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

In the Matter of the Accusation Against:	)	
	)	File No: 1B-1999-104777
LYNN JEFFREY BELL, D.P.M.	)	OAH No: N2002010615
Respondent.	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on April 11, 2003.

DATED March 12, 2003.

BOARD OF PODIATRIC MEDICINE

Anne Kronenberg
President

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

In the Matter of the Accusation Against:	
LYNN JEFFREY BELL, D.P.M. 875 East Canal Drive #10 Turlock, California 95380	Case No. 1B-1999-104777 OAH NO. N2002010615
Podiatrist License No. E03492	
Respondent.	

PROPOSED DECISION

William O. Hoover, Administrative Law Judge, Office of Administrative Hearings, heard this matter on July 22, 23, 24, 25 and 26, 2002, in Sacramento, California.

Daniel J. Turner, Deputy Attorney General, represented James Rathlesberger ("complainant"), Executive Officer of the Board of Podiatric Medicine ("Board").

John J. Sillis, Attorney at Law, represented Lynn Jeffrey Bell, D.P.M. ("respondent").

At the conclusion of the evidentiary hearing, on motion of the complainant, Paragraph 9E of the Accusation on page 6 was amended as follows:

On line 14, after "such as" strike "...Lotrisone, silver nitrate, and..."

Beginning on line 16, after "function." and continuing through lines 17 and 18, strike The complete sentence beginning with "Respondent..." and ending with "...14 days".

The record remained open for respondent to lodge any objections to complainant's declarations of costs. Respondent did not file any objections and the matter was deemed submitted on August 27, 2002.

FACTUAL FINDINGS

1. Complainant made and filed this Accusation in his official capacity. The Accusation alleges violations of Business and Professions Code sections 2234(b) (gross negligence), 2234(d) (incompetence) and 2234(c) (repeated negligent acts) in the treatment of a single diabetic patient.

2. The Board issued Podiatrist License Number E3492 to Respondent on December 9, 1987. The license will expire on October 31, 2003 and was in full force and effect at all times relevant to this proceeding.

3. On September 6, 1997 respondent saw L.D. who was referred by his family physician (Puliadi Jothikumar, M.D.) for "routine nail care". According to the referral form L.D. was 66 years old and suffered from "diabetes, adult onset". a Type II non-insulin dependent diabetic.

4. Compared to the general population, diabetic patients present special problems due to the nature of the disease/condition. Diabetics can experience compromised vascular systems due to hardening/thickening of the arteries and this in turn can impede blood flow throughout the body, especially to the extremities. As adequate blood flow is an essential element of the wound healing process, insufficient blood flow not only prevents healing but increases the likelihood of infection. Poor circulation also inhibits the flow of medication, such as antibiotics, to an affected area. Additionally, diabetics will often develop peripheral neuropathy, which impairs their ability to detect sensation in their extremities, particularly their feet. Peripheral neuropathy can and does result in undetected injuries to a diabetic who is unable to feel normal sensations of pressure or pain that would alert them to a problem.

5. Nail care, while routine for non-diabetics, is an area of concern for a diabetic because of the possibility of incurring a self-inflicted injury that may not heal properly and become infected. For that reason it is not uncommon for diabetics to be seen and treated by podiatrists. In this instance, L.D. was referred to respondent for nail trimming by his primary care physician (Puliadi Jothikumar, M.D.) and seen on September 6, 1996. A diabetic patient requires special awareness and care on the part of the podiatrist.

6. On L.D.'s first visit respondent took a brief history and examined the patient's foot. The patient's history confirmed that L.D. was a Type II diabetic and revealed that he had a heart attack in 1988. He also suffered from arthritis, high blood pressure and heart disease. Respondent testified at hearing that the purpose of the foot examination is to look for problems with the skin, deformities, bunions, bone structure, etc. The foot examination as reflected in respondent's chart notes indicate that he examined the foot for color, temperature, tone and pulses. Respondent was unable to palpate any pulses, however, the color, temperature and tone indicated to him that there was blood flow in the foot, notwithstanding the absence of pulses, and was within normal limits. Respondent stated in his testimony at hearing that he did not consider the absence of pulses significant in light of his visual findings. He opined that negative pulse findings are not unusual in the general

population, but drew no distinction in between the routine versus diabetic patient in evaluation their physical condition. Other than noting that L.D.'s nails were "onychomycotic" (evidencing fungal disease) on a separate form, respondent did not indicate the presence of any deformities or other conditions described on the form.

