



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

February 13, 2013; 8:30 a.m.
1400 West Washington St., B1
Phoenix, AZ 85007

Board Members: Joseph Leonetti, D.P.M, President
Barry Kaplan, 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: John Tellier

I. Call to Order

The meeting was called to order at 8:37a.m.

II. Roll Call

Dr. Leonetti noted for the record that all Board members were present, as were Ms. Penttinen and Mr. Tellier.

III. Approval of Minutes

a. January 9, 2013 Regular Session Minutes.

MOTION: Dr. Kaplan 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.

(THE REMAINDER OF AGENDA ITEMS WERE NOT REVIEWED IN THE ORDER IN WHICH THEY APPEAR IN THE MINUTES.)

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

a. 08-25-C – Aprajita Nakra, DPM: Providing improper orthotics and insufficient instruction on their use; failing to properly treat and ingrown toenail.

Dr. Nakra was present with attorney Ed Ladley. Dr. Jerome Cohn was the investigator for the case and was present. Ms. Penttinen explained that this case had previously been reviewed by the board a few years ago and the board had dismissed the case with a Letter of Concern. There was no individual investigator assigned to the case previously. Dr. Nakra requested that the case be reopened and be reviewed again by the board with a request to dismiss it without the Letter of Concern. Ms. Penttinen also clarified for the record that the board had previously reviewed her request to reopen this case. The board agreed to do so and Dr. Nakra was advised that the board could take any action from dismissal up to disciplinary action. Dr. Leonetti asked what would happen to the Letter of Concern which was already issued. Ms. Penttinen said she assumed that if the board voted today to take different action then the Letter of Concern would be vacated. Mr. Tellier concurred with Ms. Penttinen. Mr. Ladley explained that the reason why Dr. Nakra requested the case to be reopened was that she did not have an opportunity to respond to the complaint prior to the time that it was initially reviewed by the board back in 2008. Ms. Penttinen clarified for Dr. Leonetti that this case originally came before the board on October 8, 2008, which was prior to when Ms. Penttinen was hired as the board's Executive Director and the board began to transition its investigation process. Dr. Leonetti asked if Dr. Nakra had been notified of when the board was going to review her case and 2008. Dr. Nakra stated that she had received a request to provide records to the board, which she did, and the next contact she received was a notification that a Letter of

Concern had been issued. Ms. Penttinen reviewed the file and confirmed for the board members that there is no documentation that Dr. Nakra was notified of when this case was going to be reviewed by the board in 2008 so it is possible that Dr. Nakra was not informed of that review.

The two allegations in this case are providing improper orthotics and insufficient instruction on their use, and failing to properly treat an ingrown toenail. Dr. Cohn summarized his findings as follows: with regard to allegation number one he believes it can be substantiated based on the lack of documentation related to any re-evaluation of the orthotics. The patient was dispensed the orthotics and at the time of dispensing the only note was that they were dispensed by a nurse. There is no documentation concerning the appropriate fit. There were apparently adjustments made to the forefoot extension for length which as an individual concern would not warrant improper fitting of an orthotic. There is no documentation concerning the possible confusion with a different physician name on the orthotics at the time of dispensing in which the lab could have been contacted to verify. There was also no documentation from the time of this pick up with either the physicians note that the orthotics themselves had been checked and evaluated for size, fit or function; there were just references in terms of expectation from utilizing orthotics there is confusion when considering if appropriate instructions were given as based on the complainant's letter which said she was given different expectations by both physicians. Due to the time that has elapsed it would be impossible to determine at this time if the orthotics had fit when this initial complaint was raised. The photographs provided are not adequate to determine if they were fabricated as ordered. Dr. Cohn stated he believed that if there had been documentation within the patient's chart that the orthotics had been evaluated and the lab had been contacted to verify that these were the proper orthotics for this patient, then this allegation would not be substantiated. Dr. Cohn noted that the patient's mother complained that the orthotics were never evaluated for fit, and there is no documentation in the patient's chart that this was done. In addition, the sticker on the bottom of the orthotics has the correct patient name of but an incorrect physician name. Therefore, it is possible that the wrong orthotics were dispensed to this patient.

Dr. Cohn continued with his findings regarding allegation number two: In his review of the records he does not feel that this allegation is substantiated as there was adequate documentation describing the appearance of the toenail and the reasoning for the above-noted local treatment not utilizing any oral antibiotics. If this allegation was associated with having an avulsion prior to a matrixectomy he would also say that that was unsubstantiated as there are multiple times when a nail avulsion is appropriate prior to proceeding with a matrixectomy.

Dr. Cohn confirmed for Dr. Leonetti that he did not speak with the patient or with Dr. Nakra regarding this case. His conclusion is based upon review of the records submitted by Dr. Nakra. The board members did not have any questions for Dr. Cohn regarding his review. Dr. Nakra was then given the opportunity to address the board and provided the following statement: Dr. Nakra stated that she disagrees with Dr. Cohn and she believes the correct orthotics were dispensed to this patient. Dr. Nakra stated she believes the patient's mother was concerned about the wrong physician name on the orthotic because she believes that her son (the patient) has a common name and that is why she felt the wrong orthotics were dispensed to her son. Dr. Kaplan noted that the orthotics were also too long for the patient's foot. Dr. Nakra explained that in her office she always orders orthotics "full length" because it then gives her some ability to manipulate and/or customize the orthotic to provide better comfort for the patient's individual shoes. Dr. Kaplan stated that he understands this but the problem is that Dr. Nakra's name was not on the orthotics so he understands the patient/complainant concerned that these were not the proper orthotics. Dr. Nakra was shown the pictures submitted by the complainant which show a different physician's name, and she stated this was the first time she had ever seen that. Dr. Nakra added that the orthotics were dispensed to the patient by another physician in her practice, so she feels she is being left in a position where she is being held accountable for a different physician not properly fitting the orthotics to the patient. Dr. Leonetti pointed out that according to Dr. Nakra's office notes the orthotics were not dispensed by another physician, but rather by a nurse in her office. Dr. Nakra agreed and pointed out that the patient's mother wanted to get the orthotics quicker to which Dr. Nakra's staff agreed but they also advised the mother that the patient would not be seen by a physician for the fitting and the mother agreed. Dr. Nakra added that a follow-up appointment was made for a few weeks later for the orthotics to be evaluated by a physician.

Dr. Nakra continued and stated that the patient did come in later, but for a completely separate issue. Dr. Kaplan asked her if she evaluated the orthotics at that time. Dr. Nakra stated that she did take the orthotics out of the shoes to evaluate them and compare them against the patient's feet. Dr. Kaplan asked if she looked at the bottom of the orthotics to confirm the name. Dr. Nakra stated that she does not have any documentation to that effect so she could not say. Dr. Nakra explained to the board members the methods by which she evaluated the fit of the orthotics. She added that the patient's mother contacted her shortly thereafter to thank her for the time she spent evaluating the fit of the orthotics. Ms. Miles asked Dr. Nakra if she had any specific memory of what she did with this individual patient or if she was testifying based on her customary practices. Dr. Nakra stated that she was testifying based on what her normal practice has been; however, she stated that she does recall some specifics regarding this patient because the mother was so difficult to deal with. She added that she encouraged the patient's mother to seek a second opinion if she felt that the patient was not being treated appropriately in her office. Dr. Nakra clarified for Ms. Miles that she does not recall all of the treatment information for the patient, but only her interaction with the patient's mother.

Dr. Kaplan asked if Dr. Nakra understood the complainant's concerns based on the fact that a different doctor's name was on the patient's orthotics. Dr. Nakra replied that the patient's mother had advised her that when the patient wore the orthotics to speak out better and when he did not wear them his feet felt worse, thus implying that they were the correct orthotics. Dr. Nakra also pointed out that the patient's mother canceled a follow-up visit which had been scheduled for two weeks later, at which time the fit of the orthotics would have been checked again, but instead filed her complaint with the board. Dr. Leonetti reviewed that the Letter of Concern which was previously issued in this case had to do with improving communication skills with patients. Dr. Leonetti reviewed that the complainant's main concern was that the orthotics were never evaluated and the patient was never observed walking in them. Dr. Leonetti added that in Dr. Cohn's review the case that there was no documentation found to indicate that such an evaluation was ever done after they were dispensed. Dr. Nakra replied that a May 21st office visit note discusses the orthotics, and after that there was a phone call documented from the patient's mother indicating how happy she was with them. Dr. Leonetti pointed out that the May 21st note only indicates the patient was instructed on proper break-in of the orthotics but there's nothing documented regarding the fit or evaluation; things such as having the patient walk on the orthotics or taking them out of the shoes and having the patient stand on them may have been done but it is not documented and the patient's mother states it was never done. Dr. Nakra confirmed for Dr. Kaplan that the patient never pointed out to her that the wrong doctor's name was on the orthotics. Dr. Nakra pointed out that the orthotics were dispensed on May 9 at the insistence of the patient's mother. The May 21st appointment was an emergency appointment due to the ingrown toenail. Dr. Nakra added that the patient was seen on June 5 by another physician in her office who conducted the fitting of the orthotics and evaluated them, so she believes she is being held accountable for something that she did not do. Dr. Nakra also clarified for Dr. Leonetti that she did not perform the casting for this patient's orthotics. Dr. Leonetti stated that one of the complainant's main concerns was that they believe they were going to be seen by Dr. Nakra but then in a different office they were seen by different physician which may have caused confusion for the patient and his mother. Dr. Leonetti added that this goes back to the reason why the Letter of Concern was previously issued regarding improving communication skills, not only with patients but between physicians in Dr. Nakra's office as well as written communication.

