BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Eric Todd Travis, D.P.M.	)	**Case No. 500-2014-000137**
Doctor of Podiatric Medicine License No. E4459	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of Board of Podiatric Medicine, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 7, 2019.

IT IS SO ORDERED May 10, 2019.

BOARD OF PODIATRIC MEDICINE

By: Judith A Manzi DPM
Judith A. Manzi, D.P.M., President

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BEFORE THE
CALIFORNIA BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **ERIC TODD TRAVIS, D.P.M.** **24310 Moulton Parkway, Suite A** **Laguna Woods, CA 92637** **Doctor of Podiatric Medicine License No. E 4459,** Respondent.	Case No. 500-2014-000137 OAH No. 2017120499 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Brian Naslund (Complainant) is the Executive Officer of the California Board of Podiatric Medicine (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Christina Sein Goot, Deputy Attorney General.

2. Respondent Eric Todd Travis, D.P.M. (Respondent) is represented in this proceeding by attorney C. Keith Greer, Esq., whose address is: 17150 Via Del Campo, Suite 100, San Diego,

CA 92127-2137.

3. On or about January 17, 2003, the Board issued Doctor of Podiatric Medicine License No. E 4459 to Respondent. The Doctor of Podiatric Medicine License was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 500-2014-000137, and will expire on June 30, 2020, unless renewed.

JURISDICTION

4. First Amended Accusation No. 500-2014-000137 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on June 13, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of First Amended Accusation No. 500-2014-000137 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 500-2014-000137. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could

establish a *prima facie* case with respect to certain charges and allegations contained in First Amended Accusation No. 500-2014-000137 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that his Doctor of Podiatric Medicine License is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in First Amended Accusation No. 500-2014-000137 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

12. This stipulation shall be subject to approval by the California Board of Podiatric Medicine. Respondent understands and agrees that counsel for Complainant and the staff of the California Board of Podiatric Medicine may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Doctor of Podiatric Medicine License No. E 4459 issued to Respondent Eric Todd Travis, D.P.M. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered or possessed by Respondent during probation showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnosis for which the controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises is a violation of probation.

2. EDUCATION COURSE Within 60 days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 25 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified or Board approved and limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at the Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements, which must be scientific in nature, for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 50 hours of CME of which 25 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE Within 60 days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE/BILLING Within 30 days of the effective date of this Decision, the entire practice shall be monitored, including, but not limited to the following: medical records, charting, pre and postoperative evaluations, all surgical procedures and billing records.

The Board shall immediately, within the exercise of reasonable discretion, appoint a doctor of podiatric medicine from its panel of medical consultants or panel of expert reviewers as the monitor.

The monitor shall provide quarterly reports to the Board or its designee which include an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of podiatric medicine or billing, or both, and whether Respondent is practicing podiatric medicine safely.

The Board or its designee shall determine the frequency and practice areas to be monitored. Such monitoring shall be required during the first year of probation. Thereafter, the extent of monitoring shall be determined by the monitor. The Board or its designee may at its sole discretion also require prior approval by the monitor of any medical or surgical procedures engaged in by the Respondent. The Respondent shall pay all costs of such monitoring and shall otherwise comply with all requirements of his or her contract with the monitor, a copy of which is attached as "Appendix A - Agreement to Monitor Practice and/or Billing." If the monitor terminates the contract, or is no longer available, the Board or its designee shall appoint a new monitor immediately. Respondent shall not practice at any time during the probation until the Respondent provides a copy of the contract with the current monitor to the probation investigator and such contract is approved by the Board.

Respondent shall provide access to the practice monitor of Respondent's patient records and such monitor shall be permitted to make direct contact with any patients treated or cared for by Respondent and to discuss any matters related to Respondent's care and treatment of those patients. Respondent shall obtain any necessary patient releases to enable the monitor to review records and to make direct contact with patients. Respondent shall execute a release authorizing the monitor to provide to the Board or its designee any relevant information. If the practice monitor deems it necessary to directly contact any patient, and thus require the disclosure of such patient's identity, Respondent shall notify the patient that the patient's identity has been requested pursuant to the Decision. This notification shall be signed and dated by each patient prior to the commencement or continuation of any examination or treatment of each patient by Respondent

and a copy of such notification shall be maintained in each patient's file. The notifications signed by Respondent's patients shall be subject to inspection and copying by the Board or its designee at any time during the period of probation that Respondent is required to comply with this condition. The practice monitor will sign a confidentiality agreement requiring him or her to keep all patient information regarding Respondent's patients in complete confidence, except as otherwise required by the Board or its designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above, is a violation of probation.

6. NOTIFICATION Prior to engaging in the practice of medicine, the Respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of podiatric medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. PHYSICIAN ASSISTANTS Prior to receiving assistance from a physician assistant, Respondent must notify the supervising physician of the terms and conditions of his/her probation.

8. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of podiatric medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. PROBATION COMPLIANCE UNIT Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of podiatric medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California doctor of podiatric medicine's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office with the Board or its designee, upon request, at various intervals and either with or without notice throughout the term of probation.

12. RESIDING OR PRACTICING OUT-OF-STATE In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in section 2472 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions, with the exception of this condition, and the following terms and conditions of probation: Obey All Law; Probation Unit Compliance; and

Cost Recovery.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing podiatric medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

13. FAILURE TO PRACTICE PODIATRIC MEDICINE – CALIFORNIA RESIDENT In the event the Respondent resides in the State of California and for any reason Respondent stops practicing podiatric medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of nonpractice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in section 2472 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code section 2472.

14. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate will be fully restored.

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15. VIOLATION OF PROBATION If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, the period of probation shall be extended until the matter is final, and no petition for modification of penalty shall be considered while there is an accusation or petition to revoke probation pending against Respondent.

16. COST RECOVERY Within 90 calendar days from the effective date of the Decision or other period agreed to by the Board or its designee, Respondent shall reimburse the Board the amount of $22,000 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by Respondent shall not relieve the Respondent of his/her obligation to reimburse the Board for its costs.