7. While visual and tactile examination of the foot may permit the conclusion that blood flow is present it does not permit a conclusion about the quality of circulation. Further, although respondent testified at hearing that he performed a "leg lift" and "toe pinch" test, his notes do not reflect the performance of these tests or any resulting observation. Respondent proceeded to provide the nail care for which the patient was referred and scheduled additional appointments for routine foot care. L.D. was next seen by respondent on November 25, 1996 and March 14, 1997 for that purpose. Given the purpose of the visit and care involved, respondent's conduct and the fact that he performed no additional testing during any of these appointments is within the standard of care. That circumstance changed when the course of treatment changed from routine nail care to treatment of athletes foot and ulcers.

8. On April 4, 1997 L.D. returned to respondent complaining of left foot pain between the 4th and 5th toes and that some of his toenails were still tender. Although L.D.'s complaint as entered in respondent's notes suggests a prior complaint of tenderness, the notes do not reflect any such complaint. Respondent examined the foot and observed massaration (wet, spongy skin), erythema (redness) and exfoliation of skin (sloughing) in the area of complaint. Respondent diagnosed "tinea pedis (athletes foot). Possible infection. Onychomycotic nails." He debrided the nails, prescribed "Spectazole" and vinegar soaks (vinegar diluted in warm water) and set a follow-up appointment for April 18, 1997. At the time of this visit the use of vinegar soaks did not fall below the standard of care.

9. Vinegar contains acetic acid and in diluted form is a mild astringent with some anti-fungal and antibacterial properties depending on it degree of dilution. According to respondent it was used to help clean wounds and for its "soothing" effect. Soaks are performed in a non sterile environment and depending on the concentration (or dilution) can create a situation that can promote the spread of bacteria and consequent infection especially where open wounds are present. It is a departure from the standard of care to prescribe soaks for diabetic patients and an extreme departure where open sores are present. The evidence was not persuasive that vinegar soaks are an acceptable alternative treatment for diabetic patients with open sores.

10. At the April 18, 1997 appointment L.D.'s complaints remained the same and respondent's visual examination confirmed that "the area appears the same as before". In addition to reciting the specific conditions respondent also noted the presence of "mild swelling" especially in the "left 5th digit" (little toe). The diagnosis was tinea pedis and infection, for which respondent prescribed Keflex, Lamisil tablets and continued vinegar soaks. A follow up visit was scheduled in 10 days.

11. L.D. missed the scheduled April 28, 1997 appointment due to an illness that resulted in hospitalization and he was not seen again by respondent until June 11, 1997. On that date L.D. complained of a sore on his left little toe that had been giving him problems for the previous two weeks. Respondent's notes reflect his observation and diagnosis of a "superficial ulceration" on the toe and the absence of any signs of infection. No mention is made of the tinea pedis condition. He prescribed Gentamycin, padding and continued vinegar soaks and scheduled a follow up visit in one week. Respondent did not obtain an X-ray to determine whether there was bone involvement. He also failed to test for the presence and degree of neuropathy which was an extreme departure from the standard of care.

12. During his testimony at hearing respondent indicated that he was concerned about this new development, but this concern did not result in a new or different course of treatment or any tests to measure vascular sufficiency. Respondent stated that the presence of conditions such as redness, swelling, drainage and pain could be indicators of an infection. He also expressed his belief that that the ulcer developed due to pressure related to the position of the little toe. He testified that he noted tightness when attempting to separate the toes and described the condition as a positional deformity. It was never explained why this deformity was not noted during the initial office visit in September 1996.

