providers must also utilize surveys and participant assessment evaluations for the purpose of determining areas of clinical practice having the greatest need for instruction relevant to patient care and developments in the field of podiatric medicine and to determine whether course program objectives have been met.

The following below listed categories are recognized by BPM as having met these criteria.

- Courses approved by the California Podiatric Medical Association
- Courses approved by the American Podiatric Medical Association
- Courses certified for Category 1 credit by the American Medical Association; or affiliates
- Courses certified for Category 1 credit by the California Medical Association; or affiliates
- Courses certified for Category 1 credit by the American Osteopathic Association; or affiliates
- Courses certified for Category 1 credit by the California Osteopathic Association; or affiliates
- Courses offered by approved colleges or schools of podiatric medicine
- Courses offered by approved colleges or schools of medicine
- Courses offered by approved colleges or schools of osteopathic medicine
- Courses approved by a government agency
- Podiatric residency programs or clinical fellowships
- Courses approved by the board pursuant to the requirements set forth in Podiatric Medicine Regulation section 1399.671

**f. Who approves CE providers? If the board approves them, what is the board application review process?**

In addition to the board, the following institutions are recognized as authorized CE course provider approvers:

- The California Podiatric Medical Association
- The American Podiatric Medical Association
- The American Medical Association; or affiliates
- The California Medical Association; or affiliates
- The American Osteopathic Association; or affiliates
- The California Osteopathic Association; or affiliates
- Approved Colleges or Schools of Podiatric Medicine
- Approved Medical Schools or Colleges
- Approved Colleges or Schools of Osteopathic Medicine
- Government agencies
- Podiatric residency programs or clinical fellowships

The board also approves CE providers under the board application review process delineated in Podiatric Medicine Regulation 1399.671. The review process requires those individuals, organizations or institutions not recognized as an approved course provider to submit documents and other evidence directly to the board for verification of compliance with board mandated course requirement criteria. Courses are approved on an hour-for-hour basis and the criteria for course approval include:

- A faculty appointment in a public university, state college or private post-secondary educational institution approved by section 94310 of the California Education Code.
- A demonstrated rationale of necessity for the course and how the need was determined
- A description of course content and how it satisfies the identified need for the course
- A clearly articulated list of educational objectives that may be realistically achieved
- Description of the planned methods of teaching instruction for course delivery
- Stated intent to maintain a record of attendance for all participants

**g. How many applications for CE providers and CE courses were received? How many were approved?**

Since the last Sunset Review in 2011, the board has received 1 application for CE course approval which was approved during the 14/15 Fiscal Year.

**h. Does the board audit CE providers? If so, describe the board's policy and process.**

While the board does not actively audit CE providers, it is the board's policy under section 1399.674 of Podiatric Medicine Regulations to withdraw the approval of any individual, organization, institution or other CE provider for failure to comply with board course criteria requirements. Accordingly, BPM does monitor any stakeholder feedback provided in order to determine if action may be appropriate.

**i. Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensee's continuing competence.**

With passage of SB 1981 [Chapter 736, Statutes of 1998] BPM became and remains the only doctor-licensing board in the country to implement performance based assessments of competency beyond

continuing education alone. Contained in section 2496 of the California Business and Professions Code, the board's continuing competence program has become the hallmark for meeting BPM's stated goal of preventing patient harm and has been embraced by the profession as a mark of professionalism.

Accordingly, all California licensed DPMs must affirmatively demonstrate satisfaction of one of the eight available statutory pathways as more fully described in question 30 above in order to renew their certificate to practice podiatric medicine. Over the years, BPM has continued efforts to provide program improvements and the program as it exists today represents a higher standard of licensing and professionalism that the podiatric community has fully embraced and marked as a trademark of excellence for an elite and highly-specialized profession.

