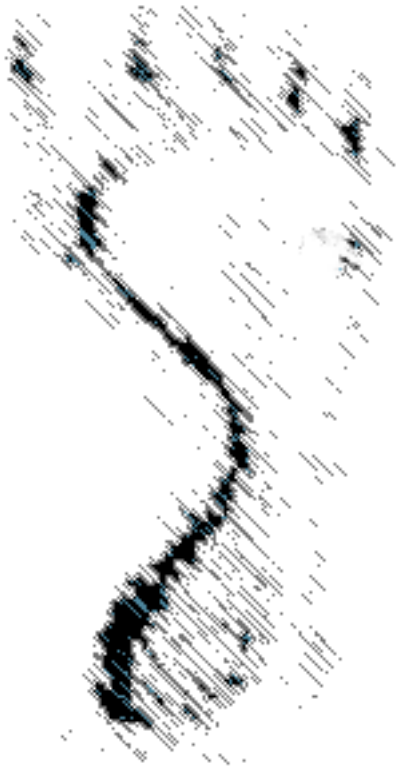
State and Consumer Services Agency
Department of Consumer Affairs

Medical Board of California

Board of Podiatric Medicine

Paul J. Califano, DPM, *President*
Anne M. Kronenberg, *Vice President*
Elaine S. Davis, DPM
Joseph M. Girard, MBA, JD
Iva P. Greene, MA



Sunset Review Report

State of California Department of Consumer Affairs

2001

Table of Contents

PART 1

CALIFORNIA BOARD OF PODIATRIC MEDICINE

BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM

BACKGROUND AND DESCRIPTION OF THE BOARD AND PROFESSION

Short Explanation of the History and Function of the Board.

The California Board of Podiatric Medicine (BPM) is the unit of the Medical Board of California (MBC) that regulates Doctors of Podiatric Medicine (DPMs). Prior to creation of the BPM, DPMs were licensed directly by the Medical Board. The oldest license in BPM's files was issued by the Board of Medical Examiners in 1926 to Charles Phoenix, Doctor of Surgical Chiropody.

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. The Committee received applications, conducted examinations, and passed its recommendations on to the Medical Board, which to this day is the agency that legally issues the DPM licenses.

The Legislature has established in § 101.6 the purpose of all consumer affairs boards. This is "to protect the people of California" by:

- establishing minimum qualifications and levels of competency
- licensing applicants
- investigating complaints
- taking disciplinary action as appropriate

These general functions have been fleshed out in Article 22 (Podiatric Medicine) of the Medical Practice Act for BPM. BPM licenses DPMs. It also approves schools and residency programs annually. While BPM performs these functions independently, it is noteworthy that under § 2479 it is the umbrella Medical Board that legally and technically issues the DPM licenses.

§ 2222 gives BPM the same enforcement powers as the Medical Board of California (MBC) under Article 12. BPM's Enforcement Coordinator keeps track of and works to expedite podiatric cases being handled by MBC's central complaint, investigation, and discipline coordination staffs and health quality units of deputy attorneys general and administrative law judges of the Department of Justice and Office of Administrative Hearings, respectively.

Current Composition of the Board (Public vs. Professional) and listing of Board Members, who appointed by, when appointed, when terms expire, and whether vacancies exist and for how long.

In the last Sunset review, BPM endorsed a having a majority of "public" Members. SB 1981 (Chapter 736, Statutes of 1998) added a third non-licensee Member to the Board so that the current composition is four (4) licensees and (3) non-licensees

The culture of the Board is that all Members are part of the public and by statute represent the public, and that the roles and duties of licensee and non-licensee Board Members are identical. The role of non-licensee Members is not special, lesser, or different in any way.

The most recent appointees are:

<u>Appointed by the Governor</u>

Paul J. Califano, DPM
Appointed 1/1/99
Terminates 6/1/02

Elaine S. Davis, DPM
Appointed 4/4/94
Re-appointed 12/15/97
Terminated 6/1/01
Grace year expires 6/1/02

Joseph M. Girard, MBA, JD
Appointed 1/199
Terminates 6/1/02

Kenneth K. Phillips, Jr., DPM
Appointed 12/15/97
Terminated 6/1/00
Grace year expired 6/1/01

Jon H. Williams, DPM
Appointed 5/7/93
Re-appointed 9/18/96
Terminated 6/1/00
Grace year expired 6/1/01

Appointed by the Speaker

Iva P. Greene, MA
Appointed 11/21/94
Terminated 6/1/98
Grace year expired 6/1/99
Re-appointed 11/2/99
Terminates 6/1/02

Appointed by Senate Rules

Anne M. Kronenberg
Appointed 8/18/99
Terminates 6/1/03

Committees and their functions.

BPM currently has five committees appointed by the president:

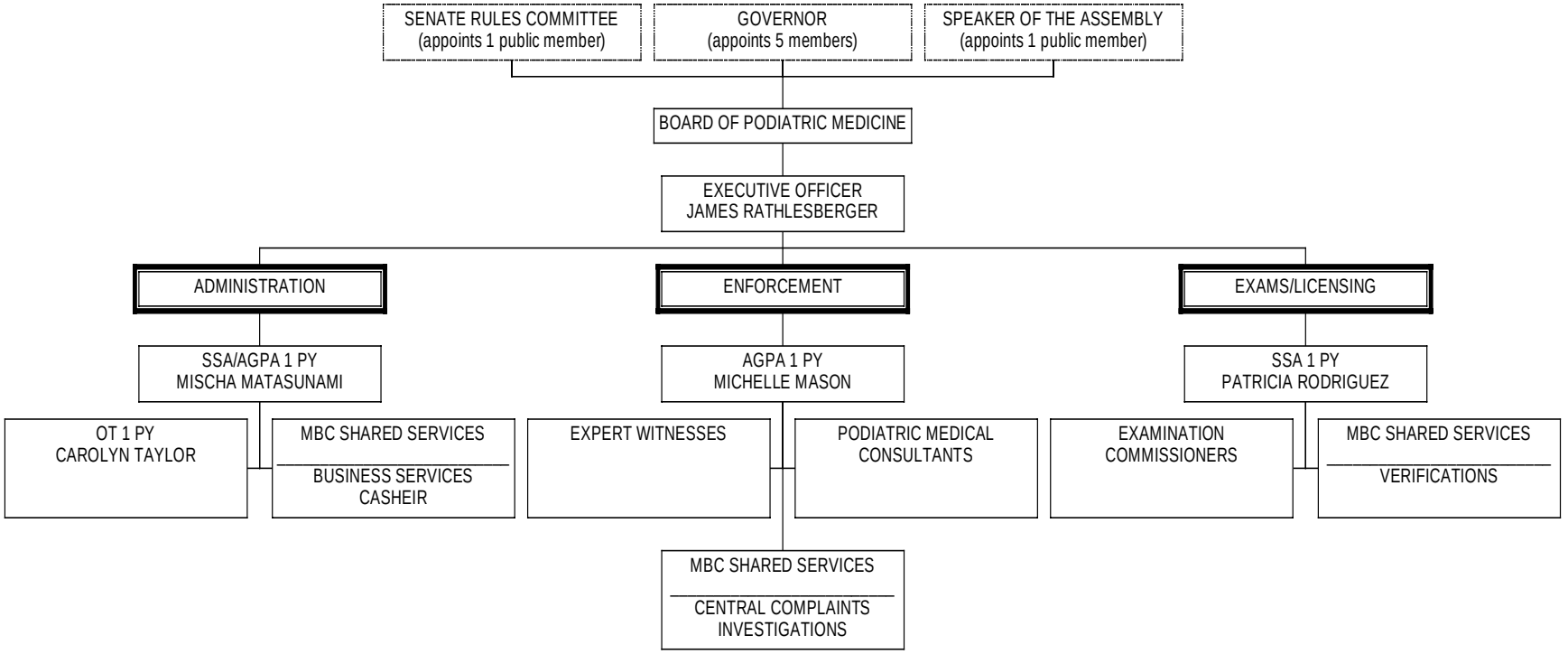
The Consumer Advocacy Committee was formed to help coordinate greater outreach to consumers.

The Examination Committee coordinates administration of the Board's licensing exam and meets twice a year, once before the May exam and then again before the November exam. It approves and selects licensees as examiners and exam consultants.

The Legislative Committee's function is to monitor and recommend positions on legislation as appropriate.

The Medical Education Committee reviews annual applications from podiatric medical schools and postgraduate residency training programs. It conducts site visits from time to time to schools and programs.

The Professional Practice Committee recommends standards for and approves candidates for podiatric medical consultants and experts who assist the board's enforcement staff. In addition, this committee handles other professional practice matters such as the review of specialty certifying boards and misleading advertising of "free" foot exams. The committee held a public hearing on the free foot exam advertising issue November 5, 1998 pursuant to a directive from the JLSRC. The board has a pending application from the American Board of Medical Specialties in Podiatry, which the committee site visited.



STATE OF CALIFORNIA – BOARD OF PODIATRIC MEDICINE
LINE ORGANIZATIONAL CHART

JAMES H. RATHLESBERGER, EXECUTIVE OFFICER

JULY 1, 2001

These are all two-person committees. The exam committee is the only one that holds regular meetings.

