JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE FINDINGS AND RECOMMENDATIONS

Review and Evaluation of the California Board of Podiatric Medicine

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Report to the
Department of Consumer Affairs

APRIL, 1998

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OVERVIEW OF THE CURRENT REGULATORY PROGRAM OF THE BOARD OF PODIATRIC MEDICINE (BPM)

BACKGROUND AND DESCRIPTION OF THE PROFESSION AND THE BOARD

Doctors of Podiatric Medicine (DPMs) are trained specialists in foot and ankle medicine, rehabilitation, and surgery. Medical doctors (MDs) receive general training in medical school and learn their specialty in postgraduate residencies. Their license does not restrict them to their specialty area, but it is a violation of law for any doctor to practice outside their area of competence. The scope of practice of podiatric medical doctors is limited *by the license itself* to the foot and angle. They are also permitted to perform angle surgery, but only if they obtain a separate ankle license. Another licensed profession involved in the care and treatment of the foot and ankle is orthopaedic physicians (MDs and Doctors of Osteopathy (DOs)). As part of their overall musculoskeletal care, they may render foot and ankle care and some may even specialize in foot and ankle work. Only MDs, DPMs, or DOs may diagnose, treat, and prescribe for medical conditions of the foot and ankle.

The scope of practice for podiatrists is defined in both Section 3502 of the B&P Code (the general provisions regarding scope of practice), and Section 2473 for DPMs performing ankle surgery. "Podiatrist medicine" means, as defined, the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. No podiatrist shall do any amputation or administer an anesthetic other than a local. A DPM may perform surgical treatment of the ankle and tendons but only at specified locations such as acute care hospitals, surgical clinics, and ambulatory surgical centers. A DPM may perform surgical treatment of the angle, provided that the licensed podiatrist is certified by the Board to perform that treatment.

The use of the title “podiatrist”, “foot specialist,” or other title indicating or implying that a person is a podiatrist, or practices podiatric medicine or foot correction, is protected under Section 2474 of the Business & Professions Code (B&P Code).

The public’s growing concern with foot care has led to some other related practitioners identified as “orthotists” and “pedorthists.” Orthotists and pedorthists may manufacture, provide and fit devices to fill an MD’s, DO’s or DPM’s prescription. They may also work independent of these doctors if they are recommending the devices for non-medical conditions, i.e., comfort or improvement in use of footwear. There is no current regulation of these two occupations.

Regulation of podiatrists (“foot doctors”) was probably sought originally by chiropodists, who treated diseases of the feet. The first chiropody school was established in New York in 1911. “Dr. School” founded the Illinois College in 1912, and it was from this school that Charles Phoenix, apparently the eighth chiropodist licensed in this state by the Board of Medical Examiners, but the earliest with a file remaining in BPM offices, graduated in 1923.

Prior to 1957, the licensing of podiatrists was carried out directly by the Board of Medical Examiners. In 1957, the Chiropody Examining Committee was established. The professional association had petitioned for an independent licensing board, but the Legislature authorized a Committee within the structure of the Medical Board. Its name was changed to Podiatry Examining Committee in 1961. Comprised originally of five licensed podiatrists and one public member, the Committee received applications, conducted examinations, and passed its recommendations on to the Medical Board, which to this day is the agency that is legally responsible for issuing the DPM licenses. However, currently the executive officer of BPM will issue the license upon fulfillment of all requirements. The BPM also issues “limited” licenses to those graduates of a podiatric school or college who are participating in a residency program approved by the Board.

The BPM is currently composed of six (6) members. Four (4) licensed professional members who are appointed by the Governor, and two (2) public members appointed by the Legislature. There is currently one vacancy on the Board. The qualifications for the BPM members are as follows:

- Three (3) are licensed podiatrists.
- Not more than one (1) member shall be a licensed podiatrist who is a full-time faculty member of a college or school of podiatric medicine.
- Two (2) are public members.

Improvements which BPM has made to its functions and operations over the past few years includes:

(1) Initiated a redesign process in 1990 of its licensing and enforcement programs.
(2) Adopted a "Board Member Conflict of Interest" policy in 1990.
(3) Adopted position descriptions for board members in 1991.
(4) Published "facts sheets" in 1994, to inform consumers and profession about requirements and activities of BPM.
(5) Adopted governance policies in 1993, which were amended in 1996.
(6) Endorsed the Code of Ethics of the American Podiatric Medical Association and Code of Medical Ethics of the American Medical Association.
(7) Had Strategic Plan approved by Governor's Office in 1997.
(8) Completed in 1997, review of its regulations pursuant to Governor's 1995 executive order to eliminate obsolete, unnecessary, or confusing regulations.

There are approximately **2,000** podiatrists licensed with BPM. The following provides licensing data for the past four years:

LICENSING DATA FOR PODIATRISTS	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Licensed	Total: **2,019**	Total: **1,990**	Total: **1,960**	Total: **1,961**
Licenses Issued	Total: **55**	Total: **43**	Total: **30**	Total: **69**
Renewals Issued	Total: **886**	Total: **888**	Total: **848**	Total: **838**
Statement of Issues Filed	Total: **1**	Total: **0**	Total: **2**	Total: **1**
Statement of Issues Withdrawn	Total: **0**	Total: **0**	Total: **0**	Total: **0**
Licenses Denied	Total: **1**	Total: **0**	Total: **0**	Total: **1**

There are approximately **640** licensed podiatrists who currently hold a license to perform surgery on the ankle, and **166** residents with training (limited) licenses. The following provides the number of podiatrists who have held ankle and limited licenses over the past four years:

