



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

May 9, 2012; 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: Marc Harris

I. Call to Order

The meeting was called to order at 8:30 AM.

II. Roll Call

Dr. Kaplan noted that Dr. Leonetti was absent. All other board members were present, as were Ms. Penttinen and Mr. Harris.

III. Approval of Minutes

a. April 11, 2012 Regular Session Minutes.

MOTION: Ms. Miles moved to approve the minutes as drafted. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

b. April 11, 2012 Executive Session Minutes.

MOTION: Ms. Miles moved to approve the minutes as drafted. Dr. Campbell 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 (NOTE: The subject matter listed for each agenda item represents the allegation(s) being investigated. The presence of allegations does not automatically indicate violation of Statute or Rule in connection with the practice of podiatry.)

a. 09-14-C – J. David Brown, DPM: Charging an excessive fee for a cam walker. (Previously reviewed and tabled on December 14, 2012. Review of additional information submitted by Dr. Brown.)

Dr. Kaplan recused himself as he was the physician investigator for this case. Dr. Campbell served as acting President. Dr. Brown was not present. Ms. Penttinen reviewed this case as follows: the board had reviewed this complaint in October 2011 at which time there were concerns about the improper use of billing code L2116 which resulted in charging an excessive fee. The board had asked Dr. Brown to correct his billing with the patient's insurance company and submit documentation of his efforts to do so. The board also had wanted Dr. Brown to obtain additional training in the areas of billing and coding. Dr. Brown's attorney, Bruce Crawford, submitted a packet to the board on January 27, 2012, and it appears that the information he provided sufficiently addresses the board's concerns. Dr. Brown has attempted to correct the billing for this patient with the insurance company but due to the insurance company's policies it is now up to the insurance to move forward with correction. Dr. Brown also submitted a completion certificate for a billing and coding seminar for six hours. When this case was last reviewed by the board, the board members had indicated that they would be willing to dismiss this case with a Letter of Concern

upon Dr. Brown demonstrating correction of the board's concerns, and it appears that Dr. Brown has done so.

Dr. Kaplan did not have any comments and the board members did not have any questions.

MOTION: Dr. Campbell moved to dismiss this case with a Letter of Concern for improper use of billing code L2116. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

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

b. 09-21-C – J. David Brown, DPM: Review of status of consent agreement previously offered by the Board.

Dr. Brown was not present. Ms. Penttinen reviewed the following information: the board had previously reviewed this case on December 14, 2011. The board voted to offer Dr. Brown a consent agreement with various requirements for a violation of A.R.S. §32-854.01 (20) which is "any conduct or practice which is or might be harmful or dangerous to the health of the patient." Mr. Crawford has had the proposed consent agreement for a little over two months. Ms. Penttinen has asked him for updates regarding whether or not Dr. Brown was willing to accept the terms of the agreement, or if there were any questions or concerns about the content of the agreement. There have been delays because Mr. Crawford was not able to meet with Dr. Brown to review the agreement for a lengthy period of time, and then once Dr. Brown reviewed it he was uncertain if he wanted to accept it. Ms. Penttinen sent Mr. Crawford an e-mail approximately one week ago asking whether he had any questions or concerns about the agreement but Mr. Crawford has not responded.

Dr. Kaplan asked how much time should be allowed for Dr. Brown to accept the consent agreement or move on to other action. Ms. Penttinen stated it would be at the board's discretion if they wanted to set a specific time period for Dr. Brown to accept the consent agreement or refer this matter to a formal hearing. Dr. Kaplan stated he feels that Dr. Brown and Mr. Crawford should be given two weeks to either accept the agreement or respond with any questions or concerns that they have about the content of the agreement. Ms. Miles asked Ms. Penttinen when her last contact was with Mr. Crawford. Ms. Penttinen advised she had sent an e-mail message to Mr. Crawford one week ago.

MOTION: Ms. Miles moved to give Mr. Crawford and Dr. Brown one week from today to accept the consent agreement or the matter would be referred to a formal hearing. There was brief discussion between Dr. Kaplan, Ms. Miles, and Ms. Penttinen regarding mailing time and whether or not correspondence to Mr. Crawford in this matter would be sent by fax and/or regular mail. Ms. Miles amended her motion to change the date of acceptance to Friday, May 18, 2012. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

c. 10-14-C – Kevin O'Brien, DPM: Practice below the standard of care for improper surgical correction of a hammertoe condition.

Dr. O'Brien was present without an attorney. Dr. Dedrie Polakof was the investigator for this case. She was present and summarized the complaint investigation as follows: the board received a complaint against Dr. O'Brien from patient D.C. The patient stated that Dr. O'Brien performed surgery to correct a hammertoe condition of her left second and third toes. She claims the surgery was not done correctly and actually made her toes worse. She also stated that Dr. O'Brien initially failed to close the surgical sites and put in stitches after she was in recovery.

