FOOTNOTES

Message From the Board President

As you might know, the Board of Podiatric Medicine (BPM) includes seven Board members—four podiatrists and three public members. For the last year, we have been two members short of a full house. Governor Brown recently appointed a third public member, Maria Cadenas Quiroz, 39, of Santa Cruz. We welcome her to the Board, and her biography will be published on the BPM website for your perusal.

We are still short one professional member. I know that several people have sent in letters of interest to the Governor's Office, but every time I ask the appointment office about this, I am told the Governor is studying a large pile of bills to sign or veto and has not had time to address this issue. Now that the signing deadline has passed, we should see some action on this front very soon, maybe even by the time you get this newsletter. We will get to see who joins myself, Judith Manzi, DPM, Kristina Dixon, MBA, Neil Mansdorf, DPM, Darlene Trujillo Elliot, and Ms. Cadenas Quiroz on the Board.

One of the important duties of Board members is to act as final reviewers of formal administrative discipline. After a complaint has been investigated by podiatric experts and the Justice Department, the Attorney General initiates a formal administrative action, and the administrative disciplinary case goes to a hearing before an Administrative Law Judge. After reviewing evidence and hearing arguments by the podiatrist and the Deputy Attorney General, the Administrative Law Judge issues a Proposed Decision, which determines the possible disciplinary action to be taken by the Board against the podiatrist. The penalty might be a revocation of the license that is "stayed" or kept in place pending the performance of remedial action of the podiatrist.

The podiatrist might need to take a record-keeping course, an ethics course or other continuing education in a particular field. Quite often, the podiatrist, in conjunction with his or her attorney, has agreed to a particular penalty and stipulates to a settlement of the disciplinary case. When the Board members get the case, they review the facts at hand in private and without any discussion and are given several choices: adopt the Administrative Law Judge's Proposed Decision as submitted, adopt with reduced penalties, reject the whole Proposed Decision, or hold the Proposed Decision until the next Board meeting when we can discuss the case in closed session. If all seven (or five or six) Board members agree to adopt as submitted, then we never see the case again. If any one of the seven (or five or six) members decides not to adopt the Proposed Decision as submitted, then a discussion ensues at the next meeting.

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BOARD OF PODIATRIC MEDICINE
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BOARD OF
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MEDICINE

FOOTNOTES

Message From the Board President continued from page 1

This is where the value of the professional members is quite important. The cases often hinge on the professional opinion of one expert podiatrist. When the panel of four professional Board members read the argument, we might have a different collective opinion that some particular practice is or is not the "standard of care." The public members listen to our discussion, which further informs their knowledge and decisions. Here is the value of a full Board. Not only can one member's objections form the basis of a further discussion, but a full panel of seven members can often come up with an opinion that is more fair to the podiatrist in question than one expert reviewer reviewing the case by his or her lonesome without the give and take of a discussion with colleagues. The Board does not often reverse or lessen the proposed discipline suggested by experts and the Attorney General's Office, but it has been known to happen. When it does happen, the Board feels that both the public and the podiatrists have been properly served.

On the legislative front, this has been a busy year. Just the week of this writing, the Governor signed all three pieces of legislation that affect podiatric medicine.

First is Senate Bill (SB) 798 (Hill, Chapter 775, Statutes of 2017). This bill is the Sunset Bill for the Medical Board of California (MBC). BPM has been included within the jurisdiction of MBC since 1957. SB 798 separates BPM from MBC and creates the California Board of Podiatric Medicine within the Department of Consumer Affairs; this is to become effective January 1, 2018. This bill will not change any rights or privileges held by doctors of podiatric medicine and it will discontinue the ankle certification requirement for a doctor of podiatric medicine to perform those services and procedures. This bill assumed that all DPMs licensed since 1984 have received ankle training and that those doing ankle procedures who were licensed before that time have been fully vetted by their respective surgical facilities. These are, after all, not procedures done in the office.

Second, Assembly Bill (AB) 1153 (Low, Chapter 793, Statutes of 2017). This bill allows for doctors of podiatric medicine to perform wound care below the tibial tubercle. My only regret is that this will not become effective before January 1, 2018.

Finally, SB 547 (Hill, Chapter 429, Statutes of 2017). This bill will allow the Board of Podiatric Medicine to begin the regulatory process for raising unscheduled fees such as the ordering of a duplicate license, or requesting a letter of good standing from the Board. These fees have not been raised since the 1980s and will help us to keep our licensing fees steady. Certainly, the DPM licensing fee is considered high. The best guess is that the expenses of our new Board will remain constant and so will the licensing fee.