OTHER LICENSURE CATEGORIES	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Licensees (By Type)	Total: **703**	Total: **755**	Total: **777**	Total: **804**
Ankle Licenses	568	599	618	638
Limited Licenses (Residency)	135	156	159	166
Licenses Issued (By Type)	Total: **98**	Total: **95**	Total: **89**	Total: **106**
Ankle Licenses	33	31	19	20
Limited Licenses (Residency)	65	64	70	86

BUDGET AND STAFF

Current Fee Schedule and Range

The BPM's sources of revenue are licensing and renewal fees from podiatrists who receive a regular, limited or ankle license. BPM is entirely special funded and no general fund monies are used to fund the operation of the Board. Renewal of the licenses are on a biennial basis. In 1990, BPM raised the biennial DPM license renewal fee to $800. This fee is $200 higher than the fee for physicians and surgeons. BPM continues to anticipate no need for fee increases in the immediate future.

Fee Schedule	Current Fee	Statutory Limit
Application Fee	$ 20	$ 20
National Board certification	$ 100	$ 100
Oral Examination	$ 700	$ 700
Ankle certification exam	$ 700	$ 700
Reexamination	$ 700	$ 700
Initial License	$ 800	$ 800
Biennial renewal	$ 800	$ 800
Penalty fee	$ 400	$ 400

Revenue and Expenditure History

[Not available at time of report.]

REVENUES	ACTUAL				PROJECTED	
	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Licensing Fees						
Fines & Penalties						
Other						
Interest						
Transfers						
TOTALS						

EXPENDITURES	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Personnel Services						
Operating Expenses						
(-) Reimbursements						
TOTALS						

Expenditures by Program Component

The BPM spends the largest proportion of its budget on enforcement, 71 percent. [See Table Below] The licensing and examination programs are almost equal in expenditures. The BPM has continued to show a decrease in budgetary expenses. As the Board indicates, it has cut all other areas of its budget to ensure uncompromised enforcement without further fee increases since 1990.

EXPENDITURES BY PROGRAM COMPONENT	FY 93-94	FY 94-95	FY 95-96	FY 96-97	Average % Spent by Program
Enforcement	$663,740	$633,379	$644,894	$629,094	**71%**
Licensing	$115,358	$117,693	$114,886	$119,741	**13%**
Examination	$109,707	$110,439	$114,472	$118,144	**13%**
Administration	$25,078	$25,586	$24,974	$26,030	**3%**
TOTALS	**$913,883**	**$887,097**	**$899,226**	**$893,009**	

Fund Condition

It is usually recommended that boards and committees maintain at least a three to six month reserve of budgetary expenditures. The BPM will have close to three months reserve for the next couple of years. [See Table Below] Beginning in FY 96/97, the BPM receives approximately $150,000 per year of transfers from the general fund as part of the required special fund payback.

ANALYSIS OF FUND CONDITION	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98 (Projected)	FY 98-99 (Projected)
Total Reserves, July 1	$95,283	$93,340	$91,884	$56,128	$142,532	$179,932
Total Rev. & Transfers	$823,415	$809,299	$786,991	$958,970	$994,400	$995,400
Total Resources	$918,698	$902,639	$878,875	$1,015,098	$1,136,932	$1,170,332
Total Expenditures	$819,825	$785,022	$824,748	$872,566	$962,000	$981,000
Reserve, June 30	$98,873	$117,617	$54,127	$142,532	$174,932	$189,332
MONTHS IN RESERVE	**1.5**	**1.7**	**0.7**	**2.0**	**2.2**	**2.3**

LICENSURE REQUIREMENTS

Education, Training, and Examination Requirements for Podiatrists

The education and training requirements to become licensed as a podiatrist are: (1) that an applicant have two years of preprofessional postsecondary education in specified subjects; (2) successful completion of four years at an approved school of podiatric medicine; and, (3) at least one year of postgraduate training in a podiatric residency program approved by the BPM.

These are comparable to the requirements for physician applicants applying to the Medical Board. However, unlike the Medical Board, the BPM has a "limited" license that is required in order to participate in a postgraduate residency program. Prior to issuance of a limited license, i.e., a training license authorizing participation in a specific residency for a specific one-year period of time, the applicant must graduate from podiatric medical school and pass Parts I and II of the written "national boards" administered by the National Board of Podiatric Medical Examiners. [The number of candidates and passage rate for the "national boards" exam for the past four years is not available. It has been requested.]

DOCTOR OF PODIATRIC MEDICINE NATIONAL CERTIFYING EXAMINATION PASS RATE				
YEARS	NATION-WIDE		CALIFORNIA ONLY	
	TOTAL CANDIDATES	PASSAGE RATE	TOTAL CANDIDATES	PASSAGE RATE
1993				
1994				
1995				
1996				

During postgraduate training, or after completed, the applicant must also pass the BPM's oral clinical examination. This exam is given twice a year (May and November). The oral exam is one-part oral interview. A panel of two examination commissioners interviews one candidate at a time. On average, about 64% of applicants have passed the oral clinical examination over the past four years.

BPM ORAL CLINICAL EXAMINATION PASS RATE				
	1994	1995	1996	1997*
CANDIDATES	66	33	52	71
PASS %	64%	49%	64%	75%
*Number of candidates and passage rate is for the May examination only.				

Only seven other states require an oral clinical examination comparable to the California exam.

Once the applicant has completed one-year of postgraduate residency training and passed the oral clinical examination, they may receive a license (certificate) to practice podiatric medicine.

