



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**

September 14, 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, Secretary-Treasurer  
John Rhodes, Public Member

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: Keely Versteegen

PLEASE NOTE: THE BOARD DID NOT REVIEW AGENDA ITEMS IN THE EXACT ORDER THEY APPEAR IN THE MINUTES.

#### **I. Call to Order**

Dr. Kaplan called the meeting to order at 8:30 a.m.

#### **II. Roll Call**

Ms. Miles was not present at the start of the meeting. Dr. Kaplan noted that she would be joining the meeting at approximately 8:45 a.m. All other Board members were present as were Ms. Penttinen and Ms. Versteegen. (Ms. Miles arrived at 9:00 a.m. Agenda items for which Ms. Miles was not present are noted as such.)

#### **III. Approval of Minutes**

a. August 10, 2011 Regular Session Minutes.

Ms. Miles and Dr. Kaplan offered corrections in regard to grammar and spelling. Ms. Miles also offered that there should be a clarification between a motion, (and second of the motion), in contrast to discussion on the motion. The other Board members were in agreement that a third item will be added to each Board action, so future minutes will reflect "motion," "discussion" and "vote." Ms. Miles also offered a correction for the substantive information regarding the following statement: "Ms. Miles states she did not believe it would be action to open a new investigation case based on a probation violation." Ms. Miles stated she reviewed the audio recording of the minutes and the discussion around this that topic was "action in relation to action on an individual's license." She feels it would not be "action on a license" to open a new case for probation violation and would like the minutes clarified to reflect that.

MOTION: Dr. Kaplan moved to approve the minutes as amended by Ms. Miles and other corrections. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. August 10, 2011 Executive Session Minutes.

MOTION: Ms. Miles moved to go into Executive Session for the purpose of reviewing confidential Executive Session minutes. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the Board adjourned into Executive Session at 9:10 a.m.

The Board returned to Regular Session at 9:13 a.m.

MOTION: Ms. Miles moved to approve the minutes as amended. Dr. Kaplan seconded the motion.  
DISCUSSION: There was no discussion on the motion.  
VOTE: The motion passed unanimously by voice vote.

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

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

Dr. Nakra was present with attorney Bruce Crawford. Dr. Dedrie Polakof was present as the investigator for the case and provided the following information: The patient, M.L., was referred to Dr. Nakra by Dr. Charles Connell who had done two previous surgeries on the patient. One was in July 2005 and included left foot bunion correction and hammertoes correction of the 2<sup>nd</sup> toe. The second surgery was in September 2006 to again correct the left 2<sup>nd</sup> toe hammertoe and hammertoe correction to the left 3<sup>rd</sup> toe. The second surgery also included injections to the left foot interspaces for neuroma pain. On June 21, 2007 Dr. Nakra performed metatarsal head resection of the left 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> toes with pin fixation. The patient developed a post-operative infection which required hospitalization and eventual amputation of the 2<sup>nd</sup> and 3<sup>rd</sup> toes. Dr. Polakof's concerns were: 1) the length of time between the procedures and the first scheduled post-operative check-up – it had been scheduled for after the 4<sup>th</sup> of July; and 2) the billing codes used by Dr. Nakra were not supported by the operative records in relation to code 99213. (Dr. Polakof stated the exact date of the first scheduled post-op visit was unknown because it was not specified in the patient's records; it was only shown to be after the 4<sup>th</sup> of July.)

Dr. Polakof continued that the patient called Dr. Nakra on July 2 and reported discomfort and a bad odor in her foot. Antibiotics were called in for the patient, but then Dr. Nakra had the patient come into her office that day. Dr. Nakra noted odor with a possible vascular compromise and frank gangrene. The patient was immediately admitted to the hospital. Dr. Nakra performed all appropriate consults with hospital staff including a vascular consultation. Regarding the billing, Dr. Polakof stated a level 3 code, (99213), on July 2 was not supported under the Evaluation and Management guidelines ("E&M"). Also, a code of 66450, which is for an injection, was billed for the surgery on June 21, but there is no documentation in the operative report to indicate what was injected, the amount injected, or why the injection was given. Dr. Polakof stated an injection should have been included in the global surgical code, but if it was a separate procedure done during the surgery then a separate operative report should have been produced to support the charge. The only documentation stated, "Following introduction of appropriate and adequate anesthesia the left foot and ankle were prepped and draped." It is unknown what was injected or whether a tourniquet was used in the procedure. Dr. Polakof confirmed the patient was under general anesthesia. Dr. Kaplan asked whether a local anesthetic was given pre- or post-operatively. Dr. Polakof stated that it was not documented but either way there would not be an indication to use epinephrine. There was discussion between Drs. Leonetti and Polakof, and Ms. Verstegen, regarding the effective date of the E&M guidelines. Dr. Polakof clarified that the guidelines became universally published in 2001, although they became effective in 2000; after 2000 an injection would be bundled under the surgical code unless a separate operative report was made.

