



Janice K. Brewer
Governor

State Of Arizona Board of Podiatry Examiners

"Protecting the Public's Health"

1400 W. Washington, Ste. 230, Phoenix, AZ 85007; (602) 542-3095; Fax: 542-3093

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

July 11, 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: Montgomery Lee

I. Call to Order

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

II. Roll Call

All Board members were present as well as Ms. Penttinen and Mr. Lee.

III. Approval of Minutes

a. June 13, 2012 Regular Session Minutes.

MOTION: Ms. Miles moved to approve the minutes. Dr. Leonetti seconded the motion.

DISCUSSION: Dr. Kaplan offered grammatical and spelling corrections. Ms. Miles amended her motion to include the suggested corrections. Dr. Leonetti seconded the corrections.

VOTE: The motion passed unanimously by voice vote.

b. June 13, 2012 Executive Session Minutes

MOTION: Ms. Miles moved to approve the minutes as written. Mr. Rhodes 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. 08-40-M – Jason Harrill, DPM: Practice below the standard of care for improper post-surgical care. Dr. Joseph Leonetti recused himself as he was the physician investigator for this matter. Dr. Harrill was present with attorney Robert Goldstucker. The Board had received a notice from PICA that a malpractice claim was filed against Dr. Harrill by patient K.J. The claim was subsequently settled in the patient's favor. Dr. Leonetti addressed the Board as follows: It is noted that this case was previously reviewed by the Board in a collateral claim filed against Dr. Scott Maling. The patient was evaluated by Dr. Maling on June 2007 for chronic right ankle pain. There was a history of multiple ankle sprains. Dr. Maling diagnosed ankle instability and a ruptured peroneal tendon. The patient was given an ankle brace and an MRI was ordered which showed a complete rupture of the peroneus brevis tendon and injury to the ATF and CF ligaments. Later that month the patient was seen m\by Dr. Maling for a pre-operative consult and the patient consented to surgery as well as the use of an EBI cold ice therapy unit. Surgery was done on 06/27/2007 and included calcaneal osteotomy, repair of the ATF and CF

ligaments, tendon transfer, and repair of the peroneus brevis tendon. The patient was sent home with the ice unit, post-operative instructions and pain medication.

Dr. Leonetti continued as follows: The patient was called the day after surgery and was reported to be doing well. On June 30 the patient called Dr. Harrill, (who was on call for Dr. Maling,) complaining of pain. The patient was offered to go to the emergency room which she declined; the patient elected to wait until Monday, July 2 to see the doctor(s) in the office. The patient was seen by Dr. Harrill who noted her toes to be cool and discolored. Dr. Harrill recommended that the patient decrease her use of the ice machine and gave her medication for nausea. Dr. Harrill spoke with Dr. Maling who recommended complete discontinuation of the ice machine and gave several recommendations for warming the patient's foot. On July 3 the patient returned to see Dr. Harrill complaining of blisters and oozing from her toes. Dr. Harrill drained and dressed the blisters and prescribed Nitro-paste. The patient was admitted to the emergency room later that day and was admitted for pain and vascular injury to the right foot which was likely due to the cold therapy. The hospital consulted with Dr. Harrill who followed the patient's care and tell Dr. Maling returned on July 8. From that point forward Dr. Maling followed the patient along with a vascular consultant and wound care providers. The patient underwent hyperbaric oxygen therapy and ultimately underwent a forefoot amputation due to the vascular complications.

Dr. Leonetti continued as follows: he reviewed the patient's complete chart from Dr. Harrill and Dr. Maling including all diagnostic films as well as the patient's records from the hospital. The board previously reviewed the associated complaint against Dr. Maling and dismissed that case. Dr. Leonetti stated that in his review of Dr. Harrill's care of the patient he feels that this was an unfortunate outcome; however, Dr. Harrill did not perform the patient's surgery and did not order the ice therapy. Dr. Leonetti finds that Dr. Harrill treated the patient appropriately and he does not find any violations in this case. He feels that the damage done by the ice machine therapy was done prior to Dr. Harrill's first assessment of the patient. He also noted that the patient was a smoker, had pre-operative undiagnosed vascular disease, and misused the ice machine. These three things had a significant impact on the patient's outcome, but he does not believe that Dr. Harrill is responsible for the end result.

Dr. Kaplan commented that the patient has stated she was not given appropriate instructions on the use of the ice therapy machine. However, he read the complete patient charts and finds that the patient was given appropriate instructions. Dr. Kaplan asked Dr. Harrill if he wanted to make any statements and Dr. Harrill declined.

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

DISCUSSION: There was no discussion on the motion.

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

b. 09-12-M – Jamie Coffey, DPM: Practice below the standard of care for improper post-surgical care. Dr. Coffey was present with attorney Bruce Crawford. Dr. Joseph Leonetti recused himself as he was the physician investigator in this matter. Dr. Leonetti summarized the case as follows: the board received a report from PICA that a malpractice claim had been filed against Dr. Coffey by the family of patient K.O. The reports states the nature of the claim as, "patient with neuromas, confirmed by MRI. Removal of neuromas occurred on November 17, 2006 and January 19, 2007. Patient is deceased and died from opiate intoxication. Claimant alleges negligent treatment and failure to properly assess the patient's status." The patient first sought Dr. Coffey in August 2006 complaining of pain in both feet. The initial diagnosis was neuroma/neuropathy which was to be treated using padding, and injections, and oral narcotic analgesics. MRI's were completed as well as a neurological consultation, both of which confirmed neuromas in both feet. The patient continued to complain of pain and was given a prescription for Percocet 7.5 mg. The left foot neuroma was removed in November of 2006 and healed without complications. The right foot neuroma was removed in January 2007 and healed without any complications other than a small amount of scarring. The patient did not receive any further pain medication after the sutures were removed. Dr. Coffey was notified by Dr. Bence that he was referring the patient for pain management and it was at that time Dr. Coffey first learned that the patient had been receiving pain medication from other doctors during the time he was treating her. The patient was last seen by Dr. Coffey on February 27, 2007 and no medications were prescribed.