BPM's organizational chart is exhibited.

Who the Board Licenses, Titles, Regulates, etc. (Practice Acts vs. Title Acts)

BPM licenses Doctors of Podiatric Medicine (DPMs) under Article 22 of the Medical Practice Act (B&P Code). SB 26, an urgency bill sponsored by JLSRC in the current legislative session, if enacted, will restore a temporarily-lapsed authority for "limited licenses" for podiatric medical residents. This is a training license. The Board also approves schools and residency programs. The Medical Board issues "fictitious name permits" for podiatric medical practices.

Any major changes to the Board since the last review. (Internal changes, strategic planning, regulatory changes or recent legislation, etc.)

In the last review, the Legislature added one public member appointed by the Governor and passed the board's recommendation for the nation's first "continuing competence" program (B&P Section 2496) for doctors. The board amended its strategic plan to address financial challenges brought by the declining number of licensees associated with managed care.

Any major studies conducted by the Board.

No.

Licensing Data [Table below]. What information does the Board provide regarding the licensee (i.e., education completed, awards, certificates, certification, specialty areas, etc.)?

The Medical Board discloses information regarding DPMs through the Verifications Unit and the Internet (http://www.docfinder.org/ca/df/casearch.htm). This information includes license history, status, and discipline, as well as the school of podiatric medicine the licensee attended and the date of graduation.

Information pertaining to awards, certificates and specialty certification is not available.

There are approximately 1,984 licensed podiatrists of the Board of Podiatric Medicine for FY 2000/01. The following provides licensing data for the past four years:

LICENSING DATA FOR PODIATRISTS	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Licensed*	Total: 1,983	Total: 1,963	Total: 1,974	Total: 1,984
California	*Data not*	1,686	1,711	1,736
Out-of-State	*Available*	277	263	248
Applications Received**	Total: 23	Total: 19	Total: 29	Total: 21
Applications Denied	Total: 1	Total: 0	Total: 0	Total: 0
Licenses Issued	Total: 75	Total: 64	Total: 61	Total: 78
Renewals Issued***	Total: 824	Total: 838	Total: 814	Total: 823
Statement of Issues Filed	Total: 1	Total: 3	Total: 0	Total: 0
Statement of Issues Withdrawn	Total: 0	Total: 0	Total: 0	Total: 0
Licenses Denied	Total: 3	Total: 1	Total: 0	Total: 0

* Valid licenses only, including fee-exempt and inactive.

** The Board utilizes a single application form for the limited license (for residency training in CA), the state oral licensing exam, and the regular license. This Applications Received data does not include limited license applications, which appear in the next table. Most but not all limited license holders take the exam and pursue regular licensure. Many but not all applicants perform their residency training (with limited license) in CA.

*** Does not include fee-exempt renewals.

OTHER LICENSURE CATEGORIES	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Licensees (Limited License)*	Total: 170	Total: 172	Total: 181	Total: 122
Applications Received (Limited License)	Total: 70	Total: 69	Total: 75	Total: 71
Applications Denied (Limited License)	Total: 0	Total: 0	Total: 0	Total: 0
Licenses Issued (Limited License)	Total: 70	Total: 69	Total: 75	Total: 71
Renewals Issued (Limited License)	Total: 100	Total: 103	Total: 106	Total: 51
Applications Received (Ankle Certification)**	Total: 24	Total: 9	Total: n/a	Total: n/a
Certificates Issued (Ankle Certification)**	Total: 24	Total: 9	Total: n/a	Total: n/a

*Required for participation in a podiatric residency program.

** SB 1981 repealed B&P Code §2473 requiring ankle certification effective 1-1-99.

BUDGET AND STAFF

Current Fee Schedule and Range

Discuss which fees are main source of revenues, when renewal is required, date of last fee(s) adjustment, and if any plans to increase fees and for what reasons. List all fees.

DPM renewal fees represent BPM's main source of revenue; over 80 percent of the total licensing fees collected. Renewals are processed biennially, at the end of a licensee's birth month.

AB 1252 (Chapter 977, Statues of 2000) temporarily increased the renewal fee to $900 until January 1, 2002. At that time, renewal fees will revert to $800 unless new legislation extends the increase.

Fee Schedule	Current Fee	Statutory Limit
Limited license	$60	$60
Duplicate license	$40	$40
Duplicate renewal receipt	$40	$40
Letter of good standing	$30	$30
Continuing education course approval	$100	$100
Oral exam appeal	$25	$25
Application fee	$20	$20
Fictitious name permit (FNP)	$50	$50
Initial wall certificate	$100	$100
Oral exam	$700	$700
Oral re-exam	$700	$700
Initial license	$800	$800
FNP renewal	$40	$40
Biennial renewal	$900	$900
Delinquent fee	$150	$150
Delinquent fee – FNP	$20	$20
Penalty fee	$450	$450

Revenue and Expenditure History

Provide brief overview of revenues and expenditures.

BPM's Special Fund represents its entire revenue. While most revenue is derived from licensing fees, it also includes enforcement-related cost recovery and fine payments.

All BPM expenditures support its programs: Enforcement, Examination, Licensing and Administrative. The focus remains on public protection, with more than 70 percent of the budget spent of Enforcement. Aside from Department-wide Budget Change Proposals, BPM has not had, nor is it anticipating any of its own.

Comparison of Revenues and Expenditures:

REVENUES	ACTUAL				PROJECTED	
	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03
Licensing Fees	789,305	803,590	832,780	889,200	832,900	779,900
Fines & Penalties	5,410	6,730	6,570	6,050	3,990	3,990
Other	8,395	5,730	5,550	4,125	4,185	4,155
Interest	12,601	27,823	32,835	33,191	33,907	23,110
TOTALS	**815,711**	**843,873**	**877,735**	**932,566**	**874,982**	**811,155**

EXPENDITURES	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03
Personnel Services	286,328	285,704	289,683	320,252	332,000	332,000
Operating Expenses	666,370	489,610	550,845	702,029	709,802	709,802
(-) Reimbursements	9,624	44,332	27,551	45,477	4,000	4,000
(-) Distributed Costs	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	**943,073**	**730,982**	**812,977**	**1,067,758**	**1,045,802**	**1,045,802**

Expenditures by Program Component

Discuss the amounts and percentages of expenditures made by program components.

EXPENDITURES BY PROGRAM COMPONENT	FY 97-98	FY 98-99	FY 99-00	FY 00-01	Average % Spent by Program
Enforcement	720,402	550,929	601,696	759,829	**73**
Examination	99,941	91,433	102,799	115,203	**11**
Licensing	108,896	109,648	112,289	120,456	**13**
Administrative	23,457	23,306	23,744	26,792	**3**
Diversion (if applicable) *	N/A	N/A	N/A	N/A	**N/A**
TOTALS	**952,696**	**775,315**	**840,528**	**1,022,280**	

* While Diversion costs totaled $5,448 in FY 97-98, since the program sunset afterwards, it would not have been meaningful to separate those costs, since it would not have allowed comparison with subsequent years.

Fund Condition

Discuss reserve level, spending trends, and if a mandated statutory reserve level exists. Also whether deficit may occur and whether fee increase or reductions is appropriate.

The reserve level is currently forecasted to continue decreasing. While the Board exercises efficient management of its funds and strives to spend under the full expenditure authority, the small size of the budget makes it highly volatile. Unpredictable and uncontrollable increases in enforcement costs and shared services can have a significant impact. Further, revenue is predicted to continue decreasing, along with the base of licensees. Although a mandated statutory reserve level does not exist, the Board seeks to maintain a projected positive fund balance.

Comparison of Revenues, Expenditures, and Reserves:

ANALYSIS OF FUND CONDITION	FY 99-00	FY 00-01	FY 01-02 (Budget Yr)	FY 02-03 (Projected)	FY 03-04 (Projected)	FY 04-05 (Projected)
Total Reserves, July 1	594,581	663,825	783,348	637,590	410,995	152,139
Total Rev. & Transfers	888,581	1,089,145	880,242	819,925	808,595	795,652
Total Resources	1,477,536	1,760,282	1,663,590	1,457,515	1,219,590	947,791
Total Expenditures	813,711	976,934	1,026,000	1,046,520	1,067,450	1,088,799
Reserve, June 30	663,825	783,348	637,590	410,995	152,139	(141,008)
MONTHS IN RESERVE	**9.8**	**9.6**	**7.5**	**4.7**	**1.7**	**(1.6)**

LICENSURE REQUIREMENTS

Education, Experience and Examination Requirements

Discuss education, experience and examination requirements for all licensure categories which the board regulates.

The education requirements for licensure are:

- Two years of postsecondary education including the subjects of chemistry, biology and physics or mathematics (§2481, last amended in 1986)
- Successful completion of four years at an approved school of podiatric medicine consisting of at least 4,000 hours in a curriculum that provides adequate instruction in the subjects listed in §2483 (last amended in 2000)

Experience required for permanent licensure is:

- Satisfactory completion of at least one year of approved postgraduate podiatric medical and surgical training (§2484, last amended in 1994)

With enactment of JLSRC's SB 26, applicants will once again be required to obtain a "limited" license prior to participating in an approved residency program (§2475). The limited license allows individuals to participate in rotations beyond the scope of podiatric medicine under appropriate supervision by a licensed physician (MD or DO). The license is issued by the board for participation in a specific training program for a specific one-year period. While the license can be renewed up to four years, a permanent license is also required for the third and fourth year of training. Limited license requirements also include postsecondary education and completion of four years of podiatric medical school.