I encourage everyone to continue practicing safe and responsible medicine and keep those patients happy!

I, and all the Board members, wish you happy Thanksgiving, happy holidays of your choice, and a happy New Year—the year of the new Board of Podiatric Medicine.

Michael A. Zapf, DPM
President, Board of Podiatric Medicine

How to Deal With a Board of Podiatric Medicine Request for Records and Interview

By Carl R. Wagreich, DPM, DABFAS

The bad news is you receive a request for records from the Board of Podiatric Medicine (BPM). The good news is you have the ability to walk away unscathed.

Here is the way a review usually works:

You have an unhappy patient for whatever reason, they file a complaint with the Central Complaint Unit of the Medical Board, and you receive a request for medical records. We have heard from our malpractice carrier over and over again, do not alter your records. This is clearly true for a Medical Board audit as well. My recommendation is that you contact your malpractice carrier, who should assign an attorney for an administrative review from the Board.

Some podiatrists take this process lightly. The worst-case scenario is that it's very costly and can result in revocation of your license to practice medicine.

What records look bad? Nothing new here:

1. Sloppy, cursory, handwritten notes.
2. Boilerplate electronic records that have nothing to do with our actual exam. Most of us do not examine the patient's ears, nose, or throat. Don't note that you did it if you did not.
3. Inaccurate, copied, and pasted notes. If you are going to copy and paste notes, please update and make appropriate changes. There are times when copied and pasted notes are OK.
4. You must have a history (either patient-filled inventory or doctor-filled) and physical exam. Another must is a consent form in the office if surgery is performed. Informed consent means a signed consent in a non-hospital setting.

You should make clear copies of all your records, as well as copies of your X-rays. BPM no longer requests your CV, so don't provide it. You should provide a narrative, preferably typewritten, so the consultant reviewing your records can get a feel for your point of view.

Your compiled records should then be forwarded to your attorney, or you can forward them directly to BPM.

One of the biggest mistakes I have observed is to not provide all of the records. As a consultant, it can be very frustrating when we have to go back two or three times and request additional records. You may want to provide copies of your CME certificates as these will eventually be requested.

Next, the case is forwarded to a consultant for review. After the consultant reviews the case, an in-person interview is usually scheduled with the podiatrist, who is welcome to bring his/her attorney, the investigator, and possibly a Deputy Attorney General.

Here are some recommendations for a successful interview:

1. Review your records prior to the interview. If you're not familiar with the case, you cannot be as helpful in stating your points of view. As consultants, we intend to give you every opportunity to let us know what was done and why it was done.
2. Please show up on time and be appropriately dressed. Being late to an interview, not showing up, or not being dressed appropriately is not helpful.
3. During the interview, neither the consultant nor the investigator should be combative. Again, we intend to give you every opportunity to give us your side of the story. On the other hand, being combative on your part at the interview does not help in the adjudication of your case.

After the interview, BPM representatives will meet and discuss the adjudication of the case. You will then be informed of the outcome.

Carl Wegreich, DPM, DABFAS,
is a BPM Consultant and Expert Witness.

BPM Annual Consultant Training

By Bethany DeAngelis, Enforcement Coordinator, Board of Podiatric Medicine

Each June, Doctors of Podiatric Medicine (DPMs) gather at the Disneyland Hotel and Convention Center in Anaheim to attend the Western Foot and Ankle Conference (Western Conference) organized by the California Podiatric Medical Association. At the Western Conference, continuing medical education is provided to DPMs through seminars and workshops.

Bethany DeAngelis, BPM Enforcement Coordinator; Clinton Dicely, Division of Investigation, Supervising Investigator; Robin Hollis, BPM Probation Monitor; Julie Brown, MBC Consumer Complaint Analyst.

In conjunction with this event, the Board of Podiatric Medicine (BPM) holds a half-day training for its contracted consultants as many are in attendance or based in Southern California. This group of dedicated professionals assist BPM with enforcement activities by providing their medical expertise throughout the investigative process. Quality-of-care issues are evaluated by podiatric medical consultants and experts, case by case, based on the standard of care. While responsible for reviewing complaints concerning quality of care, the consultants and experts also serve as a resource for BPM staff, investigators, and the Office of the Attorney General, in addition to assisting probation officers in the monitoring of probationers.