Dr. Polakof reviewed the patient's medical records as follows: the records indicate that the patient did have hammertoe deformities of the second and third toes of her left foot. The surgery that was performed included two Swanson implants. There were no x-rays to review because Dr. O'Brien's original x-rays for the patient were given to her to take to another physician and they were not returned. (The patient had gone to see Dr. James Wilson who has since abandoned his practice and all records have been destroyed by the property owner.) Dr. Polakof also obtained records from the surgical center where the

procedure was done to determine if there were any unusual events that occurred in the post-operative area. She states that there were no post-operative notes which indicated any unusual event. The surgery was performed on August 21, 2008. During the first post-operative follow-up visit on August 27, Dr. O'Brien noted normal healing and slight inflammation. On the second post-operative visit Dr. O'Brien noted increased inflammation and referred the patient to physical therapy. Dr. Polakof noted that the notes from the physical therapist indicate that very little attention was paid to the hammertoe conditions, but rather he focused on a hallux limitus and range of motion for the hallux. The patient was given exercises for the hallux but not for the hammertoes. Dr. Polakof summarized that it appears the outcome of this procedure was not a perfect, cosmetically pleasing outcome for the patient; however, she did not find any deviation from the standard of care or any violations.

Dr. Kaplan stated that normally if there were any type of unusual events in the recovery area following a surgery, the staff at the facility would document it in the patient's chart. In this case there was no such documentation so it appears that nothing unusual occurred. He added that he sees in the operative report that the patient was slightly awake at one point during the procedure but he does not find any problems with the anesthesia that was administered to the patient. Dr. Kaplan continued and stated that the operative report indicates that sutures were placed during the procedure which he believes must have occurred. If Dr. O'Brien had not placed sutures during the procedure, then as soon as the tourniquet was removed there would have been extensive bleeding inside the operating room; the bleeding would not have waited to start until the patient was in the recovery room. Dr. Polakof noted that in the post-operative pictures which were supplied by the patient, although the toes appear slightly crooked the incision sites appear slim which indicates that the suturing was done well. Dr. Kaplan noted that according to the patient the sutures were placed in the recovery room. Dr. Kaplan stated that he does not see any problems with this case. Sometimes there is a bad result but it does not indicate that the surgery was done improperly. Dr. Kaplan asked Dr. O'Brien if he had taken post-operative x-rays, and Dr. O'Brien stated that he did. Dr. Kaplan asked if those x-rays showed that the implants were still intact, and Dr. O'Brien stated that was correct. Dr. Kaplan noted that Dr. Robert Novak, who also had treated this patient, documented in his notes for this patient that he removed one of the implants in two pieces; however, it is not known if Dr. Novak had to cut the implant in order to remove it or if it had broken. Dr. O'Brien stated that he had seen the patient in September but then did not see her again until the following August so it is possible that something happened during that time which caused the implants to break. Dr. Kaplan agreed and stated that it was unclear from the records how the implants became separated into two pieces.

MOTION: Dr. Kaplan moved to dismiss this case finding no violations. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. 11-12-C – Barbara Campbell, DPM: Rude behavior toward a patient.

Dr. Campbell recused herself. Ms. Penttinen was the investigator for this case and provided the following summary: a complaint against Dr. Campbell was received from patient A.G. who stated she had seen Dr. Campbell on February 1, 2011 due to pain in her right foot. Dr. Campbell determined it was a cyst on her fourth toe. The cyst was removed and the patient was advised to return to the office for a checkup in two weeks. On February 3 the patient requested to return to the office due to excessive pain and was given an appointment time of 5 PM that afternoon. However, the patient was able to see a physician assistant at the Mayo Clinic at 1:30 PM that afternoon. The patient stated that she called Dr. Campbell's office at 1 PM to cancel her appointment but there must have been some type of miscommunication. When the patient returned to Dr. Campbell's office in March for a regular checkup she states that both Dr. Campbell and her nurse seemed very upset with her. The patient thought their demeanor was unprofessional because they told her that they had canceled dinner plans in order to accommodate her appointment on February 3. The patient feels that Dr. Campbell and her nurse should have been more willing to accept her apology.

In her written response to the complaint, Dr. Campbell stated that she has been treating this patient for a very long period of time. She believes there may have been some miscommunication and admitted there was a possibility that a message from the patient could have been lost. Ms. Penttinen stated she does

not believe losing a phone message would rise the level of a violation. When she spoke with the patient by phone, the patient was somewhat difficult to talk to and she feels this may have been a "he said-she said" incident. The patient did advise Ms. Penttinen that her foot healed with no further complications and she did not experience any delay in care. Ms. Penttinen concluded that, even giving the benefit of the doubt to the patient, she does not feel that there was any harm to the patient or any violation in this case. Dr. Kaplan noted that Dr. Campbell had been treating this patient for approximately 15 years and he found it strange that an incident like this would prompt the patient to file complaints with both the board and the Better Business Bureau. Dr. Campbell was offered the opportunity to address the board members but chose not to do so.