Dr. Nakra and Mr. Crawford addressed the Board. Mr. Crawford disagreed with Dr. Polakof's statement regarding antibiotics – none were called in. The patient was seen immediately in Dr. Nakra's office. He also disagreed regarding Dr. Nakra obtaining a vascular consult prior to surgery because the patient did not exhibit any vascular problems. It was clarified that Dr. Polakof was speaking of the patient's hospitalization on July 2. Dr. Nakra clarified that epinephrine was not given at the beginning of the surgery on June 21; it was administered at the beginning of the procedure, and she gave Marcaine at the end. Dr. Leonetti asked why that information was not included in the operative report. Dr. Nakra stated that was not a required part of the standard of care but the information was contained in the other hospital records for the procedure. Dr. Leonetti stated the operative report would more-accurately reflect what was done to the patient if Dr. Nakra had recorded what was injected and how much, particularly if a charge was to be billed for the injection. Dr. Nakra agreed. Dr. Nakra also spoke about use of the billing code 66450. She said she dictated that a post-operative injection was given and that code was billed but it was not paid.

Dr. Nakra stated that she disagrees with Dr. Polakof's opinion that pre-operative nerve blocks with epinephrine should not be done due to complications. Dr. Nakra feels information about such complications is anecdotal and not supported by medical literature. Dr. Kaplan stated he would agree with Dr. Nakra if the patient is healthy and had no prior surgeries, particularly digital surgery. However, if the patient is unhealthy or had prior surgery and the area was compromised, then giving epinephrine

might cause vascular compromise in the area. Dr. Leonetti agreed that the two previous surgeries in the same area would raise concerns about administering epinephrine because this was not a young and healthy patient. Dr. Nakra stated the patient had no co-morbidities such as being a smoker, being diabetic, peripheral artery disease or a compromised immune system. She added that the doctor who later performed the amputation of the toes stated in his report that the toes bled very well. Dr. Leonetti stated that it was not necessarily wrong to administer epinephrine but this patient was still a higher risk patient than normal. Dr. Kaplan added that the initial concern was that the operative report did not indicate when the epinephrine was given or how much but now they know.

Dr. Nakra confirmed her knowledge of the patient's two prior surgeries with Dr. Connell. Dr. Leonetti asked if Dr. Nakra would consider the patient a higher risk because of those surgeries and she said she did not. He also asked Dr. Nakra what she felt went wrong with this patient. Dr. Nakra stated the patient simply developed a post-operative infection which built up in the foot and led to vascular compromise and the onset of gangrene. She stated she had checked the patient's capillary refill in the recovery room on June 21 and it was good. She added that nothing happened during the procedure to indicate blood flow to the toes might be compromised. Dr. Leonetti stated that with having that many procedures in the same area it is important to be certain the patient knows the possible complications. Dr. Nakra explained that the surgical consent form includes the verbiage of "loss of limb" and "loss of life" and possible complications. She added that when the patient was deposed in the malpractice case she stated she did not know that meant she could possibly lose her toes and said she did not recall signing the consent form. There was brief discussion between Drs. Kaplan, Leonetti and Nakra regarding possible ways to improve consent forms to better document a patient's understanding of all possible outcomes of a surgical procedure.

Dr. Leonetti asked Dr. Nakra about the time frame between the surgery and the first scheduled post-operative check-up. He stated that two weeks seems like a very long time. If the patient had been seen sooner the infection could have been observed and treated prior to developing gangrene. With this patient in particular, he would have wanted to see her before two weeks. Dr. Nakra stated most infections will develop five to 10 days post-operatively, so if this patient had been seen three to five days after, the infection likely would not have been evident. She added that there is a trend in the medical community as a whole, which is supported by medical literature, to conduct first post-operative evaluations around two weeks after the procedure as long as the patient has no co-morbidities, and this patient did not have any co-morbidities. She also added that nothing occurred during the procedure to cause her any concern about a post-operative infection, and the patient had her cell phone number and could have called her at any time if she developed problems. Dr. Leonetti stated he believed the patient did have co-morbidities due to the previous surgeries on the 2<sup>nd</sup> and 3<sup>rd</sup> toes which caused an increased risk for complications. He added that pin fixation increases the chances for infection. Overall, he feels this patient should have been seen in less than two weeks after the surgery. Mr. Crawford stated that in the patient's deposition in the civil malpractice case, she stated she and her husband had noticed some problems 2-3 days prior to contacting Dr. Nakra's office. However, the patient stated she did not want to bother Dr. Nakra and waited until the following Monday (July 2) to call. Dr. Leonetti responded that the office visit on that date was still based on the patient's initiative to contact Dr. Nakra prior to her first scheduled post-op appointment and he feels a sooner appointment would have been more reasonable. Dr. Leonetti stated it is difficult at this point to speculate when the infection would have been apparent and what would have been seen, if anything, at the five-day or 10-day mark, and he reiterated that for this particular patient the first post-op check-up should have been sooner.

Dr. Nakra was asked if she would like to make any final comments. She stated that she has made some changes in her practice based on this case. She understands the Board's concerns but feels that each doctor has a different way of working with their patients, and different does not make any specific doctor right or wrong. Dr. Nakra stated each patient's care plan has to be tailored to them individually. She stated she now sees each surgical patient within three to seven days post-op. Dr. Leonetti asked Dr. Nakra, if medical literature supports a longer period of time before the first post-op evaluation is done, why would she change the way she conducts her practice. Dr. Nakra replied that it is because this case turned into a three-year malpractice lawsuit. Mr. Crawford added the statement that, "It is defensive medicine."

