



Janice K. Brewer
Governor

State Of Arizona Board of Podiatry Examiners
"Protecting the Public's Health"

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Barry Kaplan, DPM; Joseph Leonetti, DPM; Barbara Campbell, DPM;
M. Elizabeth Miles, Public Member; John Rhodes, Public Member; Sarah Penttinen, Executive Director

BOARD MEETING MINUTES

March 9, 2011; 8:30 a.m.
1400 West Washington St., B1
Phoenix, AZ 85007

Board Members: Barry Kaplan, D.P.M, President
Joseph Leonetti, D.P.M., Member
Barbara Campbell, D.P.M., Member
M. Elizabeth Miles, Public Member
John Rhodes, Public Member

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: Keely Verstegen

I. Call to Order

Dr. Kaplan called the meeting to order at 8:33a.m.

II. Roll Call

Dr. Kaplan noted for the record that all Board members were present and he welcomed new Public Member M. Elizabeth Miles. Ms. Penttinen and Ms. Verstegen also were present.

III. Approval of Minutes

a. February 9, 2010 Regular Session Minutes.

MOTION: Dr. Leonetti moved to approve the minutes as written. Dr. Campbell seconded the motion. There was no discussion.

VOTE: The motion passed unanimously by voice vote.

IV. Review, Discussion and Possible Action –Review of Complaints

a. 08-44-C – Alex Bui: Review of Consent Agreement offered to Dr. Bui.

Dr. Bui was not present but was represented by attorney Chares Hover. Dr. Kaplan recused himself as he was the investigator for this case. Dr. Leonetti provided a summary of the previous findings of the investigation which discovered multiple instances of inappropriate billing. The Board had previously offered Dr. Bui a consent agreement with the stipulation that if Dr. Bui did not accept the terms of the agreement the case would be referred to a formal hearing with a recommendation to revoke Dr. Bui's license. The Board has since received a request from Mr. Hover on Dr. Bui's behalf to modify the terms of the consent agreement. Ms. Penttinen advised that she has prepared the Complaint and Notice of Hearing and would file it this afternoon, depending on the Board's decision on Dr. Bui's request.

Mr. Hover addressed the Board and stated that Dr. Bui is willing to accept the consent agreement offered to him but wants to request an alternative to the three-month term of suspension. He stated Dr. Bui needs to stay in practice for the sake of continuity of patient care. He added that a three-month absence will result in patients leaving Dr. Bui's practice and he will have to rebuild his practice essentially from square one upon his return. Dr. Leonetti stated there is some concern with Dr. Bui's clinical skills due to the types of durable medical equipment he has been providing to patients. However, he feels that while a three-month suspension may be harsh, the Board needs to be certain that Dr. Bui has corrected the care and billing issues. Mr. Hover asked if the Board would be willing to stay the suspension term until or if the Board finds any violations of the other terms of the consent agreement. Dr. Leonetti stated the

Board does not intend to be punitive but the information in this case indicates fairly extensive violations of improper billing.

Mr. Hover pointed out that this case was generated by Cigna and Dr. Bui has already reimbursed them. Dr. Kaplan stated there were egregious fraudulent charges. He only reviewed ten of Dr. Bui's charts but all of them had fraudulent or excessive billing, and he feels that a more extensive audit would undoubtedly find more of the same thing. Mr. Hover replied that in other charts Dr. Bui may have overcharged but Cigna only paid Dr. Bui the contracted amount.

Ms. Versteegen stated the question to be reviewed by the Board today is what action the Board wishes to take with the consent agreement previously offered and Dr. Bui's request to modify the terms. Dr. Leonetti asked Mr. Hover if Dr. Bui would accept the consent agreement if it is not modified. Mr. Hover stated he would. Ms. Miles stated this is the worst case of inappropriate billing she has ever seen and she feels a three-month suspension is appropriate. Ms. Penttinen asked whether the Board would be willing to delay the start of the suspension.

MOTION: Ms. Miles moved to keep the same order terms of the consent agreement already offered but to delay the start of the suspension for 30 days provided that Dr. Bui signs the agreement within 48 hours. There was some discussion among the Board members as to the Board's previous decision to refer this case to a formal hearing. Ms. Miles withdrew her motion.

MOTION: Ms. Miles moved to rescind the Board's previous referral to formal hearing. Dr. Leonetti seconded the motion. There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

MOTION: Ms. Miles moved to maintain the previous consent agreement terms with the following changes: the start of the suspension will be delayed by 30 days; the probation will start immediately and be tolled during the suspension; the agreement must be signed by Dr. Bui within 48 hours of his receipt of the document. There was brief discussion on the motion regarding whether 30 days was sufficient for Dr. Bui to make arrangements for his practice. Dr. Leonetti stated it was and added that Dr. Bui's failure to sign the agreement within 48 hours would result in the case going to formal hearing. Ms. Miles agreed with the addition. Dr. Campbell seconded the motion. There was no further discussion.

VOTE: The motion passed unanimously by voice vote.

b. 09-09-M – Aprajita Nakra, DPM: Practice below the standard of care; improper billing.

Dr. Nakra was not present. Dr. Dedrie Polakof was the investigator and summarized the complaint as follows: A malpractice claim was filed against Dr. Nakra by patient M.L. and the claim was stated as "metatarsal head resection, 2-5, left foot on 06/21/2007. Patient claims continued pain and negligent treatment." A nerve block was also done. On 07/02/2007 the patient was admitted to the hospital with wet gangrene which resulted in amputation of two toes. Dr. Nakra did not note in the patient's chart what type of anesthetic was used. In her deposition in the malpractice case she stated it was epinephrine but there was no documentation regarding whether it was general anesthesia or sedation with local. Also, there was a delay in the first post-op office visit - it was 15 days after the surgery. Dr. Campbell discussed that there was a vascular consult at the hospital which found small vessel disease on the opposite foot.

The following questions were raised regarding Dr. Nakra's care of this patient:

1. What anesthesia agent was used?
2. How much was injected into the surgical foot?
3. Was epinephrine used and, if so, how much?
4. Was a tourniquet used?
5. What caused the delay in the first post-op office visit?