Upon receipt of this certification, the licensed podiatrist may also apply for an ankle surgery license. Ankle surgery applicants who were licensed prior to 1984 (when the BPM's oral exam was initiated) may qualify by taking the Board's oral clinical ankle examination, or have been certified by the American Board of Podiatric Surgery. For other applicants (licensure candidates since 1984), passage of the oral clinical examination will suffice. Over the past four years, only five licensed podiatrists have taken the Board's "ankle examination." There were no applicants for the ankle exam in 1996 and 1997. The number of applicants and passage rate from 1993-1996, is indicated in the table below.

BPM ORAL CLINICAL ANKLE EXAMINATION PASS RATE				
	1993	**1994**	**1995**	**1996**
CANDIDATES	2	2	1	0
PASS %	50%	50%	0%	
***Number of candidates and passage rate is for the May examination only.				

Time Frame to Process Applications and Issue Licenses

[Not available at time of report.]

AVERAGE DAYS TO RECEIVE LICENSE	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Application to Examination				
Examination to Issuance				
Total Average Days				

Requirements for Approval of Postgraduate Podiatric Residency Programs

The BPM requires that hospitals sponsoring residencies meet the requirements of the Accreditation Council for Graduate Medical Education (ACGME), which approves *medical* residencies, meet the minimum requirements of the Council of Podiatric Medical Education (the podiatric equivalent to ACGME), have a designated director of medical education, provide emergency medical training through emergency room rotations, measure and evaluate the progress of participants and program effectiveness.

Continuing Education/Competency Requirements

Licensed podiatrists are required to complete at least 50 hours of continuing education during each two-year renewal period, including 12 hours in subjects related to the lower extremity musculoskeletal system. They must also have a current and valid certificate in CPR. Continuing education courses are approved by the BPM, or considered as approved if approved by the BPM recognized organizations, and are sponsored by hospitals, professional associations, and podiatric medical schools.

The Board is recommending to expand the requirement for proof of continuing competency to include passage of an exam administered by the board for those licensed within the past ten years, or be approved or recertified by a specialty certifying board within the past ten years; or, have been granted a current diplomate, board-eligible, or board-qualified status within the past ten years; or, successfully completed an approved residency or fellowship program within the past ten years; or, have been granted or renewed current staff privileges with a licensed health care facility, or other approved clinic, center or organization within the past five years; or, successfully completed an approved course of study of at least four weeks duration at a podiatric school within the past five years.

Comity/Reciprocity With Other States

There is no mechanism under current law for issuing reciprocity licenses and the Board is not recommending one. All applicants are required to have completed one year of residency training and to pass the Board's oral clinical examination. There are only seven states, as indicated by the Board, which may have comparable oral clinical licensing examinations. However, they are not recognized by BPM for purposes of licensing out-of-state applicants. The Board indicates they are working with other states through the Federation of Podiatric Medical Board to develop model national licensure standards.

ENFORCEMENT ACTIVITY

ENFORCEMENT DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Complaints Received (Source)	Total:	Total:	Total:	Total:
Public				
Licensees				
Other				
Complaints Filed (By Type)	Total: **237**	Total: **288**	Total:	Total:
Competence/Negligence			**151**	**230**
Unprofessional/Personal Conduct	99	196		
Fraud	77	64	50	106
Unlicensed Activity	43	9	48	71
Health & Safety	7	14	27	31
Other	6	0	16	14
	5	5	4	4
			6	4
Complaints Closed	Total: **263**	Total: **328**	Total:	Total:
			192	**248**
Compliance Actions	Total: **10**	Total: **4**	Total: **5**	Total: **15**
ISOs & TROs Issued	0			1
Citations and Fines	7	2	1	7
Cease & Desist/Warning	3	1	2	7
Public Letter of Reprimand	0	1	1	0
		0	1	
Investigations Commenced	Total: **114**	Total: **97**	Total: **43**	Total: **87**
Referred for Criminal Action	Total: **0**	Total: **0**	Total: **5**	Total: **4**
Referred to AG's Office	Total: **11**	Total: **7**	Total: **14**	Total: **22**
Accusations Filed	13	9	9	8
Accusation Withdrawn/Dismissed	1	2	0	0
Stipulated Settlements	Total:	Total:	Total:	Total:
Disciplinary Actions	Total: **9**	Total: **16**	Total: **12**	Total: **9**
Revocation	1	3	3	2
Voluntary Surrender	0	1	4	2
Suspension	2	2	2	5
Probation	6	10	3	9

Enforcement Program Overview

The BPM receives on average about 230 complaints per year. The highest number of complaints received was 328 in FY 1994/95. The Medical Board handles complaints and investigations for BPM under a shared-services reimbursement agreement. The largest number of complaints filed deal with competence and negligence issues, unprofessional conduct, and fraud by a practicing podiatrist.

Approximately 37% of complaints, for the past four years, have been referred to one of the twelve Medical Board district offices for formal investigation. Approximately 4% of complaints ended up with an accusation being filed by the Attorney General's Office, and about 5% of complaints ended with some disciplinary action being taken against the licensee. [See Table Below]

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION								
	FY 1993/94		FY 1994/95		FY 1995/96		FY 1996/97	
COMPLAINTS RECEIVED	**237**		**288**		**151**		**230**	
Referred for Investigation	114	(48%)	97	(34%)	43	(28%)	87	(38%)
Accusations Filed	13	(5%)	9	(3%)	9	(6%)	8	(3%)
Disciplinary Actions	9	(4%)	16	(5%)	12	(8%)	9	(4%)

Case Aging Data

BPM only provided information for FY 1996/97, on the average number of days it takes to process a complaint, investigate, and reach a decision on cases received by BPM. [See Table Below] It is unknown, at this time, whether the average number of days has been increasing or decreasing over the past four years. However, it still takes an average of 3.2 years for BPM to receive a final disciplinary decision on a case.