MOTION: Dr. Leonetti moved to dismiss the case with a Letter of Concern to Dr. Nakra for, 1) the period of time between the surgery and the first scheduled post-op office visit, and 2)

documentation in the operative report to more accurately reflect all events which occurred during the procedure. Dr. Kaplan seconded the motion.

**DISCUSSION:** Dr. Leonetti stated he did not see any issues with the billing codes used. He feels that the care given to the patient did justify a level 3 code, and that is why he did not include anything about billing in his motion. Drs. Kaplan and Campbell agreed. Mr. Rhodes if the anesthesiologist in the surgery would have recorded the amounts of the injections given to the patient. Dr. Leonetti explained that there would be a circulating nurse in the room who would record all medication administration, but the surgeon doing the procedure and giving injections as part of that procedure still should include that information in their own operative report. There was no further discussion.

**VOTE:** A voice vote was called. Mr. Rhodes voted against the motion; all other Board members voted in favor of the motion. The motion passed 4-1.

**b. 09-19-C – Daniel Saunders, DPM: Practice below the standard of care for improper surgery; failing to maintain adequate records.**

Dr. Saunders was present with attorney Bruce Crawford. Dr. Kaplan recused as the investigator for the case and Dr. Leonetti served as acting President. Patient J.T. was present. Dr. Leonetti offered the patient the opportunity to address the Board. She stated that her comments to the Board at a previous meeting were still accurate. Dr. Leonetti advised that she could add comments later if she wished.

The complaint information is as follows: The allegation is practice below the standard of care for improper surgery. In December 2006 Dr. Saunders performed ankle diastasis with external fixation as an attempt at a salvage procedure rather than an ankle fusion or implant. In January 2007 a second surgery was done to exchange some of the fixation pins which were causing skin irritation. In March 2007 the patient suffered a stress fracture of the right tibia and was diagnosed with osteomyelitis. The patient believes the fracture and infection were caused by improper surgery by Dr. Saunders.

The patient saw Dr. Saunders for right ankle pain starting in 2004. She had had one previous arthroscopy of the ankle by another physician, and another arthroscopy by Dr. Saunders. Conservative pain management measures were exhausted without success. The patient was very active and an avid hiker. There was a problem with two x-rays submitted by Dr. Saunders as they are not dated and are marked as the left foot; Dr. Kaplan believes they were mismarked. There is only one intra-operative fluoroscopy film and no post-operative films. Dr. Saunders had explained the diastasis procedure to the patient and reviewed the risks and benefits. Following the initial procedure the patient stated she had irritation at some of the pin insertion sites and Dr. Saunders performed another surgery to exchange them. The pins were finally removed completely on 02/01/07. On 02/25/07 the patient told Dr. Saunders she had a wound in the surgical area which was getting larger. Dr. Saunders debrided the wound and ordered a wound vac. The next day the patient called as was concerned that the wound was not healing. On 02/27/07 Dr. Saunders sent the patient for an x-ray of the right lower leg. The report for that x-ray was read by a Board-certified radiologist and stated, "No evidence of acute fracture or destructive process." The impression was "possible post-operative and post-traumatic changes of the distal and mid tibia," but there was no indication of an infection.

Dr. Kaplan had reviewed the patient's records from Dr. Saunders, Dr. Polaski who is an infectious disease specialist and Dr. Worthington who is an orthopedic surgeon. Dr. Polaski opined that the fracture was due to infection, but it is unknown exactly what caused the infection. Dr. Kaplan stated he does not feel the allegation is substantiated by the records. However, he has the following concerns: 1) there is no indication in the chart about antibiotics being given at any time, 2) there is no indication of Dr. Saunders performing a wound culture, 3) the x-rays submitted should have been of the correct foot, or correctly marked, and 4) there were no other pre- or post-operative x-rays taken.

Dr. Kaplan feels that better record-keeping should be impressed upon Dr. Saunders. He also asked whether the Board would be able to address record-keeping at this time because it was not in the initial notice of allegations to Dr. Saunders. Ms. Penttinen explained that when the Board initially reviewed this case in March 2011 they referred it to an Informal Interview with the added allegation of ARS 32-854.01(11) which is "failing or refusing to maintain adequate records." That information was included in written correspondence sent to Dr. Saunders so he is aware of the Board's concerns in that area. Ms. Versteegen stated that if Dr. Saunders wished to discuss that matter today that would be fine. If the Board were to refer the case to an informal or formal hearing then the specific allegation of substandard

record-keeping would need to be affirmatively stated. Mr. Crawford stated that he and Dr. Saunders would be willing to discuss anything the Board wishes to talk about.

In discussion with the Board members, primarily Dr. Leonetti, Dr. Saunders addressed the Board and provided a summary of his care of the patient starting in 2004. Regarding the diastasis procedure specifically, he confirmed that the patient had a minor wound complication following the pin exchange which he treated with topical antibiotic ointment. He did send the patient out for an x-ray in February due to her concerns of infection but the radiologist did not report any finding of infection. Dr. Saunders said the patient had been ambulating well and hiking, and the next thing he knew she had gone to Las Vegas and developed the stress fracture while walking there. After that he only saw the patient in his office once at which time he discussed her status and referred her to an orthopedic surgeon.