13. On June 17, 1997 L.D. returned to respondent's office and indicated that he had stopped soaking his foot and was trying to keep it dry. Respondent's noted that the ulcer "appears the same as before", but also noted mild erythema and increased massaration in the same area as previously noted. The ulcer diagnosis continued as well as tinea pedis. Respondent prescribed Lamisil tablets, Lotrisone cream and vinegar soaks with a return visit in one week.

14. At the June 24, 1997 visit respondent noted that L.D.'s stated that he was feeling much better, had been following respondent's prescription including the vinegar soaks. Respondent noted that the "ulcer is healing nicely and appears improved" and that while massaration and erythema were still present those conditions appeared improved as well. The diagnosis of ulcer and tinea pedis continued and respondent directed L.D. to continue with the prescribed treatments.

15. At the next scheduled appointment on July 25, 1997 respondent noted that L.D. complained that the toe was still sore and no better. On exam respondent noted that the toe "appears the same as before, there is no improvement". He also noted that the fungus "is improved" but the ulcer is still present. The diagnosis remained the same as before. At this appointment respondent consulted with L.D. about performing an arthroplasty on his left little toe to relieve the pressure caused by the positional deformity and L.D. consented to the surgery.

16. In a "Request for Utilization Management Authorization" dated August 5, 1997, submitted by respondent to obtain insurance approval and coverage for the procedure, respondent stated that L.D.'s ulcer is not getting any better and his belief that the arthroplasty would relieve the pressure and rubbing and permit it to heal.

17. Prior to performance of the surgery hospital procedures required a medical examination and clearance by a physician. In this instance the examination was performed by L.D.'s family physician, Dr Jothikumar, who cleared L.D. for surgery. Dr. Jothikumar performed a thorough examination including a complete blood workup and analysis. Of significance was L.D.'s medical history indicating hypertension, diabetes, peripheral vascular disease and arteriosclerotic heart disease with a previous heart attack. Additionally, Dr. Jothikumar's examination of L.D.'s extremities revealed some edema and the presence of very weak pulses in the right foot and palpable pulses in the left foot.

18. Respondent testified at hearing that he had Dr. Kumar's report prior to surgery and was aware that he had found pulses. According to respondent hearing testimony that information provided reassurance regarding the status of L.D.'s circulation. This testimony directly contradicts respondent's deposition testimony of January 21, 1999. At that time when asked whether he was aware that Dr. Kumar was able to obtain a pulse to the foot, respondent answered "No". Additionally, respondent's deposition testimony indicates that he never communicated with Dr. Kumar about L.D.'s condition prior to the surgery and simply assumed that the patient was cleared unless he heard otherwise. While it is possible that Dr. Kumar's report could have been in respondent's possession he was not aware of its contents at the time of surgery.

19. Respondent testified further that he performed a visual and tactile examination of L.D.'s foot prior to surgery and concluded there was adequate circulation. He did not perform a Doppler test or obtain an ABI (ankle-brachial index) or refer L.D. for a vascular consult before surgery. Respondent made no attempt to determine whether the ulcer was vascular or pressure related, but assumed from its location that it was the result of pressure from the positional deformity. Given L.D.'s medical history and his responses to treatment thus far, the performance of surgery without a thorough evaluation represented an extreme departure from the standard of care.

20. The arthroplasty was performed on August 25, 1997, however, during the surgery respondent used epinephrine, a vasoconstrictor, in addition to other anesthetics. The use of epinephrine on an elderly diabetic patient was an extreme departure from the standard of care.

21. Respondent saw L.D. at his office on August 26, 1997 and noted that the toe was "in good alignment". He also noted "minimal swelling, some ecchymosis (bruising) and some bleeding present" and assessed L.D. as healing well. L.D. indicated that he had not soaked his foot yet. Antibiotics were prescribed, a dressing applied and a return visit scheduled in one week for redressing.

22. On September 2, 1997 L.D. was seen by respondent and voiced no complaints. He informed respondent he has been soaking his foot. Respondent notes reveal his observations that the toe was still in good alignment, the wound was "closed, clean and dry", there was minimal swelling and no signs of infection. He noted that "Pt healing well" and removed the sutures, applied an antibiotic and band-aid and scheduled a follow- up visit in two weeks.