17. LICENSE SURRENDER Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons, or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Board reserves the right to evaluate the Respondent's request and to exercise its discretion whether to grant the request or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice podiatric medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a podiatric medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

18. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the California Board of Podiatric Medicine and delivered to the Board or its designee within 60 days after the start of the new fiscal year. Failure to pay costs within 30 calendar days of this date is a violation of

probation.

19. NOTICE TO EMPLOYEES Respondent shall, upon or before the effective date of this Decision, post or circulate a notice which actually recites the offenses for which Respondent has been disciplined and the terms and conditions of probation to all employees involved in his/her practice. Within fifteen (15) days of the effective date of this Decision, Respondent shall cause his/her employees to report to the Board in writing, acknowledging the employees have read the Accusation and Decision in the case and understand Respondent's terms and conditions of probation.

20. CHANGES OF EMPLOYMENT Respondent shall notify the Board in writing, through the assigned probation officer, of any and all changes of employment, location, and address within thirty (30) days of such change.

21. COMPLIANCE WITH REQUIRED CONTINUING MEDICAL EDUCATION Respondent shall submit satisfactory proof biennially to the Board of compliance with the requirement to complete fifty hours of approved continuing medical education, and meet continuing competence requirements for re-licensure during each two (2) year renewal period.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, C. Keith Greer, Esq. I understand the stipulation and the effect it will have on my Doctor of Podiatric Medicine License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the California Board of Podiatric Medicine.

DATED: 4/8/2019

ERIC TODD TRAVIS, D.P.M.
Respondent

[Signatures continued on following page]

I have read and fully discussed with Respondent Eric Todd Travis, D.P.M. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 4/15/19

C. KEITH GREER, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the California Board of Podiatric Medicine.

Dated: 4/16/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

CHRISTINA SEIN GOET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 500-2014-000137

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BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ERIC TODD TRAVIS, D.P.M. 24310 Moulton Parkway, Suite A, Laguna Woods, CA 92637 Doctor of Podiatric Medicine License No. E 4459, Respondent.	Case No. 500-2014-000137 OAH Case No. 2017120499 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Brian Naslund (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Board of Podiatric Medicine, Department of Consumer Affairs.

2. On or about January 17, 2003, the Board of Podiatric Medicine issued Doctor of Podiatric Medicine License Number E 4459 to Eric Todd Travis, D.P.M. (Respondent). The Doctor of Podiatric Medicine License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Podiatric Medicine (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

4. Section 2222 of the Code states the California Board of Podiatric Medicine shall enforce and administer Code Section 2220 et seq. of the Medical Practice Act as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by the Medical Practice Act are applicable to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing Panel established under Section 11371 of the Government Code is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.

The California Board of Podiatric Medicine may order the denial of an application or issue a certificate subject to conditions as set forth in Code Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 11373, and 11529 of the Government Code. For these purposes, the California Board of Podiatric Medicine shall exercise the powers granted and be governed by the procedures set forth in the Medical Practice Act.

5. Section 2228 of the Code states:

"The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

"(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

"(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

"(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

"(d) Providing the option of alternative community service in cases other than violations relating to quality of care."

6. Section 2229 of the Code states:

"(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

"(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

"(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount."

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 125.3 of the Code states:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a

licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

". . ."

FACTS

Patient 1:

10. Patient 1, a 93-year-old male, first presented to Respondent on October 14, 2013, with complaints of pain and ambulation of the right foot. Respondent's objective findings were that J.H. had: diminished pulses; normal ranges of motion (including the digits and the metatarsal); phalangeal joint[1] issues; painful verruca plantar[2] to the 5th metatarsal right foot;[3] normal neurological lower extremity functions; and no evidence of neuroma.[4]

11. At the initial visit Patient 1 was diagnosed with: a localized painful verruca plantar (a small wart) to the 5th metatarsal right foot; keratoderma[5] acquired; pain in his limb; dystrophic onychomycotic[6] toenails; dermatophytosis toenails,[7] and; PVD.[8] Respondent's suggested treatments for Patient 1, which he performed on this date, were: sharp debridement[9] of verrucae to

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[1] Any of the hinge joints between the phalanges of the fingers or toes. Also called interphalangeal joint or digital joint.

[2] Plantar issues relate to the sole of the foot or a corresponding part.

[3] A small wart on the 5th long cylindrical bone extending from the heel to the toes.

[4] A tumor or new growth largely made up of nerve cells and nerve fibers.

[5] Keratoderma is a cutaneous manifestation most often involving the palms, soles, toes, and glans penis, and characterized by development of thick keratotic (excessive horny tissue on the skin) coverings; the lesions resemble those of pustular psoriasis.

[6] A fungal infection.

[7] Any superficial fungal infection caused by a dermatophyte and involving the stratum corneum (the outermost layer of the epidermis consisting of dead cells) of the skin, hair, and nails, including onychomycosis

[8] Peripheral vascular disease (PVD) is any abnormal condition that affects the blood vessels and lymphatic vessels, except those that supply the heart. Different kinds and degrees of PVD are characterized by a variety of signs and symptoms, such as numbness, pain, pallor, elevated blood pressure, and impaired arterial pulsations. Causative factors include obesity, cigarette smoking, stress, sedentary occupations, and numerous metabolic disorders. PVD in association with bacterial endocarditis may involve emboli in terminal arterioles and produce gangrenous infarctions of distal parts of the body, such as the tip of the nose, the pinna of the ear, the fingers, and the toes. Large emboli may occlude peripheral vessels and cause atherosclerotic occlusive disease. Treatment of severe cases may require amputation of gangrenous body parts. Less severe peripheral vascular problems may be treated by eliminating causative factors, especially cigarette smoking, and by administering various drugs, such as salicylates and anticoagulants. Some kinds of peripheral vascular disease are atherosclerosis and arteriosclerosis.

[9] Debridement is the removal of unhealthy tissue from a wound to promote healing.

pinpoint bleeding; cauterization and chemical treatment of the wart; debridement of toenails and paring of the keratodermas.