Regarding the patient's x-rays, Dr. Saunders stated he believes they are pre-op of the right foot because he has not treated the patient for left foot problems. He discussed the prior arthroscopies done on the patient and the conservative treatment that was attempted which included injections to relieve pain. He stated he has done approximately a dozen arthrodesis procedures and ideally the fixator pins are left in for six weeks if the patient can tolerate it. Regarding pin tract infections, Dr. Saunders stated he sees patients in his office nearly every day who have some type of k-wire or pin fixation and would say infections occur in less than five percent. He stated he does not know if patient J.T.'s infection was caused by the pins. Dr. Saunders and Mr. Crawford were shown the pictures submitted by the patient. Dr. Saunders confirmed that he could see some ulceration forming at the pin site(s). He treated with topical antibiotic cream and saw some improvement, but then there was regression and he began treatment with the wound vac. He stated he did not do a wound culture because he never saw an indication that it was needed. He stated the patient had concerns that the wound was not healing properly but he never saw any clinical signs of infection.

Dr. Leonetti asked if Dr. Saunders had taken x-rays in his office with the fixators in place. Dr. Saunders stated he had and that he gave copies to the Board. Ms. Penttinen advised that the Board had only received the two plain films already discussed as pre-operative and one intra-operative fluoro film. Dr. Saunders discussed the placement of the exchanged fixator pins and the standard of care for such. Regarding physical therapy Dr. Saunders stated not all patients are sent for such therapy following surgery; it depends on the patient and their activity level. He said the determining factor for when to remove the pins depends on the patient; they can be left on for three to four months. In this case he believes the removal was moved up a bit because of the patient's plans to travel out of state. Typically he would like to leave them on for at least six weeks with weight bearing, but it all depends on the patient's compliance with the post-operative course of care. Dr. Saunders stated that at the time he removed J.T.'s pins she was walking well and everything seemed okay and added that the patient had been able to go on extended hikes prior to the stress fracture occurring. He stated he has not seen any retrospective proof of osteomyelitis in the leg and reviewed that the outside x-rays which were read by a Board-certified radiologist did not show any disease process in the leg.

Mr. Rhodes asked Dr. Saunders if he felt the patient's level of activity contributed to the fracture. Dr. Saunders stated he did not know, but he feels the fact that the patient was able to regain such activity level demonstrates that the surgery was successful and was a good choice because without it she may not have been able to be so active. He added that anyone can walk for an extended period of time and develop a stress fracture, especially a person who has had surgery; it takes at least two months for bone to heal following external fixation. Dr. Leonetti asked Dr. Saunders about the wounds seen in the pictures submitted by the patient and if they showed ulcers that he had seen in the patient. Dr. Saunders confirmed that he did use a wound vac to treat one wound on the patient's leg but he is not able to determine when the patient's pictures were taken so he cannot say if the wounds shown in them were wounds that were present while he was treating the patient.

Patient J.T. addressed the Board and answered questions from Drs. Campbell and Leonetti. She stated she had spoken to Dr. Saunders numerous times about a possible infection but he would only use the word "irritation." It was after the pin replacement surgery that the large wound developed. Based on what she says Dr. Worthington told her, she believes the wound was caused by Dr. Saunders drilling a hole at that location for placement of a pin which he then did not use. J.T. clarified that she had been in Las Vegas for leisure and the hiking was the weekend prior to that trip. She confirmed that the wound was still open at the time of her hike but was covered with a bandage. When she was at physical therapy she said the wound would ooze and the physical therapist checked for signs of infection. She said Dr.

Saunders never did a wound culture and she does not recall him ever giving her any antibiotics. Then while she was walking in Las Vegas her leg spontaneously fractured. Upon returning to Phoenix she was Dr. Deiner who did a culture and ordered an MRI. She said it was Dr. Deiner who diagnosed osteomyelitis. She was hospitalized for two weeks after which time the wound finally healed. Dr. Leonetti confirmed with J.T. that Dr. Saunders had ordered the x-ray which was found by the radiologist not to show any sign of infection. J.T. disagreed with the radiologist's findings. Dr. Worthington did reconstructive surgery to the leg and an internal rod was placed due to non-union of the tibia fracture.

Dr. Leonetti and Dr. Kaplan discussed the findings of Dr. Worthington. Dr. Kaplan stated that Dr. Worthington did not document the cause of the fracture, only that there was a fracture. All Board members reviewed the x-rays submitted by Dr. Worthington. The fracture site and internal fixation device were visible. The x-rays were compared with the pictures submitted by the patient and it appears that the fracture is mid-shaft in the tibia well above the sites of the pin placements by Dr. Saunders. Dr. Kaplan stated he had believed all of the pictures submitted by the patient were immediately following surgery with Dr. Saunders, the patient confirmed that they were taken after her fracture during her course of treatment with Dr. Worthington. Dr. Leonetti asked Dr. Kaplan what was documented in Dr. Saunders' records regarding the wound. Dr. Kaplan stated there were no details of the characteristics of the wound such as the location or size, but he indicated he had done a sharp debridement. Dr. Saunders also did document that there was no drainage, swelling or signs of infection.