## 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 then 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.

<b>BPM Table 5a. Non-Ankle Certified Licensee Populations</b>		
<b>ACTIVE LICENSEES</b>		
<b>TYPE</b>	<b>PRACTICE AUTHORIZATION</b>	<b>COUNT</b>
DPM	Practice Permitted	71
DPM – Military Waiver	Practice Permitted	0
DPM – Disabled	NO PRACTICE PERMITTED	20

DPM - Retired	NO PRACTICE PERMITTED	75
<b>PRACTICE PERMITTED TOTALS</b>		<b>71</b>
<b>NO PRACTICE PERMITTED TOTALS</b>		<b>95</b>
<b>DELINQUENT/CANCELLED/REVOKED/SURRENDERED/DECEASED LICENSES</b>		
<b>DELINQUENT STATUS</b>		
<b>TYPE</b>	<b>PRACTICE AUTHORIZATION</b>	<b>COUNT</b>
DPM	NO PRACTICE PERMITTED	4
DPM – Military Waiver	NO PRACTICE PERMITTED	0
DPM – Disabled	NO PRACTICE PERMITTED	9
DPM – Retired	NO PRACTICE PERMITTED	38
<b>PRACTICE PERMITTED TOTALS</b>		<b>0</b>
<b>NO PRACTICE PERMITTED TOTALS</b>		<b>51</b>
<b>CANCELLED STATUS</b>		
<b>TYPE</b>	<b>PRACTICE AUTHORIZATION</b>	<b>COUNT</b>
DPM	NO PRACTICE PERMITTED	37
DPM – Military Waiver	NO PRACTICE PERMITTED	9
DPM – Disabled	NO PRACTICE PERMITTED	21
DPM – Retired	NO PRACTICE PERMITTED	144
<b>PRACTICE PERMITTED TOTAL</b>		<b>0</b>
<b>NO PRACTICE PERMITTED TOTAL</b>		<b>211</b>
<b>SURRENDERED STATUS</b>		
<b>TYPE</b>	<b>PRACTICE AUTHORIZATION</b>	<b>COUNT</b>
DPM	NO PRACTICE PERMITTED	26
DPM – Military Waiver	NO PRACTICE PERMITTED	0
DPM – Disabled	NO PRACTICE PERMITTED	0
DPM – Retired	NO PRACTICE PERMITTED	0
<b>PRACTICE PERMITTED TOTAL</b>		<b>0</b>
<b>NO PRACTICE PERMITTED TOTAL</b>		<b>26</b>
<b>REVOKED STATUS</b>		
<b>TYPE</b>	<b>PRACTICE AUTHORIZATION</b>	<b>COUNT</b>
DPM	NO PRACTICE PERMITTED	40
DPM – Military Waiver	NO PRACTICE PERMITTED	0
DPM – Disabled	NO PRACTICE PERMITTED	0
DPM – Retired	NO PRACTICE PERMITTED	0
<b>PRACTICE PERMITTED TOTAL</b>		<b>0</b>
<b>NO PRACTICE PERMITTED TOTAL</b>		<b>40</b>
<b>DECEASED</b>		
<b>TYPE</b>	<b>PRACTICE AUTHORIZATION</b>	<b>COUNT</b>
DPM	N/A	8
DPM – Military Waiver	N/A	0

DPM – Disabled	N/A	2
DPM – Retired	N/A	31
<b>TOTAL</b>		<b>41</b>
<b>GRAND TOTAL</b>		<b>535</b>
<b>TOTAL NON-ANKLE DPMS AUTHORIZED TO PRACTICE</b>		<b>71</b>

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 returning to the active practice of medicine.

Pursuant to section 2428 B&P, delinquent licenses are cancelled after 3 years of non-renewal. 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. The Table immediately below provides the current timeframe statuses on the 51 delinquent licensees.

<b>DELINQUENT NON ANKLE LICENSEE – STATUS BREAKDOWN</b>			
<b>COUNT</b>	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
<b>TOTAL</b>	<b>51</b>		

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 retirees 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.

<b>BPM Table 5b. Licensees without Ankle Certification permitted to Practice</b>		
<b>COUNT</b>	<b>AGE</b>	<b>NOTE</b>
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	
<b>TOTAL COUNT</b>	<b>AVG AGE</b>	
<b>71</b>	<b>67</b>	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 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 by the board to perform 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 and 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 if not sooner 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] *[i]f 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 an occupational license. First, all residency practice is required to be under the supervision of a licensed physician and surgeon. This 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 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 continuing education 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 permitted by the state medical practice act.

As it stands today, throughout residency training, DPMs stand shoulder to shoulder with MDs and DOs in all medical and surgical rotations 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 medical 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 requirements which preclude the training license from being used as a de facto occupational license and 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 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 the state. 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 through a residency program. The limitation also works to unreasonably interfere with advanced training opportunities for the state's leading physicians. 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 should be eliminated for doctors of podiatric medicine.

### **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

[...]

DRAFT