12. Patient 1 next presented to Respondent on November 4, 2013, with complaints of painful calluses with ambulation of both feet and painful dystrophic toenails of both feet. The significant objective findings were similar to the initial visit but also included: atrophic[10] skin changes; and painful lesions plantar to the 5th metatarsal bilateral.

13. Similar to the initial visit Patient 1was diagnosed with: a localized painful verruca plantar (a small wart) to the 5th metatarsal right foot; keratoderma; pain in his limb; dystrophic onychomycotic toenails; dermatophytosis toenails; and ingrown toenail, and PVD. Respondent's suggested treatments for Patient 1, which he performed on this date, were: sharp debridement of the toenails; cauterization and chemical treatment of the wart; debridement of toenails and paring of the keratodermas.

14. Patient 1 next presented to Respondent on January 6, 2014, with complaints of painful calluses with ambulation of both feet and painful dystrophic toenails on both feet. The significant objective findings were similar to the initial visit but also included atrophic skin changes. Patient 1 was again diagnosed with a localized painful verruca plantar to the 5th metatarsal right foot; keratoderma; pain in his limb; dystrophic onychomycotic toenails; dermatophytosis toenails; and ingrown toenail; and PVD. Respondent's suggested treatments for Patient 1 were to: perform digital vascular studies; a sharp debridement of the toenails; cauterization and chemical treatment of the wart; debridement of toenails; and paring of the keratodermas.

15. Patient 1 next presented to Respondent on February 10, 2014, with the same complaints of painful calluses with ambulation of both feet and painful dystrophic toenails of both feet. The significant objective findings were the same as the prior visit. The diagnosis was the same as well, with the addition of a diagnosis of Morton's Neuroma.[11]

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[10] Denoting atrophy.

[11] Morton's Nueroma is a type of perineural fibrosis described by Morton in 1876; it is not a true neuroma. It is evidenced by a sharp, burning pain, commonly between the 3rd and 4th metatarsal heads, which is worse with direct pressure.

16. Respondent's suggested treatments for Patient 1, which he performed on this date, were: sharp debridement of the toenails; cauterization and chemical treatment of the wart; a 4% Benzyl Alcohol (sclerosing) injection mixed with local anesthetic (treatment of Morton's Neuroma).

17. Patient 1 next presented to Respondent on March 10, 2014, with complaints of painful calluses with ambulation of both feet, painful dystrophic toenails of both feet and intractable plantar keratoma (IPK).[12] The significant objective findings were the same as prior visits, with the addition of a localized verruca plantar to the 5th metatarsal right foot. The diagnosis was the same as the prior visit including: a viral wart; Keratoderma; pain in limbs; PVD; ingrown toenail, and; dermatophytosis of toenails. No diagnosis of Morton's Neuroma was included on this date. Oddly, the suggested treatments included treatment for Morton's Neuroma.

18. Respondent's suggested treatments for Patient 1 on March 10, 2014, which he performed on this date, were: another sclerosing injection mixed with local anesthetic (in treatment of Morton's Neuroma); sharp debridement of verrucae to pinpoint bleeding, cauterization and chemical treatment of wart.

19. Patient 1 next presented to Respondent on April 4, 2014, with complaints of painful calluses with ambulation of both feet with neuroma abscess, painful dystrophic toenails of both feet and IPK. The significant objective findings were similar to prior visits, including a localized verruca plantar to the 5th metatarsal right foot with abscess and no signs of infection with the addition of a localized verruca plantar to the 5th metatarsal right foot. The diagnosis was the same as the prior visit including: a viral wart; Keratoderma; pain in limbs; PVD; ingrown toenail, and dermatophytosis of toenails. A diagnosis of Morton's Neuroma was included on this date. Also included on this date was a diagnosis of cellulitis and abscess of foot.

20. Respondent's suggested treatments for Patient 1 on April 4, 2014, which he performed on this date, were: another sclerosing injection mixed with local anesthetic (in treatment of Morton's Neuroma); incision and drainage of the abscess after a more proximal

[12] IPK is a focused, painful lesion that commonly takes the form of a discrete, focused callus, usually about 1 cm, on the plantar aspect of the fore foot.

anesthetic nerve block with wound curettage, and sharp debridement of verrucae to pinpoint bleeding, cauterization and chemical treatment of wart.

21. Patient 1 next presented to Respondent on April 25, 2014, with complaints of painful calluses with ambulation of both feet with neuroma abscess, painful dystrophic toenails of both feet and IPK and ulceration of posterior-plantar in the left heel. The significant objective findings were: verrucous lesion posterior on the left heel; a left heel ulcer with eschar,[13] and; a localized verruca plantar to the 5th metatarsal right foot with erythema[14] and serous drainage, including a localized verruca plantar to the 5th metatarsal right foot with abscess. The diagnosis was similar to prior visits including: a viral wart; keratodema; pain in limbs; PVD; ingrown toenail; dermatophytosis of toenails; Morton's Neuroma; cellulitis and abscess of the foot; and an ulcer in the midfoot section of the heel.

22. Respondent's significant objective findings on April 25, 2014, were again dystrophic onychomycotic toenails and painful lesions plantar to the 5th metatarsal bilateral.

23. Respondent's treatments on April 25, 2014, which he performed on this date, were: paring of the keratormas; treatment of the foot infection; treatment of a bone lesion; drainage of the abscess; and strapping of toes, ankle and foot.

24. Patient 1 next presented to Respondent on May 2, 2014, with complaints of painful calluses with ambulation of both feet with neuroma abscess, painful dystrophic toenails of both feet and verrucous IPK and ulceration of posterior-plantar in the left heel. The significant objective findings were: diminished pulses; verrucous lesion posterior on the left heel; a left heel ulcer with eschar; and a localized verruca plantar to the 5th metatarsal right foot with erythema and serous drainage, including a localized verruca plantar to the 5th metatarsal right foot with serious drainage from an abscess; dystrophic onychomycotic toenails; and painful lesions plantar to the 5th metatarsal bilateral.

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[13] Eschar is a thick, coagulated crust or slough which develops following a thermal burn or chemical or physical cauterization of the skin. It can also be the result of gangrene.