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Complaint Processing				122
Investigation				331
Pre- and Post-Accusation*				722
TOTAL AVERAGE DAYS**				**1,175**

***Case assigned to Attorney General's Office to final decision adopted by BPM.
****From date complaint received to date of final disposition of disciplinary case.

The table on the next page shows that about 42% of investigations were closed within one year for the past four years, about 22% closed within two years, and another 28% of cases taking two years or longer. About 62% of cases were closed by the Attorney General (AG) within two years. However, about 23% of cases referred to the AG will take three years, and 15% may take four years or longer.

INVESTIGATIONS CLOSED WITHIN:	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97	AVERAGE % CASES CLOSED
90 Days	5	3	7	20	**10%**
180 Days	15	8	3	8	**10%**
1 Year	28	22	11	15	**22%**
2 Years	24	27	32	18	**30%**
3 Years	19	18	8	12	**17%**
Over 3 Years	12	5	10	9	**11%**
Total Cases Closed	**103**	**83**	**71**	**82**	

AG CASES CLOSED WITHIN:	FY 1992/93	FY 1993/94	FY 1994/95	FY 1995/96	AVERAGE % CASES CLOSED
1 Year	0	3	3	12	**26%**
2 Years	7	6	8	4	**36%**
3 Years	5	7	1	3	**23%**
4 Years	1	2	0	1	**6%**
Over 4 Years	0	2	2	2	**9%**
Total Cases Closed	**13**	**20**	**14**	**22**	
Disciplinary Cases Pending	**34**	**21**	**23**	**20**	

Cite and Fine Program

BPM promulgated regulations in 1988 under B&P Code Section 125.9 setting up authority to issue citations and fines to licensed podiatrists. These administrative fines range from $100 to $2,500 per investigation, depending on gravity of the violation, the good faith of the licensee, and the history of previous violations. In 1995, BPM referenced the same regulations for purposes of citing and fining those involved in unlicensed activity pursuant to authority granted in Section 148. For the past four years, BPM has issued 17 citations and collected $11,850 in fines. There has only been 1 citation issued for unlicensed activity. [See Table Below]

CITATIONS AND FINES	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Citations Issued	7	1	2	7
Reduced, Withdrawn, Dismissed	1	0	1	2
Amount Assessed	$8,650	$1,100	$500	$4,100
Amount Collected	**$6,650**	**$1,100**	**$500**	**$3,600**

Diversion Program

Under the mandate of Section 2497.1 of the Medical Practice Act, BPM sponsors a diversion program offering assistance to licensed podiatrists experiencing alcohol and other drug dependencies. As stated by the Board, "the goal of the program is to rehabilitate the podiatrist whose competency is impaired so they may be treated and practice podiatric medicine in a manner not endangering the public health and safety." However, BPM does not consider participation in diversion to be "diversion from discipline."

The BPM diversion program is administered by the Medical Board through contractual arrangement. The Medical Board's Diversion Program and its local program facilitators charge fees to individual participants. Participants also bear the costs of their own laboratory testing. The BPM pays the Medical Board a pre-established administrative fee per participant per year, with partial year participants assessed on a pro-rated basis. The Board has, on average, about 8 participants per year, and over the past four years had 6 graduates of the program, at a cost of $76,550 (or approximately $12,800 per graduate). [See Table Below]

DIVERSION PROGRAM STATISTICS	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Program Costs	$22,080	$21,667	$18,200	$14,603
Total Participants	8-12	8-9	7	5-6
Successfully Completed	**3**	**2**	**0**	**1**

The Board is recommending that the statutory requirement for them to sponsor and administer the diversion program be sunsetted, so that these functions may be privatized. The Board indicates, that this is consistent with the Governor's guidelines to transfer activities out of state government which could be better performed in the private sector. The Board indicates that there is no reason for state licensing boards to duplicate what the private sector is adequately providing. There are many non-governmental substance abuse rehabilitation programs available to doctors, including one sponsored by the American Podiatric Medical Association. BPM believes that licensees can enter these rehabilitation programs voluntarily, as they currently do, or as a result of a disciplinary order by the Board, without having to sponsor the program. There is no evidence that state-licensing boards can administer recovery programs better than private providers.

Results of Complainant Survey

In September 1997, the Joint Committee directed all boards and committees under review this year, to conduct a consumer satisfaction survey to determine the

public's views on certain case handling parameters. (The Department of Consumer Affairs currently performs a similar review for all of its bureau's.) The Joint Committee supplied both a sample format and a list of seven questions, and indicated that a random sampling should be made of closed complaints for FY 1996/97. Consumers who filed complaints were asked to review the questions and respond to a 5-point grading scale (i.e., 5=satisfied to 1=dissatisfied).