6. The chart notes do not qualify for a level 3 E/M code which was charged.
7. Why was there not a vascular consult prior to surgery?

MOTION: Ms. Miles moved to conduct an Informal Interview with Dr. Nakra with violations as stated in the investigation report as well as .A.R.S. §32-854.01(11) for insufficient record-keeping. Dr. Campbell seconded the motion. There was no discussion.

VOTE: The motion passed unanimously by voice vote.

c. 09-19-C – Daniel Saunders, DPM: Practice below the standard of care for improper surgery.

Dr. Saunders was not present. Dr. Kaplan recused himself as he was the investigator for this case. Dr. Leonetti was the acting President. Dr. Kaplan summarized that this was a malpractice case filed by patient J.T. which was settled against Dr. Saunders. In December 2006 Dr. Saunders performed surgery on the patient's right ankle which included diastasis and external fixation which was an attempt to salvage the joint without having to fuse it. In January 2007 Dr. Saunders did another surgery to exchange two of the fixation pins due to skin irritation. In March 2007, while walking, the patient sustained a right tibia fracture and also fell at some point near the time of the fall. The patient was diagnosed with osteomyelitis. The patient has required numerous surgical and non-surgical treatments to address the osteomyelitis and correct the tibia fracture.

Dr. Kaplan stated there was no indication in Dr. Saunders' chart of osteomyelitis. Dr. Leonetti asked to verify this because there was a diagnosis of this at one point. Dr. Kaplan stated there were no cultures done by Dr. Saunders; Dr. Delwyn Worthington also treated the patient and the osteomyelitis is documented in his chart. Dr. Leonetti noted that following the patient's tibia fracture there was extensive bone debridement done and evidence of soft tissue infection. He feels this was more than a stress fracture and that the infection coincides with the initial pin placement and subsequent re-placement of two of the pins. Dr. Kaplan noted that he had concerns regarding Dr. Saunders not performing any cultures to identify a possible infection early on. He stated that he does not have much knowledge about the use of external fixators; however, the report from Dr. Schuberth, stating the fixation was done correctly, seems credible. He added that Dr

Dr. Leonetti noted that there may be some concerns about the experimental nature of performing diastasis with external fixation and that Dr. Saunders should have informed the patient. Dr. Kaplan stated there is evidence in the chart that the patient was aware of this. However, he has concerns about post-operative films, and he stated it is difficult to tell if the patient falling caused the fracture or if the infected bone fractured and caused the patient to fall. Dr. Leonetti stated infection is a known possible complication in any surgery and it seems the infection was present prior to the second surgery performed in January 2007. His concern is that there is very poor documentation in the chart and that there should have been some type of post-operative imaging done and an attempt to identify any possible infection.

Ms. Miles asked Dr. Kaplan if the post-operative care provided by Dr. Saunders was substandard of is it a case of bad documentation. Dr. Kaplan explained that he is concerned with no cultures being done, no post-operative films and no antibiotics given to the patient. He stated those things could have been done but they are not documented in the patient's chart. Dr. Leonetti stated he feels this case should be discussed with Dr. Saunders via an informal interview.

MOTION: Dr. Leonetti moved to conduct an Informal Interview with Dr. Saunders at the next available meeting date. The alleged violations noticed in the Informal Interview request should include those stated in the investigation report and the addition of A.R.S. §32-854.01(11) for failure to maintain adequate records. Dr. Campbell seconded the motion. There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Dr. Kaplan recused.

Following the Board's discussion and decision, the patient requested to address the Board.

MOTION: Ms. Miles moved to re-open discussion on this case to allow the patient to speak. Dr. Campbell seconded the motion. There was no discussion on the motion. Dr. Kaplan recused himself.

VOTE: The motion passed unanimously by voice vote with Dr. Kaplan recused from the vote.

Dr. Kaplan again recused himself and Dr. Leonetti acted as the Board President. The patient addressed the Board and stated her main concern was poor post-operative care. She said she had severe pain from the very first day following her first surgery with Dr. Saunders for which Dr. Saunders gave her a prescription for morphine. She felt he minimized the complications and never said she had an infection only that the surgical site was irritated. She stated that according to Dr. Saunders the fixator pins were moved (the second surgery) not because of an infection but because of skin irritation. The patient said she had a very large open wound in her leg but it was not at any of the initial fixator insertion sites. Dr. Leonetti stated Dr. Saunders may have drilled a hole anticipating inserting a fixator pin but then didn't. The patient stated Dr. Saunders never cultured the wound despite her numerous questions to him throughout her post-operative care with him whether there could be an infection. Dr. Saunders told her to see a physical therapist which she did in addition to having a home health nurse, both of whom stated the wound appeared to be infected.

Regarding her fall in March 2007, she stated her leg spontaneously broke while she was walking which then caused her to fall. The patient stated she had a massive infection which required a long hospital stay and extensive care with other specialists who confirmed the infection with cultures and an MRI. She stated she nearly lost her leg and has had five additional surgeries. The wound was not closed until July 2007 but the bone never healed and remained very unstable. She now has a permanent rod in her leg. The patient states she feels Dr. Saunders charting is poor and indicates he saw her on dates she does not agree with. She feels she received very substandard care from Dr. Saunders and all of this could have been avoided if Dr. Saunders had done a culture for infection.

Dr. Leonetti confirmed with the patient the previous treatments she had received for the chronic ankle pain and asked if Dr. Saunders had reviewed other options with her. The patient confirmed they had reviewed this diastasis procedure or an alternative of a joint implant which required fusion. Dr. Leonetti asked about a bone spur which was also removed from the patient's ankle and the patient confirmed that Dr. Worthington had done so because Dr. Saunders failed to remove it. It was removed in the fall of 2008. Dr. Leonetti asked the patient how she did with that surgery and she stated her ankle is very arthritic and will eventually require a fusion. Dr. Leonetti asked where the rod in her leg is located and she said it runs from the knee cap to the talus bone. Dr. Leonetti asked how the wounds have healed or look now and the patient showed the Board members her leg. Dr. Leonetti confirmed with the patient that she was aware of the Board's decision to conduct an Informal Interview with Dr. Saunders. The patient asked if she could be present. Ms. Penttinen advised it would be scheduled for the May meeting at the earliest but she will receive written notice of it. Ms. Verstegen advised that the patient would have to be present at the Informal Interview if she wanted to add any information because the Board would only be able to consider what is stated into the Interview record on that date.

d. 09-34-C – J. David Brown, DPM: Practice below the standard of care for improper surgery.