Representatives of BPM, the Medical Board of California, the Department of Consumer Affairs–Division of Investigation, and the Department of Justice–Attorney General's Office, Health Quality Enforcement Section, provide training, distribute updated and new information, and answer questions.

Training topics include:

- **Overview of the Enforcement Process**
- **Role of the Consultant**
- **Report Format (terminology, etc.)**
- **Investigative Procedures**
- **Conducting an Effective Subject Interview**
- **Probation Procedures**
- **Practice Monitoring of DPMs on Probation**

BPM's podiatric medical consultants and experts are a group of experienced, residency-trained, and board-certified DPMs. BPM currently has 13 active consultants to review the complaints received on all California DPMs, and these consultants assist with investigations and probation monitoring. BPM's goal is to have a sizable, qualified, and diverse pool of consultants located throughout the state. BPM could use additional consultants and currently has particular need in the Bay Area and the San Bernardino/Inland Empire.

If you are interested in serving the BPM as a consultant or expert and want more information on the qualifications and compensation, please contact Bethany DeAngelis, Enforcement Coordinator, at (916) 263-4324 or *Bethany.DeAngelis@dca.ca.gov*, or visit *www.bpm.ca.gov/enforcement/consultants_expertwitnesses.shtml.*

Footpath to Doctor of Podiatric Medicine

Board members of APMA at the National Conference held in Nashville in July 2017. In back, from left: Omead Barari, Mohamed Sharif, Jeffrey Sanker, Stephanie Campbell, and Anne He. In front is Elizabeth Oh.

How Going Into Medical School Straight From Undergrad Affects the Clinical Experience

Dana Brems, CPM Class of 2019

My first two years of college, I didn't know that I wanted to be a podiatrist. In fact, I thought I would have a career in research. However, after spending some time in the lab, I realized I wouldn't be happy with that lifestyle. So, I started looking into and shadowing multiple medical fields. I saw how podiatrists impacted their patients' quality of life, and I knew that this was the career for me. I quickly took the MCAT and completed my WesternU application. Within a year of learning what podiatry is, I found myself starting podiatric medical school.

Looking back, my decision to graduate college a year early in order to go straight into medical school was made fairly quickly. Since this decision was made in such a short time, I had minimal undergraduate clinical experience. My situation isn't unique. I've noticed that many of the students coming straight from undergrad also have less clinical experience than their older counterparts. Some people may assume that this lack of experience would be a disadvantage, and maybe even a risk factor for dropping out of medical school. However, I believe that is not the case. A good number of our students didn't have previous clinical experience, but are still attending school here, and are happily thriving in clinic.

Students considering medical school straight from undergrad may have an advantage if they retained information learned in college courses. However, I do not think they are at a disadvantage from students who've previously had a job in the medical field. Being in the position of "physician" is a new challenge for both people who have and haven't been in the medical field. I have started seeing patients in clinic as a third-year student, and still feel confident that I made the correct decision to pursue podiatry. There are many factors that determine successful clinical experience in medical school. However, I believe that someone feeling confident and happy in their choice to pursue podiatry is more important than their previous medical experience.

If I could give one piece of advice for undergrads it would be: If you have minimal clinical experience and aren't completely sure this is what you want to do with your life, it's OK to wait before starting medical school. Although I personally came straight into medical school, I don't think it is a necessity. Spending a year or so to volunteer at a hospital, be a scribe, work as a medical interpreter, or even shadow licensed podiatrists would be good for determining if this is something you could be passionate about. Medical school is a long and difficult path to take, and it should only be started when you as an individual feel ready for the challenge. Whether you start straight out of undergrad or wait a few years, you will still have a long, rewarding career as a podiatric physician.

Students begin to provide care to patients early in their careers.

The Art of Equilibrium

By Trent Brookshire, Class of 2019

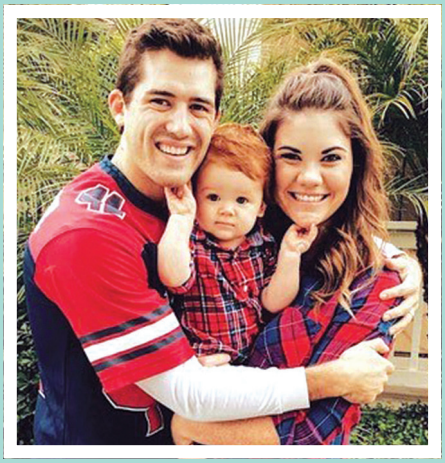
They say medicine is an art; well, so is making it through the schooling. It takes intentionality, finesse, and even creativity to balance the rigors of medical school and home life. Medical school is extremely difficult no matter what your home life is like, but it can seem nearly impossible at times with a spouse and kids at home.