23. On September 16, 1997 L.D. returned to respondent's office with no complaints, but informed respondent that he had caught his toe in the bed sheets causing it to bleed. There was no complaint of pain. Respondent examined the toe and noted "some slight dehiscence" (separation or opening) in the wound that was superficial. No erythema or signs of infection were noted. Silver nitrate, an antibiotic and Neosporin were prescribed and a follow-up visit scheduled in three weeks.

24. On October 7, 1997 L.D. returned to respondent's office stating that he had struck his toe with his cane and it was tender. Respondent examined the toe noted it was in good alignment and there was no erythema or signs of infection present. The wound was still open, but respondent concluded that L.D. was healing well. The previous prescription was repeated and the next visit scheduled in two weeks.

25. On October 14, 1997 L.D. saw respondent and complained of a "painful left little toe" and that he has been unable to sleep at night. L.D. informed respondent that peroxide and band aids were being applied to the area, but it is still uncomfortable. The alignment of the toe was still good although the wound was still open. Mild swelling was noted without erythema. Respondent noted that "Pt healing slow, possible infection". He prescribed Keflex and instructed L.D. to soak the foot in warm water and vinegar and return in one week. Although he suspected infection respondent did not order any blood tests or cultures at this visit. The prescribing of vinegar soaks at this time and from this time forward represented an extreme departure from the standard of care.

26. L.D. returned on October 21, 1997 stating that his "foot is feeling worse" and that it was more tender on the toe. L.D. also stated that the "redness on the foot" had improved from before and that he was taking a pill for the swelling. The reference to "redness" is inconsistent with respondent's negative finding of erythema on the previous visit especially in view of respondent's observation this date of moderate erythema. The exam revealed good alignment but an open wound with serous exudate. Respondent concluded that the left foot was infected and took a culture. He applied an antibiotic and dressing to the foot and gave instructions to continue soaking the foot and prescribed an oral antibiotic. L.D. was to be seen again in three days.

27. The results of the culture revealed the presence of an infection and described a "heavy growth staphylococcus aureus". The report of was prepared October 23, 1997. No follow-up culture was ever ordered to determine whether or not the infection had resolved.

28. When L.D. returned to respondent's office on October 24, 1997 he complained that his foot was still sore, of an inability to sleep and general malaise. Respondent observed and noted the left toe to be "mildly swollen and erythematic" without drainage. He further noted that the erythema and swelling in the left foot had decreased "dramatically". Respondent concluded that the infection was improving and prescribed antibiotic cream and continue with the oral antibiotic. L.D. was to be seen again in one week. In between visits respondent refilled two prescriptions one for pain pills and the other for oral antibiotics.

29. On October 31, 1997 L.D. informed respondent that he had been applying antibiotic cream, but had ceased soaking because of the stinging and was unable to tolerate bandages. He stated that he had been taking his pain and antibiotic pills, but stated that "it hurts, especially at night when he is trying to sleep". Respondent observed and noted that toe was in alignment, but that the wound was still open without exudates. He also noted a superficial ulcer on the left toe without drainage. Swelling and erythema of the foot were noted to be decreasing.

30. At this visit Respondent also made reference to "areas of blisters that were present on the dorsum of the left foot are now dry" and that scabbing was forming. While this notation clearly indicates that blisters had been observed previously there was no entry reflecting any such observation. Respondent claimed in his deposition testimony that they were present on October 24, 1997, but was not certain of the date. Although the presence of blisters can be one of the first signs of a gangrenous process, a fact acknowledged by respondent, he took no action to determine whether they were related to an infection either at the time of first observation or subsequently. Respondent concluded that "Pt healing slowly. Infection resolving", although there was evidence of a new ulcer. He continued to engage in conservative treatment applying antibiotic cream and instructing L.D. to do Epsom salts soaks. According to his notes respondent mentioned the "possibility" of intravenous (IV) antibiotic treatment, but that L.D. "refused for now".