Dr. Brown was not present. Dr. Michael Kates was the investigator and summarized the complaint as follows: The patient, L.M., had surgery with Dr. Brown on 04/24/2009 to remove a neuroma. Dr. Brown had tried conservative treatment without success. The surgery appears to have gone well according to the operative report. Post-operatively the patient developed pain and bleeding from the surgical site and called Dr. Brown's office. Dr. Frank Maben, who was working in Dr. Brown's office at the time, took over the patient's care due to Dr. Brown being out of the office. Dr. Maben performed a second procedure to stop the bleeding. The patient did not get satisfactory relief from the neuroma pain. The patient later discovered that Dr. Brown had been arrested for a DUI on 04/16/2009. She feels there is a possibility that he was impaired at the time he performed surgery on her and that this caused her post-op complications. The patient later transferred to Dr. Lewis Freed who performed another surgery to remove a stump neuroma from the same site. Dr. Freed also diagnosed RSD (reflex sympathetic dystrophy) which Drs. Brown and Maben had suspected but was not diagnosed until after the patient's

surgery with Dr. Freed. Dr. Kates confirmed that the procedure performed by Dr. Maben did control the bleeding that patient was having from the surgical site.

Dr. Leonetti discussed that there was a second procedure done by Dr. Brown on 04/24/2009 which was a "topaz procedure" on the plantar plate of the foot. Notes found in Dr. Freed's records which indicate the incision for that procedure was on the dorsal side of the foot which is unusual. Dr. Brown also used a TLS drain but it is uncertain whether that was for the neuroma or the plantar plate, but generally if a drain is used there should not be any development of a hematoma. Dr. Kaplan clarified that there were two drains in the patient's foot and Dr. Maben removed one of them when he corrected the bleeding. Dr. Kates stated that when Dr. Maben operated there was less than 1cc of fluid. He added that the patient had a minor slip/fall which could have contributed to the bleeding. Dr. Leonetti stated that TLS drains are notorious for clogging shortly after the procedure. He added that Dr. Freed also questions using a dorsal approach for a plantar plate repair. He added that doing multiple procedures in a small area there is a higher risk of damaging blood vessels and surrounding structures, and he is not satisfied with Dr. Brown's notes on this.

Dr. Leonetti asked Dr. Kates if the patient was notified by Dr. Brown of his DUI incident and that he would not be doing her follow-up care. Dr. Kates said Dr. Brown's office staff told her he had a family emergency but she was not aware of this until after the surgery. Dr. Kaplan added that at the time of the surgery Dr. Brown did not know his license was going to be suspended. Dr. Leonetti agreed but stated that a prudent person would realize there were going to be some ramifications: Dr. Brown had already been notified by the Board that there was going to be an emergency Board meeting in that case. Upon inquiry, Ms. Penttinen confirmed that Dr. Brown was notified of this on 04/21/2009. Dr. Leonetti stated that before the procedure it would be a personal decision as to whether or not Dr. Brown told the patient there might be some action taken against his license, but after his license was suspended Dr. Brown had a responsibility to tell the patient he would not be doing her follow-up care. Dr. Leonetti added that he would question doing any procedures during that time period.

Dr. Kaplan asked Dr. Kates whether the patient's fall getting out of her truck could have contributed to the bleeding or caused additional trauma to the foot. Dr. Kates said there was no way to know. Dr. Kaplan also asked Dr. Kates about the patient's fall getting out of bed on 05/13/2009 and whether multiple small injuries could have caused development of scar tissue or the stump neuroma. Dr. Kates said that any surgery can result in post-op bleeding, and RSD can develop as well, but neither of those things mean that the surgery was done poorly. Dr. Kates also feels that Dr. Maben's follow-up care was appropriate.

Next, the patient, the complainant (who is her husband P.M.) and their attorney Jeff Bouma addressed the Board. Upon inquiry Mr. Bouma stated he has been hired only for investigating this claim and the patient may or may not file a malpractice case because according to information received from Dr. Brown's attorney Bruce Crawford, Dr. Brown has filed for bankruptcy and his malpractice coverage was lapsed at the time of the patient's surgery. Dr. Kaplan asked Mr. Bouma when Dr. Brown's insurance coverage stopped but Mr. Bouma did not know.

The patient addressed the Board as follows: She now has RSD which she feels was caused by Dr. Brown when he did surgery on her. The surgery was just days after Dr. Brown's arrest for DUI with a blood alcohol level that would kill most people. She wants the Board to revoke Dr. Brown's license because he caused permanent damage to her foot. Despite being advised of an impending Board hearing on 04/27/2009 Dr. Brown demonstrated disregard for the Board by operating on 04/24/2009. His pattern of behavior over the last two years shows no regard for the Board, the public, or the safety of his patients. Dr. Brown has improperly prescribed medications and engaged in tampering with witnesses in other Board investigations against him. (It is noted that the Board has made no such findings via a final disciplinary action.) Dr. Brown failed to maintain malpractice insurance and did not have insurance on the day of her surgery which she was not aware of.

Dr. Kaplan asked the patient how she knew that there was no insurance coverage at the time of her surgery. He and Dr. Leonetti both stated there must have been insurance on that date otherwise the facility would not have allowed him to operate. Witness L.M. stated he received a letter from Mr. Crawford advising that Dr. Brown's insurance would not cover L.M.'s case. Dr. Leonetti noted that it

could be complicated to determine when the coverage was terminated. Mr. Bouma stated the hospital may not have known because they only check once per year. Ms. Verstegen advised that the Board statutes do not require malpractice insurance; lack of insurance is a facility issue and would not be a violation of Board statutes. Dr. Kaplan agreed.