Dr. Leonetti continued: after review of the complete patient record in this matter he feels Dr. Coffey acted appropriately in his treatment of the patient. He used conservative care, obtained proper consultations and referrals, and the pain medication that was prescribed to the patient was appropriate given the patient's reported level of pain. The pain medication was discontinued following the surgical course and was not aware that the patient had been receiving narcotic pain medications from other providers. Dr. Leonetti noted that the malpractice claim against Dr. Coffey was voluntarily withdrawn by the patient's family without any payment or settlement against Dr. Coffey. Dr. Leonetti concluded that he does not find any violations in this case.

Dr. Kaplan asked if the database run by the Arizona Pharmacy Board was in place at the time that this patient was being treated by Dr. Coffey and if any of the pharmacies had notified any of the providers about the prescriptions that the patient was receiving. Ms. Penttinen stated that the Pharmacy Board's database was not in place at that time. However, as the database is administered at this time there is no requirement for doctors to query that database; the only requirement is that pharmacies report to the database when they fill the prescription. Dr. Kaplan stated that unless the patient informed the physician of their prescriptions there would be no way for the physician to have that information at the time that this occurred. Dr. Leonetti agreed. Dr. Kaplan added that he feels the amount of pain medication given to the patient by Dr. Coffey was appropriate. Dr. Leonetti agreed.

MOTION: Dr. Kaplan moved to dismiss the 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. Leonetti recused.

c. 09-31-M – Bruce Werber, DPM: Practice below the standard of care for improper post-surgical care. Dr. Werber was present. Dr. Leonetti recused himself as he was the physician investigator for this case. Dr. Leonetti summarized the case as follows: Dr. Werber disclosed August 2009 license renewal application that a malpractice case had been filed against him by patient C.F. this incident occurred following surgery that Dr. Werber performed in 2004 when he was practicing in Rhode Island. The Rhode Island Podiatry Board reviewed this case and found that there were no violations. In 2000 for the patient presented to Dr. Werber's office for chronic pain as a result of a previous calcaneal fracture and rear foot surgery. Dr. Werber performed a history and physical, took x-rays and provided a brace to the patient. The patient was seen again in July of 2004 to discuss a proposed surgery which was a calcaneal osteotomy, tallar neck osteotomy, and revision triple arthrodesis of the left foot. It was noted that the patient was a smoker and was advised to discontinue smoking while healing from the procedure. The patient injured her wrist in the surgery was postponed until November 12, 2004. The procedures were done on an outpatient basis and the patient tolerated them while. She was sent home with oral pain medication and a Polar Care system to control swelling the first postoperative appointment showed that the patient was doing well and bone alignment was maintained as visualized on x-ray's. On November 16 the patient called the office complaining of increased pain and a stronger pain medication was recommended by one of Dr. Werber's associates. On November 19 the patient was seen in the office by Dr. Werber and was noted to have ischemic changes over the dorsum of the foot. The Polar Care system was discontinued and the patient was admitted to the hospital for vascular evaluation. It is noted that the patient continued to smoke during the postoperative period even after the vascular problem was identified. Dr. Werber ordered an MRI and a vascular consultation. When no vascular consultation had occurred after 48 hours, Dr. Werber discharge the patient home for Thanksgiving and then she was readmitted to another hospital. At the second hospital a vascular consultation was performed as well as an MRA which showed abrupt truncation of the dorsalis pedis artery at the interior ankle joint. The posterior tibial artery was intact. The patient underwent wound care and plasma rich protein treatments. Hyperbaric oxygen therapy was recommended but the patient refused. The patient continued to struggle with vascular compromise and elected to undergo a hallux amputation on February 5, 2005 the patient encountered slow healing and continued chronic pain which led to the patient agreeing to a trans-metatarsal amputation on May 20, 2005.

Dr. Leonetti continued as follows: Dr. Werber informed Dr. Leonetti that at one time there were 11 separates defendants named in this lawsuit. At the time he spoke with Dr. Werber all other defendants

had been dropped from the case except for him. Dr. Werber also informed Dr. Leonetti that the Rhode Island Podiatry Board had dismiss their investigation of this matter. Dr. Leonetti concluded that this patient was a high risk surgical candidate because of her previous injuries and surgeries as well as her chronic smoking. The patient worked as a nurse and understood the risks of her condition and her smoking and elected to go forward with the surgical procedures. Once the complications were noted during the postoperative period Dr. Werber acted appropriately I admitting the patient to the hospital and ordering vascular exams and initiating wound care. Dr. Werber even had the patient change hospitals because he was not satisfied with the length of time it was taking to obtain a vascular consultation that the initial hospital. Dr. Leonetti stated that this case ended with a catastrophic result for the patient due to previous trauma and surgery to the area which could have damaged blood flow, the fact that the patient was a chronic smoker and refused to stop smoking during the postoperative time, and the use of a Polar Care eyes system which can cause severe vasoconstriction and damage to an area that is already suffered vascular compromise. Dr. Leonetti concluded that he finds no violations in this matter. Dr. Kaplan asked Dr. Werber what the status of the malpractice case was. Dr. Werber stated that a settlement had been made in the patient's favor. Both Dr. Leonetti and Dr. Werber confirmed that the Rhode Island Podiatry Board dismissed their investigation of this matter.

MOTION: Dr. Kaplan 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 with Dr. Leonetti recused.

d. 09-32-M – Donald Curtis, DPM: Practice below the standard of care for improper pre-surgical care; lack of proper informed consent.