31. On November 7, 1997 L.D. stated that he had been soaking daily and taking his antibiotics. He claimed that in the past few days he had started to feel better. Respondent's examination noted the presence of two ulcers on the little toe and a dry scab on the dorsum of the foot. No erythema was noted and the swelling in the foot and toe was described as diminishing. He concluded that the infection was improving and continued with soaks, ointment applications and oral antibiotics. A follow-up appointment was scheduled in one week. In between appointments respondent refilled L.D.'s pain and oral antibiotic prescriptions.

32. On November 14, 1997 L.D. stated that he had been soaking as directed and applying the medication. He was concerned that the area between the little toe and the one next to it was still moist and tender. Respondent described the ulcer on top of the toe as "granulating in nicely" with a scab forming, but noted that the other ulcer had drainage present. He concluded that the infection was resolved and prescribed continued soaks and silver nitrate. A follow-up was scheduled in one week. Respondent's notes also reflect that he "advised the pt regarding possible vascular consultation which the patient is refusing right now."

33. L.D. was seen on November 17, 1997 by Dr. Jothikumar who noted the presence of an open area on the dorsum of the left foot and open area between the left little toe and the one next to it. He also noted moderated redness and swelling of the left foot and requested a surgical consultation. The surgical consultation was performed by Dr. James Greenbarg, who diagnosed "left fifth toe gangrene with forefoot gangrene and cellulitis." A partial amputation was performed on November 21, 1997. The evidence is compelling and convincing that the gangrenous process identified by Dr. Greenbarg was a continuation of a process that began under respondent's care and treatment of L.D.

34. The evidence is that from June 11, 1997 to November 14, 1997, L.D. experienced three open areas on or adjacent to his left little toe that never fully healed. Additionally, the tinea pedis condition was never resolved according to respondent. While diabetic patients can be expected to have slower healing rates that the general population L.D.'s condition not only failed to get better, it got worse. After June 11, 1997 it became imperative that respondent educate himself about L.D.'s diabetes and assess his condition. The evidence is overwhelming that respondent failed to recognize and react to warning signs of infection and a deteriorating condition over a period of 7-8 months. Rather than use the tools at his disposal to resolve concerns or allay suspicions respondent did nothing beyond ordering a culture and even that was done in an untimely manner. His course of treatment remained essentially unchanged despite mounting evidence that the course of treatment was not effective and the situation was worsening. Additionally, respondent's charting was inconsistent and incomplete. Although respondent did suggest IV antibiotics and a vascular consult, both of which were refused by L.D., it is clear from his own notes that these suggestions did not reflect the seriousness of the situation. With regard to the IV antibiotics respondent's notes indicate that "We also mentioned the possibility" of such treatment. And, with regard to a vascular consult respondent's notes reflect that he "also advised the pt regarding possible vascular consultation". Neither of these circumstances evoke any sense of urgency or even concern and there is no evidence that respondent explained the importance of these matters or the potential consequences for not doing them.

35. During his testimony at hearing respondent explained that he wished a vascular consult because of his concerns over L.D.'s slow healing. However, the timing of this concern seems odd considering the passage of time involved and respondent's determination on November 14, 1997 that the infection was resolved. Respondent also claimed that he did try to refer L.D. for IV antibiotic treatment through Dr. Jothikumar, but

the record provides no information about these efforts. There is no indication that Dr. Jothikumar was ever contacted on this subject by respondent.

36. The experts who testified in this matter, Dwayne Highsmith, D.P.M. and Bruce Dobbs, D.P.M. both had impressive credentials including teaching assignments. However, Dr. Highsmith's actual and practical experience in the treatment of diabetic patients was far superior to that of Dr. Dobbs. Dr. Highsmith provided specific answers to questions and appeared more knowledgeable about the methodology and treatment of diabetic patients especially those with foot ulcers. He was considered a credible witness.