The patient continued as follows: Dr. Brown failed to properly remove the neuroma in her foot and failed to control the bleeding. She has chronic pain and is on narcotic pain killers as well as nerve medication, nerve block injections and a nerve stimulator implanted in her back. She is not able to care for herself or her family. This incident has caused a large impact both emotionally and financially. Dr. Brown is a danger to the public if the Board allows him to continue practicing. Dr. Brown does not respect the Board. It is the Board's duty to protect the public and the Board had the opportunity on 04/21/2009. It is the Board's responsibility to protect Dr. Brown's patients and by not revoking his license the Board is not protecting the public.

Dr. Kaplan told the patient he understands her situation but the Board is restricted in many ways. Many things she referred to pertain to another ongoing investigation and the Board cannot consider that. Ms. Verstegen confirmed that the Board cannot discuss another ongoing case. Witness P.M. stated Dr. Brown did not meet the standard of care and had no business operating. He said that on 04/21/2009 there was already a track record of Dr. Brown's behavior. Dr. Kaplan stated that the Board does not know if Dr. Brown was impaired at the time of the patient's surgery.

Mr. Bouma addressed the Board as follows: Dr. Brown had a DUI accident on 04/16/2009 which included a single vehicle accident after which Dr. Brown was taken to the emergency room where his blood alcohol was measured at 0.38. Because Dr. Brown was notified on 04/21/2009 of the Board's impending meeting on the 27th he should not have operated on the 24th. He said Dr. Brown was late for the surgery and when the patient joked that she would have had time to go have a martini Dr. Brown responded, 'I already had mine.' The Board must investigate if Dr. Brown was physically and mentally able to perform surgery on 04/24/2009 because even a week later he would have still had alcohol in his system. Dr. Brown's long-term history indicates many problems including legal problems in 1992 and 1993. he exercised bad judgment when he decided to operate knowing he's had the DUI accident and that he may lose his license.

Dr. Leonetti asked the patient when she learned about Dr. Brown's DUI and when she learned he was not going to be in the office anymore. She replied that she learned of the DUI in June 2009 and found out he would not be in the office when she went to her first post-op appointment. Dr. Leonetti asked what the office staff told her about why he wasn't there and if they told her of his license suspension. She said they did not tell her about the suspension and only told her he had a family emergency. Dr. Leonetti asked the patient about the extent of her two falls after the surgery. She stated the first was not a fall but she was stepping out of a truck and bumped her foot on the door. With the second incident, she went to step out of bed but her foot was numb due to an injection. Dr. Leonetti noted that the operative report was unclear because it described two procedures but only one incision and asked the patient how Dr. Brown explained the procedures he was going to do with regard to the plantar plate repair. The patient said the neuroma was so big that the plantar plate was torn and Dr. Brown said he could do both by going in on the top of the foot. The incision was approximately one and a half inches.

Dr. Leonetti stated the following: from a public perspective there is something very uncomfortable about this case. Dr. Brown had to have known there was going to be some action taken against his license. Also, Dr. Brown did not tell the patient he would not be doing her follow-up care. Any surgery has potential risks including bleeding vessels which were not cauterized properly, development of a stump neuroma following a neuroma removal, RSD, and infection. In this case, all the bad things that could have happened did happen. Also, the patient experienced severe pain and Dr. Brown was not present to treat her. If Dr. Brown had properly removed the neuroma then Dr. Freed would not have had to do the procedure he did on the patient. There were too many complications in this case and there is a question as to whether Dr. Brown should have done this surgery.

Dr. Kaplan stated the Board is restricted by certain regulations but all are in agreement that something was not right in this case. Ms. Miles stated that Dr. Brown's past history does not bear on this case and the Board must be careful to determine any violations based on this case alone. Anything that happened

in 1992 or 1993 does not establish a violation in this case. Dr. Leonetti agreed but added that if a violation is found in this case then the license history can come into play with any disciplinary action that is taken. Ms. Versteegen added that Dr. Brown's Dui was already investigated and disciplined by the Board so it cannot be brought into this case during the investigation.

MOTION: Ms. Miles moved to conduct an Informal Interview with Dr. Brown with violations as stated in the investigation report plus a second allegation for potentially not informing the hospital where the patient's procedure was done that he did not have malpractice insurance at the time which would lead to misrepresentation or making false or fraudulent statements. Dr. Kaplan asked if charging an excessive fee could be added as well due to the fee he charged for the patient's initial post-op boot as it was unbundling and the billing was inconsistent with the procedures described in the patient's chart. Ms. Miles agreed. Dr. Leonetti seconded the motion. There was no further discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Following the vote Mr. Bouma revisited the issue of whether or not Dr. Brown may have been impaired at the time he performed surgery on this patient. Dr. Kaplan stated that at this point there is no way of finding that out. Ms. Penttinen stated she would follow up on getting Dr. Brown's malpractice coverage history and will verify with the hospital if needed.

e. 09-40-C – Jerome Cohn, DPM: Failure to diagnose Morton's neuroma; making false statements in a patient's medical chart.

Dr. Cohn was not present. Dr. Michael Kates was the investigator on this case and was present. He reviewed the case as follows: The allegation of making false statements in the patient's chart was in regard to the history and physical. The patient was seen on 06/09/09 by Dr. Cohn, although the patient had previous office visits with other doctors in the same office. The patient has a history of fibromyalgia. Dr. Cohn's notes in the chart are well-documented; however, the patient alleges Dr. Cohn never actually touched her feet to evaluate them. There is no way of knowing if the history and physical are accurate. Dr. Cohn did not make a specific diagnosis of a neuroma, only a generalized pain syndrome. Other doctors in the office never diagnosed a neuroma either. The patient later saw Dr. DiNucci (at another office) who did diagnose a neuroma and gave the patient an injection which provided relief of an unknown duration.