Examination requirements for permanent licensure are:

- Passage of Parts I and II of the written examination administered by the National Board of Podiatric Medical Examiners (NBPME). This exam tests for didactic knowledge of the basic and clinical sciences. (§2486, last amended in 2000)

  Individuals applying for a limited license are also required to pass all sections of Parts I and II of the NBPME's written examination.

- Passage of the oral clinical exam administered by the board (required since 1984). This exam is designed to assess whether the candidate's clinical reasoning meets entry-level competence.

What does the Board do to verify information provided by the applicant regarding education and experience? What process is used to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?

The Board requires "primary source verification" for its licensing program. Primary source verification is intended to prevent falsification of documents. Under this policy, all licensure documents certifying applicants' education, training, out of state licensure, or criminal clearance must be sent directly to the Board from the certifying organization rather than the applicant. For example, a transcript of podiatric medical education mailed to the Board by the applicant would not be acceptable even if bearing an official seal.

Applicants are required to submit fingerprint cards or undergo the "Live Scan" process in order to obtain a criminal record clearance from the state Department of Justice (including those applying for a limited license) and the Federal Bureau of Investigation (for permanent licensure). Live Scan technology allows the applicants to have their fingerprints electronically scanned and obtain results in a fraction of the time required for processing traditional fingerprint cards.

Eight separate questions on the licensing application require the applicant to disclose under penalty of perjury any disciplinary actions (past or pending), denials, or convictions related to licensing in other states or health care facilities. Applicants are also required to disclose any addictions to controlled substances and any convictions of misdemeanors or felonies.

Applicants who have been licensed in other states must arrange for their respective licensing agencies to submit verification of license status and any disciplinary actions or active investigations.

Should the Board be notified of any adverse information or criminal record, applicants must provide full and complete explanations and certified copies of all applicable court documents. After careful consideration, board staff may deny the license or endorse a stipulated agreement for a probationary license. Applicants may appeal the decision and request a hearing before an administrative law judge.

Discuss passage rates for all examinations, whether there is legitimate justification for all exams, whether exams have had an occupational analysis performed and been validated and when, and the date of the next scheduled occupational analysis for each exam.

The pass rate for the Board's oral clinical exam for the past four years is 72 percent. The overall pass rate since the exam was initiated in 1984 is 76 percent.

The Board's oral exam is designed to ascertain whether knowledge and skill in obtaining and interpreting clinical information, consistent with sound medical practice and consumer protection, meets entry-level requirements. The exam evaluates the individual's knowledge of clinical case management, ability to present sensible medical judgment, and logical reasoning processes, and determines whether they are sufficient to enable the individual to safely and effectively practice podiatric medicine.

The Board conducts an examination validation study every five years. A job analysis study was last conducted in April 2000 for NBPME by the Chauncey Group International in Princeton, New Jersey. The study identifies important responsibilities performed by podiatric doctors, as well as the knowledge necessary for competent performance. The DCA Office of Examination Resources (OER) agreed that it could be utilized as a basis to support the validity of the Board's oral clinical examination.

The board is currently working with OER in developing procedures to link responsibility and knowledge statements in the job analysis to the oral clinical exam. The exam validation study is scheduled to be completed by the end of this year.

The next occupational analysis will be scheduled sometime between 2005 and 2007 as recommended by DCA's Examination Validation Policy.

Comparison of exam passage rates for all candidates for both a national exam and California state exam:

The National Board of Podiatric Medical Examiners (NBPME) develops and oversees the National Boards Part III exam (formerly known as the Podiatric Medical Licensing Examination for States or "PMLexis"). This written examination is given twice a year on behalf of participating state licensing boards to applicants who have met the state's own licensing criteria. Actual examination scoring is completed with the assistance of the NBPME.

The National Boards Part III tests whether candidates possess clinical skills necessary for independent and unsupervised general practice of podiatric medicine. Candidates are eligible to take the exam once they receive a DPM degree and apply for licensure in a participating state.

NATIONAL BOARDS PART III (PMLexis)				
YEARS	NATION-WIDE		CALIFORNIA ONLY	
	TOTAL CANDIDATES	PASSAGE RATE	TOTAL CANDIDATES	PASSAGE RATE
1997/98	706	81%		
1998/99	640	90%		
1999/00	649	82%		
2000/01	566	86%		
***NOTES**				

Data not available

CALIFORNIA ORAL CLINICAL LICENSING EXAM				
	1997/98	**1998/99**	**1999/00**	**2000/01**
CANDIDATES*	117	109	102	88
PASS %	68%	71%	75%	75%
*General candidates only, does not include probation examinees.				

Discuss any increase or decrease in average time to process applications, provide exam and issue license.

The processing times apply only to those applicants who take and pass the first available oral examination. The majority of limited license holders who take the exam do so near the end of their first year of residency training, after which some continue with one additional year of training. Second-year residents may wait almost a whole year before paying the fee for permanent licensure. Also, a small number of limited licensees do not pursue permanent licensure as they look to practice in other states. The board utilizes a single application form for permanent and limited licenses and exams.

There has been a steady decrease in average processing times as procedures have been streamlined over the years and the number of applicants has decreased. As candidates are required to submit exam fees and applications no later than 45 days prior to the exam date, most applications are received shortly before 45 days prior to the scheduled date.

Since Board scores are valid for up to ten years, successful candidates can pursue permanent licensure during that entire period. The data shown for average days from examination to issuance are for applicants who have met all requirements within the first six months following passage of the exam.

AVERAGE DAYS TO RECEIVE LICENSE	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Application to Examination	59	58	48	46
Examination to Issuance	21	14	3	2
Total Average Days	**80**	**72**	**51**	**48**
*Average time for applicants requesting license within six months of exam passage.				

Continuing Education/Competency Requirements

Discuss briefly: changes made by the Board since last review to assure competency.

The JLSRC's bill following the last review, SB 1981 (Chapter 736, Statutes of 1998), initiated the first continuing competence program for any doctor licensing board in this country. B&P Section 2496, as amended by SB 1981, recognizes findings by groups such as the Pew Health Professions Commission that continuing education alone does not guarantee competence.

Under Section 2496, each licensee must self-certify under penalty of perjury at each biennial license renewal that she or he meets at least one of seven peer-review based pathways for re-licensure.

In brief, licensees who have been licensed for more than 10 years, have no peer-reviewed health facility privileges, and are not board certified, must either take the BPM's licensing exam or complete a special training course sponsored by an approved school under §2496 (g). BPM has approved such a program sponsored by the California College of Podiatric Medicine in conjunction with the California Podiatric Medical Association, though administrative transitions in both of those institutions have hampered the program's development.

The Board's licensing coordinator has reported:

The first two-year renewal cycle of the continuing competency requirement has concluded. In all, less than 2% of the active licensing population has been issued a waiver for this requirement. Since January 1, 1999, when the law took effect, staff has issued 15 temporary waivers and 13 permanent waivers for continuing competence. It appears that the number of temporary waivers will level off and there will be a slight increase in permanent waivers as the number of retired licensees increases.

The board's objective has been to phase the continuing competence program in as a pilot, realizing that it is a fundamental shift. The point is to make it work, and it is in fact working well. Staff utilizes the waiver authority provided in §1399.678 of the board's regulations as necessary. As part of this sunset review report, BPM is endorsing a Model Law sponsored by the Federation of Podiatric Medical Boards (FPMB) that would refine the continuing competence requirements based on our experience to date. This Model Law would provide additional pathways and ease compliance for the few who lack health facility privileges and are not certified by an approved specialty board.

How does the Board verify CE or other competency requirements?

Licensees self- certify under penalty of perjury compliance with CPR certification, 50 continuing medical education (CME) credits and continuing competence at every two-year renewal. In the past, the Board's random audits were conducted by the Medical Board's staff. This proved to be costly and

has been temporarily discontinued. The licensing coordinator is preparing to conduct random audits of one to two percent of the active licensing population.

In the event that staff utilizes the waiver authority provided in §1399.678 of the board's regulations, licensees must provide proof of a current CPR certificate, 100 hours of CME credits and evidence of compliance with the continuing competence requirement. Proof is considered to be a copy of a current CPR certification, copies of completion certificates for CME courses, lectures, seminars, etc., and written evidence of compliance with one of the seven pathways listed in §2496 for continuing competence.

Comity/Reciprocity With Other States

Discuss briefly: temporary licensing process, or any other methods used to facilitate licensing of those from other states or foreign countries. Any anticipated changes or changes made since last review?

Currently, there is no reciprocity with other states as all candidates are required to meet all of the California requirements for new licensure including residency training and passage of the state oral exam. However, the Board is recommending enactment of the Federation of Podiatric Medical Boards' *Model Law,* which is designed to standardize licensure requirements across state lines. Foreign applicants are not an issue to date as all of the four-year schools graduating Doctors of Podiatric Medicine (DPMs) are located in the U.S.

