State of California Department of Consumer Affairs

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BOARD OF PODIATRIC MEDICINE
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April 15, 2003

The Honorable Lou Correa
Chair, Assembly Business and Professions Committee
State Capitol, Room 6025
Sacramento, CA 95814

Dear Assemblyman Correa:

Re: AB 932 (Koretz)
BPM Position: **Support**

The Board of Podiatric Medicine (BPM) supports AB 932 (Koretz), which would modernize Article 22 (Podiatric Medicine) of the Medical Practice Act. It would conform the statute with current practice in many California facilities as it is administered by their medical staffs.

The Federation of Podiatric Medical Boards and BPM have endorsed a broader revision. The California Podiatric Medical Association (CPMA), the sponsor of AB 932, has narrowed this bill to accommodate the interests of other specialty groups. Nevertheless, AB 932 would still correct three problems:

1. Doctors of Podiatric Medicine (DPMs) are recognized in many facilities as experts in the care and preservation of the diabetic foot. DPMs prevent and minimize necrosis through conservative care. They perform amputation procedures as necessary to preserve healthy portions of the foot and leg, mobility, and quality of life. Literal interpretation of current law, reflecting language written in 1921 to regulate chiropodists, would disrupt diabetic foot care. Medical staffs refer this work to DPMs because it is one of the things DPMs do exceeding well. BPM's *Information on Amputations* is available: http://www.dca.ca.gov/bpm/pubs/fsamputa.htm

2. Patients and medical staffs expect DPMs to treat ulcers and wounds of the lower leg just as they treat them--and more serious conditions--on foot and ankle. BPM's interpretation of the statute does not permit this, however, leading to institutional dilemmas. BPM's *Information on Scope of Practice* is available online: http://www.dca.ca.gov/bpm/pubs/fsscope.htm

3. MD surgeons frequently ask DPMs to assist in non-foot & ankle surgeries due to their skill, availability, and doctor-patient relationships. BPM encourages this collaborative sharing of skills, but DPMs often are the only ones in the operating room not being reimbursed (as they are technically functioning as unlicensed technicians). Under AB 932, they could surgically assist under the umbrella of their license, but only when requested by the MD and only under the MD's direct supervision. BPM's current advisory language was negotiated in the mid-1990s with the California Orthopaedic Association: please see "Surgical Assisting," *Information for Health Facilities*: http://www.dca.ca.gov/bpm/pubs/fshealth.htm

AB 932 will maintain and enhance quality care. We recently asked the Medical Board Central Complaints Unit analyst managing complaints about DPMs from consumers, other doctors, and health facilities what she sees with respect to ankle surgeries, amputations, treatment of superficial conditions above the ankle, and surgical assisting in non-podiatric procedures. Her response: "I haven't seen a case involving any of your choices in quite a long time."

We note that the California Orthopaedic Association's February 13 letter comments on the Board of Podiatric Medicine. BPM has worked with COA at every opportunity. In 1992, Board representatives met with Dr. Ross and his colleagues in their offices and candidly discussed the amputation issue as it is covered in our fact sheet. For BPM to take their position would disrupt diabetic foot care for many Californians. As the Department of Consumer Affairs noted in its 1994-95 Annual Report, we encouraged COA and CPMA to resolve their differences in compromise. It is our understanding that CPMA attempted this and, in AB 932, modified the language introduced last year (AB 2728) to reflect those discussions.

COA suggests the sunsetting of the ankle license in SB 1981 (Chapter 736, Statutes of 1998) was a BPM initiative. In fact, the Joint Legislative Sunset Review Committee proposed this change. It has not diminished public safety or quality care.

BPM takes exception to COA's characterizations of podiatric medical training. Four years in podiatric medical school and follow-up postgraduate training requirements produce highly skilled podiatric medical specialists. The profession continues to strengthen its programs, sometimes over COA objections. Review of medical education literature indicates that medical educators see ongoing needs for improving medical education of MDs as well.

Dr. Ross cites a quickly prepared, four-page Medical Board staff analysis dated January 25, 1993, *Comparison of Basic Science Instruction in a Podiatric Curriculum with the Basic Science Instruction Received in an Allopathic Medical School Curriculum*. Even this memo, which podiatric medical educators said under-reported their curriculum, found that "the national podiatric average of 1,067 hours of basic science instruction is more than . . . Yale University with a total of 1,037 hours."

He also cites a 1994 Medical Board committee memo, *Final Report of Non-MD Postgraduate Training Committee*. This memo reflects how difficult it had become within the Medical Board at that time to support podiatric medicine, due to COA opposition. We point instead to the 1993 "Nelson-Medio" academic study sponsored jointly by the Medical Board and BPM. *Report on the General Medical Training and Surgical Components of Podiatric Residency Training in California: A Report to the Medical Board of California and the Board of Podiatric Medicine in California*, stated*:*

> Program directors, physician faculty, and hospital directors of professional education were almost unanimous in their positive opinion of residents' performance while on medical and surgical services. Repeatedly we heard statements such as "they perform much better than expected", "they try harder", "we can rely on them", "they teach us things we need to know." We did not encounter, nor were we told about any department or faculty member who had ceased training podiatric medical residents because of problems with the residents or their performance. When as part of our interview, we inquired of chiefs of services about responsibility for and methods of discipline, a frequent reply was "we have never had a problem with a podiatric resident; discipline has never been needed."

> These statements plus our own impressions from interviewing residents led us to the conclusion that they indeed do try very hard to make a good impression and many times therefore go beyond what is required or expected. Thus they may at times work longer hours than is optimum for their learning and well-being.
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> [http://www.dca.ca.gov/bpm/pubs/]

BPM provides more background in our newsletter, *Licensing Boards Back Model Law*, available online, also at: http://www.dca.ca.gov/bpm/pubs/

Your consideration is greatly appreciated,

Sincerely,

Anne M. Kronenberg, MPA
President
Board of Podiatric Medicine

cc: Assemblyman Koretz
Members, Assembly Business & Professions Committee