Mr. Ladley interjected and explained to the board that Dr. Nakra was being asked to provide specific information about a case that occurred five years ago. He added that Dr. Nakra requested that this case be reviewed again in 2009 and it has now been four years. He feels this puts Dr. Nakra in a difficult position when she's being asked about specific details. Ms. Miles replied that she understands that concern; she simply wanted to clarify for the record that Dr. Nakra does not have specific memory of this particular patient but is relying upon her history of normal practices in her office. Dr. Cohn added that when he was reviewing this case he relied upon his own training and experience which has taught him that if certain things were not documented then they did not occur which he believes is the standard of care as it relates to documentation. Dr. Nakra reiterated that she did not cast the patient and never saw him for follow-up to fit the orthotics so she feels she's being held accountable for something which was not her responsibility. Dr. Leonetti stated that he agreed with Dr. Cohn's assessment that if something was not documented then it did not occur. Dr. Leonetti added that if the patient and his mother were happy with the orthotics there would not have been a need for them to go to another physician to have another set made. Dr. Leonetti stated that Dr. Nakra was the person who initially recommended the

orthotics and although she did not dispense them, she did see the patient after they had been fit and dispensed, even if it was for ingrown toenail, but she did not evaluate the fit of the orthotics at any point according to the patient's chart.

Dr. Leonetti asked the board members to consider whether or not they feel there any violations in this case. He stated that with regard to the treatment of the patient's ingrown toenail he does not find any violations and he feels the treatment was adequate. However, there is still the issue of the Letter of Concern for communication. Dr. Kaplan stated that he feels the Letter of Concern should stand. Ms. Penttinen added that due to the board's records retention regarding non-disciplinary actions, the Letter of Concern would come off of Dr. Nakra's record in approximately 8 months. Dr. Leonetti stated that if this were the first time the case is being heard today, he would still have the same concerns that the board had when this case was reviewed and 2008 regarding improving communication in addition to more recent concerns regarding documentation.

MOTION: Dr. Leonetti moved to uphold the Letter of Concern previously issued by the board. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

Following the vote Mr. Ladley asked the board members to clarify if the official issue date of the Letter of Concern would be October of 2008. The board members confirmed that was correct.

b. 09-15-M – Aprajita Nakra, DPM: Development of ulcerations which caused permanent scarring to the patient's leg.

Dr. Nakra was present with attorney Ed Ladley. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof provided the following summary: the board received a report from PICA indicating that a malpractice claim had been filed against Dr. Nakra by patient K.A. That report states the nature of the complaint as, "foot surgery (not an issue). The surgeries performed were successful and uneventful. On the first post-op visit from the second surgery, insured noted a left posterior ulcer which actually references two areas of ulcerations in close proximity on the patient's left mid-calf. Insured referred patient for wound care to address same. There appeared to be no explanation for the ulcerations and they continued to decrease in size until they were noted to be completely healed during subsequent office visits. Patient claims the ulcerations resulted in an unsightly and uneven permanent scar on her calf." Dr. Polakof noted that the claim was settled with a payment to the patient. Dr. Polakof noted that there was a typographical error in the investigation report which indicated that the allegation in this case was in relation to orthotics. Mr. Ladley stated he saw the same error. The actual allegation was development of ulcerations which caused permanent scarring to the patient's leg. Mr. Ladley also noted that the copy of the investigation report which he received was not signed by the investigator. Ms. Penttinen explained that the original investigation report is not signed by the investigator until the time that the board reviews the complaint at a board meeting.

Dr. Polakof reviewed the patient's medical records as follows: Dr. Polakof pointed out that she requested x-rays for this patient but was told that there were no x-rays. She is concerned that surgery was done on this patient who was a juvenile without having any x-rays pre-operatively. The patient had an initial office visit on December 11, 2001. On December 26, 2001 surgery was performed on this patient, who was a 12-year-old female, for the following: modified McBride bunionectomy of the right foot, and proximal interphalangeal joint arthrodesis of the second digit of the right foot. On March 8, 2002 another surgery was performed on this patient which included the following: modified McBride with Austin bunionectomy of the left foot, and proximal interphalangeal joint arthrodesis of the second digit of the left foot. On April 26, 2002 there was a note indicating that the patient had developed two wounds on the posterior of the left leg measuring 3.5 cm x 2 cm and 3.0 cm x 2 cm. On May 6, 2002 an office note from Dr. Nakra indicates that she assessed a left leg ulcer and diabetes mellitus with PVD. On May 9, 2002 surgery was performed to debride the left leg wound and apply Apligraf. A note from Dr. Paul Rhee, MD dated August 12, 2003 states, "she apparently suffered some sort of iatric injury mid-left calf that measures approximately 6 x 5 cm in dimension."

Dr. Polakof continued as follows: she attempted to contact the patient's father on several occasions but was not able to reach him. She also reviewed the hospital notes which indicate that on May 12, 2002 PACU recovery nurses notified the doctor that there was a problem with the back of the child's leg. Dr. Polakof stated that she was able to speak with one of the nurses who provided care to the patient at this time. That nurse informed her that some bleeding and weeping fluids were noted on the back of the patient's left leg. The nurse applied dry dressing per standard protocol and contacted the physician. A Bovi device had been used for this patient. Dr. Polakof stated that she was unable to come to a conclusion at this time. She stated that she would like to see the patient's pre-operative x-rays. Dr. Polakof stated her opinion that the burn into the back of the patient's leg must have occurred during surgery due to an unattended Bovi device, or perhaps someone in the operating room accidentally leaned on it and caused it to fire off. The patient did go to a plastic surgeon to have the wound treated.

Dr. Leonetti stated that he recalled seeing in the records that the nursing staff contacted Dr. Wyant who was on call who advised them to treat the wound with an appointment until the patient could be seen the next week in the doctor's office. Dr. Polakof confirmed that; however, there was a delay in getting in touch with Dr. Wyant so in the mean time the nursing staff applied a dry sterile dressing. The board members did not have any other questions for Dr. Polakof.

Dr. Kaplan addressed Dr. Nakra and questioned her regarding the documentation regarding the amount of local anesthetic that she used for this patient. Dr. Kaplan noted that Dr. Nakra has appeared before this board several times in the past and the same question has come up. Dr. Nakra clarified that this is a case from several years and that she now does document the amount of local anesthetic that is injected into a patient. Dr. Leonetti asked if Dr. Nakra would like to provide any type of statement regarding the patient's x-rays. Mr. Ladley explained that by the time at this patient's condition became any sort of issue it was already late 2008. He stated that Dr. Nakra had to retrieve this patient chart out of her storage. He was advised that there may have been x-rays at the hospital but he never received them. Mr. Ladley also stated that when Dr. Nakra was requested to provide a response to the complaint in 2009 there was no request for x-rays; the first request for x-rays was received in the fall of 2012. Ms. Penttinen clarified that the initial notice letter to Dr. Nakra and subpoena for patient records did include a specific request for x-rays. Mr. Ladley stated Dr. Nakra did not have x-rays at that time and that there was a three-year period before they were requested again, at which time Dr. Nakra no longer had access to them. Dr. Kaplan asked how long Dr. Nakra keeps her patient records. Dr. Nakra stated that it would be either five or seven years depending on the age of the patient. Dr. Nakra confirmed for Dr. Campbell that the records are no longer available. Mr. Ladley stated that even with the lawsuit, the x-rays and the surgery were never in question; it was only a matter of the development of ulcers on the back of the patient's leg. Therefore, they never reviewed the x-rays. Dr. Polakof interjected and agreed, based upon statements in the chart, that the patient and her family were happy with the surgery; they were concerned due to the burns on the back of the leg which had to have been caused by the Bovi device. Dr. Polakof stated that she had no concerns with the actual surgical procedure itself or the post-operative care. Her concerns were as follows: first, on the operative report is indicated that a tourniquet was utilized in the strength of 250mm Hg which is a lot of pressure for a juvenile patient; second, she was concerned that Dr. Nakra did not recognize that the patient's injuries could have been caused by the Bovi device. Dr. Polakof clarified for Dr. Leonetti that the injuries on the patient's leg were full-thickness third degree burns which required plastic surgery. Dr. Leonetti asked Dr. Polakof if she felt that the tourniquet had anything to do with the burns cause to the patient. Dr. Polakof stated that she did not think that was the case, but anything in the records would be subject to her review as far as quality of care. After comment from Dr. Nakra, Dr. Polakof confirmed that a tourniquet was used when the surgery was done on the patient's right lower extremity, but no tourniquet was used on the left lower extremity when this burner occurred. Dr. Kaplan commented that initially he thought the patient's wound could have been caused by irritation from a Cam Walker; however, upon his review the patient's records it does seem evident to him that the burn was caused by the Bovi. Dr. Polakof added that the only reason the patient's parents filed a lawsuit was because they needed financial means to pay for the plastic reconstructive surgery so that their daughter would not have a scar the back of her leg.

