STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
Medical Board of California
BOARD OF PODIATRIC MEDICINE
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PUBLIC EDUCATION COMMITTEE
OCTOBER 21, 2015

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

6

ACTION: CONSIDER AND DISCUSS DRAFT SUNSET REVIEW REPORT COVERING SECTIONS 6, 8 AND 11

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 Public Education 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 6: Public Information Policies
2. Section 8: Workforce Development & Job Creation

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 6, 8 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 PUBLIC EDUCATION PROGRAM
As of October 8, 2015

Section 6
Public Information Policies

1. How does the board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the board's website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The Board uses the internet as an integral tool for enhancing the values of increased public agency openness and transparency. Accordingly, the Board routinely updates its website to notify the public of upcoming board activities and changes to law, regulations or guidelines or other information relevant to agency stakeholders and other interested parties. These efforts include posting Board meeting agendas online in accordance with the requirements of the Bagley-Keene Act which directly correlates into document availability at least 10-days prior to a meeting with additional post-agenda documents added immediately upon availability.

In an effort to inform the public of the people's business as quickly as possible after Board proceedings have been transacted, the Board strives to immediately post a Board Meeting "Recap of Proceedings" to its website within a week after a meeting of the full Board has taken place. Minutes from the immediately preceding Board meeting are posted to the website on the subsequent meeting's agenda and remain online after official approval and adoption by the Board. All board meeting materials remain on the website indefinitely and may be conveniently located under the board meeting archive link.

2. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long do webcast meetings remain available online?

Yes. In an effort to achieve additional enhancements for the public to monitor and potentially participate in the BPM decision-making process, at its November 7th meeting in 2014, the Board elected to support a webcasting and teleconference program for both its Board and Committee meetings. Accordingly, through utilization of DCA support services available within the Office of Information Services ("OIS"), the Board initiated webcasting for all meetings of the full board beginning calendar year 2015. Given limited DCA resources, BPM committee meetings are webcast according to DCA resource availability notwithstanding the Board's stated intention and desire to webcast all open and noticed meetings of the Board. Webcasting links remain available on the Board website indefinitely.

DRAFT

3. Does the board establish an annual meeting calendar, and post it on the board's web site?

Yes. The Board has traditionally reviewed and approved the regular meeting schedule for the following calendar year annually and usually during the last meeting of each year. The meeting schedule has then been posted to the board website as soon as adopted. This year however, with the advent of the June 5th meeting of the Board and in an effort to incorporate operational best practices, enhance consistency, predictability and probabilities for increased public participation, the Board has elected to adopt a policy establishing a set quarterly board and committee meeting schedule.

Accordingly, the newly established meeting schedule policy requires the Board and each of its standing Committees to meet quarterly with Board meetings held on the first Friday in the third month of each quarter and with all committees meeting on the Wednesday three weeks preceding the regularly scheduled meeting of the Board. Meeting calendars are to be posted to the web immediately on the first of every year.

4. Is the board's complaint disclosure policy consistent with DCA's Recommended Minimum Standards for Consumer Complaint Disclosure? Does the board post accusations and disciplinary actions consistent with DCA's Web Site Posting of Accusations and Disciplinary Actions (May 21, 2010)?

Yes. Contained in Article 9 of the Board's Podiatric Medicine Regulations, the Board's policy is to permit the public the maximum possible access to information that is legally permissible. Accordingly, the board not only meets but in some instances exceeds DCA recommended minimum standards for complaint disclosure and is consistent with DCA Website Posting of Accusations and Disciplinary Actions.

Specifically contained in section 1399.704 of Podiatric Medicine Regulations, BPM complaint disclosure policy also includes disclosure of complaints that have been referred for legal action to the Attorney General prior to the filing of an accusation. This information is disclosed on BPM's website and also available by telephone through consumer contact with BPM.

Table 8b provides a convenient reference that fully summarizes BPM public disclosure policies below.