37. Dr. Dobbs credibility was compromised by equivocal and somewhat disingenuous answers to many questions. In particular, Dr. Dobbs allowed the ALJ to misinterpret the meaning of his use of the word "soaks" when he testified that such treatment was acceptable. Throughout the proceeding the reference to vinegar soaks was clearly intended and interpreted to refer to total immersion of the foot in the solution. However, without drawing a distinction, Dr. Dobbs used the word soaks to refer to wet dressings. Dr. Dobbs did not acknowledge the distinction until directly asked by the ALJ.[1] It is also noteworthy that Dr. Dobbs neither teaches the use of vinegar soaks as a mode of treatment nor does he prescribe its use in his practice. Also, while acknowledging that the use of particular instruments and tests (i.e. Doppler and ABI) could provide useful information about a diabetic's circulation, he was dismissive of their use as essentially unreliable. Yet he indicated he would rely on a vascular surgeon consult even though the same tests would be used by that individual. Additionally, Dr. Dobbs representation of the standard of care was couched in subjective terms as he routinely deferred to respondent's individual judgment in particular instances rather than apply an objective standard.

38. On one point at least, both Dobbs and Highsmith agree with the principle expressed by Dobbs; that "flashing lights go off when a diabetic patient walks into the office because they present greater risk factors". In respondent's case it appears those flashing lights never went off. Respondent's conduct in the treatment of L.D. raises serious questions about his competency to evaluate and treat diabetic patients.

39. - The actual and reasonable costs of investigation and enforcement are not contested and are found to be $28, 584.17.

LEGAL CONCLUSIONS

1. Business and Professions Code section 2234 provides that the Board may take disciplinary action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but it not limited to, the following:

[1] Dr. Dobbs is intimately familiar with the facts of this case having been involved in the civil matter and having been deposed at length.

(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.

2. Separate and distinct causes for discipline of respondent's Podiatrist License Number E 3492 for violation of Business and Professions Code section 2234(b) (Gross negligence) has been established by reason of Factual Findings 3 through 6 and 9 through 35.

3. Cause for discipline of respondent's Podiatrist License Number E 3492 for violation of Business and Professions Code section 2234(d) (Incompetence) has been established by reason of Factual Findings 3 through 35 and 38.

4. Cause for discipline of respondent's Podiatrist License Number E 3492 for violation of Business and Professions Code section 2234(c) (Repeated negligent acts) has been established by reason of Factual Findings 3 through 35.

5. It is believed that respondent can with additional education and clinical training in the treatment of diabetic patients become a safe and competent practitioner. For that reason a stayed revocation is recommended with appropriate terms and conditions.

6. Respondent is liable for the reimbursement of the costs of investigation and enforcement pursuant to Business and Professions Code section 2497.5 in the amount of $28,584.17.

ORDER

Podiatrist License Number E 3492 issued to respondent Lynn Jeffrey Bell, D.P.M. is revoked pursuant to Legal Conclusions 2, 3 and 4 separately and for all of them. However,

said revocation is stayed and respondent is placed on probation for four (4) years upon the following terms and conditions:

1. Within 15 days after the effective date of this decision the respondent shall provide the BPM, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

2. The respondent is hereby ordered to reimburse the BPM the amount of $28,584.17 for the actual and reasonable costs of the investigation and prosecution of this matter as provided for in Section 2497.5 of the Business and Professions Code. Payment shall be in such manner and as directed by the BPM. Upon a showing of financial hardship the BPM shall permit reimbursement to be made according to an installment plan. The filing of bankruptcy shall not relieve the respondent of his or her responsibility to reimburse the BPM for its investigative and prosecution costs.

3. Respondent shall obey all federal, state and local laws, and all rules governing the practice of podiatric medicine in California.

4. Respondent shall submit quarterly declarations, under penalty of perjury, on forms provided by the BPM, stating whether there has been compliance with all the conditions of probation.

5. Notwithstanding any provision for tolling of requirements of probation, during the cessation of practice respondent shall continue to submit quarterly declarations under penalty of perjury.

6. Respondent shall comply with the BPM's probation surveillance program.

7. Respondent shall appear in person for interviews with the BPM's medical consultant, upon request, at various intervals and with reasonable notice.

8. In the event the respondent fails to satisfactorily complete any provision of the order of probation, which results in the cessation of practice, all other provisions of probation other than the submission of quarterly reports shall be held in abeyance until respondent is permitted to resume the practice of podiatry. All provisions of probation shall recommence on the effective date of resumption of practice. Periods of cessation of practice will not apply to the reduction of the probationary period.