[14] Erythema is a redness of the skin caused by congestion of the capillaries in the lower layers of the skin. It occurs with any skin injury, infection, or inflammation.

25. Respondent's diagnosis on May 2, 2014, was similar to prior visits including: a viral wart; keratoderma; pain in limbs; PVD; ingrown toenail; dermatophytosis of toenails; Morton's Neuroma; cellulitis and abscess of the foot; and an ulcer in the midfoot section of the heel.

26. Respondent's treatments on May 2, 2014, which he performed on this date, were significantly more involved than on prior visits, including: destruction of a benign lesion; debridement of toenails; trimming of skin lesions; vascular testing; a nerve block; injection treatment of nerve; treatment of two foot infections; treatment of a bone lesion; drainage of two skin abscess; strapping of the toes; strapping of the ankle and foot; debridement of subcutaneous issue; a skin substitute graft; application of an Oasis Wound Matrix;[15] and paring of the keratomas.

27. Following Respondent's treatment of Patient 1 on May 2, 2014, the patient presented in the emergency room on May 12, 2014. A culture taken from Patient 1 grew Staph Aureus and x-rays taken suggested osteomyelitis.

28. On May 13, 2014, an infectious disease consultation was performed by Dr. A.W.

29. An amputation of the 5th toe and a partial 5th metatarsal excision was performed on Patient 1 on July 27, 2014.

30. Prior to seeing Respondent, Patient 1 was already diagnosed with: dystrophic toenails; Type II Diabetes and neuropathy; plantar IPKs to the first and fifth metatarsals; and PVD.

Patient 2:

31. On January 6, 2014, Patient 2 presented to Respondent with significant bilateral medial ankle pain. X-rays were negative for coalition or bar. A diagnostic ultrasound demonstrated impingement of the laciniate ligament.[16] Patient 2 was diagnosed with dermatophytosis foot, joint pain ankle, tarsal tunnel syndrome, pain in limb, reflex sympathetic

[15] An Oasis Wound Matrix is wound dressing with SIS (Small Intestinal Submucosa) technology, similar to a skin graft.

[16] The Laciniate ligament is part of a wide band passing from the medial malleolus to the medial and upper border of the calcaneus and to the plantar surface as far as the navicular bone; it holds in place the tendons of the tibialis posterior, flexor digitorum longus, and flexor hallucis longus.

dystrophy leg, and infection by dematiaceous fungi and given a CAM walker (right ankle), ordered to soak his feet and do home exercises. He was also given a prescription for Norco 10/325 #120, lidocaine ointment 5%, 60 gm, and Lotrisone cream 1%.

32. The records for February 3, 2015, indicate that Patient 2 showed some improvement with laser therapy and wearing boots with Dr. Scholl arch supports. He stated he continued to need the pain medication due to the nerve pain, which only dissipated with rest and a lack of pressure. He also indicated that he was limited in what he could do because he had no insurance and a lack of funds. Patient 2 showed significant pain with percussion of the tarsal tunnel and with elevation of the right leg and limb in supine position. He was noted as positive for Tinel's sign[17] noted at the tibial nerve. The diagnoses was joint and ankle pain, tarsal tunnel syndrome, sympathetic dystrophy of the leg and infection by dematiaceous fungi. In addition to non-narcotic treatments, including good-fitting shoes, "Superfeet" orthotics, back and ankle exercises, Aspercream applied to feet and soaking in warm water with Epsom's salts, Patient 2 was prescribed Norco 10/325 #120.

33. The records for April 16, 2015, indicate that Patient 2 had continued, bilateral, medial ankle pain. There was significant pain with percussion of the right tarsal tunnel and positive Tinel's sign noted at the tibial nerve. The diagnoses were again joint and ankle pain, tarsal tunnel syndrome, sympathetic dystrophy leg and infection by dematiaceous fungi. The patient was given laser therapy.

34. The records for May 12, 2015, state that Patient 2 reported no real change in status after having laser therapy and doing soaking exercises. He continued to complain of stabbing pain and that his back pain had increased, as well. The diagnoses remained the same. He was given therapeutic laser and a local injection at the tarsal tunnel with 1 cc of 0.5% Marcaine, plain and 1 cc of Decadron. Unna boots were applied to both ankles and he was ordered to continue with the other regimens.

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[17] Tinel's sign is a way to detect irritated nerves. It is performed by lightly tapping (percussing) over the nerve to elicit a sensation of tingling or "pins and needles" in the distribution of the nerve.

35. The records for July 28, 2015, indicate that the injection at the tarsal tunnel helped slightly, however the pain remained shooting and stabbing measuring 9/10 on the standard pain scale. He stated that without Norco he developed severe aching pain with no refractory period. He was treated with diagnostic ultrasound that demonstrated swelling in the tarsal tunnel. A trigger point injection was performed using lidocaine and Marcaine with Celestone Soluspan to both feet and strappings were applied. A prescription for Norco 10/325 #120 was provided.

36. The records for August 18, 2015, appear to duplicate prior visits. Patient 2 reported significant medial, bilateral ankle pain with slight improvement with the laser therapy. He was wearing heel cushions and stated he continued to need pain medication. The objective findings and diagnoses remained unchanged. The treatment consisted of pain counseling, laser therapy 6 watts for 3 minutes, a CAM walker, soaking the feet and a prescription for Norco 10/325 #120, with a recommendation to do physical therapy exercises.

37. The records for September 22, 2015, indicate that Patient 2 was using the CAM boot with slight improvement. He also felt that Advil was providing some relief. The patient stated that he had been taking his pain medication very carefully. Respondent asked the patient if he would see Dr. K. for a second opinion. The objective findings, diagnoses and treatment plan remained unchanged. The patient was told to wear a night splint and the prescription for Norco 10/325 #120 was again provided.