DRAFT

BPM Table 8b. Board of Podiatric Medicine Public Disclosure of Information			
Document	**When Public**	**Retention Period**	**Applicable Statute**
SUSPENSION ORDERS			
PENAL CODE (PC) 23 SUSPENSION (Partial or full license restrictions per this code; limited or no practice allowed while suspension is in place)	Date issued by a criminal court	Available indefinitely	Designated Public Document pursuant to 803.1
AUTOMATIC SUSPENSION ORDER (B&P 2236.1) (Licensed suspended per this section; no practice allowed while license is suspended)	Date issued by Board	Available indefinitely	Designated Public Document pursuant to 803.1
INTERIM SUSPENSION ORDER (ISO) (Licensee's practice has been temporarily restricted or suspended by an ALJ)	Date issued by an ALJ	Available indefinitely	Designated Public Document pursuant to 803.1
TEMPORARY RESTRAINING ORDER (TRO) (B&P 125.7) (Licensee's practice temporarily restricted or suspended by a court judge)	Date issued by a court judge	Available indefinitely	Designated Public Document pursuant to 803.1

DRAFT

Document	When Public	Retention Period	Applicable Statute
PLEADINGS			
ACCUSATION/PETITION TO REVOKE PROBATION/ACCUSATION AND PETITION TO REVOKE PROBATION (includes any amended or supplemental accusations)	Date filed by the BPM	Available indefinitely	Designated Public Document pursuant to 803.1
STATEMENT OF ISSUES (Document, similar to an Accusation, that lists reasons for denial of an application for licensure)	Date filed by BPM	Available indefinitely	Designated Public Document pursuant to Title 16 CCR Section 1399.703
DISMISSED ACCUSATION (Accusation dismissed after administrative hearing)	Date filed by BPM	1 year after withdrawal date	Available for 1 year after withdrawal date pursuant to Title 16 CCR Section 1399.703
WITHDRAWN ACCUSATION (Accusation filed by AG's Office was withdrawn before administrative hearing)	Date document filed by BPM	1 year after withdrawal date	Available for 1 year after withdrawal date pursuant to Title 16 CCR Section 1399.703
PROBATIONARY CERTIFICATE (Conditional license issued to an applicant on probationary terms and conditions)	On the ordered date after adoption	Available indefinitely	Designated Public Document pursuant to 803.1
Document	**When Public**	**Retention Period**	**Applicable Statute**
FINAL ACTIONS/DECISIONS			
PUBLIC LETTER OF REPRIMAND (B&P 2233) (A lesser form of discipline that can be negotiated	Date issued by the Medical Board	Available indefinitely	Designated Public Document

DRAFT

for minor violations **before** the filing of formal charges [Accusations])			pursuant to 803.1
PUBLIC REPRIMAND/PUBLIC LETTER OF REPRIMAND (whether or not the Accusation is withdrawn) issued **following** an administrative hearing	30 days after receipt by BPM or upon adoption, whichever occurs first	Available indefinitely	Designated Public Document pursuant to 803.1
PROPOSED DECISIONS (e.g., revocation, suspension, probation, limitation on practice)	30 days after receipt by BPM or upon adoption, whichever occurs first	Available indefinitely	Designated Public Document pursuant to 803.1
CITATION ORDER (Citation is a written order describing the nature of a violation, including the specific code of law violated; it is not a disciplinary action) including those with terms and conditions: an education course, examination and/or cost recovery	Date issued by the Board	Retention: Available for 5 years from the date resolved, or if withdrawn or dismissed, deleted immediately from Web site pursuant to Title 16 CCR Section 1399.698	Designated Public Document pursuant to 803.1
Document	**When Public**	**Retention Period**	**Applicable Statute**
MISCELLANEOUS			
SURRENDER of LICENSE (either the licensee surrenders while charges are pending, or the licensee surrenders during probation without further administrative action pending)	On Date issued by Board	Available indefinitely	Designated Public Document pursuant to 803.1
JUDGMENT/ARBITRATION AWARD (only the information regarding the matter is	Date Board becomes aware	Remains on profile 10	Designated as public information pursuant to 803.1 - No documents