ENFORCEMENT ACTIVITY

ENFORCEMENT DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Inquiries	Total: NDA	Total: NDA	Total: NDA	Total: NDA
Complaints Received (Source)	Total: 210	Total: 271	Total: 195	Total: 229
Public	137	135	91	138
Licensee/Professional Groups[1]	26	40	51	19
Governmental Agencies	10	32	33	39
Other [2]	37	64	20	33
Complaints Filed (By Type)	Total: 210	Total: 271	Total: 195	Total: 229
Competence/Negligence	105	159	110	128
Unprofessional Conduct	46	64	51	75
Fraud	24	11	13	13
Health & Safety	1	0	1	2
Unlicensed Activity	21	21	10	4
Personal Conduct	13	16	10	7
Complaints Closed	Total: 152	Total: 222	Total: 168	Total: 184
Investigations Commenced	Total: 59	Total: 56	Total: 53	Total:42
Compliance Actions	Total: 19	Total: 50	Total: 44	Total: 29
ISOs & TROs Issued[3]	0	1	2	0
Citations and Fines	11	35	15	5
Public Letter of Reprimand	1	1	1	0
Cease & Desist/Warning	5	13	26	24
Referred for Diversion	2	0	0	0
Compel Examination	0	0	0	0
Referred for Criminal Action	Total: 1	Total: 2	Total: 2	Total: 2
Referred to AG's Office	Total: 27	Total: 23	Total: 9	Total: 15
Accusations Filed[4]	12	13	5	10
Accusations Withdrawn	1	1	0	1
Accusations Dismissed	0	0	0	0
Stipulated Settlements	Total: 5	Total: 19	Total: 5	Total: 7
Disciplinary Actions[5]	Total: 7	Total: 20	Total: 9	Total: 10
Revocation	2	1	1	1
Voluntary Surrender	3	4	1	2
Suspension Only	0	0	0	0
Probation with Suspension	1	0	1	0
Probation	1	13	4	5
Probationary License Issued	0	0	0	0
Probation Violations	Total: 1	Total: 4	Total: 1	Total: 2
Suspension or Probation	0	2	0	1
Revocation or Surrender	1	2	1	1

[1] Includes complaints based upon reports required by Business and Professions Code Sections 800 and 2240(a).
[2] Includes anonymous and miscellaneous complaints.
[3] Includes Automatic Suspension Orders.
[4] Includes Petitions to Revoke Probation and Accusations and Petitions to Revoke Probation.
[5] Total includes alternate discipline decisions and all public reprimands (already listed above in Compliance Actions).

Enforcement Program Overview

The Board of Podiatric Medicine (BPM) has the responsibility for enforcing the disciplinary and criminal provisions of the Medical Practice Act as they apply to Doctors of Podiatric Medicine (DPMs). BPM enforcement duties include: the administration and hearing of disciplinary actions; carrying out disciplinary actions appropriate to findings made by the BPM or an administrative law judge; suspending, revoking or placing other restrictions on a DPM license after the conclusion of disciplinary actions; and reviewing the quality of medical practice carried out by licensees.

The Medical Board of California (MBC) handles complaints and investigations for BPM under the shared-services reimbursement agreement. The mission of MBC's Field Operations Unit is to provide accurate, timely and objective investigations regarding allegations of misconduct by licensees of the MBC and other health professionals and to develop information for filing criminal, administrative and civil actions.

The Board must not only adhere to the requirements of the Administrative Procedure Act, but must prove violations of the Medical Practice Act to a clear and convincing standard in order to discipline doctors. Like consumers, legislators, and the MBC, the BPM shares an interest in speedy justice, while being mindful of the due process that must be accorded every person. Therefore, the BPM directs the MBC staff to pursue each step of the investigative and disciplinary processes with the objective of ensuring investigations are completed expediently, accurately and objectively. The enforcement process also requires that the legal and judicial services be provided by the Office of the Attorney General and the Office of Administrative Hearings.

Discuss statistics in enforcement data. What is the source of most of the complaints? Are there some unique reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report any judgments taken against the licensee. Any current problems with board's receiving relevant complaint information or obtaining information for investigation purposes? What are the largest number and type of complaints filed (incompetence, unprofessional conduct, etc.)? Explain which type of cases are being stipulated for settlement. Any significant changes since last review (increases or decreases)?

Referencing the Enforcement Data table above, the BPM averages 226 complaints per year with the greatest source of the complaints coming from the public (approximately half.) The bulk of the complaints filed against DPMs is for incompetence and/or negligence (quality of care issues) and averages approximately 126 per year. An average of 181 complaints was closed each year without investigation, while 53 warranted investigation. Of the complaints investigated, an average of 36 received compliance actions, 2 were referred for criminal action, 19 were referred to the Attorney General's Office, 9 received stipulated settlements, disciplinary actions were taken on 12 cases and 2 violated probation.

The following are some unique reporting mandates, per the Business & Professions Code 800 series, that assist the BPM with its responsibilities.

801 - Every insurer providing professional liability insurance to a licensee must send a report within 30 days to the Board as to any settlement over $30,000 or arbitration award of any amount from a claim or action for damages for death or personal injury caused by that person.

802.1 - A physician and surgeon must report any of the following to the board within 30 days: 1) an indictment or information charging the physician with a felony, 2) the conviction of the physician and surgeon, including any guilty verdict or plea of guilty or no contest of a felony.

802.5 - A coroner must report within 90 days to the Board any findings by a pathologist indicating a death may be the result of a DPMs gross negligence or incompetence.

803.5 - The district attorney, city attorney, and prosecuting agencies must notify the Board immediately upon obtaining information of any filings charging a felony against a licensee of the Board.

803.6 - The clerk of the court must send any felony preliminary hearing transcript concerning a defendant licensee to the Board. In any case where a probation report on a licensee is prepared for a court, a copy of that report must be sent by the probation officer to the Board.

MBC receives these reports, and therefore the BPM will defer to MBC as to whether there has been improvement in compliance. There has been concern about hospital compliance in submitting reports of peer review disciplinary action.

Whenever appropriate, all types of cases are being stipulated for settlement. BPM staff is always open to settlement discussions. Stipulated surrenders can be quicker, more certain, and less costly than fighting for revocation through an administrative hearing. Even in egregious cases where staff wants outright revocation, a voluntary surrender accomplishes the goal with less risk and expenditure of funds and official personnel time. The enforcement coordinator and the executive officer work with the assigned Deputy Attorney General (DAG) in all administrative cases. Management and the assigned DAG refer to the board's Manual of Disciplinary Guidelines and Model Disciplinary Orders; however, the DAGs are also given flexibility to use their professional knowledge and judgement to negotiate a settlement.

Since the last Sunset Review in October 1997 there has been a decrease in the number of investigations opened. The average of 85 investigations per year has decreased to an average of 53. On the other hand, the average number of cases being referred to the Attorney General's office has increased from 13 to 18.

Discuss what percentage of complaints are referred for investigation, then to accusation, and end up having some disciplinary action taken. What overall statistics show as to increases or decreases in disciplinary action since last review. [See Table Below]

Based on the following table of complaints received, an average of 80 percent were closed, 23 percent were referred for investigation, 4 percent went to accusations, and 5 percent went to disciplinary action. Since the last Sunset Review, the average number of disciplinary actions has remained the same, approximately 12 per year.

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION				
	FY 1997/98	**FY 1998/99**	**FY 1999/00**	**FY 2000/01**
COMPLAINTS RECEIVED	**210**	**271**	**195**	**229**
Complaints Closed	**152 – 72%**	**222 – 82%**	**168 – 86%**	**184 – 80%**
Referred for Investigation	**59 - 28%**	**56 – 21%**	**53 – 27%**	**42 – 18%**
Accusation Filed	**12– 6%**	**13 – 5%**	**5 – 3%**	**10 – 4%**
Disciplinary Action	**7 - 3%**	**20 – 7%**	**9 – 5%**	**10 – 4%**

Case Aging Data

Discuss time frames for processing complaints, investigation of cases, from completed investigation to formal charges being filed, and from filing of the accusation to final disposition of the case. Discuss if any changes from last review. [See Table Below]

Complaint processing by MBC's Enforcement Program staff occurs in various stages. Complaints involving DPMs are received in the MBC Central Complaint Unit (CCU) and are assigned to a staff person within one day of receipt. Staff enter the complaint in the Consumer Affairs System (CAS) automated tracking system, and generate an acknowledgment letter to the complainant within 3 to 5 working days.

After the CCU initially handles complaints, they may be referred to BPM medical consultants or to one of the 12 MBC District Offices for investigation by a field investigator. Investigations become the responsibility of district office staff to resolve and/or refer for administrative, criminal or civil action. [See Table Below]

Referencing the Case Aging Data table, the following average processing days include: 86 days to process a complaint; 331 days to investigate a complaint; 77 days from completed investigation to formal charges filed; 462 days from formal charges filed to conclusion of disciplinary case; and 1,058 days total (approximately 3 years) from the date a complaint was received to the date of final disposition of a disciplinary case. [See Table Below] The total days has decreased by almost one year (the last review showed an average of 1396 days.)