38. The records for December 22, 2015, indicate that Patient 2 complained of increased bilateral, medial ankle pain stating that he had been very active. Pain was shooting and described as 10/10. However, this appears overstated as a pain at 10/10 would be so severe as to be debilitating. Patient 2 was using the CAM boot but stated he had not done physical therapy because of pain. The objective findings, diagnoses and treatment plan remained unchanged. At this visit the Chronic Pain Form was signed. Respondent also noted that he was going to attempt to procure a TENS unit for the patient. A prescription for Norco 10/325 #120 was also provided.

39. The records for January 19, 2016, again state that Patient 2 presented with significant complaints of bilateral, medial ankle pain. He also reported pain in calf muscles when lying down and other pain in his legs and he continued to confirm that he needed pain medication. The

other notes in the chart appear to duplicate the April 16, 2015 notes almost word for word. At this visit the first MRI was ordered. A prescription for Norco 10/325 #120, was again provided.

40. In the records for March 17, 2016, Patient 2 related improvement after the last injections, which lasted 6-7 days, more so on the left foot. He still complained of pain at the 9/10 range. Respondent suggested surgery, but the patient stated that he could not afford it. The objective findings, diagnoses and treatment plan remained unchanged. Laser therapy 6 watts for 3 minutes was again provided and Low Dye strappings applied. The TENS machine was dispensed to the patient. The patient was ordered to continue all prior treatment, and in addition to the Norco 10/325 #120 prescription, samples of Lyrica[18] and Metanx[19] were dispensed.

41. The records for June 16, 2016, state that Patient 2 again made the same complaint of bilateral ankle and foot pain, with the right worse than left and was frustrated because his foot pain was only better when he was off his feet. He continued to request pain medication and rated his pain as 9/10, which appears overstated. Patient 2 also stated that the TENS machine caused some pain after treatment. He also noted the Lyrica and Metanx had no effect and he discontinued using them. He stated the Lyrica made him dizzy. The fundamental objective findings, diagnoses and treatment plan remained unchanged. A prescription for Norco 10/325 was provided. The patient was also referred to Dr. H. for pain management hoping that an epidural injection would help with the global pain.

42. The records for August 11, 2016, indicate that Patient 2 reported improvement in both ankles but continued to have pain with any major activities. He also stated that the last injection did not help with pain and may have worsened it. The patient indicated that he had called Dr. H.'s office, but that Dr. H. was unable to see him. The objective findings, diagnoses and treatment plan remained unchanged. He was again given laser therapy 6 watts for 3 minutes both ankles; a light Unna's boot was applied bilaterally to be removed in 3 days; an Ace bandage was dispensed; diagnostic ultrasound was used bilaterally, and Advil, 3 pills with food, was recommended.

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[18] Lyrica is used for neuropathic pain related to diabetic peripheral neuropathy.

[19] Metanx is a prescription medical food made by Pamlab that contains L-methylfolate (as Metafolin, a calcium salt of vitamin B9), methylcobalamin (vitamin B12) and pyridoxal 5'-phosphate (vitamin B6). It is a vitamin B supplement. Metanx is indicated for the dietary management of peripheral neuropathy.

Respondent discussed the current medications with Patient 2 and explained that he would not increase the prescription without consulting with a spine specialist and a pain management team. According to the notes, Respondent explained to the patient that his job was to take care of the feet and make him functional and pain-free.

43. The records for October 11, 2016, indicate that Patient 2 stated that the pain medication was not helping as much as it first did and he agreed that pain management might help. Respondent noted increased edema and confirmed that the patient had shooting pain at his medial ankle. On this visit the objective findings included extreme pain with active or forced inversion of the subtalar joint and with passive eversion. Respondent's notes indicate pain with ankle joint and subtalar joint motion and along the tarsal tunnel of the right foot more than the left. There were no changes in the diagnoses and no significant changes in the treatment plan. A prescription for Norco 10/325 #120 was again provided. He also received a prescription for compression socks.

44. The records for October 12, 2016, the second appointment in two days, indicate that Patient 2 presented for complaints of bilateral ankle pain. He stated that he could not afford to see a spine specialist and did not want surgery. He had reduced his pain medications and noted that laser therapy had helped. He was preparing for his coming wedding and was wearing good shoes. His prescription for Norco 10/325 #120 remained the same and Lotrisone was added. Objective findings now included severe allodynia in both feet, medial swelling bilaterally, pain with passive inversion and eversion, and edema bilaterally. Again, Respondent noted positive Tinel's sign with percussion of the tibial nerve bilaterally. The report of pain remained out of proportion to the actual observations. On this occasion the diagnoses included complex regional pain syndrome of both lower limbs, plantar fascial fibromatosis,[20] tinea pedis, tarsal tunnel syndrome bilaterally and localized edema. Treatments were therapeutic laser therapy, increased to 7.0 watts for 3 minutes bilaterally, soaking instructions and possible blood testing in the future.

45. The records for January 5, 2017, indicate that Patient 2's pain continued and that he had tried the compression socks but they caused more pain because of pressure on the tibial

[20] The occurrence of multiple fibromas in the plantar fascia.

nerve. On this visit he requested surgery and also denied the abuse of medication. The objective findings, diagnosis and treatment remained the same as the prior visit. Again, a prescription for Norco 10/325 #120 was provided.

46. The records for February 2, 2017, note that Patient 2 had intense pain in the right foot and stated that the pain began with his first step in the morning and did not dissipate throughout the day. He requested surgery again but Respondent indicated that the patient was not a good candidate for surgery. Patient 2 mentioned a longer acting pain medication which Respondent refused to provide until the patient was seen by pain management for a full evaluation of his spine. The objective findings, diagnosis and treatment remained the same as the prior visit, except for the addition of localized edema. Treatment included laser therapy 7.0 watts for 3 minutes bilaterally and he was given information on back and ankle exercises, no heavy lifting or any activity that exacerbated the ankle pain. A prescription for Norco 10/325 #120 was provided.

47. On March 9, 2017, Patient 2 continued to complain of bilateral ankle and foot pain and Respondent advised him that a second opinion was needed. Pain management was discussed and the patient indicated that he was willing to proceed with MRIs. Respondent's notes reflect that he advised the patient that: "Orthopedic consultation and further pain management is needed because the current regimen has not been enough to allow the patient to function at an acceptable level. He wears his boot when he can and notes that the pain is persistent." The treatment plan remained fundamentally the same with pain management counseling, Low Dye strapping and laser therapy of 6.0 watts for 3 minutes to both feet. Patient 2 was given Tramadol samples to try instead of Norco, although a refill was given for Norco 10/325 #120.