Dr. Leonetti asked Dr. Nakra what she thought was the cause of the injury to the patient's leg. Dr. Nakra stated she did not believe it was the Bovi but actually the Bovi pad. She stated that the Bovi pad was under the drapes covering the patient's leg down to her ankle; after the surgery the nurses removed the Bovi pad so she believes that the patient either had a reaction to the adhesive on the pad or perhaps the

nurses removed it too quickly. Dr. Nakra stated that if the patient had been burned she would have complained of pain which she did not. She added that the nurses noted the wound to be a superficial abrasion. There was brief discussion between Dr. Polakof and the board members regarding the appropriate site for a grounding pad for use with electrical surgical devices. Dr. Kaplan stated his opinion that it is impossible to tell how the burn occurred. Dr. Polakof agreed and stated that was why she was unable to come to a conclusion in this case. Dr. Leonetti stated he agreed and stated it was simply an unfortunate incident of an unknown cause. Dr. Leonetti stated he does not feel there is any violation in this case.

MOTION: Dr. Leonetti 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.

c. 11-09-M – Kelvin Crezee, DPM: Practice below the standard of care for operating on the wrong foot. Dr. Crezee was present with attorney Bruce Crawford. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof provided the following summary of the complaint: the board received notification from PICA and the National Practitioner Data Bank that a malpractice case had been filed against Dr. Crezee by patient R.R. The nature of the claim was stated as, "Wrong site surgery. Patient was diagnosed with a bilateral exostosis and needed surgery on both feet; however, surgery was scheduled for the left foot and insured operated on the right foot instead." In his written response Dr. Crezee stated that the patient had bilateral heel pain, with the left being worse than the right and the left heel was to be operated on first. During the surgical procedure the doctor was advised that he was operating on the wrong extremity. He had to complete the surgery, and he wrote that he visualized the same deformity on the right foot and he removed the heel enlargement, secured the Achilles tendon, and closed the incision site appropriately. He then notified the patient's spouse and the patient in the recovery room of the surgery done the wrong foot.

Dr. Polakof continued as follows: review of the patient's medical records reveals that surgery was recommended for a retrocalcaneal exostectomy with reattachment of the Achilles tendon. The surgery was performed on December 11, 2009. Dr. Crezee marked the left extremity in the pre-operative area prior to the surgery with the word "yes." Dr. Crezee did apply the tourniquet to the right side prior to the nursing staff beginning the process of washing and draping the surgical site prior to the procedure initiation. Halfway through the surgery the doctor realized that it was a wrong site incident. The pre-operative paperwork, the surgical center scheduling forms, the pre-procedure insurance company form, and the surgical consent form all request treatment for a repair of the Achilles tendon of the left ankle and open reduction of a fracture of the calcaneus of the left foot. The billing codes submitted for the planned surgery included code 28415, which was for open reduction and internal fixation of the left calcaneus, and 27650, repair of the left Achilles tendon. The office notes and physical therapy notes all indicates a retrocalcaneal exostectomy with reattachment of the Achilles tendon on the left foot. The malpractice case was settled with a judgment in favor of the patient on September 15, 2011. Dr. Polakof finds in conclusion that the allegation of practicing below the standard of care for operating on the wrong foot is substantiated.

Dr. Leonetti asked Dr. Crezee if he had a response. Dr. Crezee stated that Dr. Polakof's report was correct. Upon questioning from Dr. Leonetti, Dr. Crezee explained that the tourniquet had been applied not to the thigh area but to the calf area of the right leg. He had marked the patient's left leg but somehow when the patient was turned over into a prone position the tourniquet ended up being applied to the right leg. Dr. Crezee stated that he used a flouroscope to visualize the area of the surgical incision prior to initiating the procedure and he noted the same deformities in the right foot as what he had anticipated in the left foot. Prior to completing the procedure he realized that he was performing the procedure on the wrong foot. However, the plan with this patient was to perform the same procedure on both feet eventually, so at that point he had no option but to continue the procedure and finish it. Dr. Crezee stated that immediately following the procedure he went to the waiting room and discussed what happened with the patient and his wife. Dr. Leonetti asked what their reaction was. Dr. Crezee stated they were both very understanding at that time, but the patient was still somewhat groggy. Dr. Crezee

added that he followed up with the patient the following week and intended to continue care with this patient; however, the patient wanted to continue care with another physician.

Dr. Kaplan asked Dr. Crezee if the surgical center where this procedure was performed conducts what is known as a "timeout." Dr. Crezee said a timeout occurred prior to anesthesia when the patient is supine on the gurney. Then the patient is rolled from the gurney onto the surgical bed and appropriate padding is applied at various places underneath the patient's body, after which the appropriate surgical curtains and three things are put in place. Dr. Kaplan asked if another timeout would have been done at that time. Dr. Crezee stated there was not at that time, but there is now. Dr. Crezee added that at this particular surgical facility there have been numerous modifications to surgical procedures to eliminate wrong site surgeries when dealing with extremities, including different colored socks or extremity covers to assist in identifying the correct surgical site. Dr. Campbell noted that in the operative report Dr. Crezee did not indicate the surgery was performed on the wrong extremity. Dr. Crezee admitted that it was not documented in the operative report but stated he fully admits that it was the wrong extremity. Dr. Polakof offered discussion regarding the wrong site surgery and stated that the World Health Organization did not recommend "timeout" as a medical industry standard until 2011, whereas this incident occurred in 2009. Dr. Kaplan noted that in Dr. Crezee's written response he indicated that the patient was not charged for this surgical procedure. Dr. Crezee confirmed that the patient was not charged by anybody including himself or the surgical center. Dr. Leonetti also noted that he did not find any mention in the operative report that surgery was done on the wrong extremity. He had questioned Dr. Polakof regarding the post-operative notes because he was not able to read them. Dr. Polakof stated that her review of the medical records revealed that the post-operative notes do indicate that surgery was done on the right foot rather than the left foot. Mr. Crawford addressed the board and acknowledged that the operative report does not indicate that surgery was done on the incorrect foot. He added that the operative report correctly reflects the surgical procedure that was done and that it has never been debated that surgery was done on the wrong extremity. Dr. Leonetti agreed that he does not believe that the doctor tried to hide anything about this incident; however, he had questions regarding what type of documentation would need to be done in incidents such as this to indicate that surgery had been done on the wrong site, such as whether it would be included in the initial operative report or a supplemental report.

Upon questioning from Ms. Miles, Dr. Crezee confirmed that the patient would have eventually needed surgery on both feet for the same condition. Mr. Crawford added that the patient did have the exact same procedure done on the left foot by the physician with whom he sought care after Dr. Crezee. Dr. Kaplan stated that his question was that if the left foot, (the correct foot), had been operated on first, that the patient's symptoms on the right foot may have subsided to the point that additional surgery may not have been needed. Dr. Leonetti stated that wrong site surgery is a common problem in the medical community and that this situation could have ended up much worse than it did. Ms. Miles stated that that was the basis of her concern in trying to differentiate whether the surgery was actually needed on the extremity on which Dr. Crezee performed it. Dr. Leonetti stated that the fact that the patient needed the same type of surgery on the right foot is somewhat mitigating; however, the patient did not consent to surgery on the right foot, he consented to surgery on the left foot.