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1997/98	**FY 1998/99**	**FY 1999/00**	**FY 2000/01**
Complaint Processing	**132**	**67**	**86**	**69**
Investigations	**355**	**418**	**300**	**252**
Pre-Accusation*	**102**	**74**	**86**	**45**
Post-Accusation**	**707**	**323**	**334**	**483**
TOTAL AVERAGE DAYS* **	**1361†**	**1232†**	**688†**	**952†**

*****From completed investigation to formal charges being filed.
******From formal charges filed to conclusion of disciplinary case.
*******From date complaint received to date of final disposition of disciplinary case.

† This is not the sum of the above numbers because the disciplinary cases finalized in each fiscal year may or may not be the same as the complaints or accusations filed in that same year.

Discuss time frames for closing of investigations and AG cases over past four years, and average percentage of cases taking over 2 to 4+ years, and any decreases or increases in the percentage of cases being closed each year. Discuss any changes from last review.

Complaint handling and investigations comprise the majority of the Board's enforcement actions. An investigation is resolved when it is closed without action, an administrative citation and fine is issued, or the case is referred to the Office of the Attorney General for action. Our time frames have improved since the last review: 22 percent of our investigations were closed within 90 days, 16 percent were closed within 180 days, 27 percent were closed within one year, 24 percent were closed within two years, 9 percent were closed within three years, and 3 percent took more than three years. The figures from the last report reflect that 10 percent were closed within 90 days, 10 percent were closed within 180 days, 22 percent were closed within one year, 30 percent were closed within two years, 17 percent were closed within three years, and 11 percent took more than three years.

After an investigation is referred to the Attorney General, the BPM Enforcement Coordinator's focus shifts to working with deputy attorneys general and support personnel. BPM is working with the Attorney General's Office to schedule settlement conferences shortly after the accusation is filed and to schedule the administrative hearings as quickly as possible, depending on the calendar of the participants.

Occasionally, when an administrative case is pending against a DPM, and the same allegations are pursued criminally by a criminal prosecutor (e.g., District Attorney's Office), the prosecutor may request that the BPM delay its administrative case action until the criminal case is resolved so as to avoid a *collateral estoppel* situation which may compromise the criminal case. The doctrine of *collateral estoppel* provides that issues argued and decided in one proceeding cannot be relitigated in a subsequent proceeding.

Of the cases that were referred to the Attorney General's Office, 62 percent were closed within one year, 28 percent were closed within two years, 7 percent were closed within three years, and 3 percent (2 cases) took more than four years to complete. Since the last review there has been a decrease in the number of days it takes to close cases referred to the AG's office. The last report showed that 26 cases were closed after two years. In the last four years that number has dropped to 6 cases. Of these 6 cases, all of them involved multiple case filings that resulted in the necessity to file supplemental accusations. Two of the cases involved dual filings (administrative and criminal). One of the cases involved an alternate discipline decision which required the respondent to complete the Physician Assessment and Clinical Education (PACE) Program prior to case closure.

INVESTIGATIONS CLOSED WITHIN:	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01	AVERAGE % CASES CLOSED
90 Days	14	12	11	10	**22%**
180 Days	12	4	10	8	**16%**
1 Year	18	14	7	19	**27%**
2 Years	14	12	18	7	**24%**
3 Years	4	13	1	1	**9%**
Over 3 Years	5	2	0	0	**3%**
Total Cases Closed	**67**	**57**	**47**	**45**	
AG CASES CLOSED WITHIN:	**FY 1997/98**	**FY 1998/99**	**FY 1999/00**	**FY 2000/01**	**AVERAGE % CASES CLOSED**
1 Year	8	15	8	6	**62%**
2 Years	0	8	5	4	**28%**
3 Years	1	1	1	1	**7%**
4 Years	0	0	0	0	**0%**
Over 4 Years	1	0	0	1	**3%**
Total Cases Closed	**10**	**24**	**14**	**12**	
Disciplinary Cases Pending	**24**	**19**	**17**	**16**	

Cite and Fine Program

Discuss the extent to which the board has used cite and fine authority. Discuss any changes from last review and last time regulations were updated. [See Table Below]

BPM first promulgated regulations to issue citations and fines in 1988 under authority of B&P §125.9. These administrative fines range from $100 to $2,500 per investigation, depending on the gravity of the violation, the good faith of the subject, and the history of previous violations. The citation program has increased the effectiveness of the Board's complaint handling process by providing a method to address less serious violations of the law without resorting to the disciplinary process.

An average of 17 citations and fines was issued per year during the four-year period. The total amount of fines collected during that time was approximately $4,619 per year. The Board has used the Citation and Fine Program most frequently to cite DPMs who have violated the following:

Business & Professions Codes:

- 651 - Advertising; Fraudulent, Misleading or Deceptive
- 2052 - Unlicensed Practice of Medicine
- 2054 - Unlawful Representation as a Physician
- 2266 - Failure to Maintain Adequate and Accurate Medical Records
- 2278 - Use of Title "Doctor"
- 2285 - Practice Under False or Fictitious Name w/o Fictitious Name Permit
- 2474 - Unlawful Representations

Cite and fine regulations (§§ 1399.696 – 1399.699) were updated in 2000: Business and Professions Code Section 2234 – Unprofessional Conduct was added to the list of citable offenses. This allows the board to cite and fine for unprofessional conduct, e.g., repeated acts of simple negligence. The Board also updated its regulations in 2001 to codify long-standing review procedures: that the executive officer bases decisions on quality-of-care issues (or requiring medical judgement) on the findings of a board-approved medical consultant or expert. In January 2001 a public hearing was held to update BPM's public disclosure and record retention policy. This change would maintain consistency with the MBC policy of purging citations from public records five (5) years from the date of resolution.

BPM uses the cite and fine program to obtain compliance with the law and will frequently withdraw citations or reduce fines based on compliance obtained and demonstrated good faith of the licensee. As the program has succeeded in helping the Board demonstrate an ability to enforce the law, the number of violations in areas such as advertising has diminished.

CITATIONS AND FINES	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Citations	11	35	15	5
Total Citations With Fines	11	35	15	5
Amount Assessed	3,550	17,650	7,000	12,500
Reduced, Withdrawn, Dismissed	11	32	13	0
Amount Collected	2,050	6,325	7,900	2,200

Diversion Program

Discuss the board's diversion program, the extent to which it is used, the outcomes of those who participate, the overall costs of the program compared with its successes.

The Legislature sunsetted BPM's diversion program in the last review. The board indicated it was not aware of any evidence that state agencies administer drug and alcohol abuse programs more efficiently than the private sector. DPMs may enter private programs on their own, confidentially, or be required to enroll in one as a result of BPM-imposed discipline when appropriate.

Results of Complainant Satisfaction Survey

Discuss the results of the Survey.

Pursuant to the JLSRC directions, BPM mailed its surveys on April 18, 2001. The response rate was 46.5 percent. Since 1997 was partially surveyed in the last sunset review, complaints that had been previously surveyed were not included again.

Respondents indicated that they were quite satisfied with the accessibility of information regarding where to file a complaint, as well as the way in which they were treated during the handling of a case. However, results also indicated that consumers showed some concern with regard to the procedures and outcomes that followed complaint initiation. These concerns pertained to the following: 1) Informative measures that were taken as a case was

being handled, 2) the opportunity to receive advice regarding a particular complaint, 3) the time it took to process a complaint, and 4) the case result.

Complaint handling is performed for BPM by the Medical Board's Central Complaints and investigative staffs. MBC must handle podiatric complaints within its own overall priority system, and BPM's Enforcement Coordinator works full time to expedite these cases.

CONSUMER SATISFACTION SURVEY RESULTS*				
QUESTIONS	**Percent Satisfied by Calendar Year**			
# Surveys Mailed: 215 **# Surveys Returned: 100**	**1997**	**1998**	**1999**	**2000**
1. Were you satisfied with knowing where to file a complaint and whom to contact?	56	79	81	82
2. When you initially contacted the Board, were you satisfied with the way you were treated and how your complaint was handled?	56	61	73	68
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?	33	31	52	32
4. Were you satisfied with the way the Board kept you informed about the status of your complaint?	33	36	58	39
5. Were you satisfied with the time it took to process your complaint and to investigate, settle, or prosecute your case?	33	31	49	37
6. Were you satisfied with the final outcome of your case?	22	22	25	19
7. Were you satisfied with the overall service provided by the Board?	**22**	**32**	**41**	**25**

*****All boards and committees under review this year shall 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 bureaus.) A list of seven questions have been provided. Each board or committee shall take a random sampling of closed complaints and disciplinary actions for a four year period. Consumers who filed complaints should be asked to review the questions and respond to a 5-point grading scale (i.e., 5, 4, 3 =satisfied to 1, 2 =dissatisfied). The board or committee shall provide the percent of satisfaction for each of the past four years.

ENFORCEMENT EXPENDITURES AND COST RECOVERY

Average Costs for Disciplinary Cases

Discuss the average costs incurred by the board for the investigation and prosecution of cases, and which type of cases average more than others. Explain if the board is having any difficulty in budgeting for Prosecution and Hearing costs, and whether cases may have been delayed because of cost overruns.