Dr. Leonetti asked if Dr. DiNucci's records were reviewed. Dr. Kates stated they were and they indicate that the injection seemed to help the patient's pain and that Dr. DiNucci sent the patient for a neurological consult. Dr. Kaplan asked Dr. Kates what his conclusion was. Dr. Kates stated he did not find either allegation substantiated by the patient's records. Ms. Miles stated Dr. Cohn's written response regarding the allegation of falsifying the patient's chart is troubling because he never said "I did not falsify the chart" but only questions "why would I falsify the chart?" She suggested further investigation to interview Dr. Cohn about this. There was brief discussion among the Board members about this suggestion. Ms. Versteegen advised that the investigation could be continued with Dr. Kates interviewing Dr. Cohn and reporting back to the Board. The Board agreed and Dr. Kates stated he will interview Dr. Cohn and provide a supplemental report to the Board at the April Board meeting.

f. 09-44-M – J. David Brown, DPM: Practice below the standard of care for improper surgery.

Dr. Brown was not present. Dr. Dedrie Polakof was the investigator and summarized the case as follows: A PICA report was received indicating Dr. Brown performed bunion surgery on patient J.B. with lengthening of the extensor longus tendon. Subsequently the patient developed an infection in the tendon and had a reconstructive surgery. The patient then developed a staph infection and went to another physician for follow-up care.

Dr. Kaplan said that in reading the operative report he noted that a "Z incision" was used to lengthen the tendon, but then it also says that a lengthening was not done and only a defect in the tendon was removed. He added that the surgical consent form only indicates a bunion correction, not a tendon

lengthening, although it does not necessarily need to be spelled out in the consent form. Dr. Leonetti agreed. Dr. Kaplan stated he was concerned that the operative report says the extensor tendon was lengthened when it actually wasn't. Dr. Polakof stated she has done this type of surgery and upon incision found that there was thickening of the tendon. However, when she reads this report she does not see how a piece of tendon could be removed without some type of graft. Dr. Kaplan said he is not sure the tendon was removed; it seems Dr. Brown tried to thin the tendon but it is unclear.

Dr. Campbell reviewed the following statements from the operative report: "The tendon was exposed to determine the extent of defect. Repair of the tendon was performed in a Z-lengthening fashion. However, tendon was not lengthened as the defect was removed. The tendon was re-approximated using 2-0 Vicryl." Dr. Kaplan stated that is not a lengthening.

Dr. Polakof stated that if Dr. Brown performed the procedure the way it is stated in the report then it is more extensive than just bunion repair; it involves more reconstruction because the joint capsule is weakened due to suture material used in previous surgeries. She added that with a weakened joint capsule any attachment will not hold together very well and will not heal. Dr. Polakof stated that she has seen cases where, rather than using Vicryl, an interposed wire was placed to make the joint more stable until it is able to heal for some time, but this case was not like that. She stated the bad part was not that the tendon was not going to heal on its own but that the patient got an infection.

Dr. Kaplan stated it is difficult to follow what Dr. Brown did in this procedure. Dr. Leonetti said it seems like Dr. Brown attempted to do a Z-lengthening but may have over-lengthened the tendon or went all the way through it and had to repair it. Dr. Polakof agreed both options were possible and added that if the tendon was contracted and the lengthening was above and beyond then there is no flexibility left. Dr. Leonetti agreed.

Dr. Polakof concluded that the allegation of improper surgery was not substantiated. She explained that rather than being a violation, this procedure just did not turn out the way Dr. Brown thought it would. She stated he may have run into more problems if he did not have the technical expertise to repair a tendon or use a graft, and she added that even expert surgeons run into problems and sometimes the best thing to do is to do no more harm and close up (conclude the surgery). She is not certain if that was Dr. Brown's thinking in this case. Dr. Leonetti stated that the records seem to indicate Dr. Brown later discussed with the patient repairing this tendon with a graft. Dr. Polakof feels that would be a correct repair procedure. Dr. Leonetti stated that if Dr. Brown was considering such a procedure he must have some experience with it and perhaps graft material just was not available at the time of this procedure.

Dr. Leonetti asked Dr. Polakof about the infection the patient developed. Dr. Polakof said that MRSA is very difficult to treat and requires IV antibiotics. It was noted in the chart that the patient had gotten her foot wet during the early post-operative period. Dr. Polakof does not believe that contributed to the infection. She stated infection is a known complication of any surgery. Dr. Leonetti agreed.

MOTION: Ms. Miles moved to dismiss this case finding no violations. Dr. Kaplan seconded the motion. There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

g. 10-02-C – Rajesh Daulat, DPM: Improper surgery; making false statement in a patient's medical chart.

Dr. Daulat was not present. Dr. Dedrie Polakof was the investigator and summarized the case as follows: The patient, M.Z., had surgery to correct a Haglund's deformity on the right foot which is a bump on the back of the heel. It is common in ages 16-21 and grows as the Achilles tendon pulls and causes inflammation. The patient agreed to surgical correction. Surgery was done on a Saturday morning at John C. Lincoln hospital. Dr. Daulat removed the Achilles tendon and removed the overgrowth of the heel bone, then reattached the Achilles tendon using a surgical anchor. The patient was given standard post-operative instructions. The patient developed pain and inflammation and ended up having a second surgery done by Dr. Peter Mitchell who took out the anchor and found a cyst which was most likely due

to a reaction to the surgical material. The Achilles tendon had to be repaired, and the patient had another surgery with Dr. Mitchell but it is not related to this case.

Dr. Kaplan stated the patient's x-rays show a foreign body in the right foot and asked if there were films from Dr. Mitchell. Dr. Polakof stated there were pre-op x-rays and an MRI but no films from Dr. Mitchell. Also Dr. Daulat did not submit any post-op x-rays. Dr. Kaplan asked if Dr. Polakof interviewed Dr. Daulat or Dr. Mitchell. She said she did interview Dr. Daulat but when she attempted to contact Dr. Mitchell his physician assistant told her that all information was in the patient's records. When she spoke with Dr. Daulat they discussed the complaints made by the patient. First, the patient said the procedure was done at a "questionable facility," but John C. Lincoln is a well-established and accredited hospital. Second, the patient questioned the doctor's ability to perform a standard Haglund's / calcaneal revision, but Dr. Daulat said there was nothing unusual about this particular procedure.