48. The notes for May 16, 2017, show that Patient 2 continued to complain of pain and was taking Advil and Norco for pain control. He stated he would like to have surgery after his wedding. The office treatments and plan remained the same. Patient 2 was again given a prescription for Norco 10/325 #120 and was also given samples of Flector Patches of 1.3%.

49. On the June 8, 2017 visit, Patient 2 stated the strapping[21] helped his feet and the Flector patch allowed him to sleep better. He had been using the patch on his back also.

[21] Taping of the feet, particularly the arches.

Respondent advised Patient 2 that he would not prescribe stronger medication until the patient got a pain consultation and that an MRI was indicated. A prescription for Norco 10/325 #120 was given and an MRI for bilateral ankles was ordered.

50. On June 15, 2017, Respondent examined Patient 2 again for his bilateral foot and ankle pain complaints. Respondent noted that the patient did not present a history of opioid abuse but did require comprehensive pain management as he had been on the medications for an extended period of time and needed alternative therapy. The office treatments and plan remained the same. Patient 2 was again given a prescription for Norco 10/325 #120. Respondent referred the patient to BASIC Spine, Dr. O., Dr. T. or Dr. L.

51. On July 18, 2017, Patient 2 continued to complain of tremendous pain. He had reviewed the tarsal tunnel surgery on YouTube and wished to proceed. Pain medication was discussed at great length. The office treatments and plan remained the same. Patient 2 was again given a prescription for Norco 10/325 #120.

52. On the visit of August 22, 2017, Patient 2 continued to complain of pain and Respondent's notes indicate he told the Patient that he was unwilling to continue to treat the patient with pain medication without a second opinion and further pain management, although he agreed to "one more time." The patient stated that the majority of his pain was in the right ankle. He requested the surgery, but Respondent noted that surgery might not be the best option until the back gets evaluated with further MRI evaluation. The office treatments and plan remained the same. Patient 2 was again given a prescription for Norco 10/325 #120. This appears to be the last Norco prescription provided.

53. On September 7, 2017, Patient 2 continued to complain of pain in both feet and ankles. He said he was taking more Motrin to control his back pain and that he had an appointment with pain management. The office treatments and plan remained the same.

54. On October 12, 2017, Patient 2 continued to complain of bilateral ankle pain. He was taking Motrin, had not seen a spine specialist and no longer wished to have surgery. He stated he was able to reduce his pain medication and the laser therapy had helped a little. He was preparing for his wedding the following weekend. The office treatments and plan remained the same.

55. On December 16, 2017, Patient 2's pain was described as sharp, burning and radiating, with a pain level of 9/10. At this visit no treatments were given, and a simple history of the patient is in the notes with very little else.

Patient 3:

56. On December 4, and 11, 2014 (Respondent's notes were essentially the same), Patient 3 complained of severe pain from gouty, post-traumatic arthritis. He had a history of two traumatic events, a fracture with dislocation of the sesamoids (seen on x-rays) and a history of gout. He was wearing a pneumatic walking boot and requested pain medication. He currently had prescriptions for allopurinol, Norco, and Indocin. Respondent's notes indicate findings of pain with palpation of all aspects of the right first metatarsophalangeal joint, swelling at the joint, and severe pain and tenderness of the sesamoid apparatus. X-rays demonstrated maligned sesamoids, proximal phalanx fracture distally with joint space narrowing and subchondral sclerosis. Respondent's diagnosis was of hallux rigidus, pain in limbs, and traumatic arthropathy ankle. The treatment plan was for an MRI of the right foot. Surgery was also discussed for right foot.

57. On December 23, 2014, Patient 3 returned to review the MRI results and to discuss surgery. The MRI results confirmed severe degeneration of the right first MPJ with erosive changes of the cartilage, fracture of the right proximal phalanx (not acute), severe degenerative changes of the sesamoid apparatus, capsular thickening and erosive periarticular changes strongly supportive of gout, bone marrow edema seen in the proximal phalanx and some in the metatarsal. He had been on pain therapy for two years and stated that his foot pain was increasing. He had been immobilized in a boot and wore inserts in his shoes. He had chronic pain in his back and in his foot and was taking multiple medications including allopurinol, Indocin, Plavix, Lipitor, nitroglycerin, multi-vitamins, folic acid, zinc, gabapentin, amiodarone, Lexapro, bupropion, and Ambien. The objective findings and treatment plan remained the same from prior visits. A prescription for Norco 10/325 #100 was provided.

58. On January 15, 2015, Patient 3 presented with a gouty attack with severe pain partially under control with Norco asking for stronger pain medication. He had taken Percocet

for his back before. Objective findings included severe pain of the right 1st MPJ, slight erythematous and 2+ edema was noted. The objective findings and treatment plan remained fundamentally the same from prior visits. A prescription for Percocet 10/325 #120 was provided and an MRI of the right foot was ordered.

59. On February 10, 2015, Patient 3 advised Respondent that the pain and swelling were worse and Percocet was not strong enough. The objective findings and treatment plan remained the same from prior visits. X-rays confirmed maligned sesamoids, distal proximal phalanx fracture with joint space narrowing and subchondral sclerosis. The objective findings and treatment plan remained fundamentally the same from prior visits. A prescription for MS Contin 60 mg., was provided.

60. On March 19, 2015, Respondent's notes indicate that this was the first postoperative visit following right foot first MPJ total implant arthroplasty surgery on March 12, 2015. The patient was doing well, although he did complain of severe right foot pain. He had been taking MS Contin, Indocin and Norco. Objective findings were good toe alignment but too much pain to evaluate motion. X-rays of the right foot demonstrated good implant position with some gouty changes and no signs of infection. The assessment was pain in limb. Respondent redressed the surgical site. No prescriptions were given on this date.