Dr. Leonetti again addressed Dr. Saunders and asked him if he had drilled a hole for a pin placement which he ended up not using. Dr. Saunders stated he cannot confirm that, but in this patient's case he changed the construction of the frame and the replacement pins would not have been placed in the area where the wound developed. He stated he does not believe the wound was due to a pin tract or drill hole. Mr. Crawford interjected that the post-operative records do describe the wound regarding size, granulation and that there were no signs of infection. Dr. Saunders stated the wound he was treating was lateral to one of the pins and was superficial, about 1cm in size. However, the patient stated the wound above the pin sites is what Dr. Saunders had been treating. Dr. Saunders stated the wound in the patient's picture is in the same general vicinity, and Mr. Crawford asserted that the wound in the patient's pictures is from after Dr. Worthington's surgery.

In summary, Dr. Leonetti stated that the arthrodesis procedure was an acceptable form of treatment for the patient's chronic pain prior to a fusion or implant. He believes the patient was a good candidate for the procedure and understood the possible risks associated with use of external fixators. He does not find any violations to support an improper surgery. Looking at the post-operative x-rays he believes the fracture was well above the level of pin insertions, and the x-ray on 03/02/07 showed no signs of infection. He feels that if there was an infection present on that date which was significant enough to cause a fracture on 03/13/07, it would have been seen on the x-ray. Dr. Leonetti added, however, that he does have concerns with Dr. Saunders' documentation. He stated the documentation falls below acceptable standards because of: 1) the x-rays were mismarked, 2) the lack of documentation regarding the injections given to the patient during the conservative treatment prior to surgery, and 3) the wound care description is questionable. The patient had a very bad incident with the fracture but Dr. Saunders never treated her after that. Wounds and infections can be complications of this type of surgery but it could happen anywhere to any patient. He does not have any issue with the surgery, just the overall documentation. Ms. Miles asked Drs. Leonetti and Campbell if they were satisfied that Dr. Saunders met the minimum standard of care and both stated yes. Dr. Leonetti stated that an MRI may or may not have picked on the infection sooner but Dr. Saunders had no indication that an MRI was necessary; this was just an unfortunate outcome..

**MOTION:** Dr. Leonetti moved to dismiss this case with a Letter of Concern for improper documentation and lack of documentation throughout the patient's course of care. Dr. Campbell seconded the motion.

**DISCUSSION:** Mr. Rhodes asked whether the x-rays being mismarked would be the fault of Dr. Saunders or the radiologist. Dr. Leonetti stated for x-rays done in Dr. Saunders' office, Dr. Saunders would be responsible. There was no further discussion.

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

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**c. 10-01-C – Roberta Rowland, DPM: Inappropriate prescribing.**

Dr. Rowland was not present. Dr. Dedrie Polakof was the physician investigator and summarized the case. The Board received a complaint from R.H. who had dated E.S., a patient of Dr. Rowland. R.H. alleged that Dr. Rowland inappropriately prescribed narcotics to patient E.S. Dr. Polakof attempted to contact the complainant several times unsuccessfully because the phone number was disconnected. She was able to speak with Dr. Rowland by phone to review patient's E.S.'s information. Dr. Rowland had in fact prescribed pain medication to the patient but only in relation to surgical procedures performed by her. Dr. Polakof found no incident where medication was prescribed which was unrelated to a surgical procedure. She finds that the medication prescribed was appropriate and she did not see any violations in the care provided to the patient by Dr. Rowland. Dr. Leonetti asked about the nature of the complaint. Dr. Polakof explained that the complainant alleged that prescriptions for narcotics were being given to E.S. without a medical cause. Dr. Polakof added that the complainant had asked Dr. Rowland for a narcotics prescription for her own use but Dr. Rowland had refused. Dr. Polakof added that Dr. Rowland also had filed a complaint of harassment with the sheriff's office against R.H., and it was after that that R.H. filed her complaint with the Board.

**MOTION:** Ms. Miles moved to dismiss the complaint finding no violations. Dr. Kaplan seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

**d. 10-16-C – J. David Brown, DPM: Providing unnecessary treatment to a patient.**

Dr. Brown was not present. Attorney Bruce Crawford was present earlier in the meeting and had advised the Board that he inadvertently told Dr. Brown that he would not need to be present today. Mr. Crawford is not representing Dr. Brown in this case, but he apparently had confused this matter with another matter pending before the Board for which he is representing Dr. Brown. Ms. Penttinen offered that Dr. Brown had been properly notified on this matter being on today's agenda and he had not contacted her in this regard. Ms. Miles stated that based on the information provided by Mr. Crawford she would like to postpone review of this case due to unusual circumstances. Mr. Rhodes and Dr. Leonetti voice their agreement. The Board members agreed to postpone review of this matter until the October 12, 2011 meeting.