Dr. Kaplan asked if it is standard in a Haglund's procedure to sever the Achilles tendon. Dr. Polakof stated it could be done several ways. A lateral or medial approach could be taken, going on from the side. She said different doctors can do this procedure different ways and still end up with the same result. Dr. Kaplan said that going into the Achilles tendon adds to the complexity of the procedure. Dr. Leonetti added that a side approach may cause problems getting around the tendon to reach the opposite side of the bone. Dr. Polakof agreed but stated that with this patient she would question going in directly on the back of the heel for the first surgery. For a revision surgery it might be appropriate but a rear approach will cause a buildup of scar tissue and if this patient wants to wear high-heeled shoes she will have trouble.

Ms. Miles reviewed Dr. Polakof's report which indicates her opinion that the procedure was not done improperly. She asked if the standard of care was met. Dr. Polakof said that it was. In this case substandard care would mean that doctor did not reattach the tendon correctly or did not take sufficient bone off. The patient's reaction and inflammation was unfortunate.

Drs. Kaplan and Leonetti reviewed the patient's pre-op x-rays and demonstrated the pertinent anatomy to the public Board members. Dr. Leonetti asked for Dr. Polakof's conclusion. She stated she did not feel there was any violation. Dr. Leonetti reviewed that when the patient went back to Dr. Daulat after the surgery she told him something was wrong and that she had pain and swelling. Dr. Polakof stated those are common symptoms following surgery. Dr. Leonetti asked about a post-op MRI because it would have shown if there was a build-up of fluid around the anchor. Dr. Polakof said there was an MRI but not from Dr. Daulat because the patient left his care.

The patient addressed the Board and asked how the Board could make any comparison if they do not have all of her records. She said that when Dr. Mitchell did her first surgery, (to revise Dr. Daulat's procedure), when he cut her foot open it was full of puss. Dr. Mitchell also told her that only half of the bone was removed that should have been. The patient was upset that the Board did not have Dr. Mitchell's records. Ms. Miles assured her that we have his chart but he did not send her films. Dr. Kaplan added that he is unable to visualize anything on the inter-operative films. The Board does have the film reports from Dr. Mitchell just not the actual films. Dr. Leonetti asked Ms. Penttinen if the records were requested via a subpoena. Ms. Penttinen confirmed that a subpoena was sent and asked for all records including films; she will follow up with Dr. Mitchell to find out why the films weren't sent. The patient stated the x-rays were done in Dr. Mitchell's office but the MRI was done at an outside clinic.

Ms. Miles stated she would like to table this case to continue the investigation and obtain the missing films. Dr. Kaplan agreed. Ms. Penttinen will obtain those films and forward to Dr. Polakof. The patient spoke stating that when she told Dr. Daulat of her symptoms he thought she was faking. She said she wore a walking boot for two years and that she went to Dr. Mitchell because Dr. Daulat wasn't doing anything to help her. Dr. Leonetti asked the patient if Dr. Daulat told her where the incision would be. She said he only gave her a foot diagram showing where the surgery would be and told her he would go in on the back side, but she thought he would cut in a straight line not the zig-zag cut she has. The patient also said Dr. Mitchell has advised her that her Achilles tendon is now too thinned out to repair. She added that she cannot do any physical activity now such as running. Dr. Kaplan advised the patient that she will be notified once the films have been obtained and the case is scheduled for Board review again.

h. 10-04-C – William Leonetti, DPM: Making false statements in a patient’s medical chart.

Dr. Leonetti was not present. Dr. Joseph Leonetti recused himself from review of this case. Dr. Dedrie Polakof was the investigator and summarized the case as follows: The patient B.F. went to Dr. Leonetti with a complaint of foot pain. The patient was on worker’s compensation but Dr. Leonetti’s treatment was not an independent medical evaluation for a compensation claim. Diagnostic images revealed an old un-united fracture which may be contributing to the patient’s problems with pain and mobility. Dr. Leonetti found no problems with range of motion in the foot and referred the patient to physical therapy. Exploratory surgery was considered which had not been done at the time the complaint was filed. Dr. Polakof noted that the patient has flat feet which makes her x-rays difficult to read to determine any bony abnormalities. Dr. Leonetti stated there was not much he could do for the patient. Dr. Polakof concluded that, while the patient may have had frustrating experience with Dr. Leonetti, she finds the patient’s records to be accurate and she does not find any violations.

The patient was present with another witness, R.A., who addressed the Board on her behalf. He stated he and the patient were upset because Dr. Leonetti closed the case and he feels more diagnostic testing could have shown the patient was still having problems but Dr. Leonetti denied her that. He said Dr. Leonetti “alleged” that the patient’s foot could be moved in any directions without pain. Ms. Burns asked R.A.’s relationship to the patient and he said he was her father. Ms. Burns asked if he had accompanied the patient to her office visits. R. A. stated he was with the patient during many office visits but not all. He said the patient called him many times in pain stating Dr. Leonetti did not find anything wrong with her. He also saw the patient many times and when he touched her foot she was in pain so he knows Dr. Leonetti could not have found that she was not in pain when he evaluated her. Ms. Burns asked R.A. if he was at that particular office visits and he said he was not. He added that he knew the patient was in pain because of other things he saw her doing like trying to get in and out of the bathtub and having trouble walking. He discussed the patient’s history prior to Dr. Leonetti’s care. He stated Dr. Leonetti accused her of wearing the wrong shoes. Ms. Burns said Dr. Leonetti noted that the patient wore flip-flops to her office visits which was inappropriate because she needed close shoes. Ms. Burns pointed out that in the complaint the patient said she did not wear closed shoes because they caused her pain. R.A. agreed and said he’s never seen the patient wear closed shoes except for a boot she has now from a more recent surgery. He said the patient was told to do things by Dr. Leonetti to do things that he didn’t think were appropriate, such as walking too soon.