AVERAGE COST PER CASE INVESTIGATED	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Cost of Investigation & Experts	**$160,105**	**$119,409**	**$120,431**	**127,125**
Number of Cases Closed	67	57	47	45
Average Cost Per Case	2,390	2,095	2,562	2,825
AVERAGE COST PER CASE REFERRED TO AG	**FY 1997/98**	**FY 1998/99**	**FY 1999/00**	**FY 2000/01**
Cost of Prosecution & Hearings	**$283,154**	**$135,684**	**$190,891**	**315,172**
Number of Cases Referred	27	23	9	15
Average Cost Per Case Referred	$10,487	$5,899	$21,210	21,011
AVERAGE COST PER DISCIPLINARY CASE (Final Decisions)	**12,877**	**7,994**	**23,772**	**23,836**

Cost Recovery Efforts

Discuss the board's efforts in obtaining cost recovery. Discuss any changes from the last review.

Per BPM's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, cost recovery is a general requirement sought in all cases. In stipulated agreements, cost recovery is always part of negotiations, although it is secondary in importance to public protection. Further, the Board has made it a standard to request probation monitoring costs, in addition to cost recovery, as part of its agreements.

While there appears to have been a decline in cost recovery compared to the last review, the previous data included a stipulated cost recovery of over half a million dollars, awarded in an unfair business practices case.

COST RECOVERY DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Enforcement Expenditures	**443,259**	**255,093**	**311,322**	**442,297**
# Potential Cases for Recovery*	7	20	9	10
# Cases Recovery Ordered	2	9	3	5
Amount of Cost Recovery Ordered	25,738	31,758	19,141	22,500
Amount Collected	**3,675**	**27,904**	**9,402**	**22,019**

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

RESTITUTION PROVIDED TO CONSUMERS

Discuss the board's efforts in obtaining restitution for the individual complainant, and whether they have any formal restitution program and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Discuss any changes from last review.

Many complaints come to MBC and BPM as a result of malpractice filings, and it is the civil malpractice system in which restitution is generally addressed (even before the case comes before MBC). Medical Board administrative authority under the Medical Practice Act is oriented principally toward protection of future patients through licensee discipline, while the civil malpractice system is extensively used for restitution for harm already committed. The Medical Board has no jurisdiction over billing issues outside of insurance fraud. BPM's *Manual of Disciplinary Guidelines*, promulgated as guidance to the Attorney General and Administrative Law Judges (ALJs), provides the following language for "restitution to consumers or other injured partners":

> Within 90 days of the effective date of this Decision, respondent shall provide proof to the BPM or its designee of restitution in the amount $_____ paid to _____. Failure to pay restitution shall be considered a violation of probation.
>
> NOTE: In offenses involving economic exploitation, restitution is a necessary term of probation. For example, restitution would be a standard term in any case involving Medi-Cal or other insurance fraud. The amount of restitution shall be no less than the amount of money that was fraudulently obtained by the licensee. Evidence relating to the amount of restitution would have to be introduced at the administrative hearing.

In BPM's experience, restitution is usually addressed prior to the administrative hearing before an ALJ.

RESTITUTION DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Amount Ordered	0	0	0	0
Amount Collected	0	0	0	0

COMPLAINT DISCLOSURE POLICY

Briefly describe the board's complaint disclosure policy. At what point in the disciplinary process is information made available to the public concerning the licensee and what type of information is made available? Does the board have problems obtaining particular types of information?

BPM operates under the same disclosure laws as the Medical Board, and the MBC verifications unit handles BPM verification. The following table indicates what is disclosed as public information.

TYPE OF INFORMATION PROVIDED	YES	NO
Complaint Filed		X
Citation	X	
Fine	X	
Letter of Reprimand	X	
Pending Investigation		X
Investigation Completed		X
Arbitration Decision	X	
Referred to AG: Pre-Accusation		X
Referred to AG: Post-Accusation	X	
Settlement Decision	X	
Disciplinary Action Taken	X	
Civil Judgment	X	
Malpractice Decision	X	
Criminal Violation: Felony Misdemeanor	X	 X

CONSUMER OUTREACH, EDUCATION AND USE OF THE INTERNET

Discuss what methods are used by the board to provide consumer outreach and education. Discuss whether the board offers online information to consumers about the activities of the board, where and how to file complaints, and information about licensees, or believes it is feasible/appropriate to do so.

BPM uses its website (www.dca.ca.gov/bpm) extensively to disseminate information and strengthen its public protection program. The Internet has become a popular means of communication, increasingly available to consumers, at a very low cost.

The "Consumer Guide" section of the website has several crucial links, including:

- *License Verification*, which allows anyone, free of charge, to look up a doctor (by name or license number) and obtain the related license status, which includes any disciplinary action codes, address of record, license issuance and expiration dates, and the podiatric medical school attended and year of graduation;
- *Complaints*, which includes an online fill-in form that consumers can then print and mail to the MBC Central Complaint Unit;
- *Information for Consumers*, a valuable BPM fact sheet providing an overview on podiatric medicine, helpful tips on choosing a doctor, and further contact information for medical issues as well as fraud and HMO problems;
- *Ordering Public Documents*, which links to the MBC web page containing all the necessary information for ordering copies of disciplinary decisions on doctors (both MDs and DPMs).

Under the "Enforcement" section, the *Disciplinary Actions* link provides a listing, updated monthly, of all the Board's actions since the inception of its website. It includes Decisions, Surrender While Charges Pending, Accusations Filed, Accusations Withdrawn or Dismissed, Accusations and Petitions to Revoke Probation, and Statement of Issues Filed and Decisions.

For consumers interested in gaining an understanding of the organization of the Board, the "About BPM" section provides links to its *Governance Policies*, *Strategic Plan*, *The Law* (which links to both statues and regulations), and *Committees*. In accordance with the requirement that state agencies maintain a website that provides meeting notices online, BPM's "Meetings" section has been updated to include links to its *Calendar* of upcoming Board Meeting dates, *Agendas* for the meetings, posted simultaneously to the mailed notices, and *Meeting Summaries*, supplemented most recently with *Minutes* of the meetings.

In addition to the above sections, BPM's "Links" page provides an extensive list of *Government Agencies* and *Consumer References*.

Finally, the BPM home page has an e-mail link, (bpm@dca.ca.gov), which consumers can use to e-mail the Board at their own leisure instead of making a telephone call during business hours. BPM staff monitors e-mail throughout the day and responds promptly to all inquiries.

Supplementing its web outreach, BPM has participated in statewide consumer education efforts. BPM was represented in two Department of Consumer Affairs sponsored events during the National Consumer Protection Week, February 5 – 10, 2001. Staff participated in the Consumer Assistance Day

at Florin Mall in Sacramento on February 9, and the State Senior Services Fair at the Pico Rivera Senior Center, hosted by Assemblyman Thomas Calderon on February 10. The Spanish translation of the "Information for Consumers" fact sheet was able to reach a significant number of Spanish-speaking consumers attending the fair.

Discuss whether the board conducts online business with consumer/licensees, or believes it is feasible/appropriate to do so.

Aside from the e-mail communications mentioned above, the Board does not currently have the capability of initiating online business efforts. However, pursuant to the Governor's Executive Order D-17-00 on eGovernment, the Department of General Services will be implementing online credit card payments for all state agencies. The Board of Registered Nursing has been piloting the program for DCA. Depending on its success, other boards may be added during 2001. BPM has reiterated its interest to DCA in participating in this program and will follow DCA's guidelines.

Discuss whether the board offers online license information and applications (initial and renewal licenses, address changes, etc.), or believes it is feasible/appropriate to do so.

The Board extends its services for licensees online over several areas. The "Licensing" section of the website includes links such as:

- *Summary of Requirements and Important Information*, which is the online replica of the cover information sent with application packages. It outlines the requirements for licensure in California, the scope of practice for DPMs, and information needed after licensure, such as meeting continuing competence requirements, obtaining other related certificates, and reporting requirements.
- *Fee Schedule*
- *Licensee Forms*, which contains all the Board's forms for renewals, license status changes, and waivers. These are fill-in forms which licensees can print and submit by mail. The Board does not yet offer its initial application package online, since it has not found a feasible way to handle electronic fingerprint cards or Live Scan forms (which need to be completed in triplicate).

The Board also accepts address changes by e-mail, as long as the licensee provides proof of identity by supplying the correct social security number.

All of BPM's *Fact Sheets* can be found in the "Publications" section, covering several areas of interest to licensees, such as advertising, amputations, and license status options. Further, the "Education" section contains detailed information regarding meeting continuing competence requirements. For prospective licensees, the "Testing" section provides all of the details regarding the Board's exam.

Discuss whether the board offers online testing/examination services for both initial and renewal licenses, or believes it is feasible/appropriate to do so.

Since the Board's examination is oral clinical, it is not a candidate for online administration. Renewal of licenses does not require testing. The Board's *Strategic Plan* includes a goal of working with the National Board of Podiatric Medical Examiners to upgrade NBPME's Part III clinical reasoning exam to California standards so that BPM can transition to using that exam instead of the current oral exam. NBPME is moving to online testing.

What streamlining of administrative functions would be necessary if the above services and information was provided via the Internet?