Dr. Curtis was present with attorney Bruce Crawford. Dr. Leonetti recused himself as he was the physician investigator for this case. Dr. Leonetti reviewed the case as follows on his 2009 license renewal application Dr. Curtis disclosed that he had a malpractice action filed against him during the previous year. This case was filed in the state of Utah by patient C.O. the patient was initially seen by Dr. Curtis on April 16, 2007 complaining of a painful bump over the first M PJ of the right foot. Dr. Curtis reviewed the patient's medical history evaluated the patient and took x-rays. He discussed conservative treatment with the patient as well as surgical intervention and the patient elected to go forward with surgery as follows: correction of bunion, right foot, with insertion of tight rope to the right first and second metatarsals. The procedure was performed on April 23, 2007 and the patient was followed post-operatively with the combination of the cast and the surgical shoe. On May 22nd 2007 physical therapy was recommended due to continued pain and swelling. On June 6, 2007 the patient was given an injection of steroids and pain medication in the first interspace in an effort to reduce pain and swelling. On July 3, 2007 the patient was evaluated and was complaining of continued pain and Dr. Curtis made a recommendation to remove the tight rope which the patient refused. Dr. Curtis requested a second opinion from a surgeon, Dr. Rhodes, with experience in dealing with the tight were procedure because he was planning to relocate to Arizona. Dr. Curtis contacted the patient by phone on July 10 and 26 2007 to discuss the second opinion with Dr. Rhodes. Dr. Curtis did review the patient's care with Dr. Rhodes who was familiar with the tight rope procedure and has treated complications arising from its implantation. After July 26, 2007 Dr. Curtis was living a practicing in Arizona. Dr. Leonetti concluded by stating that upon his review of the complete file he does not feel that the allegation in this case is substantiated. Dr. Leonetti added that the tight rope procedure is often very complicated and there have been several developments in the procedure since it was first introduced. He feels that Dr. Curtis appropriately explained the procedure to the patient and obtained proper informed consent. He also feels that Dr. Curtis acted appropriately in obtaining a second opinion from another physician who was familiar with the complications of this type of procedure.

Dr. Kaplan asked Dr. Curtis if he could review the informed consent due to difficulty reading the handwriting. Mr. Crawford advised the board that the patient records which were submitted to the board were obtained from Colorado and have obviously been copied a number of times making some of the documents difficult to read. Dr. Kaplan stated that he only wanted to review the handwritten portion of the consent form. Dr. Curtis stated the following: "I hereby authorize Mike podiatrist Dr. Curtis and any associates or assistants of his choice to perform upon me the following procedures: correction of bunion, removal of bone spur, and use of wire and/or pins or screws to maintain alignment for the intended

purpose of eliminating bone spur, reinforced joint, and maintain alignment." Dr. Kaplan asked if by "wire" Dr. Curtis meant the tight rope, which Dr. Curtis confirmed.

MOTION: Dr. Kaplan 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 with Dr. Leonetti recused.

e. 09-34-C – J. David Brown, DPM: Improper surgery to remove a neuroma which results in bleeding at the surgical site, additional surgery, and pain.

Dr. Brown was present with attorney Bruce Crawford. Dr. Dedrie Polakof was the investigator and was present. Dr. Polakof summarized the case as follows: the board received a written complaint from P.M. on behalf of his wife L.M. who underwent surgery with Dr. Brown on April 24, 2009 to remove a neuroma from between the third and fourth toes of her right foot. For several days following the surgery the patient experienced continuous severe pain and some bleeding through the incision site. The patient was told that Dr. Brown was not available so she followed up his partner Dr. Frank Maben. Eventually the patient went to the emergency room on May 11 and again on May 13, 2009. On the May 13 visit a vascular specialist performed an ultrasound on the patient's foot and found two arteries which were bleeding. The patient underwent surgery that evening by Dr. Raven to correct the bleeding arteries. On May 15 after continuing to experience severe pain the patient returned to the hospital where Dr. Maben arrived at administered nerve blocks in the foot. The patient was hospitalized for four days and was later diagnosed with reflex sympathetic dystrophy.

Dr. Polakof continued as follows: the complainant stated that following his wife's problems he researched Dr. Brown's history and learned that he had been involved in a DUI accident on April 16, 2009 and that his podiatry license was suspended on April 27, 2009 which was three days after the patient's surgery. The complainant also had referred to information he found in Podiatry Board meeting minutes referring to allegations that Dr. Brown had been diverting prescription narcotics, which was presumably a complaint filed in 2007 which remains open at this time. The complainant also alleged that an unknown physician whom he believes to be Dr. Brown was cited by Mercy Gilbert Hospital for attempting to perform surgery while intoxicated and that there had been complaints from Dr. Brown's employees that he was under the influence of alcohol while working. (It is noted that the board has not received any complaints or any information to indicate that Dr. Brown was cited by that hospital or that there were complaints regarding him being under the influence of alcohol or try to perform surgery will impaired.) The complainant was aware that Dr. Brown was notified on April 21, 2009 of the board's investigation regarding his DUI incident and feels that Dr. Brown should not have been allowed to perform surgery on April 24 and that by doing so he was "reckless and negligent."

Dr. Polakof continued as follows: Dr. Brown performs surgery on the patient on April 24, 2009 at Mercy Gilbert Hospital. The first postoperative visit was on May 7, 2009 with Dr. Maben. The patient was seen in the emergency room on May 11 for severe foot pain and on May 13 at which time the arterial bleeding was diagnosed and Dr. Maben performs surgery to correct the bleeding. On May 15 patient was still experiencing severe pain at which time Dr. Maben performed a nerve block and the patient was hospitalized for five days. On May 18 the patient was seen by a pain management specialist and was diagnosed with RSD. Dr. Polakof stated that the patient has had an extremely difficult postoperative course and continues to be treated for chronic pain management. The complainant has alleged that Dr. Brown was impaired at the time he performed surgery on the patient. Dr. Polakof stated that she did contact Mercy Gilbert Hospital to obtain any available peer review documentation; however, all of that information is confidential, therefore there is no evidence to show that Dr. Brown was impaired at the time he performs surgery on the patient. Dr. Polakof concluded that she finds the allegation in this case to be unsubstantiated. Dr. Kaplan asked Dr. Brown if he would like to add any information at this time in light of the investigation report and Dr. Brown stated he did not.