Dr. Kaplan asked R.A. to clarify some of the confusion about what treatments and referrals were made by Dr. Leonetti and when. While the patient made her way to the front of the room to address the Board, R.A. asked why Dr. Leonetti would state the patient did not have any problems but still make referrals for other treatment and give her pain medicine. Dr. Kaplan asked R.A. how the case was closed only due to Dr. Leonetti. R.A. stated it was because Dr. Leonetti said there was “no finding” which resulted in the patient losing her income and being forced to move. Dr. Kaplan confirmed that the patient was still being treated by going to physical therapy. R.A. claimed that Dr. Leonetti documented that patient did not go to therapy when in fact she had.

The patient then addressed the Board. She stated that she should not have been sent to physical therapy because the bone rubbing on the nerve would cause aggravation which is what happened. Dr. Kaplan asked the patient if Dr. Leonetti told her she should return to Dr. Keller or Dr. Martin. The patient clarified that Dr. Martin was after Dr. Leonetti. R.A. said the patient’s CT scan and x-rays showed the problems the patient was having with the bone in her foot and Dr. Leonetti should have seen that the bone was never removed by Dr. Keller as the patient thought had been done. The patient stated Dr. Leonetti never checked the nerves in her feet with an MRI which she thinks should have been done. Dr. Kaplan stated that Dr. Leonetti did treat her for a short period of time, he referred her to physical therapy and prescribed anti-inflammatory medications. The patient interrupted Dr. Kaplan again stating that Dr. Leonetti should have checked her nerves, and that he should not make up statements and ignore her like she was crazy and close her worker’s compensation claim. Dr. Joseph Leonetti who was seated in the gallery pointed out to the Board members that doctors do not close such compensation cases; they only make recommendations and the decisions are made by the insurance company.

Dr. Kaplan summarized that the complaint before the Board is that Dr. Leonetti falsified the patient's chart. The investigator finds no violations and he does not find any false statements in the patient's chart.

MOTION: Dr. Kaplan moved to dismiss the case finding no violations. The patient interjected and asked Dr. Kaplan if it was OK for Dr. Leonetti to state in her chart that she shaves her legs when she does not shave them, or if it was OK for Dr. Leonetti to assume that because she could trim her own toenails that she did not have any problems. She said that these were false statements in her chart. Dr. Kaplan advised the patient that the Board is now deliberating and there is a motion on the floor. He asked if there was a second to the motion. Ms. Miles seconded the motion. There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Ms. Miles addressed the patient and the Board and stated there were many things discussed today which were outside the scope of the initial complaint, but Dr. Polakof's review did include a review of the standard of care provided by Dr. Leonetti. She stated that there were contradictions to a certain extent in the patient's complaint and responses today regarding whether she was wearing closed shoes as directed by Dr. Leonetti or flip-flops as noted in her chart. She stated she understands the patient may be frustrated but she does not see anything that rises to the level of disciplinary action. R.A. began reviewing again the standard of care provided by Dr. Leonetti and there was brief discussion. Ms. Penttinen stated that the complaint only concerned the allegation of false statements in the chart. The patient said she could file another complaint. Ms. Miles reiterated that the investigator did review all the patient's records and did not find any violations regarding the standard of care.

i. 10-17-M – Stephen Barrett, DPM: Practice below the standard of care. (Request received from Dr. Barrett's attorney to administratively close this matter with no investigation.)

The Board reviewed the PICA report received in this case which states a claim was filed against Dr. Barrett on 02/25/2010. The "nature of claim" was stated as, "Arthrodesis – patient did well post op / returned complaining of pain in foot / pain not at surgical site / most likely twisted ankle / patient not happy with response / primary surgeon feels patient in trying to stay on disability. Note: Dr. Barrett had one consultation with the patient and only assisted the surgeon once in surgery on this patient. The primary surgeon is a Texas doctor, not licensed in AZ, and the surgery occurred in Texas."

The Board previously decided to open a complaint investigation and notice was sent to Dr. Barrett. The Board has now received a request from Dr. Barrett's attorney John Huffman to close this matter without action against Dr. Barrett. Mr. Huffman provided a written statement which indicates that a "notice of claim" was sent but no civil suit was actually filed. He also confirmed that Dr. Barrett only assisted the primary surgeon. The Board reviewed the request and feels that any failure of the patient to file a civil suit is not relevant. However, due to Dr. Barrett's role in the patient's course of care dismissal may be appropriate.

MOTION: Ms. Miles moved to dismiss this case without prejudice and refer the information to the Texas podiatry Board. Dr. Campbell seconded the motion. There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

V. Review, Discussion and Possible Action – Probation / Disciplinary Action Status Reports

a. 08-03-C – Elaine Shapiro: Monthly update.

Ms. Penttinen reviewed that Dr. Shapiro's last progress report from Dr. Sucher was received in February, so the next report is due in May. She has not received any reports of non-compliance.

b. 09-13-M – Patrick Farrell: Monthly update.

Dr. Kaplan reviewed the correspondence submitted by Dr. Farrell which indicates that for the month of January he did not perform any surgical procedures as defined in his consent agreement.

c. 09-17-B – J. David Brown: Monthly update and probation status interview.

Dr. Brown was present with attorney Bruce Crawford. Ms. Penttinen advised that the most recent progress report from Dr. Sucher was received on January 2011 so the next report is due in April. There have been no reports of non-compliance since the last progress report. Mr. Crawford addressed the Board regarding the statements made during review of case number 09-34-C, specifically Dr. Brown's malpractice insurance, and stated Dr. Brown does have malpractice coverage. Dr. Brown stated he believes he has always had malpractice coverage, particularly at the time of patient L.M.'s surgery (09-34-C). Following the Board meeting he will submit a written explanation and timeline of his malpractice coverage.

Dr. Brown also stated he filed for personal bankruptcy approximately two weeks ago. He stated he has had a lot of stressors to deal with including finances, problems with current and former employees, and facing Board complaint investigations. However, he added that filing for personal bankruptcy has actually reduced a lot of stress and that he is working to eliminate all the other stressors as much as possible.