Dr. Kaplan stated that in his summary he feels there are violations because the surgery was performed on the wrong site. Dr. Kaplan stated that he would like to issue a Decree of Censure with the allegation being substantiated for practice below the standard of care for operating on the wrong foot. Ms. Penttinen asked Dr. Kaplan to confirm if he found that the alleged violations as stated in the investigators report would both be included [A.R.S §32-854.01(16) & (20).] Dr. Leonetti added that he felt there needed to be an additional violation for lack of informed consent. Ms. Miles pointed out that this was not an Informal Hearing, so at this point the board would be offering a consent agreement.

MOTION: Ms. Miles moved to go into executive session for the purpose of obtaining legal advice.
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 10:57 AM.

The board returned to Regular Session at 11:02 AM.

Mr. Crawford addressed the board and asked them to reconsider the issuance of a Decree of Censure because such an action is perceived in the medical community as a severe discipline and he does not believe that this case warrants that. Mr. Crawford added that the same type of situation has happened to many good doctors and that Dr. Crezee handled this situation appropriately once he discovered the error. He also stated that Dr. Crezee and the surgical facility have instituted measures to prevent this type of event from happening again. Mr. Crawford stated that he feels a Letter of Concern would be sufficient in this case.

MOTION: Dr. Kaplan moved to offer Dr. Crezee a consent agreement for a Decree of Censure for Violations of A.R.S. §32-854.01 (9)(16)&(20). Dr. Leonetti seconded the motion.

DISCUSSION: Ms. Miles stated that she does not wish to include the violation of paragraph (16) regarding negligence because she does not feel that this case rises to that level. Ms. Miles also stated that she feels the motion should include a time period of 30 days from the date that the agreement is sent to him for Dr. Crezee to accept the consent agreement and if not accepted then the case would be referred to an Informal Hearing. Dr. Kaplan agreed to amend his motion to remove a violation of paragraph (16) and to include the suggested timeframe for acceptance. Dr. Leonetti seconded the amended motion.

VOTE: The motion passed unanimously by voice vote.

d. 11-15-C – Aprajita Nakra, DPM: Practice below the standard of care for improper surgery; improper billing.

e. 11-16-C – Aprajita Nakra, DPM: Practice below the standard of care for improper surgery; failure to complete proper pre- and post-operative physical exams; failure to provide the patient's medical records to another healthcare provider.

[Agenda items IV(d)&(e) were discussed simultaneously.]

Mr. Crawford addressed the board and reviewed that he had submitted a request to the board for both of these cases that the board's review be put on hold. Each of these cases has a patient who has filed a simultaneous malpractice lawsuit. Mr. Crawford stated that the attorney representing both of those patients advised them to file complaints with the board and intends to use the board's actions as leverage in the malpractice lawsuits. Ms. Miles asked for the status of each of the malpractice cases. Mr. Crawford stated that each case is near the end of discovery and they will soon be talking to the judge to set trial dates. Mr. Crawford also stated that he planned to address the board today during the Call to the Public to discuss this type of situation in general.

MOTION: Ms. Miles stated that she would like to make a motion that review of both of these cases be postponed but without stating specifically that the postponement is until the malpractice lawsuits are completed. She would like the board to retain the ability to recall the cases at any time. Mr. Crawford stated that once the cases are completed both he and Dr. Nakra would be willing to cooperate with the board in any fashion and provide any information necessary to complete the board's complaint investigations. Drs. Kaplan and Leonetti agreed with Ms. Miles. Dr. Kaplan seconded the motion.

DISCUSSION: There was no further discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

f. 11-24-C – Peyman Elison, DPM: Improper surgery which resulted in on-going pain, numbness and weakness of the patient's left lower leg; improper surgical consent.

Dr. Elison was present with attorney Heather Neal. Dr. Dedrie Polakof was the investigator for this case and was present. Dr. Leonetti pointed out that the board members were in receipt of additional documentation submitted by the patient. Ms. Penttinen advised that she had just received this documentation from the patient this morning. The patient had contacted her approximately 1 week ago stating she had additional information. At that time Ms. Penttinen advised the patient that the investigation was already complete and the investigators report had already been submitted to the board members. She also advised the patient that if she wanted to submit additional information she could do so at the board meeting and to be sure to make enough copies for each of the board members. Ms.

Penttinen clarified for Dr. Leonetti that Dr. Polakof had not seen this information. Ms. Neal also advised that neither she nor Dr. Elison had seen this additional information. Dr. Leonetti asked Mr. Tellier what the board should do with this additional information. Mr. Tellier advised that the board could accept the documentation as only a part of the record or the board members could consider the information contained in the documents if they so wished. Ms. Neal stated that Dr. Elison would object to the use of the information submitted by the patient today because he has not had an opportunity to review it or respond to it. Dr. Leonetti stated that one option the board has would be to table this case until next month's board meeting in order to allow the board members time to review this additional information submitted by the patient. He asked the other board members that their thoughts were. Ms. Miles stated that due to the late submission of this information she does not feel it is necessary to postpone review of the case at this time, especially in consideration that this is simply the board's initial review. She stated that she felt the board should go forward with the initial review and then make a determination if further investigation is necessary. The remaining board members agreed.

Dr. Polakof summarized the complaint information as follows: the board received a complaint against Dr. Elison from patient L.F. the patient started seeing Dr. Elison in October 2010 and was experiencing pain, numbness, burning, stiffness and redness of the left lower leg. On December 3, 2010 Dr. Elison performed nerve release surgery which the patient feels was not necessary and did not alleviate her symptoms. The patient also states the surgical consent form she signed was not accurate and she was not aware of the procedure Dr. Elison planned to perform. Review of Dr. Elison's records for this patient indicates the initial office visit was on October 26, 2010. Dr. Elison documented a history of radiating pain, fibromyalgia, and difficulty walking. Neurological testing was performed to confirm the diagnosis of multiple crush syndrome and entrapment syndrome. On November 17, 2010 a surgical consent form was signed in Dr. Elison's office. The consent had multiple pages and was reviewed with the patient by both the doctor and his staff. The patient's signature and/or initials are on each page. On December 3, 2010 surgery was performed which included decompression/neurolysis/internal neurolysis procedure of the common peroneal nerve, deep peroneal nerve, posterior tibial nerve, medial calcaneal nerve, medial plantar nerve, and lateral plantar nerve in the left lower leg and foot.

Dr. Polakof continued: the patient had expressed concern about the length of time that it took to investigate her complaint and why Dr. Elison was allowed to renew his license prior to her complaint case being heard by the board. Dr. Polakof noted that the initial complaint was submitted to the Arizona Board of Medical Examiners in August of 2011. The patient has been to multiple doctors for care and is still being treated for leg and foot pain. She has had a rash that was very painful and also provided pictures to the board for their review.

Dr. Polakof continued: Review of the patient's chart shows that Dr. Elison diagnosed the patient with multiple crush syndrome and entrapment syndrome. Dr. Elison performed the appropriate neurological testing and the surgery was performed. The patient was treated appropriately and in a timely manner. Dr. Elison is aware that the patient has been diagnosed with causalgia but he has not seen her to confirm this diagnosis or assist in her treatment. The patient had been treated prior to the surgery and following the surgery with medical, chiropractic and physical therapy. The patient was diagnosed with RSD and received treatment for that. The patient also had two EMG's: the first was done in January 2009 with a conclusion that she had peroneal neuropathy; the second was in May 2011 with a conclusion of neuropathy and peroneal neuropathy.

Dr. Polakof continued: It appears that the patient is extremely frustrated in her care due to the following things: she is angry that she was sent a letter by Dr. Elison terminating her from his practice for being verbally abusive to his staff. The patient denies this allegation. However, in review of the patient's notes from her primary care physician in Wisconsin, that doctor dictated that the patient needs to cope better with her anger management. The patient also was frustrated due to a rash that developed on her ankle. The patient is reporting foot pain but it does not seem to be as irritating to her as the two other concerns just listed. However, the patient states that the pain in her foot is worse after surgery than before. Treatment has been initiated for the RSD and a review of the notes by the patient's physicians in Wisconsin, including her primary care doctor, orthopedist, and podiatrist, that syndrome is coming under control. Dr. Polakof concluded that she finds both of the allegations to be unsubstantiated. Dr. Polakof confirmed for Dr. Leonetti that her opinion regarding the surgical consent form is that it was a proper consent. Dr. Polakof feels that the surgical procedure was properly explained to the patient and each

page of the consent forms were dated and initialed. Dr. Polakof also confirmed for Dr. Leonetti that she feels the surgical procedure was appropriate for this patient and was performed properly; however, the patient just happened to develop causalgia which is a known potential complication of the surgery. Dr. Polakof confirmed to Ms. Miles that she reviewed all of the available patient records which included preoperative, operative, and postoperative care from all of the patient's physicians in two states. Ms. Miles asked Dr. Polakof if medical records from 2013 would be likely to change her opinion in this case. Dr. Polakof stated she did not think so because the surgery was already done and the development of RSD had already occurred. Dr. Polakof also confirmed for Ms. Miles that she did not speak directly to the patient in this case. When asked why, Dr. Polakof stated that she also did not contact Dr. Elison because she felt that there was sufficient information in the file to complete her review. Dr. Leonetti asked Dr. Polakof about the rash which the patient developed and if she felt it was related to the surgical procedure performed by Dr. Elison. Dr. Polakof stated it was a simple dermatitis which could have developed from any of the wound care products used in the postoperative period.