**V. Review, Discussion and Possible Action – Probation / Disciplinary Matters**

**a. 07-28-C – Kent Peterson, DPM: Monthly update.**

(Ms. Miles was not present.) Ms. Penttinen confirmed that Dr. Peterson has been advised that the Board would like him to appear at the October Board meeting to review his complete charts for the probation period. Dr. Peterson also has been asked to provide billing records for all charts already submitted. She was contacted by Dr. Peterson's staff who advised they are sending the HCFA forms and Ms. Penttinen will forward them to Dr. Leonetti upon receipt. However, there has been no confirmation as to whether Dr. Peterson will appear in October.

Attorney Bruce Crawford, who represents Dr. Peterson in this matter, was present and addressed the Board. He stated that due to a schedule conflict Dr. Peterson would like to postpone his appearance before the Board until the November Board meeting. Dr. Kaplan stated that should be fine as long as he submits all the necessary records through the present time. There was discussion among the Board members and Ms. Penttinen regarding the period of probation. It was a three-month probation with the consent agreement signed in March 2011, so records were submitted for the months of April, May and June. Ms. Penttinen stated Dr. Peterson's staff indicated they would not be sending records for July, August or September because that was not part of the probation period. Dr. Leonetti asked Ms. Verstegen for her opinion as Dr. Peterson has not requested termination of his probation. Ms. Verstegen reviewed the document and confirmed the probation was for a set time period. Ms. Penttinen confirmed that there was no requirement in the consent agreement for Dr. Peterson to formally request termination of his probation. Dr. Leonetti stated the Board will evaluate all the charts that have been submitted once the billing records have been received. All present Board members agreed that it was acceptable to postpone Dr. Peterson's appearance to the November meeting. Mr. Crawford stated he would ensure that Dr. Peterson submits the necessary billing records.

Mr. Rhodes asked if the probation is already terminated, would it be necessary to reinstate the probation at this time. Dr. Leonetti stated that even though the probation period is technically over the Board can

still evaluate the records submitted and can initiate a separate action if needed if there any problems discovered in those records. Dr. Kaplan confirmed this. Mr. Crawford offered that he feels it would be best to handle any concerns under the present matter without opening a separate case. Dr. Leonetti stated that before any further action would be taken the Board needs to evaluate the records already submitted. Drs. Kaplan and Leonetti confirmed that the issue at this point is that Dr. Peterson did not submit complete charts because he did not submit the billing records, so the first step is for the billing records to be submitted and the Board will go from there. Ms. Verstegen offered that if there is a problem discovered in the records the Board could offer an amendment to the consent agreement already in place to extend the period of probation for further review of patient charts.

b. 08-03-C – Elaine Shapiro, DPM: Monthly update.

(Ms. Miles was not present.) Ms. Penttinen advised that the last quarterly report was received last month so the next one is due in November. She has not received any reports from Dr. Sucher of any on-compliance.

c. 08-44-C – Alex Bui, DPM: Monthly update.

(Ms. Miles was not present.) Ms. Penttinen reviewed the CME approval request she received yesterday from Dr. Bui for a course by the American College of Foot & Ankle Surgeons. The course would provide 10 hours of CME in billing so Dr. Bui would still need 15 hours. Dr. Bui also is still working on providing more information on “E/M University” and “Dr. Jensen” for the Board to review for the other CME courses he has proposed, although he has decided to forego any of the hospital-related courses. Dr. Leonetti stated he feels the ACFAS is a good course and that organization is well-respected

MOTION: Dr. Leonetti moved to approve the ACFAS course. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Dr. Kaplan also review the letter submitted by Dr. Bui indicating he does not have any charts to submit for the previous month for durable medical equipment charges.

d. 09-17-B – J. David Brown, DPM: Monthly update.

(Ms. Miles was not present.) Ms. Penttinen advised that the last quarterly report was received last month so the next one is due in November. She has not received any reports from Dr. Sucher of any on-compliance.

e. 11-07-B – James Wilson, DPM: Update on Order of Revocation.

(Ms. Miles was not present.) Ms. Penttinen advised that Order issued by the Board, which accepted the recommendation of the Administrative Law Judge to revoke Dr. Wilson’s license, had been signed and sent to Dr. Wilson. The last date for Dr. Wilson to file an appeal to that action was August 30, 2011. No appeal was received so as of August 31 Dr. Wilson’s license is revoked. The matter is now officially closed. Dr. Kaplan asked if there was any update as to what happened with Dr. Wilson’s patient charts in his office. Ms. Penttinen stated that to her knowledge the landlord of the office building was still trying to figure out what to do.

## **VI. Review, Discussion and Possible Action on Administrative Matters**

a. Discussion regarding time frame for physicians to re-apply for a license if they have previously had their license revoked or surrendered.