Dr. Leonetti confirmed that Dr. Brown's DUI incident occurred on April 16, 2009. Dr. Leonetti asked Dr. Brown if he'd been undergoing any type of drug testing between April 16 and April 24. Dr. Brown stated he was not. Dr. Brown confirmed for Dr. Leonetti that due to his license suspension on April 27 he was not able to follow-up with the patient post-operatively. Dr. Leonetti asked Dr. Brown if he was aware of

the information provided by Dr. Maben related to the fact that the patient had post-operative bleeding. Dr. Brown stated that he was aware that Vicki was not aware of what had caused it. Dr. Leonetti reviewed Dr. Maben's testimony earlier this morning which indicated that the bleeding was caused by suturing through superficial blood vessels. Dr. Kaplan reviewed that the patient surgery was conducted on April 24 which was a Friday and was three days prior to Dr. Brown's license suspension. He asked Dr. Brown if you received any calls during that three day period regarding the patient and Dr. Brown stated he did not. Dr. Polakof confirmed for Dr. Kaplan that the patient did not report any problems between the date of the surgery and the first scheduled post-operative office visit which was scheduled for May 7, 2009. Dr. Polakof added that the patient was having pain on the first day after surgery but went to the emergency room visit because the pain had triggered a migraine headache.

Mr. Crawford addressed the board and discussed Dr. Brown's suspension on April 27, 2009. He reminded the board that there had even been discussion as to whether or not Dr. Brown could be present in his office to complete administrative tasks; however, the board had strongly urged against even doing that, so Dr. Brown could not have been involved in any care of this patient after the 27th. Dr. Kaplan stated that three-day time span was his only concern. Dr. Kaplan stated that he would like to go into executive session for the purpose of obtaining legal advice.

MOTION: Dr. Kaplan moved to go into Executive Session for the purpose of obtaining legal advice. Dr. Leonetti 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 9:27 AM.

The Board returned to Regular Session at 9:38 AM.

Dr. Leonetti asked Dr. Polakof if this matter also involved malpractice action and Dr. Polakof stated she was not certain. Mr. Crawford confirmed that there is a malpractice case but stated he is not Dr. Brown's attorney in that civil matter. Mr. Crawford added that he believes the civil cases in the very early stages. Dr. Leonetti asked Dr. Polakof if, in her investigation of this case, her goal was to determine whether or not Dr. Brown was impaired at the time surgery was performed on the patient. Dr. Polakof stated yes. Dr. Leonetti asked Dr. Polakof if she also reviewed the surgical procedure and Dr. Polakof stated that reviewing the surgery was part of her overall review of the case. Upon questioning from Ms. Miles, Dr. Polakof confirmed that after her complete review of this case she did not find any problems with the surgery that was performed by Dr. Brown or anything that would be considered a violation of the board statutes. Dr. Polakof stated that she reviewed all of the peri-operative documentation including the operative report and did not find anything out of the ordinary. Ms. Miles asked Dr. Polakof if the complications seen in this case could have occurred even in the absence of any type of malpractice. Dr. Polakof stated that was correct. Dr. Kaplan added that the procedure was not a simple neuroma; Dr. Brown also did a plantar plate repair to the fourth M PJ. Dr. Polakof confirmed for Dr. Kaplan that a "Topaz device" was used and the surgical approach was on the dorsal side of the foot using the same incision sites as for the neuroma removal. Dr. Brown confirmed that there was one surgical incision. Dr. Kaplan asked Dr. Polakof whether or not she felt that doing the plantar plate repair could have complicated the neuroma removal by doing them at the same time. Dr. Polakof stated that any time during multiple procedures done there is a higher risk of complications. However, she added that by removing the neuroma there was additional space opened up allowing access to complete the plantar plate repair.

Dr. Leonetti asked Dr. Brown how a Topaz device can be inserted and attached to the plantar plate using a dorsal approach. Dr. Brown stated that according to the operative report he freed up both sides of the metatarsal and was able to properly position the device. Dr. Leonetti described the Topaz device and how it is intended to work, and he added that he feels it would be nearly impossible to properly use the device for a plantar plate repair using a dorsal incision. Dr. Leonetti stated that he questions whether the procedure was documented properly and/or performed properly. Dr. Kaplan asked Dr. Brown if he billed for both the neuroma removal and the Topaz procedure. Dr. Brown stated he did not know and he was provided a copy of the patient's records to review. Dr. Polakof reviewed the records as well and stated that Dr. Brown billed for code 28270 which is a capsulotomy of an M PJ with or without tendon repair for each joint as a separate procedure, and code 28080 for neuroma excision. Upon questioning from Dr.

Kaplan, Dr. Polakof stated that the Topaz procedure was billed as the major procedure and that there may have been incorrect billing modifiers used or possible unbundling.

Dr. Kaplan added that, aside from the billing concerns, the types of procedures which were done created a great deal of trauma in that area of the foot which could have led to the patient's post-operative complications. Dr. Kaplan again reviewed Dr. Maben's comments from earlier this morning which stated that the arteries had been sutured; however, the ultrasound report indicates that the arteries had been cut. Mr. Crawford offered his opinion that the Dr. who actually looked at the incision site during the second surgery would have a better diagnosis than an ultrasound picture. Dr. Leonetti stated that he was concerned that Dr. Brown is describing a plantar plate repair as a minor procedure but billed as the major procedure using the wrong billing code. He added that he feels would be extremely difficult if not impossible to perform the Topaz procedure from a dorsal incision. The board members and Dr. Polakof also discussed the appropriate relative time frames for conducting the types of procedures that Dr. Brown did on this patient.

MOTION: Ms. Miles moved to dismiss the case. Mr. Rhodes seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed by a vote of 3-2 with Drs. Kaplan and Leonetti dissenting.

f. 11-03-M – David Lee, DPM: Practice below the standard of care for improper bunion correction surgery.