MOTION: Dr. Kaplan moved to dismiss this case finding no violations. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

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

e. 11-14-C – Marvin Dobkin, DPM: Failing or refusing to provide medical records upon request.

Dr. Dobkin was not present. Ms. Penttinen was the investigator for this case and provided the following summary: a complaint against Dr. Dobkin was received from patient M.R. who had been in the custody of the Arizona Department of Corrections, ("ADC"), since 2009. The patient alleged that he had made several requests to Dr. Dobkin for copies of his medical records to be submitted to the ADC but they have not been sent. Patient explained that he has several problems with his feet and is also a diabetic. He states that the medical shoes provided to him by the ADC are not sufficient for his needs; however, they will not provide him with what he feels is appropriate shoe gear unless they can review the medical records from Dr. Dobkin. The patient felt that his medical care was being compromised due to Dr. Dobkin's failure to submit his records. Because the patient was incarcerated at the time of his complaint Ms. Penttinen was not able to interview him. He did not provide copies of any medical records requests or indicate in his written complaint the dates that his requests were sent.

In his written response Dr. Dobkin stated that he had not received any requests for copies of the patient's medical records. He also stated that it may be possible that perhaps one request was misplaced in his office, but not multiple requests. Dr. Dobkin did submit a copy of the patient's medical records which demonstrates that he does still have custody of them in accordance with the appropriate medical records retention laws. Ms. Penttinen contacted Dr. Dobkin by phone and asked if he had subsequently sent a copy of the patient's records to the ADC. Dr. Dobkin stated he had not and would not do so unless he received a written request from the patient. Ms. Penttinen added that she had sent a letter to the patient advising him that the board would be reviewing his complaint. However, that letter was returned by the ADC with a note indicating that he is no longer in their custody. It is unknown when the patient was released; however, the patient has not contacted the board in any way to provide updated contact information. Ms. Penttinen concluded that based on Dr. Dobkin's response and lack of information from the patient there is not sufficient evidence to support a violation.

Dr. Kaplan stated that the records could not be sent without a request from the patient. He added that if multiple requests had been sent they would have been copied in the patient's chart and in his opinion it is unlikely that multiple records requests would have been lost or not retained in the chart. Ms. Penttinen stated that in her opinion the only alternative would be if Dr. Dobkin had purposely destroyed the records requests which is unlikely. Ms. Miles stated that, once Dr. Dobkin received a copy of the complaint, she is disappointed that he would not send the records at that time. Ms. Penttinen asked Ms. Miles if she meant that she would have considered the complaint letter to the board to be a request for the records, and Ms. Miles stated yes. Dr. Kaplan stated that he disagreed with this and asked where the records would have been sent to. Ms. Penttinen clarified that the patient's address at the ADC was on the copy of the complaint letter that was sent to Dr. Dobkin, but it is unknown what date he was released from custody. Dr. Kaplan asked Dr. Campbell how she would handle this type of situation. Dr. Campbell stated that she would have sent an authorization form to the patient advising him to complete it and return it to her, then she would send the records. Ms. Miles added that the patient being imprisoned would have caused a great deal of difficulty communicating with him or getting an authorization form to him. Dr. Kaplan added that he is uncertain how he would handle this type of situation but would consider the actions described by Dr. Campbell.

MOTION: Ms. Miles moved to dismiss this case finding no violations. Dr. Campbell seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

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

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

Ms. Penttinen reviewed the update letter submitted by Dr. Sucher. The update indicates that Dr. Shapiro is not participating in any monitoring activities. The board will continue to receive updates from Dr. Sucher until the final status of Dr. Shapiro's license is determined.

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

Dr. Kaplan reviewed the monthly update from Dr. Bui which indicates that he did not have any charts or records to submit for DME billing during the month of April.

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

Ms. Penttinen reviewed the update letter submitted by Dr. Sucher. The update indicates that Dr. Brown is in compliance with all monitoring requirements. Dr. Sucher also provided the board with copies of all of Dr. Brown's drug tests which came up positive during the last quarter. Those positive results are for medications for which Dr. Brown has proper prescriptions, and the quantitative levels indicate that Dr. Brown is using those medications within acceptable therapeutic ranges.

VI. Review, Discussion and Possible Action on Administrative Matters

a. Review of advertisement by Premier Research regarding a medical study of bunions.