Dr. Leonetti asked about the delay at the beginning of this complaint investigation. Ms. Penttinen stated there was a delay because the patient initially sent her complaint to the Arizona Medical Board who then forwarded the complaint to the Podiatry Board. There also was some difficulty in initially contacting the patient because she only lives in Arizona part-time. Dr. Campbell asked Dr. Polakof to define her understanding of "crush syndrome" and why that term was used to describe this patient's condition. Dr. Polakof stated that in her research a crush syndrome is defined as any nerve that has been pulled or irritated, or compartment syndrome, which is different from a nerve entrapment. There were no further questions of the board for Dr. Polakof.

Dr. Leonetti asked Dr. Elison if he had anything else you wish to add. Dr. Elison stated that he believed he upheld the standard of care in this case. Dr. Elison confirmed for Dr. Leonetti that he performed multiple nerve releases on this patient. Dr. Leonetti asked him what his understanding was of a crush syndrome. Dr. Elison stated that his understanding of multiple crush syndrome is when a nerve is being pulled or irritated at multiple sites. He added that he sees this very frequently in his practice and it causes many different types of symptoms such as pain and burning which this patient did exhibit. Dr. Elison confirmed for Dr. Leonetti that his diagnosis that this patient had multiple nerve problems was based on his physical examination as well as nerve testing which was abnormal. Dr. Leonetti reviewed the surgical consent form which indicated that Dr. Elison was going to perform multiple nerve releases and asked Dr. Elison if he explained to the patient the potential risks and complications. Dr. Elison stated that he has done hundreds of similar procedures and always provides the same information to the patients, spending 30 to 60 minutes with them explaining the procedure and the potential risks. Dr. Leonetti asked if Dr. Elison was happy with outcome of this procedure and Dr. Elison stated he was. Dr. Leonetti asked if Dr. Elison was aware of any other physical conditions the patient may have had which had symptoms similar to a crush syndrome. Dr. Elison stated that the patient did demonstrate symptoms concurrent with fibromyalgia and he was aware of that diagnosis. Dr. Elison also confirmed that he was aware the patient had nerve compressions in her back. Dr. Leonetti asked if that would affect the surgical outcome or the procedure that Dr. Elison chose to perform. Dr. Elison stated that his procedure was appropriate based on the testing he did which indicated that there were nerve disruptions below the knee. Dr. Elison confirmed for Dr. Campbell that he was not aware of any previous trauma to that patient's extremity. There were no further questions from the board members.

The patient was present with her husband and addressed the board. The patient stated that when she signed the surgical consent form all of the wording was not contained in the form; Dr. Elison told her he would fill it in later. Dr. Leonetti showed her a consent form with typed information on the top regarding the procedure and asked her to confirm that that was blank when she signed it. The patient stated she believed so. The patient stated that the "crush stuff" was never discussed with her and she did not know what that was. She said she went to see Dr. Elison due to neuropathy and according to her other physicians there is no surgery for neuropathy. The patient stated she wanted to read a letter that she wrote dated February 9, 2013 because she feels it is very important due to the length of time that this complaint investigation took. The patient was upset that all of her individual correspondence was not specifically replied to and that the investigator did not contact her to talk to her. The patient claimed that she received no correspondence from the board at all. The patient also claimed that her complaint was sent to the Podiatry Board before she sent it to the Arizona Medical Board so she does not understand any delays. Ms. Penttinen reviewed the file and explained that she initially received the complaint which

had been forwarded from the Arizona Medical Board and was received on August 11, 2011. She later received a copy of the complaint directly from the patient in October 2011. The patient claims that she sent a letter to this board in July of 2011 which Ms. Penttinen stated is not in the record. The patient then proceeded with reading her letter dated February 9 in which she stated that she had additional information to demonstrate that the surgery performed by Dr. Elison was not necessary. The patient requested that the board members review a letter sent on November 30, 2011 and asked them to explain why none of her physicians were contacted individually to discuss her medical care with them. The patient states that the letter she allegedly sent in July 2011 contained several questions which she feels this board must answer. The patient also claims that Dr. Elison refused to give for copies of her medical records. The patient feels that Dr. Elison slandered her by noting in her chart that she had used "filthy language." The patient stated that she has seen three additional physicians in the last month and she would like those records to be added to the file.

The patient continued: she had an EMG test done by another physician which she feels Dr. Elison should have done prior to performing surgery on her. She claims that none of her other physicians recognize whatever type of testing it was that Dr. Elison did on her prior to surgery. The patient discussed various other physicians she has been evaluated by and her understanding of their assessment of her physical condition and the surgery performed by Dr. Elison. The patient claims Dr. Elison told her that the procedure he would be performing would be a very simple one and that she would be pain free within several weeks postoperatively. However, her pain has increased since the surgery and is at times intolerable. The patient stated that she has had numerous negative consequences on her lifestyle due to the pain that she is now enduring.

Dr. Leonetti addressed the patient and reviewed Dr. Elison's comment that he was satisfied with the outcome of the procedure. He asked the patient whether she had ever discussed her feelings with Dr. Elison regarding the outcome and that she was worse off than before. The patient stated she did. Dr. Leonetti then reviewed with the patient again the consent forms and the patient confirmed that she did sign them. Upon further questioning from Dr. Leonetti the patient stated that she was only told there would be a small incision but she really wasn't certain what all Dr. Elison had planned to do. The patient confirmed for Dr. Leonetti that she would not have signed a blank surgical consent form, but she does not remember any of the procedure information being typed on the form. The patient stated that she believes the EMG performed in 2009 does not show any type of nerve problems or entrapment.

Dr. Leonetti asked the board members if they felt any additional time would be needed in order to review the documents submitted by the patient this morning. Dr. Kaplan stated he did not but he wanted to clarify for the patient that the only two allegations were improper surgery which resulted in ongoing pain, numbness and weakness of the leg, and improper surgical consent. The patient asked why the issue of foul language was not going to be addressed. Dr. Kaplan advised her that that would not be an allegation or violation. Ms. Penttinen clarified for the record that she did review the patient's complaint information by phone and sent her written notice indicating the two allegations in this case as Dr. Kaplan just reviewed them. The patient claims that she never received any such documentation from Ms. Penttinen. The patient also asked why she had to call the Governor's office in order to get a response and asked what the board had done with her certified mail letter. The patient again claimed that she had sent a letter in July of 2011 and it was again clarified that that letter had never been received by the board. Dr. Kaplan explained to the patient that the board receives a large volume of complaints which has an effect on the amount of time that it takes to investigate each complaint, also that there are several different procedural steps which must be followed in order to be thorough. Dr. Kaplan assured the patient that her complaint was not ignored. The patient's husband addressed the board and stated that he believes this is more of an emotional issue for her because of the amount of pain that she is been in and the length of time of that pain. Upon questioning from Ms. Miles the patient confirmed that the information in her letter to the Arizona Medical Board which was forwarded in August of 2011 would have been substantively similar to the letter that she states she sent directly to this board in July of 2011. Ms. Miles therefore concluded that this board not receiving her July letter does not have any substantial impact, particularly considering the volume of additional information that the patient submitted after her initial complaint was received. The patient again questioned the board as to why they did not contact each one of for individual physicians when she told him that she wanted them to. Dr. Leonetti explained to the patient that the investigator reviewed all of the records that have been submitted and was able to form a conclusion based upon those records without the need to discuss anything directly with her physicians.