The survey below actually reflects satisfaction (or dissatisfaction) with the Medical Board, since complaints, investigations and enforcement are handled by this agency. Out of 93 surveys sent to former consumers who had filed complaints with BPM and the Medical Board, 50 were returned. The results indicate that approximately 82% of respondents were satisfied with knowing where to file a complaint and who to contact, and 72% were satisfied with the way they were treated by BPM, the Medical Board, and its staff. However, only 58% were satisfied with the way they were kept informed about the status of their complaint, and only 50% were satisfied with the time it takes to handle their complaint and take final disciplinary action. **Only 28% were satisfied with the final outcome of their complaint, and 48% satisfied with the overall service provided by BPM and the Medical Board.**

CONSUMER SATISFACTION SURVEY RESULTS*					
QUESTIONS	**RESPONSES**				
# Surveys Mailed: 93 **# Surveys Returned: 50 (50%)**	***SATISFIED***			***DISSATISFIED***	
	5	***4***	***3***	***2***	***1***
1. Were you satisfied with knowing where to file a complaint and whom to contact?	52%	16%	14%	0%	16%
2. When you initially contacted the Board, were you satisfied with the way you were treated and how your complaint was handled?	34%	22%	16%	4%	24%
3. Were you satisfied with the information and advice you received on the handling of your complaint and any further action the Board would take?	26%	12%	22%	6%	30%
4. Were you satisfied with the way the Board kept you informed about the status of your complaint?	24%	14%	20%	16%	26%
5. Were you satisfied with the time it took to process your complaint and to investigate, settle, or prosecute your case?	14%	16%	20%	12%	36%
6. Were you satisfied with the final outcome of your case?	14%	2%	10%	4%	66%
7. Were you satisfied with the overall service provided by the Board?	**18%**	**14%**	**16%**	**12%**	**36%**

ENFORCEMENT EXPENDITURES AND COST RECOVERY

Average Costs for Disciplinary Cases

The average investigation costs are lower than most other cases handled by the Medical Board, however the average costs for the Attorney General's Office are just about the same. [See Table Below] Average costs for disciplinary cases seem to be declining, but costs for FY 1996/97 are lower because many of the cases referred to the Attorney General will be billed in later years.

AVERAGE COST PER CASE INVESTIGATED	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Cost of Investigation & Experts	$169,575	$187,272	$175,587	$183,933
Number of Cases Closed	103	83	71	82
Average Cost Per Case	$1,646	$2,256	$2,473	$2,243
AVERAGE COST PER CASE PROSECUTED	**FY 1993/94**	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**
Cost of Prosecution & Hearings	$218,305	$164,666	$194,582	$158,826
Number of Cases Completed	13	20	14	22
Average Cost Per Case	$16,793	$8,233	$13,898	$7,219
AVERAGE COST PER DISCIPLINARY CASE	**$18,439**	**$10,489**	**$16,371**	**$9,462**

Cost Recovery Efforts

BPM began collecting cost recovery under Section 125.3 of the B&P Code in 1986, and has collected $731,186 to date. The law allows BPM recovery of reasonable investigative and Attorney General Costs up until the time of the hearing. BPM has made cost recovery a general requirement sought in all cases, including those that are settled through a stipulated agreement. Cost recoveries are generally collected over a several-year period of time during the term of probation.

Cost recovery ordered by the BPM over the past four years has remained rather constant, except for the FY 1994/95. [See Table On Next Page] Amounts collected from FY 1993/94 through FY 1995/96 reflect amounts received from a 1990 superior court case settlement of approximately $500,000. The FY 1996/97 may more adequately reflect both cost recovery ordered and collected.

COST RECOVERY DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Enforcement Expenditures	$663,740	$633,379	$644,894	$629,094
Potential Cases for Recovery*	9	16	12	9
Amount Ordered	$42,802	$16,625	$41,849	$40,434
Amount Collected**	**$89,489**	**$102,499**	**$69,642**	**$10,905**

***The "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation, or violations, of the Medical Practice Act.

****Amounts for FY 93/94, 94/95, and 95/96 include quarterly payments from a 1990 superior court case settlement that was paid in full in December 1995.

RESTITUTION PROVIDED TO CONSUMERS

The Medical Board, as indicated earlier, handles complaints for BPM. The Medical Board claims that restitution is often impossible because there is no reasonable means to attach a dollar amount to the victim's loss of health or life in the context of an administrative process. Moreover, victims of medical malpractice pursue their own civil actions against physicians and are more successful than the Medical Board would be to obtain monetary compensation. This is primarily due to the lesser standard (burden) of proof required in civil actions (i.e., preponderance of evidence) than the standard required to support administrative action (i.e., clear and convincing to a reasonable certainty) by the Board. However, when appropriate and feasible, the Medical Board does pursue restitution when appropriate and has been successful in obtaining some monetary compensation to victims of medical practitioners. In FY 1995/96, the Medical Board ordered $601,500 in restitution from physicians to be paid to victims or their family members. It is unknown if any restitution was provided based on a complaint filed against a podiatrist.

COMPLAINT DISCLOSURE POLICY

The Medical Board discloses public information about licensed podiatrists through its verification unit, and BPM has asked that it also include DPMs in verifications information provided to consumers and health facilities over the Internet. Any information disclosed concerning physicians and surgeons is also required to be disclosed by the Medical Board for DPMs.

CONSUMER OUTREACH AND EDUCATION

The BPM provides information to consumers regarding its role and how to file complaints against practitioners through a number of fact sheets. *Information for Consumers* is one of the fact sheets which is available in English, Spanish, and Chinese. It is distributed daily from BPM upon request and in mass quantities at consumer health fairs around the state. A C*onsumer Checklist* is provided on the back of this fact sheet. The *Consumer Checklist* informs consumers about how to make informed decisions about using a DPM, and how to file complaints with the Medical Board. A number of phone numbers are provided to verify the license of the DPM or file a complaint with the Medical Board. *Information for Health Facilities*, while aimed directly at hospital medical staff offices, is another publication to describe the duties and responsibilities of the BPM, and the practice and education requirements of DPMs.

There are also fact sheets which provide general information for licensees, information on the diversion program, and information on advertising and clarification of the law regarding amputations and treatment of the foot by DPMs.

2.

IDENTIFIED ISSUES, RECOMMENDATIONS, AND FINAL ACTION OF THE JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE REGARDING THE BOARD OF PODIATRIC MEDICINE

ISSUE #1. Should the State licensing of podiatrists be continued?