9. In the event respondent should leave California to reside or to practice outside the state, respondent must notify the BPM in writing of the dates of departure and return. Periods of residency or practice outside California will not apply to the reduction of this probationary period.

10. Upon successful completion of probation, respondent's certificate will be fully restored.

11. If respondent violates probation in any respect, the BPM, 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 BPM 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.

12. Respondent shall submit satisfactory proof biennially to the BPM of compliance with the requirement to complete fifty hours of approved continuing medical education, meet continuing competence requirements, and possess a current, valid certificate in basic cardiopulmonary resuscitation (CPR) for re-licensure during each two (2) year renewal period.

13. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his or her license to the BPM. The BPM 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 tendered license, respondent will no longer be subject to the terms and conditions of probation.

14. Within 90 days of the effective date of this decision, and by that date each subsequent year of probation thereafter, respondent shall submit to the BPM or its designee, for its prior approval, an educational program or course related to Evaluation and Treatment of the Diabetic Patient, which shall not be less than 40 hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the BPM or its designee may administer an examination to test respondent's knowledge of the course. Each year of probation, respondent shall provide proof of attendance for 40 hours of pre-approved continuing medical education in satisfaction of this condition.

15. Within 60 days of the effective date of this decision, respondent shall submit to the Board of Podiatric Medicine for its prior approval a course in Ethics, which respondent shall successfully complete during the first year of probation.

16. Within 90 days of the effective date of this decision, respondent shall submit to the BPM or its designee, for its prior approval, an intensive clinical training program related to the Evaluation and Treatment of the Diabetic Patient. The exact number of hours and the specific content of the program shall be determined by the BPM or its designee and will be in addition to the Continuing Medical education requirements for re-licensure. Respondent shall successfully complete the training program no later than the date set by

BPM for completion and will be required to pass an examination approved by the BPM, related to the program's contents. At the discretion of and approval by BPM attendance at a designated PACE program may be substituted for this requirement.

17. Respondent shall take and pass an oral clinical examination to be administered by the BPM or its designee on a date(s) to be set by BPM. If respondent fails this examination, respondent shall take and pass an oral clinical examination to be administered by the BPM or its designee on a date to be set by BPM. If respondent fails this examination, respondent shall take and pass an oral clinical examination to be administered by the BPM or its designee on a subsequent date set by the BPM Refusal or failure to take any required examination shall be deemed a failure of the examination and a violation of probation. After three failures, respondent must wait one year to take each necessary re-examination thereafter, and each exam shall be one of the BPM's regularly scheduled examination dates. The respondent shall pay the cost of the examination(s).

If the respondent fails to take and pass the first available oral clinical examination, respondent shall be suspended from the practice of podiatric medicine. The respondent shall cease the practice of medicine within 72 hours of being given notice by the BPM or its designee that respondent has failed to take or has failed to pass the examination. Respondent shall remain suspended from the practice of medicine until the oral clinical examination has been successfully passed, as evidenced by written notice to respondent from the BPM or its designee.

18. During the period of probation, respondent is prohibited from accepting or treating either directly or through referrals diabetic patients. After one year of probation respondent may petition the BPM to lift this restriction provided that all required educational and clinical training has been completed satisfactorily and respondent has not failed any oral examination, even if it were passed subsequently.

19. In settlements or orders which provide for a cessation of practice, respondent shall comply with procedures provided by the BPM regarding notification and management of patients.

20. Respondent shall pay the administrative costs incurred by the BPM associated with probation monitoring each and every year of probation. Such costs shall be payable to the BPM at the end of each fiscal year. Respondent will be provided with an invoice at the close of each fiscal year which must be paid within 30 days of receipt. The final invoice will be provided upon termination of probation and is also due and payable within 30 days of receipt. Failure to pay such costs shall be considered a violation of probation.

21. 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 BPM in writing, acknowledging the employees have

read the Accusation and Decision in the case and understand respondent's terms and conditions of probation.

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

Dated: 1/31/03

WILLIAM O. HOOVER
Administrative Law Judge
Office of Administrative Hearings