Dr. Lee was present with attorney Bruce Crawford. Dr. Deidra Polakof was the investigator for the case and was present. Dr. Leonetti stated for the record that he had evaluated this patient on a one-time basis. Dr. Polakof has a copy of the report that he generated based on that one office visit. Dr. Kaplan asked whether the board would be able to ask questions specifically of Dr. Leonetti if needed. Mr. Lee advised that if Dr. Leonetti were to participate in the review and decision on this matter than he would not be able to provide any witness testimony. Mr. Lee asked Dr. Leonetti if he felt he would be able to remain objective and base his decision in this matter on the entirety of the case and not his specific individual treatment of the patient. Dr. Leonetti stated that he could.

Dr. Kaplan summarized the case as follows: the board received a complaint against Dr. Lee from patient D.W. The board subsequently received a notification from PICA that the patient had filed a malpractice claim against Dr. Lee. On the PICA report the nature of the claim was stated as, "bunion surgery space-space patient claims it is been one year since the surgery and she still is not healed and is in pain; also claims RSD." The patient was present and addressed the board as follows: September 30, 2009 was her first appointment with Dr. Lee. He gave her six or seven diagnoses of problems with her feet including the need for bunion correction on both feet. He wanted to do the left foot correction first because it was worse than the right foot and also told her that she would need orthotics for the rest of her life. She asked Dr. Lee three or four times if there was any other alternative to surgery so that she could make the proper decision; however, she stated she was not given that opportunity. On October 22, 2009 she again asked Dr. Lee if there was any alternative. Dr. Lee gave her an insurance reimbursement paper regarding orthotic shoes. Her x-rays show that she had osteoarthritis which Dr. Lee did not disclose to her. The patient adamantly denied having x-rays taken on November 12, 2009; she only had x-rays on the first office visit and immediately following the first surgery. She also states that when she requested her records the office visit for November 12, 2009 was missing and she did not receive it until almost a year later. The patient states her husband was present at every office visit and can verify that x-rays were not taken on that date. Since her surgery the patient has done research on her own regarding why she was having continued pain. Upon receiving Dr. Kaplan the patient stated that she has been evaluated by other physicians and has received a diagnosis of RSD. The patient did not bring any medical records with her to the board is limited to the records that were subpoenaed up to this point. Ms. Penttinen stated that if it is the board's wish to table this matter for further investigation she can issue subpoenas to all of the necessary providers. Dr. Leonetti specifically mentioned North Valley Neurology.

Patient continued as follows: as she was going to other physicians she continued to question her condition based on her MRI and x-rays that had been taken. She went to a rheumatologist who told her that her x-rays of August 30, 2009, (it is likely this date is misstated from September 30, 2009), she was told that she had rheumatoid arthritis in her feet. In March 2010 Dr. Lee diagnosed her with causalgia but

did not tell her what it was so she had to look it up herself. The patient states there are only two ways to get causalgia - one is from lupus and the other is from osteoarthritis with surgery in the same area. Dr. Leonetti advised the patient that that information was not necessarily correct. The patient continued: the patient states she has been devastated ever since the surgery. She is able to go out and do some things but not like she did before the surgery. Dr. Leonetti asked the patient who is treating her at the present time for her chronic pain. The patient stated she is saying an internal medicine specialist who is treating her with Cymbalta and another medication that she does not remember the name of but it is similar to Benadryl. Patient said that she it also been on Lyrica at one time but could not take it. Upon questioning from Dr. Kaplan the patient stated that she is not seeing any other specialists at this time such as a neurologist or rheumatologist. Patient stated she is doing exercises that are assigned to her by her chiropractor. Dr. Kaplan asked the patient if she ever had injections in her lower back to address her foot pain. The patient stated she had and that "it lasted about nine months." Dr. Leonetti asked what the patient's prognosis is that this time as far as the level treatment she will need from here forward. Patient stated she will continue taking Cymbalta until it stops working or if she has an allergic reaction.

Dr. Leonetti asked the patient about when she saw Dr. Lee and discussed surgery and whether or not Dr. Lee had explained the surgical procedure to her. He also asked her if she had signed a consent form or any type of the diagram which illustrated the type of procedure that would be done. The patient stated Dr. Lee showed her on a piece of paper and that she signed three separate consent forms regarding what to do before surgery, what to do after surgery, and how to take care of the wound. Dr. Leonetti asked the patient if Dr. Lee spoke with her regarding the possible complications of the surgery including infection and possible nerve damage. The patient stated Dr. Lee did not talk to her about that. The patient stated she did not recall signing any type of paperwork that included any of the risks or complications of the surgery. Upon questioning, the patient confirmed for Dr. Leonetti that Dr. Lee had prescribed physical therapy; however, she did not want to do it because of the amount of pain that she was in. The patient's husband added that he attempted to massage the patient's foot when her pain attacks came on but that she was experiencing an extreme amount of pain.

Dr. Leonetti noted that the diagnosis of causalgia is often referred to in the same context as reflex sympathetic dystrophy and CRPS, (chronic regional pain syndrome), to which the patient agreed. Dr. Leonetti added that such diagnoses are often the result of a traumatic injury to the area which could be caused by surgery, and injection, or something as simple as bumping a toe. There can be many causes to such a diagnosis; however, most physicians agree that appropriate treatment of such a condition includes therapy at a very early stage in the post-operative time period. Dr. Leonetti added that post-operative pain is risk of any surgery and that what he was concerned with is whether the patient was appropriately informed of the risks and potential complications of the surgery. The patient stated that she was only told that she needed to have the surgery and that she would have to wear orthopedic shoes for the rest of her life. The patient stated she was not informed of any possible side effects of the surgery and that of Dr. Lee had informed her of the potential risks she would've looked into it herself to make a better decision. Dr. Leonetti asked the patient if she read the consent form before she signed it. The patient stated she read three consent forms as previously described. Dr. Leonetti referred to a specific document labeled "alternative complications in inverse reactions to surgery." The patient stated that that specific form was never given to her. Dr. Leonetti and other board members noted that this specific form contain the patient signature at the bottom. The patient adamantly denied ever signing this form and added that she never saw that specific form until she hired an attorney. The patient became argumentative with the board members and stated again that she hired an attorney approximately one year after her surgery. It was at that time that she obtained all for medical records and first saw the documents to which Dr. Leonetti had referred. The patient claimed that she did not see this particular document until asked seven months later when her attorney told her that he would not be will to help her. Dr. Leonetti asked the patient to confirm if it was her position that the paper listing the possible complications and adverse reactions was never signed by her, but was later inserted into the medical records after the fact. The patient stated that was correct.