DRAFT

available, no documents are available from the Medical Board)		years	provided
MEDICAL MALPRACTICE SETTLEMENTS (only the information that licensee has 3 (low-risk category) or 4 (high-risk category) settlements within a 10 year period.	When the BPM is notified that licensee meets criteria	Remains on profile while criteria met	Designated as public information pursuant to 803.1 - No documents provided
FELONY CONVICTION (only the information regarding the conviction is available)	Date Board becomes aware	Available indefinitely	Designated Public Document pursuant to Title 16 CCR Section 1399.703(f)
805 REPORTS to the public - resulting from termination or revocation of hospital privileges for medical disciplinary cause or reason	Date Board becomes aware	Available indefinitely	Designated Public Document pursuant to Title 16 CCR Section 1399.703(b)
OUT-OF-STATE ACTIONS - discipline taken against a licensee by either a board or by another state or jurisdiction	Date Board becomes aware	Available indefinitely	Designated Public Document pursuant to Title 16 CCR Section 1399.703(b)

DRAFT

5. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

The Board provides the public with the following information disclosures regarding current and past licensees:

- Name of Licensee as appearing in Board records
- Address of record
- Podiatric Medical School name
- Year graduated
- License number and type
- License issue date and expiration
- License status
- Public record actions or disciplinary information

6. What methods are used by the board to provide consumer outreach and education?

The board has historically used a multi-pronged approach to consumer education and outreach which has consisted of using: 1) the board website; 2) licensing education; and 3) pamphlets and brochures; and 4) personal appearances.

Board Website

The board relies heavily on BPM's website which is an extremely informative venue for both consumers and the practice community having been expertly and methodically identified all potential matters relating to both consumer protection concerns in addition to applicable DPM and stakeholder matters. It is a mainstay of board outreach effort and provides electronic access to licensing information and applications for applicants, research and information on laws and regulations governing podiatric medicine, and convenient information to consumers on both health and well-being in addition to information on enforcement, disciplinary matters and how-to information for filing complaints.

Licensing Education

As touched on in response to questions 16 and 17 in section 4 above, through the years BPM has perfected a customer-centric licensing process that has directly contributed to the creation of a personalized, streamlined and efficient licensing program function which personally guides applicants through the licensing process that has eliminated delay and backlog for nearly 25 years. Staff has literally worked one-on-one with hundreds of residents, advising them of document requirements and answering questions covering all aspects of the process which has served to save time, resources and avoid needless last minute applications for licensure. This internal outreach process has been in place for several decades and serves as a matter of personal pride for all board staff.

Pamphlets and Brochures

The board has a rich and successful track record of publication and distribution of DCA consumer pamphlets on various subjects touching on diabetes, orthotics and how doctors of podiatric medicine promote health and well-being. BPM informational fact-sheets have also been extensively incorporated over the years and cover subjects as diverse as: medical advertising; complaint, enforcement and disciplinary information; health facility privileging and credentialing; discrimination by health facilities; medical record retention; information for students; scope of practice; important contact information; and many other topics.

Personal Appearances

DRAFT

Personal appearances have traditionally been a useful tool for outreach to professional conferences and community events. However, state travel restrictions have significantly reduced attendance in recent years. Nevertheless, where travel is permitted under current guidelines outreach is occasionally performed at events such as the annual Western Foot and Ankle Conference sponsored the California Podiatric Medical Association.

In addition to the efforts above, recently—with board adoption of its new Strategic Plan 2015-2018 at the March 6, 2015 meeting of the board—BPM has endeavored to rededicate itself to enhanced consumer protection outreach and education. The Strategic Plan has brought forth a new mission, vision and values statement with ambitious drive for accomplishing increased outreach to stakeholders, consumers and the profession.

As part of these outreach and education objectives, the groundwork for the development and implementation of new tools has been laid. These efforts include re-inauguration of the board's quarterly newsletter that had been defunct for several years; development and publication of a comprehensive board publication regarding the "Laws Relating to the Practice of Podiatric Medicine" that will serve as a convenient reference source on federal and state laws governing the podiatric medicine for both consumers and the profession; and planned integration of internet FAQs covering critical consumer and stakeholder information that will help constrain user focus to crucial information in an organized and easily accessible manner.

Section 8
Workforce Development and Job Creation

7. What actions has the board taken in terms of workforce development?

BPM does not actively engage in economic development activities for businesses or workers that lead to job creation and/or improved economic competitiveness as it is not structured to specifically create jobs or provide training to citizens or residents of California to learn specific medical job skills and abilities.