Dr. Leonetti again reviewed the two allegations being reviewed in this case. He stated that he felt the surgical consent form was appropriate. With regard to the procedure, Dr. Leonetti stated that various physicians will have differing opinions as to the effectiveness of this type of surgical nerve decompression. However, the patient elected to go forward with the procedure and Dr. Elison does this type of procedure on a regular basis. The patient again asked the board members why they would not answer the questions put forward in her letter which she read today dated February 9. She also asked Ms. Penttinen why her phone calls were not all returned. Dr. Leonetti stated that a response to those questions would not be necessary. The patient asked if Dr. Elison was licensed to perform this particular procedure and Dr. Leonetti informed her that he was. Dr. Campbell asked the patient if the physical therapy has been helpful for her and the patient stated that it was. Ms. Miles addressed the physician members to confirm to her that they have reviewed all of the medical records available in this case and asked them to confirm if they concur with Dr. Polakof's conclusion. Dr. Campbell stated that she is aware that Dr. Elison has trained with Dr. Dellon who is considered a leading expert in this type of surgery. Dr. Elison also made appropriate referrals for the patient for dermatology and physical therapy. Dr. Campbell also noted that the specific details included in Dr. Elison's operative report confirmed the entrapment of the nerves. Dr. Leonetti stated that his concerns are whether or not Dr. Elison was properly trained to perform this procedure, if the procedure was done appropriately, and whether he properly explained the procedure to the patient. Dr. Leonetti stated that he finds all of those things were done properly. Dr. Leonetti added that although this type of procedure can be controversial he feels that Dr. Elison is properly trained to perform it. Dr. Leonetti confirmed for Ms. Miles that he does feel Dr. Elison met the standard of care and he does not believe there is any violation.

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

DISCUSSION: Upon discussion Dr. Leonetti stated that this case is unfortunate because sometimes these types of procedures do result in an aggravation of the nerves symptoms. However, that does not indicate that there was any deviation from the standard of care.

VOTE: The motion passed unanimously by voice vote.

g. 11-36-C – Arthur Tallis, DPM: Advising a patient to walk and releasing back to work too soon following a fracture of the left great toe.

Dr. Tallis was not present. The patient was present. Dr. Jerome Cohn was the investigator for the case and was present. Dr. Cohn provided the following summary of the complaint investigation: the board received a complaint against Dr. Tallis from patient E.K. On September 15, 2011 the patient was working at the airport when a motorized cart weighing approximately 2000 pounds ran over her left foot twice. She suffered a non-displaced fracture of the big toe and later developed compartment syndrome. She was initially seen at St. Luke's emergency room and evaluated for multiple injuries which included a digital fracture of the hallux and laceration which was repaired. Care had included a brace, crutches, and wound care. The examination had revealed neurovascular status to be intact and no remarks concerning compartment syndrome. Wound care was provided and the patient was referred to Concentra for further care. The patient was seen at Concentra the following day. Review of those notes described that the patient was feeling better. At that time the evaluation demonstrated the neurovascular status to be intact and again, there was no discussion concerning compartment syndrome. The patient was instructed to remain on "no work" status she was advised to use crutches and not put any weight on the foot. She was referred for a podiatry evaluation.

Dr. Cohn continued: the patient was first seen by Dr. Tallis on September 20, 2011 at which time Dr. Tallis documented that the patient had sustained multiple injuries including minor injuries to her right forearm, face, scalp, chest, and hand in addition to the injuries to her foot. The patient described her pain level as 7/10. Dr. Tallis documented the vascular status to be intact and within normal limits. The neurological status described the Achilles and patellar tendon reflexes on the right to be present 3/4 and deferred on the left. Dermatologic evaluation describes a laceration on the foot with sutures present in the sulcus of the fifth digit. Musculoskeletal evaluation noted +3 edema on the dorsum of the left foot with some blistering. Skin temperature was noted to be within normal limits. There was no discussion regarding atrophy or thinning of the skin. X-rays were reviewed and they described a fracture of the distal phalanx of the left foot great toe. Dr. Tallis's assessment included a crush injury with laceration, and

treatment had included dressings of the wound, restricted work status including 100% sitting and use of crutches at all times. The patient's second evaluation with Dr. Tallis was on September 27, 2011. The subjective note states that the patient had been on a modified work status, however her employer had not accommodated the status. The patient presented that day walking in a Cam boot but was not using crutches because it was hurting her armpit when she had to walk long distances. The x-rays taken that day revealed healing of the fracture. The laceration also was healing and sutures were removed. It was noted that there was an increase in redness surrounding the blisters. Dr. Tallis's assessment was unchanged; his plan consisted of wound care, removal of sutures and initiation of antibiotics. According to Dr. Tallis's treatment plan the patient was to remain on a modified work status which included sedentary work 50% of the time with walking and working as tolerated and to return to his office in two weeks.

Dr. Cohn continued: the patient did not return to Dr. Tallis's office but continued her care with Dr. Richard Jacoby. Dr. Jacoby's evaluation of the patient on September 30, 2011 described a contusion on the left foot dorsally with swelling, tenderness and ecchymosis. The laceration was healed and x-rays confirmed a non-displaced fracture. The patient had a cast boot and had difficulty walking. She was instructed to continue with the cast, elevating the foot, and utilizing a roll-about for non-weight bearing. The patient had another follow-up with Dr. Jacoby on October 5, 2011 at which time she was forming an eschar at it was Dr. Jacoby's impression that she was going to require debridement. Debridement surgery was performed on October 11 which did describe necrosis and a large hematoma which was evacuated followed by application of an Apligraf. The patient continued care with Dr. Jacoby which included multiple treatments for wound care to heal the ulceration of the left foot. Dr. Cohn stated that he did not interview the patient because he felt that the information contained in the investigation file was sufficient for him to complete his investigation of the patient's complaint. He also did not interview Dr. Tallis as he felt that the chart notes were adequate and consistent.

Dr. Cohn concluded as follows: he feels that Dr. Tallis treated the patient's injury appropriately and that his work modification recommendations were appropriate although it appears that the patient's employer was not able to accommodate her restrictions. He added that there had been some discussion of concerns about the patient developing compartment syndrome but he did not feel that there was adequate documentation to support that. Dr. Cohn stated there was no question that there was extensive soft tissue injury consistent with the type of injury that the patient sustained which would require the need for the surgical intervention that was performed by Dr. Jacoby. Dr. Cohn feels that if there was immediate concern for acute compartment syndrome it would have been identified much sooner either through the emergency room or through Concentra. Dr. Cohn concluded that the patient had been instructed to remain out of work initially and then later instructed to return to work only if the work restriction accommodations were able to be met by her employer.

Dr. Leonetti stated that he did not find any documentation in the records regarding compartment syndrome. Dr. Leonetti agreed with Dr. Cohn that if a compartment syndrome were to develop after a crush injury such as this it would have been noted much sooner. Dr. Kaplan asked Dr. Cohn how the term compartment syndrome came about. Dr. Cohn stated he could not recall specifically but he believes that term was used in the patient's complaint; however, there is no mention of compartment syndrome in any of the treatment records in the file. Dr. Leonetti reviewed that the patient's complaint was that Dr. Tallis recommended that she returned to work too soon. However, with work-related injuries there are often work accommodations that are recommended but the employer may not be able to make such accommodations; this does not mean that the patient was cleared to return to work too soon from a medical standpoint. Dr. Cohn also noted that in the patient's second visit with Dr. Tallis there was a note that the patient had been walking at work because her employer could not accommodate her work restrictions. There were no further questions from the board for Dr. Cohn.

The patient was present and addressed the board as follows: she feels that Dr. Tallis did not listen to her complaints regarding her injury and her pain. She states she advised Dr. Tallis of what her job included, which required a great deal of walking, but that she was not even able to put on a shoe at that time. She also stated that the boot Dr. Tallis gave her did not fit well because it was rubbing against one of the injured areas of her foot. The patient confirmed for Dr. Leonetti that she was initially off work completely for a period of two weeks. The patient also explained that she was unable to use crutches due to injuries to her hands and her chest which were sustained in the same injury. Dr. Leonetti asked the patient if she

had an open lesion on her foot at the time she began treatment with Dr. Jacoby. The patient stated she submitted pictures which show the status of her foot at that time. Dr. Leonetti said that it appears in the pictures that the lesion was not open. The patient stated her foot was swollen with blackened skin and that she had compartment syndrome. Dr. Leonetti asked the patient who used the term compartment syndrome and the patient stated it was Dr. Jacoby. Dr. Leonetti pointed out that Dr. Jacoby did not document that in his records or in the operative report. Dr. Leonetti then reviewed the records from Dr. Tallis including the x-rays which show that there is a small "chip" fracture of the hallux. A walking boot or surgical shoe would have been appropriate for that. However, the last time she saw Dr. Tallis there was no open wound on her foot. The patient confirmed this. Dr. Leonetti stated it is possible for a physician to send the patient back to work with restrictions, but if the employer is not able to accommodate those restrictions with alternative duties it is not the doctor's fault. If Dr. Tallis had released the patient to go back to work 100% there may have been a problem with that; however that is not what Dr. Tallis recommended. Dr. Leonetti advised the patient that her return to work status, based on Dr. Tallis's recommendation, was an issue between her and her employer. There was brief discussion between Dr. Leonetti and the patient regarding the debridement and subsequent wound care that was performed by Dr. Jacoby and how that led to the other issues that the patient encountered during the healing process.