For the record Ms. Penttinen reviewed three separate documents with the patient. The first was titled "what to do before surgery." The patient confirmed that it was her signature on that form. The second document was titled "what to do after my surgery." The patient again confirmed that it was her signature on that paper. The third document was called a "surgical consent form" and contained initials down the left margin and the patient's signature at the bottom. The patient confirmed that it was her signature on

that form. Ms. Penttinen then reviewed with the patient a diagram of the foot which illustrated where the screw was going to be placed in the patient's foot and asked the patient if she signed that form. The patient stated that she did not remember that form. Ms. Penttinen then reviewed with the patient of form titled "alternatives, complications, and adverse reactions from surgery." That form had both the patient's signature and her husband's signature. Both the patient and her husband denied signing this form. The patient stated that the only time she ever saw this form was approximately one year after the surgery was performed. Dr. Leonetti address the board members and the patient and stated that the main question at this time is whether or not the patient signed the diagram which indicated where the screws would be placed and the form which explained the risks and complications from the surgery. The patient confirmed for Dr. Leonetti her belief that those forms were fabricated at some point after her surgery but prior to the time that her records were sent to her attorney. The patient's husband pointed out that he doesn't think he would have signed any type of form. Dr. Leonetti stated that it would not be unusual for a witness to sign consent forms along with the patient to confirm that the patient did sign it and that the form was reviewed and read prior to signing. Dr. Leonetti pointed out that on the foot diagram which illustrated the placement of the screws there was only the patient signature. However, the form indicating the risks and potential complications of surgery bars the signatures of both the patient and her husband. Dr. Leonetti asked the patient and her husband if it was their position that the signatures on both of those forms did not occur prior to the surgery. The patient stated that was correct. Upon questioning from Dr. Kaplan the patient also stated that she never received a copy of the form which addressed the potential alternatives to surgical correction of her bunion. The patient stated she did sign the surgical consent form and that she and her husband signs of form regarding what to do before the surgery. Upon questioning for Dr. Kaplan, Ms. Penttinen clarified that the patient stated she did not sign the foot diagram or the documents titled "alternatives, complications, and adverse effects from surgery." Ms. Penttinen also pointed out that Dr. Lee has transferred his records to an electronic medical record system and no longer has the original signed documents available. Upon questioning from Dr. Kaplan the patient stated that she believes both her and her husband's signatures on the two documents in question were not authentic. When Dr. Kaplan asked the patient who would have signed those documents the patient stated she did not know. The patient also confirmed for Dr. Kaplan that she did sign a consent for the surgery at the surgical center which was a separate document from the consent form she signed with Dr. Lee. Dr. Kaplan also asked the patient about the dates that x-rays were taken by Dr. Lee. The patient stated that she had x-rays taken on December 11, 2009. (It is noted that Dr. Lee's records do not reflect any date of service for December 11, 2009. The closest date of service to that date is December 9, 2009.) The patient then corrected herself and stated that the date of the x-rays in question was November 12, 2009. Dr. Kaplan pointed out the patient that the date on the x-ray submitted by Dr. Lee was November 12, 2009 as date stamped on the films. The patient denied that x-rays were ever taken on November 12. Dr. Kaplan also asked the patient about an independent medical opinion which she sought from a Dr. Malone in California who she also is now suing. The patient stated she is suing because of a lack of standard of care because when Dr. Malone is returned her records that was the first time she ever saw x-rays dated November 12, 2009. Upon questioning by Dr. Kaplan the patient stated that her request for payment of \$700 from Dr. Malone has not been paid in she has not had any involvement with him recently.

The board members reviewed hardcopy x-ray films as well as a disk that was provided by Dr. Lee of the patient's foot. Dr. Polakof then addressed the board as follows: Dr. Polakof reviewed the complainant's information and PICA report information. On the patient's initial office visit with Dr. Lee on September 30, 2009 the patient's chief complaints consisted of bilateral bunions as well as leg and knee pain. Surgery was performed on October 9, 2009. During the patient's third post-operative visit the patient refused to allow Dr. Lee to attempt to move the toe and refuse physical therapy. The patient was scheduled to return in one week but fail to do so. On November 12, 2009 x-rays were performed which confirmed that the patient's osteotomy was healed and the patient was in need of physical therapy. Her range of motion was noted to be inadequate and stiff. At seven weeks post-operative, the patient was diagnosed with neuritis and was given a prescription for "kick" gel and pain medication. The patient returned in one week and was diagnosed with RST and was referred to a pain management specialist. Dr. Polakof stated the patient's RST diagnosis is an unfortunate complication of the surgery she underwent. Dr. Polakof also noted that Dr. Lee was never served with the civil malpractice lawsuit and the PICA claim was closed on January 19, 2011.

Dr. Polakof continued as follows: the patient's first office visit was on September 30, 2009 at which time the patient revealed the bunion history of 10 years with pain and that she was wearing inadequate orthotics. On October 7, 2009 the patient had a pre-operative surgical visit and surgery was subsequently performed on October 9, 2009 for correction of the 1st metatarsal-phalangeal joint with screw fixation. On October 14, 2009 the patient had her first post-operative visit at which time she exhibited pain and anxiety. On October 22, 2009 the patient was noted as having her condition improving and she was prescribed Valium 5 mg quantity 14 at that time. On October 29, 2009 the patient was seen by Dr. Lee but she would not allow him to perform range of motion exercises. At that time the patient also refused physical therapy. On November 12, 2009 the records reflect that the patient was seen by Dr. Lee reported that the pain in her foot was "much better." Mild edema was noted as well as decreased range of motion at 15°. On that date of service Dr. Lee also noted the patient is not compliant. On that date the patient also was prescribed Valium and ibuprofen. On December 2, 2009 the patient was seen again at which time Dr. Lee noted mild edema and range of motion at 15° he prescribed the "kick" gel as well as Vicodin and ibuprofen and physical therapy. On December 9, 2009 the patient was diagnosed with a cause of pain as causalgia. She was referred to pain management for treatment of RSD. As of December 30, 2009 the patient had been scheduled to follow-up with a pain management specialist and a neurologist had prescribed the medication Neurontin. On January 28, 2010 the patient had epidural injections administered by her pain management specialist and on March 3, 2010 the patient discussed the potential complications and symptoms of her RSD diagnosis.