(Ms. Miles was not present.) Dr. Kaplan explained that he had requested this subject to be placed no a meeting agenda for Board discussion because when the Order was issued for the revocation of Dr. James Wilson’s license there was no time period included for when he could re-apply for a license. He stated that in the past the Board included a time frame for how long the physician would have to wait before re-applying for a license and he would like to be able to consider that for any future license revocations the Board may consider. Ms. Verstegen advised that such a time period could be included in a consent agreement but the Board does not have the statutory authority to include it in a disciplinary Order. There was discussion among the Board members and Ms. Penttinen regarding the order issued against Dr. Wilson in contrast to the previous consent agreement for surrender of license which was accepted by the Board in the matter of Dr. Corina Hollander. Ms. Penttinen confirmed that there was no stipulation in Dr. Hollander’s agreement regarding a time period for re-application; however, the Board still would have the option, if appropriate, to deny a re-application based on the nature of any surrender

or revocation. Ms. Verstegen confirmed that a time-prohibition stipulation could be added to future consent agreements of this nature.

b. Email correspondence received from Assistant Attorney General Seth Hargraves following the August 10, 2011 Board meeting.

(Ms. Miles was not present.) Dr. Kaplan reviewed the correspondence submitted by Mr. Hargraves. Mr. Hargraves believes that because agenda items were reviewed out-of-order in comparison to the Board meeting agenda, the minutes should be written in the exact order that the agenda items were considered in order to make the minutes "accurate." Dr. Kaplan noted that the Board reserves the ability to review agenda items out-of-order, and despite Mr. Hargraves' objection the Board elected to maintain the meeting minutes as drafted (in agenda order). Dr. Kaplan asked what type of response Mr. Hargraves was requesting. Ms. Penttinen stated that Mr. Hargraves wanted a confirmation that the Board disagreed with his advice and she did not want to respond before consulting the Board members. Dr. Kaplan asked if the Board disagrees with his advice would he then go to another source for another opinion. Ms. Penttinen stated she was uncertain of the intent of Mr. Hargraves' email. Ms. Verstegen stated that she does not feel the Board needs to take any action in this matter. She stated that there was discussion in one of her staff meetings on this matter and there was no clear consensus or directive. She feels that the Board's minutes are acceptable as is, but added that it may be helpful to add language to the Board's minutes to indicate that agenda items may have been reviewed out-of-order. Dr. Kaplan asked if the Board needed to take any formal action on this matter. Ms. Penttinen said the Board could just let her know if they would like her to send any official response.

Dr. Leonetti said he said the Board should also review the second issue raised by Mr. Hargraves which was that the Board took action to terminate an order of probation under the agenda heading of "probation monthly update." He asked Ms. Verstegen if she agreed with the Board's decision to terminate a probation order without it being specifically agendized as a "request for termination." Ms. Verstegen advised that it may be beneficial going forward, if the Board has received a request to terminate a probation order," to specify that on the agenda. Ms. Penttinen advised that she had spoken with Marc Harris who is one of the leaders of the Licensing and Enforcement Section of the Attorney General's Office. He had suggested that a small change in the language of the Board's agendas which is reflected in today's agenda. It now says, "Review, Discussion and Possible Action: Probation / Disciplinary Matters" so it is now more inclusive of all probation-related issues. Ms. Penttinen also stated that Mr. Harris did not have any issue with the Board taking action on a probation termination request under the heading "monthly update." However, he did suggest specifying such a request on the agenda simply to avoid any confusion or need for clarification such as the present discussion. The present Board members were in agreement that no response would be sent to Mr. Hargraves.

c. CME approval request from Dr. Joyce Ratner.

(Ms. Miles was not present.) Ms. Penttinen advised that Dr. Ratner is taking a course to become a personal fitness trainer and wanted approval for all 25 hours of CME for her 2012 podiatry license renewal due to the volume of subject matter in the trainer's course regarding such things as anatomy and physiology, cardiovascular issues, biomechanics, etc. The course is an internet-based, independent study program; however, Dr. Ratner has upgraded her program so that she is working directly with a program instructor on a regular basis and it is more of a one-on-one program in contrast to straight independent study. Dr. Leonetti stated he thinks it is a nice course but not related to podiatry for CME purposes. Dr. Kaplan stated he agreed and stated he had reviewed the index of the courses and does not find enough relation to podiatry. Ms. Penttinen added that she had reviewed the course content with Dr. Ratner who understood that topics such as "building a rapport with your fitness patient" probably would not be approved but she was more interested in approval of the physiology-related topics. Drs. Kaplan, Leonetti and Campbell agreed it would be too difficult to pull out information from the course book to determine which portions were relevant. Dr. Leonetti stated he does not feel this is a program designed to further educate a podiatry physician in the practice of medicine.

MOTION: Dr. Leonetti moved to deny the request for CME. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. 2012 Board meeting dates, and examination dates for new license applicants.

(Ms. Miles was not present.) Ms. Penttinen reviewed the proposed meeting dates for 2012. There are no schedule or holiday conflicts with keeping the meetings on the second Wednesday of each month.

The Board agreed with these dates. The Board also agreed to hold the oral examinations for new license applicants in June and December. The Board meetings will start at 8:00 a.m. on those two dates and 8:30 a.m. for all other dates.