61. Patient 3's March 26, 2015, visit was 2 weeks after surgery and more pain and swelling of the right foot was noted with the possibility of a gouty attack. He was taking MS Contin 60 mg extended release, Indocin 50 mg and Norco 10/325. Objective findings remained the same as the prior visit and the treatment plans was continued from the prior visit. A prescription for MS Contin 30 mg #90 for severe pain and Medrol Dosepak for gout were provided.

62. On April 2, 2015, Patient 3 presented for the three week exam post surgery reporting that the gout had improved with the Medrol Dosepak. He complained of severe pain and requested discontinuance of the extended release tablets because the shorter-acting pain medication was adequate. Pain protocol was discussed again with the patient. Objective findings

remained the same as the prior visit and the treatment plan was continued from the prior visit. A prescription for MS Contin 30 mg #90, was provided.

63. On April 16, 2015, one month after surgery, Patient 3 continued to complain of severe pain. Objective findings remained the same as the prior visit and the treatment plan was continued from the prior visit. The patient was given a referral to Dr. B. for management of his difficulty with sleeping and pain issues..

64. On April 30, 2015, Patient 3 again complained of severe right foot pain. Respondent advised the patient that the pain may be more from gout than the surgery. His medication list at this visit included morphine 30 mg, Medrol Dosepak, OxyContin 10 mg, MS Contin 60 mg, Indocin 50 mg, and Norco 10/325 mg. A prescription for MS Contin 30 mg #90, was given.

65. On May 7, 2015, Patient 3 complained of swelling and erythema of the left ankle with extreme pain and also pain in the surgical foot, the right foot and requested more Indocin. He also indicated that he would like to decrease his pain medications from the current prescriptions for morphine 30 mg, Medrol Dosepak, OxyContin 10 mg, MS Contin 60 mg, Indocin 50 mg, and Norco 10/325 mg. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. Prescriptions for MS Contin 30 mg #90, Colcrys 0.6 mg, and Indocin 50 mg were provided.

66. On June 11, 2015, Patient 3 reported that the pain at the left ankle was improved. Respondent's notes indicate that he told the patient that he was a difficult pain case and further pain management was discussed. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. His medication list included Colcrys 0.6 mg, Indocin 50 mg, morphine 30 mg, Medrol Dosepak, OxyContin 10 mg, MS Contin 60 mg, and Norco 10/325 mg. Prescriptions were provided for allopurinol 300 mg, Indocin 50 mg, and MS Contin 30 mg #120.

67. On July 2, 2015, Patient 3 complained of extreme right foot pain, but the gout seemed controlled. Respondent recommended a second opinion and encouraged the patient to not take more pain medication than necessary. Objective findings remained fundamentally the same as

the prior visit and the treatment plan was continued from the prior visit. Prescriptions for MS Contin 30 mg #120 and Lidocaine ointment 5% were given.

68. On July 23, 2015, Patient 3 complained of pain walking and standing complicated by his gout. He was also being monitored by Dr. B. Objective findings remained fundamentally the same as the prior visits and the treatment plan was continued from the prior visit. Again, a prescription for MS Contin 30 mg. #120 was given.

69. The August 18, 2015, records indicate Patient 3's discouragement with the lack of improvement. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. Again, a prescription for MS Contin 30 mg. #120 was given.

70. On September 17, 2015, Patient 3 was seen for his six month status check. Respondent's notes indicate very little improvement. The patient continued to have pain despite taking morphine sulfate at night. Respondent also noted that "[h]e continues to not let anybody else treat his feet due to lack of trust issues." Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. Again, a prescription for MS Contin 30 mg. #120 was given.

71. On October 15, 2015, Patient 3 reported that a laser treatment (not noted in the prior visit's records) held the pain to 6/10 for 24 hours, with less shooting pain, but after 24 hours the pain came back at 9/10. His gout was well-maintained. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. A diagnostic ultrasound demonstrated erosive changes around the joint implant and slight edema with hypo-echoic signal noted. Again, Patient 3 was given a prescription for MS Contin 30 mg. #100 and morphine ER 30 mg. tablet. Also, Patient 3 was given a prescription and a Metanx sample was dispensed along with alpha lipoic acid and vitamin B supplements.

72. On November 10, 2015, Patient 3 claimed some relief with the laser therapy. He continued to have nerve-like symptoms and refused acupuncture because of the needles. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. He received laser therapy and was given a prescription for

allopurinol 200 mg #60, morphine ER 30 mg. tablet. Again, Patient 3 was given a prescription and a Metanx sample was dispensed along with alpha lipoic acid and vitamin B supplements.

73. On December 8, 2015, Patient 3 continued to complain of pain with more in the arch area; however, the joint remained sensitive to touch. Physical therapy had been virtually non-existent. Medication had been monitored by Dr. B. He complained of cold feet at night. He was taking multiple medications including allopurinol, indocin, Plavix, Lipitor, nitroglycerin, multivitamin, folic acid, zinc, gabapentin, amiodarone, Lexapro, bupropion, Ambien, morphine, OxyContin, MS Contin and Norco. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. Respondent discussed a possible neurologic work-up and getting a second opinion with neurologist Dr. K. Again, Patient 3 was given a prescription for MS Contin 30 mg. #100 and morphine ER 30 mg. tablet and a Metanx sample was dispensed.

74. On January 5, 2016, Patient 3 continued to take pain medications for his continuing left foot pain continued. On this visit an Opioid Contract was signed. Objective findings remained fundamentally the same as the prior visit and the treatment plan was continued from the prior visit. Patient 3 received laser therapy and TENS treatment. Again, Patient 3 was given a prescription for MS Contin 30 mg. #100 and allopurinol 200 mg was given.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct-Gross Negligence)

75. By reason of the matters set forth above in paragraphs 10 through 74, incorporated herein by this reference, Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he engaged in unprofessional conduct constituting gross negligence. The circumstances are as follows:

76. Although Patient 1 was known to be diabetic with peripheral neuropathy and vascular disease, the charting is replete with objective findings indicating chronic atrophic skin changes, prolonged capillary filling times and diminished peripheral pulses. The only studies on record are Flochek studies, which do not sufficiently evaluate or comprehensibly evaluate the distal

vasculature.