Dr. Polakof continued as follows: the patient has alleged two years of medical complications relating to her bunion surgery. This includes multiple physician reviews, physical therapy, pain management, as well as eye and general health concerns. The patient was given certain pain medications to which she had an allergic reaction. The patient had multiple consultations with Dr. Joseph Leonetti on March 29, 2010, Dr. Benjamin Harris on August 17, 2011, Dr. Lurly Pero on September 7, 2011, Dr. Kerry Zang on January 25, 2012, and Dr. William Fishco on February 8, 2012. In Dr. Polakof's review of all of the patient's records she finds that all physicians agree that the patient surgical outcome was unfortunate, but that the patient needs pain management treatment and adaptive changes to be able to live with her present condition. Specifically, in Dr. Fishco's evaluation it is noted that the patient is a high risk patient and he would not wish to perform surgery upon her. In conclusion, Dr. Polakof stated that she does not find any violations of statutes regarding the practice of podiatry in Arizona; the patient's simply experience an unfortunate surgical outcome.

Upon discussion with the board members, Ms. Miles asked Dr. Polakof to confirm whether or not she believed that, upon her review of the complete patient record in this matter, this was simply an unfortunate surgical outcome versus something negligent which occurred during the surgery which caused the patient's complications. Dr. Polakof stated that was correct. Dr. Polakof added that in her experience as a podiatrist of 28 years she would never want to see a patient end up with RSD because it is one of the worst complications that the patient can encounter; if there were a complication, she would rather see one that could be corrected surgically. However, it review of the patient's complete medical records is fortunate for the patient that her RSD complication was caught so early, (two months post-operatively), so that she could begin treatment sooner.

Dr. Kaplan asked Dr. Lee and his legal counsel if they would like to make any statement at this time. Dr. Lee stated that he had nothing to add at this time. Mr. Crawford offered a correction that as of the date he supplied Dr. Lee's written response to the patient's complaints the civil lawsuit had not been filed at that time. Subsequent to that, the patient filed her complaint through PICA Pro Per, (meaning she does not have an attorney.) The patient recently filed a request to dismiss the complaint which has not yet been ruled upon by the judge in the civil matter. Dr. Leonetti asked Dr. Lee about his office procedure about having consent forms for surgical procedures signed by patients. Dr. Lee stated that he always finds the consent forms with the patients prior to surgery. Dr. Lee also affirmed for Dr. Leonetti that he remembered that he had reviewed every paragraph of the informed consent form with the patient as she initialed each paragraph and signed at the bottom and that he had reviewed the potential risks and complications of the surgery with the patient. Dr. Leonetti stated he agreed with Dr. Polakof that the complications experienced by the patient in this case are rare but very possible complications of this type of surgery. Dr. Leonetti added that the patient's outcome was unfortunate but that the consent form appropriately express the potential complications and risks of the procedure. Dr. Leonetti stated that,

although he is not an expert in handwriting analysis, it appears that it is the patient signature on the informed consent form for the surgical procedure.

MOTION: Dr. Kaplan moved to dismiss this case finding violations. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

g. 11-33-M – Frank Maben, DPM: Practice below the standard of care for improper post-surgical care. Dr. Maben was present with attorney Robert Goldstucker. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof summarized the case as follows: The Board received a report from PICA indicating that a malpractice case had been filed against Dr. Maben by patient L.M. The Board had previously received a complaint against Dr. J. David Brown from P.M. who is the husband of L.M. The complainant stated that his wife underwent surgery with Dr. Brown on 04/24/09 at Mercy Gilbert Hospital, ("MGH"), to remove a neuroma from between the 3rd and 4th toes of her right foot. For several days following the surgery, the patient experienced continuous severe pain and some bleeding through the incision site. The patient was told that Dr. Brown was not available so she followed up with his partner Dr. Frank Maben. Eventually she went to the emergency room at MGH on 05/11/09 and 05/13/09. On the 05/13/09 visit, a vascular specialist performed an ultrasound on the patient's foot and found two arteries which were bleeding. The patient underwent surgery that evening by Dr. Maben. On 05/15/09, after continuing to experience severe pain, the patient returned the MGH where Dr. Maben arrived and administered nerve blocks in the foot. The patient spent four days in the hospital and was diagnosed with Reflex Sympathetic Dystrophy. The patient continues to see a pain management specialist and has had an extensive recovery. The patient believes Dr. Maben was negligent in his post-operative care of her.

Dr. Polakof continued as follows: Dr. Maben did not perform the original surgery on the patient. He treated the patient post-operatively and performed the second surgery to close two arteries which were trapped in the sub-cuticular closure of the original surgical site. The patient continues to undergo pain management therapy but the foot has not completely recovered. Dr. Polakof stated that Dr. Maben was put into a situation where he attempted to salvage the foot; however, she does not find the Dr. Maben committed any violations in his care of the patient. She added that the hospital wanted to discharge the patient before Dr. Maben felt it was appropriate, so he made certain that the patient stated in the hospital and tell a pain management consultation could be completed.