If the initial license application package were to be offered via the Internet, the Board would experience minimal in-house administrative streamlining, since staff would have to mail a fewer number of application packages.

However, if online transactions for renewals were provided, significant streamlining of administrative functions would occur at DCA's Automated Cashiering Unit, which processes renewals for all of the boards.

Please describe if there are other ways use of the Internet by the board could improve services to consumers/licensees.

BPM has already improved its services considerably, by allowing easy access to information 24 hours a day, seven days a week, including online license verification and the possibility of communicating with the Board via e-mail. BPM will remain receptive to new uses of the Internet to continue improving the quality of services offered to both consumers and licensees.

Discuss what types of practices are increasingly occurring outside California's traditional "marketplaces" that fall under the jurisdiction of your board.

One possibility the Board has considered is online medical advice. However, the Board has not yet learned of any websites offering DPM services.

Discuss what type of challenges the board faces with respect to online advice "practice without presence," privacy, targeted marketing, and other issues.

Challenges are still unknown, since BPM has not received any related complaints to date.

Discuss whether the board has any plans to regulate Internet business practices or believes there is a need to do so.

The Board will follow DCA and MBC policies and procedures as they take effect.

PART 2.

CALIFORNIA BOARD OF PODIATRIC MEDICINE

PROGRAM BOARD'S RESPONSE TO ISSUES IDENTIFIED AND FORMER RECOMMENDATIONS MADE BY THE JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE

ISSUE #1. Should the State licensing of Doctors of Podiatric Medicine be continued?

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

BOARD RESPONSE:

BPM concurs.

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.

BOARD RESPONSE:

SB 26, a JLSRC-sponsored urgency bill which would re-authorize the limited license, is currently pending legislation. The Senate Business & Professions Committee analysis commented:

> When the Board of Podiatric Medicine (BPM) was reviewed by the JLSRC in 1997/98, it was the recommendation of the JLSRC that the limited license be eliminated. Since there was no similar license requirement for physicians participating in postgraduate residency programs, it did not appear that a limited license should be required for podiatric medical residents. The BPM agreed at that time, but wanted some time to investigate the matter further. The JLSRC recommended a sunset date be placed on this limited license requirement for July 1, 2000, and

in the meantime the BPM justify why this requirement should be continued.

Since the review of the BPM, the Board has investigated the need to continue with this license requirement for podiatric medical residents. They surveyed several podiatric residency programs (there are currently 50 residency programs with a total of 115 residents) and contacted the Federation of State Medical Boards (FSMB) and the Center for Public Interest Law (CPIL) at the University of San Diego. All agreed that the limited license requirement should be continued.

ISSUE #3. Should the statue 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.

BOARD RESPONSE:

This was accomplished with BPM's support in SB 1981, sponsored by JLSRC in 1998 (Chapter 736, Statutes of 1998).

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?

BOARD RESPONSE:

Experience suggests at the present time that the best course for BPM is to coordinate as closely as possible with the Medical Board for inclusion in Medical Board legislation where appropriate and to track other laws and regulations to the extent indicated and coordinate with them in parallel action wherever practicable.

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 Committee, 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.

BOARD RESPONSE:

The Board's Professional Practice Committee held a public hearing November 5, 1998. A widely-distributed hearing notice drew written and oral testimony from consumers, attorneys, doctors, federal, state and local law enforcement officers, the Center for Public Interest Law, the American Diabetes Association, the California College of Podiatric Medicine, the California Podiatric Medical Association (CPMA), and an insurance company administering Medicare in California. Following this hearing, the full Board approved a 16-page report with recommended legislation on April 30, 1999 and submitted it to the JLSRC. The Legislature passed a broader bill, AB 1231 (Chapter 907, Statutes of 1999), and BPM has incorporated the new B&P Section 17537.11 into its citation and fine authority. AB 1231 stated "The Legislature finds and declares that consumers, particularly senior citizens, have been harmed by the deceptive and unfair use of . . . so-called free, gift, or prize coupons."

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."

BOARD RESPONSE:

SB 1981 (Chapter 736, Statutes of 1998) granted DPM the same authority already possessed by other doctor-licensing boards under B&P Section 651. At this writing, BPM is reviewing an application for approval from the American Board of Medical Specialties in Podiatry. Under the statute, ABMSP must demonstrate that its standards are equivalent to those of specialty boards recognized by the Council on Podiatric Medical Education.

ISSUE #7. Should residency programs approved by the 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.

BOARD RESPONSE:

BPM amended Section 1399.667 of its regulations operative September 20, 1998 (Register 98, No. 34) to implement this recommendation.

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 the 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.

BOARD RESPONSE:

JLRSC addressed this issue in SB 1981 (Chapter 736, Statutes of 1998). Section 1 of the bill read "The Joint Legislative Sunset Review Committee shall review, in conjunction with the Legislative Analyst's Office, and in consultation with the Board of Podiatric Medicine, the department, the University of California, and the California College of Podiatric Medicine, the expenditure of funds for the support of educational and related programs in the field of podiatry." That review was conducted.

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 recommendations 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.

BOARD RESPONSE:

The JLSRC's bill following the last review, SB 1981 (Chapter 736, Statutes of 1998), initiated the first continuing competence program for any doctor licensing board in this country. B&P Section 2496, as amended by SB 1981, recognizes findings by groups such as the Pew Health Professions Commission that continuing education alone does not guarantee competence.

Under Section 2496, each licensee must self-certify under penalty of perjury at each biennial license renewal that she or he meets at least one of seven peer-review-based pathways for re-licensure. In brief, licensees who have been licensed for more than 10 years, have no peer-reviewed health facility privileges, and are not board certified, must either take the BPM's licensing exam or complete a special training course sponsored by an approved school under §2496 (g). BPM has approved such a program

sponsored by the California College of Podiatric Medicine in conjunction with the California Podiatric Medical Association. However, administrative transitions in both of those institutions have hampered the program's development.

The Board's licensing coordinator has reported:

> The first two-year renewal cycle of the continuing competency requirement has concluded. In all, less than 2% of the active licensing population has been issued a waiver for this requirement. Since January 1, 1999, when the law took effect, staff has issued 15 temporary waivers and 13 permanent waivers for continuing competence. It appears that the number of temporary waivers will level off and there will be a slight increase in permanent waivers as the number of retired licensees increases.

The board's objective has been to phase the continuing competence program in as a pilot, realizing that it is a fundamental shift. The point is to make it work, and it is in fact working well. Staff utilizes the waiver authority provided in §1399.678 of the board's regulations as necessary. As part of this sunset review report, BPM is endorsing a Model Law sponsored by the Federation of Podiatric Medical Boards (FPMB) that would refine the continuing competence requirements based on our experience to date. This Model Law would provide additional pathways and ease compliance for the few who lack health facility privileges and are not certified by an approved specialty board.

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

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

BOARD RESPONSE:

This was accomplished. This information may now be accessed through either the Medical or Podiatric Medical Boards' web sites or directly at:

http://www.docfinder.org/ca/df/casearch.htm

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.

BOARD RESPONSE:

The Joint Committee, by a vote of 3-3, did not adopt this 1998 Departmental and staff recommendation. However, the Committee by SB 1981 (Chapter 736, Statutes of 1998) did sunset BPM's diversion program. BPM assured the Joint Committee that it could successfully privatize its drug and alcohol abuse rehabilitation program, and has done so. There was no evidence that government could administer rehab programs better than the many private sector programs into which licensees can choose to enter anonymously. BPM does not divert these individuals from discipline. If impairment is determined to be a factor contributing to violations leading to discipline, BPM will require participation in a rehab program as a term and condition of probation.

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.

BOARD RESPONSE:

BPM has challenged the status quo through its Strategic Planning over the last decade and urged consideration of organizational options, including a merger with the Medical Board. Finding little interest or support for that from any sector, aside recently from one heavily-disciplined podiatric business, the Board amended its Strategic Plan shortly after the last sunset review. Currently, BPM's Strategic Plan "is intended to insure the continuation of BPM as a semi-autonomous board" for the immediate future.

With a small base of licensees, peaking at 2,134 in FY 1992/93, the Board has had the highest professional licensing fee in California. A function of economy of scales, the renewal fee for DPMs ($800 biennially in California) is even higher in States such as Washington, which maintain a separate podiatric board with even fewer licensees.

Traditionally a profession of fee-for-service, solo practitioners providing elective as well as primary care services, podiatric medicine's ranks have been thinned by changing health care economics and managed care. The number of fee-paying licensees has dropped:

1992/93	2,134
1993/94	1,962
1994/55	1,924
1995/96	1,849
1996/97	1,845
1997/98	1,858
1998/99	1,853
1999/00	1,751
2000/01	1,755

The loss of 379 licensees since 1992 has reduced BPM's annual revenue from renewal fees by more than $150,000, or 15% of budget. The Board's response has been to attempt to:

- utilize its non-disciplinary citation and fine program to respond to lesser quality of care and other violations to conserve enforcement funds for those cases where only the more expensive disciplinary process initiated by an Accusation is appropriate (essential in order to maintain the deterrence factor)

- implement the nation's first Continuing Competence requirement for doctors to prevent patient harm proactively rather than react to it after the fact, which requires expensive discipline.