Dr. Leonetti asked Dr. Brown about his weekly routine and recovery activities. Dr. Brown stated he goes to three 12-step meetings per week in addition to a group he meets with on Tuesdays which consists of approximately 16 other physicians in recovery. He met with Dr. Sucher approximately six months ago but has regular meetings with his staff. He is required to call in everyday to learn if he must provide a urine drug screen that day. If so, there is a service which comes to his office to collect his sample so he doesn't have to leave his office. Dr. Brown said he also still has a breathalyzer device in his car due to his DUI conviction requirements. And he added that he tries to travel on the weekends whenever he can, to help reduce stress.

All Board members agreed that Dr. Brown appears to be doing well in his recovery. Dr. Brown confirmed that he will fax to the Board information regarding his malpractice insurance status and history and an explanation of some of the issues he has had with his employees.

VI. Review, Discussion and Possible Action on Administrative Matters

a. Election of Secretary-Treasurer.

Dr. Kaplan explained that due to the former Secretary-Treasurer not being re-appointed the Board need to vote for a replacement and he asked if anyone would like to volunteer. Ms. Miles stated she would do so.

MOTION: Dr. Kaplan moved to elect Ms. Miles as the Board's Secretary-Treasurer. Dr. Leonetti seconded the motion. There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote with Ms. Miles abstaining.

b. CME approval request from Arizona Podiatric Medical Association.

The Board members reviewed the CME request which included eight monthly AzPMA meetings and one annual conference.

MOTION: Dr. Leonetti moved to approve the CME courses on September 22, October 20, and November 20, 2010; January 19, and February 23, 2011, and the annual conference on May 20-22, 2011 for 18 hours; and to deny the course on December 11, 2010. Dr. Kaplan seconded the motion. Upon discussion the Board members stated additional information is needed regarding the March 23, 2011 course before a decision could be made.

VOTE: The motion passed unanimously by voice vote.

c. New License application(s):

- i. Derek Hunchak, DPM.

MOTION: Ms. Miles moved to approve the license application of Dr. Hunchak. Dr. Kaplan seconded the motion. There was no discussion.

VOTE: The motion passed unanimously by voice vote.

VII. Executive Director's Report – Review, Discussion and Possible Action

a. Open complaint status report.

Ms. Penttinen reviewed the report which indicates there are currently 58 open complaint investigations. This includes the cases reviewed today and those that are pending a voluntary disciplinary agreement or referred to formal hearing. She also advised that there are nine cases ready to assigned to an investigator and she has received two new complaints in the last month.

b. Update on budget status and proposed sweeps of Board cash.

Ms. Penttinen reviewed for Ms. Miles the previous Board discussion regarding this. The Board's revenues and expenses were projected through the end of the fiscal year and estimated that the Board would have approximately \$84,000.00 in case. However, the legislature has proposed sweeping \$62,000.00 of that before the end of the current fiscal year and an additional \$14,000.00 in FY12. Ms. Miles asked if the Board was still on a two-year budget cycle and Ms. Penttinen stated it is now one year at a time. Ms. Penttinen stated that if that mush money is taken out of these two years, without a fee increase the Board will be on the verge of being bankrupt. She has spoken with the Board's budget analyst (at the Office of Strategic Planning and Budgeting) and found that office used revenue forecast and figures which were very inaccurate. OSPB has projected the Board's revenue in the current year to be almost \$150,000.00 which is not possible. The Board had higher than usual revenue in FY10 because the license renewals fall on the cusp of the start and end of fiscal years, and she tried to explain to OPSB that even if all licensees renewed prior to June 30 the Board would have approximately \$130,000-134,000 in revenue at the very most. Ms. Penttinen stated she has had a great deal of difficulty working with OSPB staff. She has provided them with extensive information to demonstrate annual license totals going back several years which can be correlated into a more accurate revenue forecast. She was told by OSPB staff that they utilized a monthly revenue review to make their projections which she feels is inappropriate due to the fact that nearly all Board revenue is generated from annual license renewals which only occur at one time during the year, not month to month. After many discussions, OSPB stated they would not issue an agency-specific correction but rather what they called a "global" correction, and they stated this would be done before the legislature votes on a final budget. However, the Board will essentially have to wait to see what the final budget bill looks like when it is signed by the Governor. There was brief discussion offered by Ms. Miles regarding the license renewal time frames and fees. She suggested the possibility of a fee increase if needed. Ms. Penttinen stated the Board has enough money to get through the current year, and the Board has already voted to request a small fee increase to cover the costs associated with the investigation consultants. If necessary, that fee increase request could be modified.

c. Malpractice case report.

- i. Dr. Kelvin Crezee: Claim reported 01/20/11. Nature of claim: "Wrong site surgery." (Not previously reviewed by the Board.)
- ii. Dr. Carl Beecroft.: Claim reported 01/20/11. Nature of claim: "Wrong site surgery." (Not previously reviewed by the Board.)
- iii. Dr. David Lee: Claim reported on 11/03/10; closed on 01/19/11. Nature of claim: "Bunion surgery – patient claims it has been one year since the surgery and she is still not healed and in pain; also claims RSD." NOTE: Claim was closed for \$0 due to Dr. Lee never being served. (Not previously reviewed by the Board.)

The Board members reviewed the information provided in the PICA reports and determined that a complaint investigation file should be opened for each one.

d. Legislative report.

- i. SB 1044: Continuation bill.
Ms. Penttinen advised that this bill should be going through final vote in the House of Representatives any day. She does not have any concerns about it passing.
- ii. SB 1315: Statute changes.

Ms. Penttinen advised that this bill was scheduled to be heard in the House Health Committee today. She had requested a postponement which was initially denied; however, the legislature has been given one additional week to hear bills in committee so this bill will now be heard on March 16th. In addition Ms. Penttinen has learned that this bill has also been assigned to a new committee in the House called the Employment and Regulatory Affairs Committee. She is uncertain of the scope of this committee and was given rather vague information from House staff. It is unknown when that committee will hear this bill but she will keep the Board informed.

VIII. Call To The Public

There were no requests to speak during the call to the public.

IX. Next Board Meeting Date:

a. April 13, 2011 at 8:30 a.m.

X. Adjournment

There being no other business before the Board, the meeting was adjourned at 1:08p.m.