As a licensing agency however, over the last 25 years the board has been able to provide those applicants meeting the minimum qualifications for licensure nearly same-day issuance of certificates to practice podiatric medicine once all documents satisfying an applicant's licensure requirements have been received. This has gone extremely far to ensure a smooth and seamless transition into the podiatric medical professions without delay as individuals cannot legally perform the duties required until properly licensed by the board.

The total license issuance rate averages 106 licenses a 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 training licenses. In addition, the Board issues an average of 1106 renewals each year. These efforts help to ensure continued unproblematic access to both medical employment and training programs for the state's robust and competitive podiatric medical community.

8. Describe any assessment the board has conducted on the impact of licensing delays.

The Board has not had any licensing delays for nearly the last 25 years. Accordingly, the board has not had cause to conduct a delay assessment. The board will endeavor to continue to provide same-day licensure issuance to all applicants once all licensing requirements have been conclusively met. For fuller discussion of BPM licensing cycles, the Board's licensing process has been more fully described in questions 16 and 17 in section 4 above.

9. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

The board has a record of successful educational outreach and accomplishment with podiatric medical teaching institutions and potential licensees. Beginning with personalized outreach performed as a part of the board's licensing function; BPM directly works one-on-one with potential licensees beginning late in their medical educational programs as residency approaches. Applicants are often personally guided through the application process and in some instances are immediately telephoned with their new license number when issued.

BPM's focus on customer-centric processes with applicants has directly contributed to the creation of a personalized, streamlined and efficient licensing program function that has worked to eliminate delay and backlog for nearly 25 years. The board has also published and distributed an informational career pamphlet for prospective students entitled "Step into a Rewarding Career in Podiatric Medicine" and has linked private association recruitment materials on its website which chronicle a series of career profiles focusing on doctors of podiatric medicine and surgical residents to highlight the rewards of a career in podiatric medicine.

The Board has also been instrumental in offering early technical consultation to Western University of Health Sciences for support in helping to establish the second school of podiatric medicine in the state in 2009; one of nine in the entire United States.

Going forward, with board adoption of its Strategic Plan for 2015-2018 at the March 6, 2015 meeting of the board, the board has endeavored to rededicate itself to enhanced consumer protection outreach and education. The new Strategic Plan has brought forth a new mission, vision and values statement with ambitious drive for accomplishing increased public outreach to stakeholders, consumers and the profession; which will of course include potential licensees.

Part of these renewed outreach and education objectives include re-inauguration of the board's quarterly newsletter that had been defunct for several years which is planned to also target educational institutions and potential licenses to better inform of the board's licensing requirements and processes.

10. Provide any workforce development data collected by the board, such as:

a. Workforce shortages

DRAFT

b. Successful training programs.

While the board keeps abreast of economic and workforce development data it is not appropriately resourced to act on information collected. For example, as of 2013 it has been known that the pipeline of future practitioners is smaller than in years past notwithstanding more educational institutions of podiatric medicine.

During the 1980's the average graduating class was composed of 580 individuals. This stayed constant during the 1990's with an average graduating class of 582 individuals. However, in the last two decades the average graduating populations have decreased with 482 and 528 graduates in the 2000's and through the 2010's, respectively. Indeed, even internally, it is projected that the board's licensee population will begin to retire in the next five years at a slightly higher rate than newly inducted licensees which is expected to result in a slight negative imbalance to BPM's relatively invariable licensee base and revenue stream.

What is more, it is also known that there is a shortage of residency positions in podiatric medicine nationally. The number of active first year residency positions does not equal those approved and each year there are programs that do not fill the full complement of positions due to funding concerns, among other things. The total residency placement statistics for 2013 compiled by the American Association of Colleges of Podiatric Medicine are illustrative. A full 16% or 99 total students were reportedly unable to find residency placements for the 2013/2014 training year out of a total of 631 total residency applicants.

While the reasons for the residency shortages nationally are undoubtedly both myriad and complex, the fact remains; the future of the profession is intertwined with finding a long term solution to this issue.

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.**

DRAFT

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

DRAFT

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

DRAFT

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 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.

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**	

DRAFT

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.

<u>Conclusion</u>

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] *[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 a de facto occupational license. First, all residency practice is required to be under the supervision of a licensed physician and

DRAFT

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 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 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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