- e. License renewal applications: The Board will review, discuss and take action to approve, deny, or issue a deficiency notice for the following physicians' license renewal applications and/or dispensing registrations:

Randall Brower  
Todd Haddon  
David Jenkins  
Noland Jones  
Cindy Mann

Steven Mann  
Hartley Miltchin  
Roland Palmquist  
Deo Rampertab  
Maria Sangalang

Vivian Seater-Benson  
Robert Taylor  
Edward Tierney  
Kyle Vaughn  
Todd Zang

In relation to Dr. Palmquist, Ms. Penttinen explained that the renewal application was not received by August 31, 2011, but it was post-marked on that date. Dr. Palmquist works for a federal hospital in Parker, Arizona and told Ms. Penttinen that the hospital had held the paperwork while producing a check for the renewal fee. The Board members were in agreement that the post-mark date would be accepted as a timely filing. In relation to Drs. Tierney and Haddon, the Board members elected to refund the late renewal fees paid by both doctors. The actual forms, though incorrect, had been timely filed although the corrections and deficiencies were not corrected until after July 30. The Board members determined that as long as the application form is submitted timely and is substantially complete, a late fee would not be assessed. Ms. Penttinen stated she would submit the necessary documentation to refund the late fees for Drs. Tierney and Haddon. In relation to Dr. Bui, Dr. Kaplan noted that Dr. Bui did not indicate he wished to renew a dispensing registration. Ms. Penttinen advised that she had reviewed Dr. Bui's license file and he has never held a registration to dispense drugs and devices. The Board members were in agreement that an investigation case should be opened on Dr. Bui for dispensing durable medical equipment without a registration to dispense drug and devices. In relation to Dr. Zang, he completed 17.75 hours of CME and requested that the Board waive the remainder of his CME requirement due to personal issues. Dr. Zang did not provide any information to support a CME waiver under A.A.C. R-25-505. The Board members were in agreement to provide a 60-day extension to Dr. Zang to complete the outstanding CME hours. Dr. Leonetti also would like additional information regarding the CME courses which were submitted; all Board members were in agreement. In relation to Dr. Brown, Dr. Kaplan would like Ms. Penttinen to inquire with Dr. Brown and obtain additional information regarding malpractice cases disclosed on his renewal application and open investigations if not done so already.

MOTION: Dr. Kaplan moved to approve all license renewal applications, exclusive of Dr. Zang. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

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

### a. Request for salary increase.

The Board reviewed a salary increase request submitted by Ms. Penttinen. Ms. Penttinen explained that her current salary is \$56,650 annually and she has not had a salary increase since she began with the Board in December 2008. She is requesting a new salary of \$62,500 which represents a 5% increase for each of two years. Ms. Penttinen explained the associated Employee Related Expenses and had the Board's financial reports available for review. There was discussion among the Board members about the amount of the increase and associated costs. Dr. Leonetti stated that in the current economic climate he would be in favor of increasing the salary to \$60,000 annually. Ms. Miles stated she would support an increase of 3% per year.

MOTION: Dr. Leonetti moved to approve a salary increase to the amount of \$60,000 annually. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Following the vote Ms. Penttinen asked to clarify if the increase would be effective beginning at the start of the next pay period. All Board members were in agreement that it would.

b. Open complaint status report.

Ms. Penttinen advised that updating the database and removing old complaints has been very cumbersome so she has worked off the Excel spreadsheet she presented to the Board at last month's meeting. The Board currently has 66 open complaints and the spreadsheet provided today indicates the status of each complaint, including those that were scheduled for review either today or for the October meeting. There are also many cases ready to be assigned to investigators which she and Dr. Kaplan will review immediately following today's Board meeting.

c. New Legislation: HB 2520 which amended A.R.S. §32-3214 regarding Board actions posted to the Board's website.

(Ms. Miles was not present.) Ms. Penttinen reviewed that there had been a bill which was passed during the 2010 legislative session which amended A.R.S. §32-3214. At amended at that time, the statute stated that a healthcare regulatory board was not allowed to post to its public website any non-disciplinary actions, but did allow the posting of Advisory Letters or Letters of Concern. Essentially the only action affected by this was a non-disciplinary order or continuing medical education. However, another bill was passed in the 2011 legislative session to amend this statute again. The statute now prohibits the posting of any non-disciplinary action including Advisory Letters and Letters of Concern. The enacting law also requires that all healthcare regulatory boards provide language on their websites indicating to the public that not all publicly available information is posted on the website and further information can be obtained by contacting the board's office. The required compliance date is January 1, 2012. Ms. Penttinen will work with the contracted IT staff to modify the database and the Board's website prior to the compliance date. Dr. Kaplan asked if the non-disciplinary information could still be given to the public if they call by phone. Ms. Penttinen stated it could. Dr. Kaplan also asked about Board meeting minutes. Ms. Penttinen explained that the law does not prohibit including information on non-disciplinary actions in the Board's meeting minutes and that those minutes can still be published on the Board's website. Dr. Leonetti noted that it is ironic that there has been such a push to make information available to the public but now the Board is going to have a website that is not accurate.

d. Malpractice case report.

Dr. Kaplan reviewed that no new malpractice reports had been received in the last month.

**VIII. Call To The Public**

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

**IX. Next Board Meeting Date:**

a. October 12, 2011 at 8:30 a.m.

**X. Adjournment**

MOTION: Dr. Kaplan moved to adjourn the meeting. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote and the meeting was adjourned at 12:15 p.m.