My first son was born midway through first year, during the thick of immunology didactics. Initially, I was struggling to stay afloat. I was grappling with my newly acquired ropes of fatherhood and trying to be an attentive husband, all while maintaining my intense study schedule. I had to adapt quickly or some area of my life was going to plummet.

Everyone's situation is different. For me, I found it very difficult to study once I arrived home. So, I spent more time on campus to study after classes. I utilized my lunches and breaks in between to review and ask questions. I relied heavily upon classmates to hold me accountable and met up often to review the relentless onslaught of new material. I used my drive to and from campus productively, re-listening to previous lectures or calling family members to stay in touch.

It is imperative that you take breaks from the constant stress and studies, otherwise you will not make it through medical school. Since I was able to maximize my time outside of the house, this allowed me to devote precious time to my wife and newborn baby. No matter how busy I was, I always tried to take the first hour I got home to give undivided attention to my family. I got to ask about their day, help out around the house, and play with my baby. When I made it home early enough, I could help with, or at least enjoy, dinner with the family. Then it was time to clean up, give the baby his bath, and do the bedtime routine: dressing, bottle, brushing teeth, bedtime book, and rocking to sleep. By the time I shut the door to the nursery, it was already late at night. I still think it is important to have quality time with my wife because it is not the same while watching a baby. Sometimes we would chat some more or play a game for thirty minutes or so, but then it was time for me to get back to studying. I could usually squeeze in an hour or two more of study time before I fell asleep on my notes or stumbled back to the bedroom.

It is crucial to find your support system. For me, it was my wife. She not only encouraged me throughout the whole process, but was extremely helpful. On nights when I needed extra time to study, she took on everything—and I mean everything! She took care of our baby all day long, cooked, cleaned, and helped me with any errands I was struggling to finish. On top of all that, she works full-time over 50 hours a week owning and operating a photography business! I do not know how she does it all, but I am so blessed to have her in my life. She balances being the best wife, mother, and business owner. Maybe that's what inspires me to balance my roles of father, husband, and student.



Analisa and Bryer are grateful to Trent for spending quality family time.

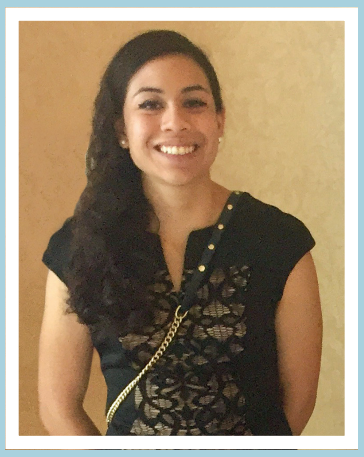
All the loved ones in your life can be seen as burdens or blessings. When you correctly calibrate your perspective, you realize what an advantage it is to have these people in your life. Yes, it takes time to maintain these relationships. At times, it added hours of chores, increased my stress, and decreased my sleep. However, the benefits were unsurpassable. After an overwhelming day of treading water in the lecture hall, nothing feels as uplifting as a welcome home hug from that special someone. In my case, it was my wife. Every day she boosted my morale with her joyous smile. When she made me laugh, I momentarily forgot about the stresses that loomed within next Friday's exam. Then, I got to hold my child. You can only understand the joy this brings once you have a child of your own. This was the most fulfilling study break, and I was so fortunate to have him in my life during these stressful times.

Instead of looking at the chores in your life as time-consuming burdens, use them as physical reminders to count your blessings. When taking out the trash, be thankful you have arms and legs to do so. When changing your baby's diaper, consider it foul-smelling proof that your child's gastrointestinal system is working properly. I was thankful for the lecture recordings because I was able to utilize this resource to re-watch dozens of lectures while feeding or rocking our baby. On the days when there is no time for exercising at the gym, at least you can do push-ups wherever you are (which is what I resorted to often while playing with my son). I learned first-hand how perspective brings contentment—and having babies makes you efficient.

Families are dynamic and ever-changing. Everyone is busy and has stressful home-life events happening throughout their schooling careers. It is how we adapt to these situations that allows us to persevere; this perseverance builds unshakable character that will define us for the duration of our medical endeavors.