JLSRC reported in 1988 that:

> 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.

BPM will support any organizational change proposed by the Department or JLSRC and will develop and implement necessary plans as indicated. BPM's development of plans would have to be done in cooperation with the Department and the Medical Board.

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

<u>Recommendation</u>: 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 Podiatric Medicine, 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.

BOARD RESPONSE:

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, with 4 licensees and 3 non-licensees.

Based on experience at BPM, the quantity of licensee and non-licensee members is probably less important than the quality. Having a critical mass of both licensee and non-licensee members seems helpful and the current composition may be optimal.

Appendix

[The Board of Podiatric Medicine by unanimous vote February 16, 2000 endorsed the following national "Model Law" developed by the federation of state licensing boards.]

FEDERATION OF PODIATRIC MEDICAL BOARDS

Guidelines for State Podiatric Medical Practice Acts

http://www.fpmb.org/modellaw.html

INTRODUCTION

The Federation of Podiatric Medical Boards offers this Guide to those concerned with state licensing of Doctors of Podiatric Medicine (DPMs). It is not intended to be comprehensive in every aspect of licensing, discipline, and adjudication, but addresses those that are specific to podiatric medicine to encourage standardization.

A more comprehensive model for state practice acts is the Federation of State Medical Boards' *A Guide to the Essentials of a Modern Medical Practice Act*. Many elements of a podiatric practice act should be identical or nearly so to those for medical doctors. Examples include telemedicine, malpractice reporting, and record keeping requirements.

Podiatric medicine is a small medical specialty, with about 15,000 podiatric doctors practicing in the U.S. Instituted as a separate profession, it has its own association, accrediting body, national examining board, specialty boards, colleges, and degree. DPMs graduate from one of seven four-year podiatric medical schools, all in the U.S. Almost all graduates complete additional postgraduate training. Once licensed, they are independent practitioners of medicine within their

scope of practice, which is generally the foot and ankle. They independently diagnose, treat, and prescribe within this scope.

Some related sections of state law, e.g., hospital administration, are usually codified separately from professional licensing and are not covered herein. It may be important to note, however, that DPMs like other doctors should be privileged based on demonstrated training and competence. They should not be granted privileges automatically for the full scope of their license, nor may they be arbitrarily denied a privilege because of their degree if the procedure is within their legal scope of practice under state law.

The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) standards permit facilities to privilege DPMs to perform complete medical history and physical examinations (H&Ps). H&Ps are included implicitly in the model "practice authorized" provision below, as they are currently in most state laws. Like other privileges, this should be granted individually based on training and competence.
This Guide will be updated and revised as appropriate. Comments and suggestions are greatly encouraged.

MODEL PROVISIONS

Practice Authorized

The license to practice podiatric medicine authorizes the holder to practice podiatric medicine.

"Podiatric medicine" is the practice of medicine on the lower extremity, and includes the diagnosis and treatment of conditions affecting the human foot and ankle and related structures, including those anatomical structures of the leg inserting into or affecting the functions of the foot, and local manifestations of systemic conditions as they appear on the lower extremity, and superficial conditions of the leg, by all appropriate systems and means, including the prescribing and administering of drugs and medicines.

A doctor of podiatric medicine may assist a licensed physician and surgeon who holds a medical doctor or osteopathic medical doctor degree in non-podiatric procedures.

Unlawful Representations

Any person who uses in any sign or in any advertisement or otherwise, the word or words "doctor of podiatric medicine," "podiatric physician and surgeon," "podiatrist," "foot specialist," or any other term or terms or any letters indicating or implying that he or she is a doctor of podiatric medicine, or that he or she practices podiatric medicine, or holds himself or herself out as practicing podiatric medicine, without having at the time of so doing a valid, unrevoked, and unsuspended license to practice podiatric medicine, or medicine or osteopathic medicine, is guilty of a misdemeanor.

It is unlawful for a doctor of podiatric medicine to advertise any affiliation with or recognition by any specialty certifying agency that is not approved by the Council on Podiatric Medical

Education or approved by the board as having equivalent standards.

Student Practice

Nothing shall be construed to prevent a regularly matriculated student undertaking a course of professional instruction in an approved school of podiatric medicine from participating in medical training whenever and wherever prescribed as part of his or her course of study. Such training beyond the scope of podiatric medicine shall be under the supervision of a physician and surgeon holding the degree of medical doctor or doctor of osteopathic medicine.

Practice by Residents

Unless otherwise provided by law, no postgraduate trainee, intern, resident, postdoctoral fellow, or instructor may engage in the practice of podiatric medicine, or receive compensation therefor, or offer to engage in the practice of podiatric medicine unless he or she holds a valid, unrevoked, and unsuspended license to practice podiatric medicine.

However, a graduate of an approved school who is issued a training license by the board, which may be renewed annually, for the purpose of participating in a specified postgraduate training program approved by the board for a specified one-year period of time, may engage in the practice of podiatric medicine whenever and wherever required as a part of that program and may receive compensation for that practice. A graduate with a training license in an approved internship, residency, or fellowship program may participate in medical training rotations beyond the scope of podiatric medicine under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathic medicine degree wherever and whenever prescribed as a part of the training program, and may receive compensation for that practice. If a graduate fails to receive a license to practice podiatric medicine within three years from the commencement of his or her postgraduate training, all privileges and exemptions under this section shall automatically cease.

Evaluation of Applications

The board shall have full authority to investigate and evaluate each applicant applying for a license to practice podiatric medicine and to make a determination regarding the issuance of a license in accordance with the provisions of this statute.

Qualifications for Licensure

The board may issue a license to practice podiatric medicine provided:

(a) The applicant has met the premedical requirements.

(b) The applicant has graduated from an accredited school of podiatric medicine approved by the board.

(c) The applicant has presented to the board directly from the National Board of Podiatric Medical Examiners of the United States evidence that he or she has passed all parts of its

examination within the past ten years.

(d) The applicant has satisfactorily completed two years of postgraduate training approved by the board.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a license.

(f) The board determines that no disciplinary action has been taken against the applicant by any licensing authority and the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitute a pattern of negligence or incompetence.

(g) The applicant has presented to the board directly from the Federation of Podiatric Medical Boards a disciplinary data bank report.

Premedical Requirements

Each applicant shall have presented to the board directly from the educational institution an official transcript showing that he or she has completed a minimum of two years of

preprofessional postsecondary education, with subjects including chemistry, biological sciences, and physics or mathematics.

Curriculum Required

Each applicant shall have it shown by official transcript submitted directly to the board by an approved school that he or she has successfully completed a medical curriculum extending over a period of at least four academic years in an accredited school of podiatric medicine approved by the board. The total number of hours of all courses shall consist of a minimum of 4,000 hours.

The curriculum for all applicants shall provide for adequate instruction in the following:

Alcoholism and substance abuse detection
Anesthesia
Anatomy, including embryology, histology, and neuroanatomy
Behavioral science
Biochemistry
Biomechanics-including lower extremity orthopedics
Child abuse detection
Dermatology
Geriatric medicine
Human sexuality
Infectious diseases
Medical ethics
Medicine, including podiatric medicine and pediatrics
Neurology
Pathology, microbiology, and immunology
Pharmacology, including materia medica and toxicology
Physical and laboratory diagnosis
Physical medicine
Physiology
Podiatric medicine

Preventive medicine, including nutrition
Psychiatry
Radiology and radiation safety
Spousal or partner abuse detection
Surgery, including orthopedic and podiatric surgery
Therapeutics
Women's health

Postgraduate Training

In addition to any other requirements, before a license to practice podiatric medicine may be issued, each applicant shall have it shown by evidence submitted directly to the board by the sponsoring institution that he or she has satisfactorily completed two years of approved postgraduate medical and surgical training in podiatric residency. This shall include training in the performance of history and physical examinations and provide entry-level clinical training in both podiatric medicine and podiatric surgery.

"Podiatric residency" means a program of supervised postgraduate clinical training, one year or more in duration, approved by the board. The board may approve only those podiatric residencies that in its determination

(a) reasonably conform with the Accreditation Council for Graduate Medical Education's institutional requirements applicable to all medical residency programs,
(b) are approved by the Council on Podiatric Medical Education, and
(c) comply with the requirements of this state.

Continuing Competence

In order to insure the continuing competence of persons licensed to practice podiatric medicine, the board shall require those licensees to demonstrate completion of at least 50 hours of approved continuing medical education within the last two years and satisfaction of one of the following requirements at each license renewal:

(a) passage of an examination administered or approved by the board within the past ten years.
(b) passage of the part of the National Board of Podiatric Medical Examiners of the United States examination testing for clinical competence within the past ten years.
(c) passage of an examination administered within the past ten years by a specialty certifying board recognized by the Council on Podiatric Medical Education or approved by the board as having equivalent standards.
(d) successful completion within the past ten years of a residency or fellowship program approved by the Council on Podiatric Medical Education or the board.
(e) granting or renewal of current staff privileges within the past five years by a health care facility, clinic, center, or organization that is licensed, certified, accredited, maintained, operated, funded, or otherwise approved by a federal, state, or local government agency.
(f) successful completion within the past five years of an extended course of study approved by the board.