Recommendation: ***Both the Department and Committee staff recommended that the licensing and regulation of podiatrists by the State of California be continued.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: Regulation of the Podiatry profession is made necessary by the critical roles performed in the practice of podiatric medicine, and the potential for serious harm to the public's life, health and safety if podiatric medicine is performed by an unqualified or incompetent practitioner. Podiatrists provide primary health care and specialty health care-related services to their patients. Such practice requires a high degree of education, training, and experience. While not defined as "physicians" under California law (as they are in some other states), they are licensed by the Medical Board under the State Medical Practice Act as independent practitioners of medicine and surgery of the *foot and ankle.* They have the same rights to independently diagnose, administer medical treatment, and prescribe medication. Doctors of podiatric medicine, in effect, make independent medical judgments with every patient. They are located in a number of health-related settings including hospitals, clinics, nursing homes, and in solo practice. It is indicated that an estimated 2.6 million Californians are exposed annually to the podiatric medical profession. All states currently license podiatrists.

ISSUE #2. Should the "limited" license required to participate in a postgraduate podiatric residency program be eliminated?

Recommendation: ***Both the Department and Committee staff recommended eliminating the requirement for a limited license for those residents participating in a residency program.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: Section 2475 of the B&P Code requires graduates of an approved college or school of podiatric medicine to obtain a "limited" license in order to participate in a postgraduate residency program. Prior to issuance of a limited license, the applicant for a limited license must have passed Parts I and II of the written "national boards" administered by the National Board of Podiatric Medical Examiners. The limited license to participate in the residency program may be renewed annually for up to four years. However, if the graduate fails to receive the regular license to practice podiatric medicine within two years, the limited license will be automatically revoked. It is not clear what purpose this limited license serves. There is no similar license for physicians participating in postgraduate residency programs. The Board of Podiatric Medicine (BPM) also indicates that many hospital personnel are unaware that the law requires residents of their programs in podiatric medicine to have a limited license, and could be putting their institutions in malpractice or accreditation jeopardy for not requiring the limited license of its residents.

ISSUE #3. Should the statute requiring a special ankle surgery certification and examination sunset sometime in the near future?

Recommendation: ***Both the Department and Committee staff recommended eliminating the requirement for an ankle surgery license from statute.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: In 1983, the Legislature authorized a special ankle surgery license that allows licensed podiatrists to perform surgical treatment of the ankle in specified settings. To obtain this license, the podiatrist is required to have passed one of three examinations: (1) the oral clinical licensing exam (required of all initial licensure candidates since 1984); (2) the Board's own oral clinical ankle surgery licensing examination (offered to those licensed prior to 1984); or the specialty certification exam given the American Board of Podiatric Surgery. It would seem that, at some point in time, passage of the oral clinical licensing exam should be

sufficient for purposes of performing ankle surgery without any specialty licensure necessary. It should also be noted, that only 5 licensed podiatrist have taken the special Board ankle exam since 1993, and none in 1996-97. There are currently about 638 licensed podiatrists (out of 2000) who have been certified to perform surgical treatment of the ankle.

ISSUE #4. Should the "public protection" provisions relating to physicians and surgeons apply to the regulation of podiatrists, as recommended by the Board of Podiatric Medicine?

Recommendation: ***No recommendation at this time. The Board should indicate which "public protection" provisions of the Medical Practice Act should apply, or should all current and future provisions apply as long as they are not related to the physicians and surgeons scope of practice?***

Comment: The BPM is part of the Medical Board, and it is the Medical Board that actually licenses doctors of podiatric medicine under the Medical Practice Act. However, the BPM argues that podiatrists are not "physician and surgeons," and therefore are overlooked, inadvertently, as laws regulating "physician and surgeons" are enacted. This forces the Board to spend limited resources continually following a "me too" catch-up effort, often finding it difficult to capture interest or attention within the Legislature. In the area of regulations, the Board also finds itself duplicating the efforts of the Medical Board, frequently again in a catch-up manner to plug loopholes open to its licensees.

ISSUE #5. Should the advertising of "free foot exams" be prohibited as recommended by the Board of Podiatric Medicine?

Recommendation: ***The Department concurred with the preliminary recommendation of the Joint Committe that the Board justify why this prohibition is necessary. The Board provided the Joint Committee with some information concerning this issue. However, Committee staff believed that additional input and justification was necessary before a recommendation was made to prohibit the advertising of "free foot exams" by podiatrists. Committee staff recommended that the Board hold a public hearing to discuss the issue with consumer groups, including the Center for Public Interest Law, the profession, Department of Health Services, and representatives of low-income areas, which are targeted for such services. Findings and recommendations could then be forwarded to the Legislature and Joint Committee for consideration.***

Vote: ***The Joint Committee adopted the recommendation of Committee staff by a vote of 6-0.***

Comment: The Board indicates that the advertising of "free foot exams" is often an element in quality-of-care and other complaints. It is the opinion of the Board that there is no such thing as a "free exam." Such advertising is inherently misleading. The Board sees this type of activity frequently and claims there are even public relations firms marketing it to licensees. Patients frequently find themselves responsible for services "not included," the Board argues. The Federal Inspector General and the Medical Board's anti-fraud staff testified before the Board in support of its proposal. They pointed out such ads frequently target low-income neighborhoods, and that the advertising doctors, once possessing the government and private insurance ID numbers, sometimes bill repeatedly for unprovided services. This restriction on advertising for free foot exams is similar to a Optometry Board statute dealing with free "eye exams." The restriction would not apply to health fairs, free clinics, or other charitable programs.