MOTION: Dr. Leonetti 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.

h. 11-37-C – Bruce Levin, DPM: Practice below the standard of care for improper bunion correction. Dr. Levin was present with attorney Bruce Crawford. Dr. Dedrie Polakof was the investigator for the case and was present. The patient also was present with her spouse. Dr. Polakof provided the following summary: The Board received a complaint against Dr. Levin from patient B.C. The patient stated that she had surgery with Dr. Levin on November 5, 2010 for bunion correction of the left foot. Following surgery she continued to experience pain and could not wear shoes because her great toe was crossing over her second toe. Dr. Levin ordered aggressive physical therapy but advised the patient that her x-rays showed good alignment of the first MPJ. In April 2011 the patient sought a second opinion from Dr. Stanley Graves who ordered an MRI which the patient states showed the bunion was not properly corrected. The patient had corrective surgery with Dr. Graves and states that she has now recovered.

Dr. Polakof continued as follows: her review of the patient's medical records show that Dr. Levin performed surgery on November 5, 2010 on the patient's left foot which included arthroplasty with partial osteotomy of the first MPJ. It is noted that preoperative x-rays from October 8, 2010 do reveal a long first metatarsal, decreased joint space of the first MPJ, and Bipartate Sesamoid. The patient submitted photographs of her feet preoperatively which reveal a very prominent extensor tendon bilaterally with bunion deformity greater on the left foot and hammertoes. In office visit notes from March 22, 2011 Dr. Levin noted that there was some elevatus of the hallux and possible increased valgus rotation of the hallux toward the second digit. Dr. Polakof noted that the patient stated in her complaint letter that she was doing very well initially after surgery. Four weeks postoperatively there was a wound dihescence and her toes started to cross over causing increased pain. Physical therapy was ordered but the patient continued to have significant pain. On April 14, 2011 the patient sought a second opinion from Dr. Graves and was diagnosed with an extension deformity following bunion surgery of the left foot. On May 9, 2011 Dr. Graves performed surgery which included a surgical fusion arthrodesis.

Dr. Polakof continued: the patient was initially seen by Dr. Levin on October 15, 2009 with the complaint of painful bunions to both feet. Following surgery of the left foot on November 5, 2010 physical therapy was initiated on December 3, 2010. When the wounds dihescence occurred patient was given Keflex on December 9. Physical therapy notes indicate that in March of 2011 the patient was doing well and that the joint mobility was within normal limits. However, on March 22, 2011 the patient returned to Dr. Levin complaining for the first time about increased stiffness of the left first toe and pressure on the second metatarsal area. More aggressive physical therapy was advised and the doctor noted that if physical therapy failed then a joint manipulation under anesthesia would be performed. That joint manipulation was done on March 31, 2011. Dr. Levin also documented a discussion with the patient and her husband concerning a second surgical opinion and he gave her the names of three other physicians. In

conclusion Dr. Polakof finds that the allegation of improper surgery to correct the bunion is not substantiated.

Dr. Leonetti asked Dr. Polakof if the patient developed an infection during the postoperative period. Dr. Polakof stated the infection was noted one month later after the stitches had come out. Dr. Leonetti and the other board members reviewed the pictures that were submitted by the patient as well as the x-rays submitted by Dr. Levin. Dr. Polakof explained upon questioning by Dr. Leonetti that she would like to explore with Dr. Levin his thought process and planning this patient's surgery and whether or not a different surgical technique may have been appropriate for this patient. The board members did not have any further questions for Dr. Polakof.

Dr. Levin was then given the opportunity to address the board. He stated he felt his care of the patient was appropriate. Regarding the wound dehiscence, he initially thought that the patient may have been having an allergic reaction to Neosporin or possibly a bandage adhesive. He stated that he did not notice any puss or drainage from the wound but elected to still prescribe antibiotics. He had the patient continue with physical therapy which seemed to be helping until March when the patient reported having stiffness of the joint. Dr. Levin confirmed for Dr. Leonetti that at some point after the surgery he did note that the patient's toe was no longer in the position he wanted it to be in. His first thought for treatment was to try more aggressive physical therapy and if that did not work and he would proceed with the joint manipulation under anesthesia. He explained both of these to the patient by phone. He performed the manipulation in his office and felt that he did get some release of the joint but he was still concerned about it and advised the patient that another surgical correction may be necessary.

Dr. Leonetti asked Dr. Levin about why he chose the particular surgical procedure that he did for this patient and how the patient initially presented to him. Dr. Levin stated that the patient was complaining of pain in the joint but he did not observe any extreme hallux limitus initially. Dr. Leonetti asked if Dr. Levin evaluated the sesamoid bones during the surgery. Dr. Levin stated that they appeared to be okay and he was more concerned with the extensor tendon. He added that there was definite contraction of the brevis tendon and he also performed a lengthening of the extensor tendon. Dr. Levin stated he also noted some fluid in the joint had concerns that the patient was developing mild arthritis, but after tendon lengthening he noted that there was good range of motion in the joint. Upon further questioning from Dr. Leonetti, Dr. Levin stated that he did not consider an osteotomy because the angle of the joint did not warrant that; he felt an arthroplasty would be sufficient. Dr. Leonetti asked Dr. Levin what he recommended to the patient after the physical therapy and the joint manipulation. Dr. Levin stated that he advised the patient she may be more comfortable getting a second opinion and he provided her with the names of three other physicians. He added that he did consider doing a revision procedure which likely would have been a fusion of the joint; however, he got the impression from the patient that she would not want to have any more surgical procedures done by him. Dr. Levin confirmed that the patient did return to his office one more time in April of 2011 at which time he again discussed various options with the patient. She had not sought out a second opinion at that time.

Dr. Kaplan asked Dr. Levin what procedure the patient consented to having done. Dr. Levin stated the consent form indicated an arthroplasty with removal of a bump on the medial side of the first metatarsal. Dr. Levin also clarified for Dr. Kaplan that removal of any diseased bone around the head of the metatarsal he would consider being included in the osteotomy. Dr. Kaplan advised Dr. Levin that what he did was not exactly an arthroplasty but more of an osteotomy. Dr. Kaplan then reviewed the operative report regarding Dr. Levin's statement that the "usual technique" was used to lengthen the tendon. Dr. Levin stated he used a malleable device underneath the furthest proximal end of the tendon and did a partial release one half the length of the tendon and then did the same thing at the furthest distal end. Dr. Levin confirmed for Dr. Kaplan that he did remove some hypertrophy on the medial side of the proximal phalanx. Dr. Levin stated that he was able to complete both the joint revision and tendon lengthening through one incision which was approximately 3cm. There was discussion between Dr. Leonetti and Dr. Levin regarding the patient's follow-up notes as well as the billing with regard to Dr. Levin billing for and using the term arthroplasty. Dr. Kaplan states it was an incorrect term to use and that billing for an arthroplasty resulted in higher reimbursement. (Later in the discussion the CPT codes and definitions were reviewed and it was determined that Dr. Levin did use the appropriate billing code.) Dr. Kaplan then asked Dr. Levin how he thought the extensor tendon contracted so significantly in the postoperative period. Dr. Levin stated that the only thing he could think of is that it may have contracted when the

dihescence occurred. Dr. Levin also confirmed for Dr. Kaplan that he did not believe he caused any damage to that tendon during the surgical procedure. He also confirmed that he did not notice any contracture of the toe until March of 2011.

Dr. Campbell asked Dr. Levin about his vascular assessment of the patient preoperatively and whether or not there was a specialty vascular consultation. Dr. Levin stated there was not because he felt that the patient had adequate blood flow despite the PT pulses being difficult to palpate. Dr. Campbell also asked about the patient's history of smoking because there was conflicting information in the patient's record. Dr. Levin stated that he did not believe the patient had been smoking prior to or around the time of the surgery. Dr. Campbell noted the records from Dr. Graves which indicate that the patient had been a smoker for 20 years and had quit in 2011. Dr. Campbell also asked if Dr. Levin had discussed with the patient any type of arthritis in the joint. Dr. Levin stated he did tell the patient following the surgery that there was fluid in the joint when he was doing the procedure so she was likely to be starting to have some arthritic changes. Dr. Campbell asked whether Dr. Levin knew if there had been any postoperative injury to the foot. Dr. Levin said he had wondered about that but the patient did not recall any injury when he asked her. Dr. Campbell also noted that on the surgical consent form there is no signature from Dr. Levin. Dr. Levin stated he did not know why that happened. Mr. Crawford added that there also would have been a separate surgical consent form from the surgical facility.