Dr. Leonetti asked Dr. Polakof where Dr. Brown was during the patient's postoperative care. Dr. Polakof stated that Dr. Brown's license was suspended in an unrelated matter shortly after the patient surgery was performed. Dr. Leonetti agreed with Dr. Polakof assessment that Dr. Maben was placed into an unfortunate situation in caring for the patient following the original surgery. He added that he feels Dr. Maben treated the patient appropriately with correcting the arterial bleeds, keeping the patient hospitalized, and ordering pain management, and he does not believe there were any violations in this case. Dr. Kaplan asked Dr. Maben what his opinion was as to what caused the arterial bleeds. Dr. Maben stated that the original surgical site was closed with a monocril stitch and when he opened the original surgical site he found that there was bleeding from the proximal end of the site. Dr. Maben stated that it may have been possible that the arteries were caught up in the stitches when Dr. Brown closed the site during the original procedure. Dr. Kaplan asked Dr. Maben to confirm if there was postoperative bleeding which caused a hematoma in the area. Dr. Maben stated that was correct. Upon questioning from Dr. Kaplan, Dr. Maben confirmed that his surgery on the patient was conducted on May 13; the patient's arterial bleeding had been intermittent from the time of the original surgery until May 13 and only when the pressure was applied to the foot.

MOTION: Dr. Leonetti moved to dismiss this case finding no violations. Ms. Miles 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. 08-44-C – Alex Bui, DPM: Monthly update.

Ms. Penttinen advised that Dr. Bui's monthly report regarding billing for durable medical equipment had not yet been received. In addition, she sent to Dr. Bui a subpoena for patient records as discussed during the June 13, 2012 board meeting. She received a call yesterday from Dr. Bui who asked if the scope of the subpoena could be narrowed to only include dates of service for care provided after he was placed on probation with the board. Ms. Penttinen had advised Dr. Bui that she was not able to alter the scope of the subpoena because it was issued pursuant to a board motion, but he could submit a written request to modify the subpoena and she would present it to the board members for review.

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

Ms. Penttinen advised the board that the last progress report from Dr. Sucher was received in May. The next report is due in August. She has not received any reports of noncompliance.

VI. Review, Discussion and Possible Action on Administrative Matters

a. 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:

Suzanne Abraham
David Agoada
Brian Allen
Steven Axt
Daniel Bangart
Keith Bangart
Stephen Barrett
David Bates
Justin Beabes
Janet Black
Kenneth Blocher
Erich Bock
Steven Born
Joseph Borreggine
Raymond Botte
Mark Brekke
Brian Broadhead
William Burke
Maria Buitrago
Garald Campbell
Zina Cappiello
Allison Cheney
Jamie Coffey
Stanton Cohen
Jerome Cohn
Karl Collins
Charles Connell
Samuel Cox
Donald Curtis
Evan Cwass
Rajesh Daulat
Brian Dechowit
Joseph DeRose
Dennis DiMatteo
Carlos Dimidjian
Kris DiNucci
Samuel Dolnick
Peyman Elison
Viedra Elison
Susan Erredge
Michael Esber
Albert Eulano
Robert Evans
Dale Feinberg
John Ferguson
Barton Fink
William Fishco

Timothy Fisher
Mark Forman
Robert Fridrich
Robert Frykberg
Christopher Funk
James Garber
Stephen Geller
Ryan Golub
Mark Gorman
Douglas Griffin
Arnold Gross
Todd Haddon
Thomas Hale
Myron Hansen
Jason Harrill
Richard Jacoby
Travis Jensen
Jacob Jones
Matthew Jones
Robert Kenrich
Anthony Kimble
Jonathan King
Barbara Kluger
Alan Kravitz
Todd Lamster
Kirk Larkin
Jay Larson
David Laurino
David Lee
Herbert Lee
Joseph Leonetti
Michael Leonetti
Gregory Loo
Therese Losi
Stanley Lubek
Frank Maben
Scott Maling
Neil Mansdorf
Verlan Marshall
Peter Merrill
Cathleen McCarthy
Cameron McKay
Floyd Miller
Lois Miller
Hartley Miltchin
Pierre Momjian
Richard Mott

Craig Murad
Peter Myskiw
Ronald Nagy
Anna Natcher
Brian Neerings
Katherine Neiderer
Glenn Nelson
Dennis Noss
Kevin O'Brien
Ron Olsen
Jeffrey Page
Lisa Pallini
Roland Palmquist
Marie Paul
Jeffrey Pawlowski
Raymond Peterson
Mark Pipher
John Powers
Richard Quint
Ralph Rabin
Richard Rand
Terry Ranta
Joyce Ratner
Trena Reed
Jeffrey Resnick
Kathleen Richards
Lee Richer
Terance Roach
Michael Rosenblum
Roberta Rowland
Karen Sallus
Daniel Saunders
Edward Scates
Daniel Schulman
Arthur Seidner
Allen Sherman
James Shoffer
Timothy Short
James Stocker
Antonius Su
Christopher Suykerbuyk
Arthur Tallis
Selena Tang
John Tassone
Robert Taylor
George Thaler
Chad Thompson

Terence Thompson
Edward Tierney
Eric Trattner
Thomas Troy
Phillip Tutnauer
Kyle Vaughn
Wayne Vetter

Melanie Violand
Mark Weisfeld
Bruce Werber
Loren Wessel
Bradley Whitaker
Edward Wiebe
Lance Wissman

Margaret Withrow
Paul Woodward
Susan Young
Robert Zachow
Larry Zonis

Dr. Leonetti recused himself from the review of renewal applications for himself and Dr. Michael Leonetti.

MOTION: Ms. Miles moved to approve the license renewal applications for Drs. Joseph and Michael Leonetti. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

MOTION: Ms. Miles moved to issue a substantive deficiency to obtain additional information from Drs. Rajesh Daulat, Peter Merrill, Roberta Rowland, Wayne Vetter, Bradley Whitaker and Susan Young. Dr. Kaplan seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

MOTION: Dr. Leonetti moved to approve the license renewal applications for all other physicians listed above. Dr. Campbell 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 reviewed the open complaint status report which indicates that there are currently 61 open complaints. This total includes the cases reviewed during today's meeting, and she has received seven new complaints in the last month.

b. Malpractice case report. (None at this time.)

There were no malpractice reports received within 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. August 8, 2012 at 8:30 a.m.

X. Adjournment

MOTION: Dr. Kaplan moved to adjourn the meeting. Ms. Miles 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 11:28 AM.