The California Podiatric Medical Association argues against prohibiting "free foot exams" by podiatrists. They indicate that providing such exams, especially in low income areas, has helped doctors of podiatric medicine to identify those who have diabetes and prevent possible amputations of lower extremities. They argue that this issue should be further discussed, and to review other alternatives to dealing with fraud which may result from "free foot exams."

Committee staff are still concerned with how extensive or serious this problem is within California, and whether current laws may be sufficient to deal with this type of fraud. The Board should further investigate this issue, and allow input from all effected parties, by conducting a public hearing. Findings and recommendations could then be forwarded to the Legislature and Joint Committee for consideration.

ISSUE #6. Should podiatrists be restricted from making a statement that they are "board certified," unless the specialty board has been approved or recognized by the Board of Podiatric Medicine?

Recommendation: ***The Department did not address this issue. Committee staff concurred with the recommendation of the Board of Podiatric Medicine to require all specialty boards to be approved or recognized by Board, before a podiatrist can make a statement that they are "board certified."***

Vote: ***The Joint Committee adopted the recommendation of the Board and Committee staff by a vote of 6-0.***

Comment: Language was included in a bill last year, which would have given the Board authority and responsibility, that the Medical, Dental, and Optometry boards currently have, to allow licensees to only advertise certification by any specialty board, if the specialty board has demonstrated to the Board that it has standards equivalent to those of the two boards approved by the national accrediting body, the Council on Podiatric Medical Education. The bill, SB 1347, was passed out of the Business and Professions Committee, the Senate, and the Assembly Health and Appropriations Committee. However, the language was pulled out of the bill on the Assembly Floor for reasons other than any particular opposition or concerns regarding the bill. There appears to be no controversy surrounding this issue.

ISSUE #7. Should residency programs approved by Board of Podiatric Medicine be required to have at least a fifty percent pass rate for residents taking the Board's oral clinical examination, as recommended by the Board?

Recommendation: ***Department did not address this issue. Committee staff concurred with the recommendation of the Board of Podiatric Medicine to require residency programs to have at least a fifty percent pass rate for residents taking the Board's oral clinical examination.***

Vote: ***The Joint Committee adopted the recommendation of the Board and Committee staff by a vote of 6-0.***

Comment: All graduates of a college or school of podiatric medicine are required to complete one year of postgraduate training in a residency program to receive a license to practice podiatric medicine. The board is responsible for approving these postgraduate residency programs. The board has initiated the process to promulgate a new regulation stating that residency programs must "have at least fifty per cent pass rate for residents taking the Board's (state) oral clinical examination within the most recent five-year period," and that, "If a residency program falls below the specified fifty per cent pass rate, the board, after placing the program on provisional approval, may grant the program approval if it determines on evidence obtained by the board's own site visit team or other evidence satisfactory to the board, that the program is in reasonable conformance with all applicable requirements." The Board indicates that current requirements do not address the measurement of a program's effectiveness as demonstrated by the ability of its residents to pass the board's oral clinical licensing examination. This would at least establish a standard by which to review and approve residency programs.

ISSUE #8. Should an external audit, or at least some summary report from the University of California system, be provided to the Legislature to determine if it is providing appropriate funds for podiatric medical training, as suggested by Board of Podiatric Medicine?

Recommendation: ***Department did not address this issue. Committee staff concurred with the recommendation of the Board of Podiatric Medicine to require an audit, or at least some summary report from the University of California system, to determine if appropriate funds are being provided for podiatric medical training.***

Vote: ***The Joint Committee adopted the recommendation of the Board and Committee staff by a vote of 6-0.***

Comment: BPM indicates that many of its residency programs are in small community hospitals because it has had difficulty gaining access to large teaching hospitals, especially those in the UC system. It argues that podiatric medical residents should be included in the mix of professionals provided at least some access for training in the state's publicly-supported health science teaching centers.

ISSUE #9. Should the continuing competency requirement for podiatrists be expanded as recommended by the Board of Podiatric Medicine?

Recommendation: ***The Department did not address this issue. Committee staff recommended supporting in concept the Board's recommendation to expand continuing competency standards for podiatrists, but the Board should still indicate what the impact may be to current licensees in attempting to fulfill these new requirements before any proposal is adopted.***

Vote: ***The Joint Committee adopted the recommendation of Committee staff by a vote of 6-0.***

Comment: Currently, each doctor of podiatric medicine is required to complete 50 hours of approved continuing education, including a minimum of 12 hours in subjects related to the lower extremity muscular skeletal system. The Board is recommending to expand the requirement for proof of continuing competency to include passage of an exam administered by the board within the past ten years, or be approved or recertified by a specialty certifying board within the past ten years; or, have been granted a current diplomate, board-eligible, or board-qualified status within the past ten years; or, successfully completed an approved residency or fellowship program within the past ten years; or, have been granted or renewed current staff privileges with a licensed health care facility, or other approved clinic,

center or organization within the past five years; or, successfully completed an approved course of study of at least four weeks duration at a podiatric school within the past five years.

ISSUE #10. Should the Medical Board be required to include information concerning licensed podiatrists on their internet verification system, as recommended by Board of Podiatric Medicine?

Recommendation: ***Both the Department and Committee staff recommended including licensed podiatrist information on Medical Board's internet verification system.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: AB 103 was signed into law this year, and requires the Medical Board to report over the internet any arbitration awards and malpractice judgments against the physician, hospital disciplinary actions, whether the physician's license is in good standing, any board disciplinary actions or criminal actions taken against the physician, and provide links to information on a physician's specialty board certifications. BPM argues that the Medical Board should include DPM information, as well, since they maintain all of the data concerning the licensing and disciplinary actions taken against licensed podiatrists. It would also be very costly to post this information on a separate website, and would not be "user friendly," since consumers usually contact the Medical Board when they have a complaint involving a podiatrist.