Transition From a Classroom Setting to a Clinical One

Aleena Resendez, Class of 2019



Beginning the third year means leaving the classroom setting for good and entering a clinical setting. For me, this was a fundamental turning point in my career because for years all my learning had been spent passively listening to lecturers or reading from a textbook. Now it was up to me to create a tailored treatment plan for the patient. I remember one specific moment where I was asked to see a patient in the Emergency Department. After coming back up to the call room to write my progress note, the resident asked me how I wanted to treat my patient. It was the first time I was granted the autonomy to come up with a game plan to treat this patient with the resident. All of what I had learned in my two years of medical school suddenly became applicable, and it was my responsibility to integrate everything I learned into that very second. It was from that moment on that I started to hold myself accountable for my learning outside of the classroom. Each day after clinic, I would go home and look up at least one thing I wasn't sure of and how it was being applied to each patient. I've realized that just because you aren't presented with lectures anymore doesn't mean you should stop learning. Medicine is always changing, and I believe it should be a physician's job to be up to date on medicine's new additions.

Another element that makes a clinical setting different from a classroom setting is that there isn't one set treatment for each diagnosis like there is on a test. I've realized that patients are complex and usually have multiple co-morbidities that must be accounted for while coming up with a treatment plan. There are numerous ways to treat a patient based on each circumstance and patient preference. While this part of medicine can be rather difficult, it makes it a team effort. I love that everyone is there to help one another regardless of their title or specialized fields. Everyone is there because they care deeply about helping people, and that's what makes waking up super early and leaving late from clinic worth it.

How Going Into Medical School After Being a Professional Affects the Clinical Experience

Tommy Yates, WUCPM Class of 2020

I came into undergrad with a bunch of credits from high school, so I was basically a year ahead right off the bat. I met with my adviser a couple of times my first semester, and I realized that I could graduate early if I planned my classes out about a year in advance. The credits from high school let me register early, so I got the classes I needed, worked hard, and graduated a year early. During those years, I had already made up my mind about medicine and had been volunteering and shadowing as much as possible. I figured that graduating a year early would not only help me stand out on medical school applications, but it would also cut down on my debt. I considered myself a shoe-in for medical school.

I did, however, have a girlfriend at the time, and she was two years behind me in school. We had talked about what we would do once I finished undergrad, and I decided that I would stay and live with her until she graduated. I looked for a job but quickly realized that for all the studies I had put in during school, I didn't know as much about how to get a job. So, I applied to everything. I ended up splitting my time between online tutoring, yardwork-for-hire, and volunteering at a community hospital. About two weeks in, I got a call from the local Safeway. It was close enough that I could ride my bike, so I said, "Why not?" The interview was for a grocery clerk position, and, at the end of the interview, the lady interviewing me suggested that I work in the pharmacy based on my interest in the medical field. So, I took the pharmacy job.

It was a really difficult job in that it showed me a totally different side of medicine that admittedly I was oblivious to. I learned about all the behind-the-scenes regulations that govern the interactions between providers and pharmacies and patients. More still, I learned about all the real-world

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Podiatric Medicine Treating Diabetic Complications in California

By Judith Manzi, DPM, Board of Podiatric Medicine Vice President

The Board of Podiatric Medicine (BPM) is the California board that regulates podiatric medical doctors who treat diseases of the feet, ankles, and lower limbs.

During the 2017 legislative cycle, the state Legislature expanded the scope of a podiatric surgeon's practice to include wound care below the tibial tubercle (AB 1153, Low, Chapter 793, Statutes of 2017).

This expansion reflected the daily practice of medicine as many podiatric surgeons have historically been brought in to handle difficult wounds of the lower extremities. Some of these wounds result from trauma, congenital deformity, and peripheral vascular disease. However, many result from the consequences of diabetes. The "team" approach to these complex problems often is led by the podiatric surgeon and includes vascular surgeons, endocrinologists, nephrologists, and primary care specialists, to name a few.

One in 10 Californians are diabetic. Twenty-five percent of all diabetics develop foot and leg ulcers. The risk of developing a wound that results in limb loss among diabetics is one in eight. Hospitalization and amputations in the lower extremities is expensive, and conservative estimates relate diabetic foot ulcers (DFUs) to roughly $17 billion in national spending annually.