77. A vascular consultation for Patient 1 was indicated, but never obtained. Respondent's failure to perform sufficient vascular studies and his failure to obtain a vascular consultation in a diabetic patient with chronic vascular changes constitutes gross negligence.

78. Respondent's failure to perform sufficient vascular studies and his failure to obtain a vascular consultation in a diabetic patient with chronic vascular changes resulted in Patient 1's developing a non-healing ulceration that lead to a partial amputation of his foot and constitutes gross negligence.

79. Patient 1 was previously diagnosed with peripheral neuropathy and that diagnosis had been validated with objective findings in records available to Respondent. However, Respondent still debrided the verrucae to pinpoint bleeding and failed to provide more consistent care for the ulceration, which contributed to Patient 1's developing a non-healing ulceration leading to a partial amputation of his foot constituting gross negligence.

80. Patient 1's verrucae was debrided to pinpoint bleeding and/or treated with chemicals under occlusion on numerous occasions. This service was not provided in a timely manner and there were no biopsies performed to validate the diagnosis. The treatment resulted in ulceration of the skin in a dysvascular and neuropathic foot, which, in a 93-year-old man with inadequate circulation, created an ulceration from pinpoint bleeding that was difficult to heal. Without having protective sensation Patient 1 could not guard and protect this area, thus potentiating the ulceration and contributing to Patient 1's developing a non-healing ulceration, constituting gross negligence.

81. Respondent's repetitive sclerosing injections therapeutically scarred and shrank distal nerves as well as other tissues. Without vascular or neurologic validation these injections can complicate healing and cause ulceration, abscess and infection. Respondent's repeated injections resulted in an abscess in Patient 1's foot, which eventually led to a partial foot amputation, constituting gross negligence.

82. Despite serous drainage in the verrucae and/or the IPK on numerous visits, a culture was never done, blood glucose levels were not monitored and an infectious disease consult was

not obtained. Neither were X-rays ordered. Respondent's failure to obtain a culture or take other actions in response to the objective findings for Patient 1 constitutes gross negligence.

83. Despite knowledge that Patient 1 had multiple medical issues regarding his lower extremities, including diabetes, with neuropathy and peripheral vascular disease Respondent continued giving Patient 1 sclerosing injections. These injections were not the appropriate therapy and because they were delivered in an area adjacent to an ulceration, a markedly enhanced risk of abscess and infection development was present and occurred, which eventually led to a partial foot amputation, constituting gross negligence.

84. In his treatment of Patient 2 Respondent over utilized controlled medications, which constitutes gross negligence.

85. In his treatment of Patient 2 Respondent treated the patient for conditions outside of the scope of podiatry including back problems and depression, which constitutes gross negligence.

86. In his treatment of Patient 2 Respondent did not comply with all the requirements for monitoring and testing of a long-term opioid user, he performed repeated, unnecessary diagnostic studies and he performed repeated laser therapy at intervals not proven to provide a significant long-term improvement, which constitutes gross negligence.

87. In his treatment of Patient 3 Respondent over utilized controlled medications, which constitutes gross negligence.

88. In his treatment of Patient 3 Respondent did not comply with all the requirements for monitoring and testing of a long-term opioid user, which constitutes gross negligence.

89. In his treatment of Patient 3 Respondent performed repeated, unnecessary diagnostic studies, which constitutes gross negligence.

90. In his treatment of Patient 3 Respondent performed repeated, performed laser therapy at intervals not proven to provide a significant long-term improvement, which constitutes gross negligence.

91. In his treatment of Patient 3 Respondent did not assess the patient's overall health status or coordinate treatment with the patient's primary care physician despite prescribing

medications (like allopurinol) which require appropriate laboratory testing to assess renal and hepatic status, which constitutes gross negligence.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct-Repeated Negligent Acts)

92. By reason of the matters set forth above in paragraphs 10 through 74, incorporated herein by this reference, Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in unprofessional conduct constituting repeated negligent acts. The circumstances are as follows:

93. The facts and circumstances in paragraphs 74 through 91, above, are incorporated by reference as if set forth in full herein.

94. There were no findings in the charting for Patient 1 to indicate a Morton's Neuroma, but, despite the absence of any objective evidence, benzyl alcohol sclerosing injections were performed on five occasions. The inappropriate charting relative to the services that were provided on five occasions constitutes repeated negligent acts.

95. Respondent coupled multiple diagnoses for Patient 1 that need to be separated. Respondent's coupled diagnosis must be either a verrucae or an IPK, not both. An abscess is also a separate diagnosis, but was not separated by Respondent. Taken together these constitute repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Accurate and Adequate Medical Records)

96. By reason of the matters set forth above in paragraphs 9 through 73, incorporated herein by this reference, Respondent is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate medical records for Patients 1, 2 and 3.

FOURTH CAUSE FOR DISCIPLINE
(Dishonest Acts)

97. By reason of the matters set forth above in paragraphs 9 through 73, incorporated herein by this reference, Respondent is subject to disciplinary action under Code section 2234,

subdivision (e), in that he engaged in unprofessional conduct constituting dishonesty. The circumstances are as follows:

98. Patient 1 received a paring of the hyperkeratosis and treatment of verrucae on multiple visits. The repetitive billing of paring of the hyperkeratosis and treatment of the verrucae on the same locations on the same visits represents fraudulent billing, constituting dishonesty.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Podiatric Medicine issue a decision:

1. Revoking or suspending Doctor of Podiatric Medicine License No. E 4459, issued to Eric Todd Travis, D.P.M.;

2. Ordering Eric Todd Travis, D.P.M., to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Ordering Eric Todd Travis, D.P.M., if placed on probation, to pay the Board the costs of probation monitoring, and;

4. Taking such other and further action as deemed necessary and proper.

DATED: June 13, 2018

BRIAN NASLUND
Executive Officer
Board of Podiatric Medicine
State of California Department of Consumer Affairs
Complainant

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