Dr. Levin stated in conclusion that he was uncertain why the patient had the outcome that she did or what caused the contracture of the tendon. He stated that as soon as he noticed it he addressed it by prescribing physical therapy and all of the conservative care that he could think of. He reiterated that he had suggested the patient obtain a second opinion with another physician and he is uncertain what else he could have done.

The patient then addressed the board as follows: the patient stated that what Dr. Levin explained was accurate as far as discussing treatment options with her including the surgery. The patient stated she had been concerned because Dr. Levin took x-rays every time she went to the office but never reviewed them with her. The patient reviewed the x-rays she had with her and stated that the one taken three days postoperatively does show that her toe was in an elevated position and curving over to the side. She says the x-rays taken on November 22 also show the same thing. The patient said that any time she mentioned this to Dr. Levin he would get upset with her. She confirmed that she did go to physical therapy for approximately 3 months. She also said that Dr. Levin told her that one day she would be walking and she would hear a loud crack which would be the scar tissue in the joint releasing and her toe would then be in the correct position but that never happened. The patient stated she was not able to wear regular shoes because of the position of her big toe laying over her second toe.

The patient confirmed for Dr. Leonetti that Dr. Levin had called her at home to discuss her status. She stated that Dr. Levin had done a cortisone injection but was very upset with her and again told her that once the scar tissue breaks apart everything would be fine. The patient stated she had difficulty expressing her concerns to Dr. Levin because of the way he was getting upset with her. Dr. Levin then told her that he could give her a dyna-splint and said he wanted to send her to a different therapist. However, the patient claims that Dr. Levin never mentioned to her that she was developing arthritis in her foot. The patient stated Dr. Levin told her he could do surgery again or send her to another therapist, but her husband suggested that she get a second opinion from another doctor. The patient confirmed for Dr. Leonetti that she did not seek treatment with any of the physicians that Dr. Levin recommended to her because she did not trust his recommendation based on how he treated her in the office. The patient's husband then spoke and told the board that despite Dr. Levin's notes the physical therapy was not working. He added that Dr. Graves told his wife that no amount of physical therapy would never correct her joint. There was brief discussion regarding confusion that occurred between the patient, her physical therapist and Dr. Levin. The patient's husband stated that the entire situation was eventually blown out of proportion, but added that he felt Dr. Levin behaved in a very unprofessional manner in many ways. There was also brief discussion regarding a great deal of confusion surrounding who had suggested getting a second opinion with another surgeon and when Dr. Levin provided the patient with the names of other podiatrists. The patient stated that she was reluctant to file a complaint. She stated that everybody makes mistakes and she could understand that; however, she was upset with the way that Dr. Levin treated her and felt that he behaved in a very unprofessional manner. Upon a question from Dr. Leonetti, the patient's husband stated that Dr. Graves told him and his wife that if Dr. Levin had done the

bunion correction properly she would not have encountered any complications or require any additional surgery. The patient stated her foot is now doing much better after the surgery with Dr. Graves. Upon questioning from Dr. Kaplan the patient stated that she did not injure her foot at any time during the postoperative period. She also added that this has affected her in such a way that she is no longer able to wear high heeled shoes which she liked.

The board members did not have any other questions for the patient or her husband. Dr. Leonetti reviewed the MRI which had been ordered by Dr. Graves which he feels indicates that there was some mild arthritic change in the joint, some adhesions in the sesamoid area, and some scar tissue which can be expected with any type of surgery. Dr. Leonetti said it is possible that the adhesions and scar tissue could have been exacerbated by the infection and could have affected the tendon; once that point is reached joint fusion or joint implant would be the only options. Dr. Leonetti added that this patient did have an unfortunate outcome but he does not feel that Dr. Levin fell below the standard of care with this surgery.

MOTION: Dr. Leonetti moved to dismiss this case finding no violations. Dr. Kaplan 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.

Dr. Polakof was present and reviewed with the board the report she submitted regarding her review of patient charts and associated billing records which were requested of Dr. Bui for a probation evaluation. Two of the 10 patients whose charts were reviewed were cash-pay patients; Dr. Polakof reviewed the patient chart information and associated billings for the remaining eight patients. There was discussion among the physician board members and Dr. Polakof regarding the specific billing codes that were used by Dr. Bui for each patient and Dr. Polakof was able to answer all of the board's questions. Following discussion the board members determined that no action is needed at this time.

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

Ms. Penttinen reviewed her email correspondence with Dr. Michel Sucher who is monitoring Dr. Brown's probation. Ms. Penttinen has asked Dr. Sucher to follow up with her regarding conducting a pain management evaluation of Dr. Brown to determine any need for ongoing prescription medication. Dr. Sucher has advised Ms. Penttinen that he plans to conduct such an evaluation after Dr. Brown returns from vacation. Ms. Penttinen will continue to follow up with Dr. Sucher until the evaluation is completed and will provide another update at the March Board meeting.

VI. Review, Discussion and Possible Action on Administrative Matters

a. HB 2316: Composition of boards and commissions.

Ms. Penttinen reviewed the bill which regards the composition of boards and commissions. A similar bill was introduced into the Legislature last year which proposed that no more than 25 percent of a board or commission be comprised of persons who are regulated by that board or commission. That bill did not get passed. This new bill proposes that boards and commissions be comprised so that the persons who are regulated thereby do not represent a majority of the board or commission members. Ms. Penttinen stated she does not know at this time if this bill would require that this board add additional members or perhaps change one of the Physician Members to a Public Member. She did speak with Joe Abate who is the lobbyist for the Az Podiatric Medical Association and he is of the opinion that this bill will not go anywhere. Ms. Penttinen also attempted to contact the Governor's Office of Boards and Commissions to obtain information regarding how this bill would be implemented if passed and in what time frame, but she has not heard back from that office. Ms. Penttinen will continue to monitor the bill and provide updates to the Board.

b. HB 2231: Credit card and online payments for agency fees.

Ms. Penttinen stated that she just became aware of this bill a few days ago. The bill would require all state agencies to accept credit card and debit card online payments for any license fee or agency fee between \$5 and \$250. She is uncertain of the status of the bill at this point but wanted to make the board

members aware that this was pending. There would obviously be a lot of logistics involved in setting up credit or debit card payments/online payments. Ms. Penttinen stated that she will keep the board members informed of the status of this bill as it progresses.

c. CME approval request from Arizona Institute of Footcare Physicians.

The board members reviewed a CME approval request submitted by Dr. Mia Horvath on behalf of Arizona Institute of Footcare Physicians. Dr. Horvath had submitted a CD containing copies of several of the PowerPoint presentations used in their CME program. Ms. Penttinen printed hard copies of some of those for the board to review. They are requesting approval for one half hour of CME per week.

MOTION: Dr. Leonetti moved to approve this CME request. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

d. Review of new license application for the following physicians:

- i. Kamran Farahani, DPM.
- ii. Kaitlin Nelson-Rinaldi, DPM.

MOTION: Dr. Leonetti moved to approve the license applications for both 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.

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

a. Open complaint status report.

Ms. Penttinen advised that she received two new complaints in the last month, so there are currently 56 open complaints including the cases that were on today's agenda. Ms. Penttinen stated that both of the board's investigators currently have approximately 4 cases they are working on; she assigns them cases in a sort of "round robin" basis so they are usually working on approximately 4 cases at any one time.

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

VIII. Call To The Public

Attorney Bruce Crawford was present and requested to address the board. Mr. Crawford was advised that the board could not engage in any discussion with him and that their actions would be limited to placing any topic of discussion on an agenda for future board meeting. Mr. Crawford stated as follows: He is starting to see many malpractice cases where the doctor is being asked questions about the status of the board's investigation of a complaint filed by the same patient. Mr. Crawford explained that his clients do receive a copy of the board's investigation reports with a cover letter from Ms. Penttinen stating that the report is confidential and cannot be redistributed which he feels is correct under the Board's laws. However, when the board reviews the complaints during the board meetings and the investigator reads their report to the board, attorneys representing the patient in the malpractice suits are present in the board meeting to obtain that information and then question why the physician is not able to speak about it (during the malpractice litigation). Mr. Crawford stressed that he is not offering any criticism of the board regarding the complaint investigation process or the review of complaints during board meetings. He suggested that during the board meetings one possibility would be for the investigator to provide a more shortened summary of their investigation report. He added that he does not want to have his clients get in trouble with the board for discussing something related to a board investigation if they are not supposed to. Following Mr. Crawford's comments the board members instructed Ms. Penttinen to place this matter on the agenda for discussion for the next regularly scheduled board meeting.

IX. Next Board Meeting Date:

- a. March 13, 2013 at 8:30 a.m.

/

X. Adjournment

MOTION: Ms. Miles moved to adjourn the meeting. Mr. Rhodes 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 12:55PM.