ISSUE #11. Should section 2497.1 of the Business and Professions Code, which requires the Board of Podiatric Medicine to provide a diversion program, be sunsetted as recommended by the Board?

Recommendation: ***The Department recommended that the Board of Podiatric Medicine, the Medical Board, the Department, other boards with diversion programs, and the Legislature research an appropriate approach to privatizing diversion programs with special attention to the existing participants. Committee staff concurred with this recommendation and recommended that the Medical Board, in conjunction with other boards providing diversion programs, report to the Joint Committee by September 1, 1999, on a plan to privatize diversion programs.***

Vote: ***The Joint Committee did not adopt the recommendation of the Department and Committee staff by a vote of 3-3.***

Comment: The BPM diversion program is currently administered by the Medical Board through contractual arrangement. The Board has on average about 8 participants per year, and over the past four years has had 6 graduates at a cost of $76,550 (or approximately $12,800 per graduate). The Board is recommending that the statutory requirement for them to sponsor and administer the diversion program be sunsetted, so that these functions may be privatized. The Board indicates, that this is consistent with the Governor's guidelines to transfer activities out of state government, which could be better performed in the private sector. The Board indicates that there is no reason for state licensing boards to duplicate what the private sector is adequately providing. There are many non-governmental substance abuse rehabilitation programs available to doctors, including one sponsored by the American Podiatric Medical Association. BPM believes that licensees can enter these rehabilitation programs voluntarily, as they currently do, or as a result of a disciplinary order by the Board, without having to sponsor the program. There is no evidence that state-licensing boards can administer recovery programs better than private providers.

ISSUE #12. Should the Board of Podiatric Medicine continue to be under the jurisdiction of the Medical Board, be given statutory independence as an independent board, merged with the Medical Board (as is recommended by the Board), or should its operations and functions be assumed by the Department of Consumer Affairs?

Recommendation: ***Both the Department and Committee staff recommended that the Board of Podiatric Medicine continue as the agency responsible for the regulation of the practice of podiatric medicine. Committee staff recommended that the sunset date of the Board be extended for four years (to July 1, 2003). In the meantime, the Board should evaluate whether merger with the Medical Board would be more efficient and effective in regulating the profession of podiatric medicine, and present a plan for merger at the time of their next sunset review.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: BPM is operating efficiently and is carrying out its mandate for public protection effectively. As reported by the Center for Public Interest Law (CPIL), BPM is a consumer protection leader among the Department's occupational licensing boards, and the recommendations made by BPM during the sunset review process continue this trend and are worthy of serious consideration.

The BPM currently has no independent statutory authority for passing regulations, licensing and disciplining podiatrists. The BPM operates mostly in an advisory

capacity to the Medical Board and provides administrative services in the processing of applications for licensure of podiatrists, and in providing examinations. The Board has indicated, "It is working to hasten the day when BPM can be sunsetted and its programs fully merged back to the Medical Board without the concern about professional discrimination." BPM should evaluate why merger would be more efficient and effective in regulating the profession of podiatric medicine, and provide a specific plan for merger during their next sunset review.

ISSUE #13. Should the composition of the Board of Podiatric Medicine be changed to a public majority as recommended by the Board?

Recommendation: ***This Board has 6 members, of which 4 are licensed podiatrists and 2 are public members. The Department generally recommends a public member majority and an odd number of members for regulatory boards. For the Board of Podiatry, the Department recommended an increase in public membership to improve balance consistent with those guidelines. Committee staff concurred with the Department and the Board, and recommended adding two more public members to the Board and removing one of the podiatrist members. The composition of the Board would be 7 members, but with 3 licensed podiatrists and 4 public members.***

Vote: ***The Joint Committee did not adopt the recommendation of the Board, Department and Committee staff. The Joint Committee adopted a substitute recommendation, by a vote of 6-0, to change the composition of the Board to 7 members, but with 4 licensed podiatrists and 3 public members.***

Comment: The current Board consists of 6 members, with 4 licensed podiatrists and 2 public members. The Board voted two years ago to seek a majority of public members. It is requesting a change to increase the Board to 9 members, with 5 public members, and 4 licensed podiatrists. An alternative composition suggested by the Board would be 7 members, with 4 public members and 3 licensed podiatrists.

The Board indicates that it conducted a consumer survey of 175 complainants, and out of 67 who responded, 60 percent said they would have more confidence in licensing boards "if they were composed of a majority of public members rather than doctors." The Board also cites a study conducted in 1990, by the School of Public Administration at the University of Southern California, which found in part, after reviewing a number of state health-related boards, that professional majority boards tend to have fewer serious disciplinary actions, and concluded that the

number of professionals on the board consistently affects board performance in pursuing disciplinary actions against licensees.

Others in support of this change include the Center for Public Interest Law (CPIL) and Consumers for Quality Care. The Joint Committee has also received a letter of support from Senator Robert Presley, who is currently a public member serving on this Board and from Dixon Arnett, former Executive Director of the Medical Board. The California Podiatric Medical Association is opposed to this change.

The Joint Committee changed the composition of the Board of Vocational Nurses and Psychiatric Technicians last year to a public majority. There are also recommendations to increase public membership on several health-related boards this year, and create a public majority for the Physical Therapy Board and the merged Audiology and Hearing Aid Dispenser Board. All trade boards are a public majority. As indicated, the Department and Administration recommend a public majority and an odd member board.