Dr. Kaplan reviewed an advertisement which he discovered from a company called Premier Research for a research study. The study involves testing of an investigational pain medication following bunion surgery. The advertisement indicates that bunion removal surgery will be conducted by a board-certified podiatrist. Dr. Kaplan had gone to the website for Premier Research and found that this study is being conducted in Arizona, Texas and Utah. Dr. Kaplan stated that he had a concern that there was no specific physician's name listed in the advertisement and he believes there was a law recently passed regarding this. Ms. Penttinen offered clarification that the law which she believed Dr. Kaplan was referring to is a law that requires a medical doctor to include in their advertising what type of doctor they are such as M.D. or D.O. This clarifies for the public that when a doctor is reference in healthcare related advertisements the doctor is an actual healthcare practitioner and not a PhD. Dr. Kaplan agreed.

Ms. Penttinen had printed information from the company's website (www.mybunionstudy.com) for the board members to review. The main page on that website includes a "preliminary questionnaire" for potential patients to complete if they wish to participate in the study. Dr. Kaplan stated that there had been a similar study done in the Phoenix area in the past and the board received a complaint from a patient in that study. The patient believed that his bunion deformity was going to be completely corrected; however, what was actually done was just a shaving of the end of the first metatarsal bone. Dr. Kaplan reviewed the statement in the advertisement which says, "Must also be willing to participate in three overnight stays in the clinic." Dr. Kaplan was concerned that the name of the clinic or type of clinic was not specified. He is also concerned that the advertisement may be misleading regarding exactly what type of procedure is going to be done. Ms. Penttinen stated that if it was the board's desire she could contact Premier Research and find out which doctors are going to be performing the procedures as well as the exact type of procedure that will be done. Dr. Kaplan agreed and added that he would also like to know the name of the clinic being used. Ms. Miles suggested that Ms. Penttinen could complete the preliminary questionnaire on the website as if she were a patient, and then obtain the information the board would like when the research company contacts her. Dr. Kaplan stated he felt that was a good suggestion. Mr. Harris suggested that the board memorialize this decision with a motion.

MOTION: Ms. Miles moved to have Ms. Penttinen conduct an investigation regarding this research study by completing the information on the research company's website as if she were a potential patient for the purpose of determining which doctors are involved, which clinic

is being used, and what type of procedures going to be done. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

- b. 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:

Petrusia Howansky, DPM
Joseph Knochel, DPM
Duane Kratzer, DPM
Kelly Reber, DPM
Travis Reber, DPM

M.A. Rosales, DPM
Kenneth Rowe, DPM
Alan Shih, DPM

The board members reviewed the license renewal applications for each of the physicians listed above. Ms. Penttinen had previously determined that each of the applications was administratively complete. The board members determined that there were no substantive deficiencies for any of these renewal applications. However, the board members wished to open a complaint investigation case for Dr. Kelly Reber regarding malpractice information disclosed on his application form.

MOTION: Dr. Kaplan moved to open a complaint investigation file for Dr. Reber as noted above. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

MOTION: Dr. Campbell moved to approve the license renewal applications for each of the physicians listed above. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

- c. Review of new license applications:
- i. Jessica Duggan, DPM.
 - ii. Ronaldo Holgado, DPM
 - iii. Nathan Jeppesen, DPM.

The board members reviewed the new license applications for each of the physicians listed above. Ms. Penttinen had previously determined that each of the applications was administratively complete. The board members determined that there were no substantive deficiencies for any of these applications.

MOTION: Ms. Miles moved to approve the license applications for each of the three physicians listed above and allow them to sit for the oral exam in June 2012. Mr. Rhodes 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. Open complaint status report.

Ms. Penttinen advised that there are currently 56 open complaints including those which were on today's agenda. She added that she is receiving subpoenaed documents and responses from the physicians; however, some cases have required numerous subpoenas so it is taking a little extra time to get all of those records back.

- b. Malpractice case report.

- i. Brent Nixon, DPM: Claim from patient B.T filed on 06/29/2011 and settled for \$0 on 02/21/2012 due to the doctor never being served. (B.T. has not filed a complaint with the Board.)

Dr. Kaplan reviewed the PICA report which indicates that although a claim was filed against Dr. Nixon, the lawsuit was never filed and Dr. Nixon was never served. Therefore, the claim was closed with a \$0 settlement. Ms. Miles also noted that both Dr. Nixon and the patient live in Georgia. Dr. Kaplan stated that normally, for out-of-state incidents, this board has deferred to the other state's podiatry board. Ms. Miles stated she does not feel any action needs to be taken in this matter. The remaining board members were in agreement.

VIII. Call To The Public

There were no requests to speak during the Call to the Public.

IX. Next Board Meeting Date:

a. June 13, 2012 at 8:00 a.m.

X. Adjournment

MOTION: Ms. Miles moved to adjourn the meeting. Dr. Kaplan 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 9:32 AM.