Diabetic wounds impose a large economic burden on our healthcare system. We spend 5.4 times more in health care costs on caring for a diabetic patient with a foot ulcer in the year after the first ulcer appears and 2.8 times more in the second year. It is disproportionally high when compared to the cost of caring for a diabetic patient that does not develop a wound.

With proper management and care, many of the 80,000-plus amputations of toes, feet, and lower legs that American diabetics undergo each year are preventable. Amputation may end the grueling cycle of non-healing wounds and infection on a limb; however, the patient still faces grim odds. More than half will develop ulcers and infections in the remaining foot and undergo additional amputations. And within five years, more than 40 percent will die.

The Centers for Disease Control and Prevention (CDC) estimates that good foot care could reduce the risk of amputation in diabetic patients by 45 to 85 percent. What we can do to reduce the chances of a diabetic needing an amputation is to assure access to a podiatric surgeon for all diabetics. Prevention, prevention, prevention is the key. Podiatrists are often the first health care professionals to detect diabetes in a patient. Many will see a podiatrist with a complaint of their feet feeling numb, or a sore on a toe that won't heal. These are often the first signs of a problem. Educating a diabetic patient on proper foot care and assessing the need for additional consultation with a vascular surgeon, primary care doctor, and nutritionist is key. The team approach to these complex wounds is successful, and it is often the podiatric surgeon who orchestrates this care and leads the charge.

As a Board, we are excited and proud to share this breakthrough podiatric scope expansion with the well-deserved and finally recognized role that our podiatric surgeons here in California play in helping diabetics live longer and more productive lives.

The Board has been focused on this public health crisis and welcomes input from all stakeholders as how to best address this crisis in California. The UCLA Center for Health Policy Research published the latest findings for Californians: *http://healthpolicy.ucla.edu/publications/Documents/PDF/2017/podiatricservices-brief-jun2017.pdf*.

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problems that patients have being bounced around from facility to facility and having to deal with their insurance companies. But perhaps the most valuable lesson I took away from working behind that counter was practicing my customer service skills. I knew I would never become a pharmacist, but I have a really good shot at becoming a better doctor because of what I learned working in a retail pharmacy. I think anything that makes you reassess your perspective and opens you to expanding your compassion and empathy is entirely worth the time, even if it means delaying your life plans. It is, without doubt, the most influential component of my medical education thus far. And it would have been completely overlooked had I not been open-minded enough to compromise, to deviate from the path that I had been paving for myself for years.

Administrative Actions: April 1–September 30, 2017

DOCTORS OF PODIATRIC MEDICINE

Ebaugh, John, DPM
Indio, CA
License number: E-4495
Decision Effective: 04/14/17
Revoked, Stayed, 3 Years' Probation
http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=E&licenseNumber=4495&name=EBAUGH, JOHN EDWARD

Keller, Brian, DPM
Lincoln, CA
License number: E-4185
Decision Effective: 06/02/17
Revoked, Stayed, 5 Years' Probation
http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=E&licenseNumber=4185&name=KELLER, BRIAN PATRICK

VanDyck, Neil, DPM
Roseville, CA
License number: E-2481
Decision Effective: 06/22/17
Stipulated Surrender
http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=E&licenseNumber=2481&name=VANDYCK, NEIL ALAN

To file a complaint against a DPM, visit:

http://www.mbc.ca.gov/Consumers/Complaints/

To view a doctor's profile and obtain a copy of the action(s), go to:

www.breeze.ca.gov

For assistance, call: (800) 633-2322

Additional information regarding disciplinary matters for Doctors of Podiatric Medicine can be found at the following web pages:

www.bpm.ca.gov/consumers/dispsumm.shtml

www.bpm.ca.gov/consumers/agreferrals.shtml

Important Dates

2017

November 23 & 24 — State holiday (Thanksgiving and Day After Thanksgiving)

December 1 — BPM Board meeting

December 25 — State holiday (Christmas holiday observed)

2018

January 1 — Statutes take effect (Cal. Const., Art. IV, Sec. 8(c))

January 1 — State holiday (New Year's Day observed)

January 3 — Legislature reconvenes (J.R. 51(a)(4))

January 10 — Budget must be submitted by Governor (Cal. Const., Art. IV, Sec. 12(a))

January 15 — State holiday (Martin Luther King Jr. Day)

February 16 — Last day for bills to be introduced (J.R. 54(a), 61(b)(4))

February 19 — State holiday (Presidents' Day)

March 2 — BPM Board meeting

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