

**SUNSET EVALUATION REPORT**  
**PODIATRISTS**  
**Chapter 463E, Hawaii Revised Statutes**

**A Report to the Governor and the Legislature of the State of Hawaii**

**Submitted by the**  
**Legislative Auditor of the State of Hawaii**

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## FOREWORD

Under the "Sunset Law," licensing boards and commissions and regulated programs are terminated at specified times unless they are reestablished by the Legislature. Hawaii's Sunset Law, or the Hawaii Regulatory Licensing Reform Act of 1977, scheduled for termination 38 occupational licensing programs over a six-year period. These programs are repealed unless they are specifically reestablished by the Legislature. In 1979, the Legislature assigned the Office of the Legislative Auditor responsibility for evaluating each program prior to its repeal.

This report evaluates the regulation of podiatrists under Chapter 463E, Hawaii Revised Statutes. It presents our findings as to whether the program complies with the Sunset Law and whether there is a reasonable need to regulate podiatrists to protect public health, safety, or welfare. It includes our recommendation on whether the program should be continued, modified, or repealed.

We acknowledge the cooperation and assistance extended to our staff by the Board of Medical Examiners, the Department of Commerce and Consumer Affairs, and other officials contacted during the course of our examination.

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## Chapter 1

### INTRODUCTION

The Hawaii Regulatory Licensing Reform Act of 1977, or Sunset Law, repeals statutes concerning 38 state licensing boards and commissions over a six-year period. Each year, six to eight licensing statutes are scheduled to be repealed unless specifically reenacted by the Legislature.

In 1979, the Legislature amended the law to make the Legislative Auditor responsible for evaluating each licensing program prior to its repeal and to recommend to the Legislature whether the statute should be reenacted, modified, or permitted to expire as scheduled. In 1980, the Legislature further amended the law to require the Legislative Auditor to evaluate the effectiveness and efficiency of the licensing program, even if he determines that the program should not be reenacted.

#### **Objective of the Evaluation**

The objective of the evaluation is: To determine whether, in light of the policies set forth in the Sunset Law, the public interest is best served by reenactment, modification, or repeal of Chapter 463E, Hawaii Revised Statutes.

#### **Scope of the Evaluation**

This report examines the history of the statute on the regulation of podiatrists and the public health, safety, or welfare that the statute was designed to protect. It then assesses the effectiveness of the statute in preventing public injury and the continuing need for the statute.

#### **Organization of the Report**

This report consists of three chapters: Chapter 1, this introduction and the framework developed for evaluating the licensing program; Chapter 2, background information on the regulated industry and the enabling legislation; and Chapter 3, our evaluation and recommendations.

## Framework for Evaluation

Hawaii's Regulatory Licensing Reform Act of 1977, or Sunset Law, reflects rising public antipathy toward what is seen as unwarranted government interference in citizens' lives. The Sunset Law sets up a timetable terminating various occupational licensing boards. Unless reestablished, the boards disappear or "sunset" at a prescribed moment in time.

In the Sunset Law, the Legislature established policies on the regulation of professions and vocations. The law requires that each occupational licensing program be assessed against these policies in determining whether the program should be reestablished or permitted to expire as scheduled. These policies, as amended in 1980, are:

1. The regulation and licensing of professions and vocations by the State shall be undertaken only where reasonably necessary to protect the health, safety, or welfare of consumers of the services; the purpose of regulation shall be the protection of the public welfare and not that of the regulated profession or vocation.

2. Where regulation of professions and vocations is reasonably necessary to protect consumers, government regulation in the form of full licensure or other restrictions on the professions or vocations should be retained or adopted.

3. Professional and vocational regulation shall be imposed where necessary to protect consumers who, because of a variety of circumstances, may be at a disadvantage in choosing or relying on the provider of the services.

4. Evidence of abuses by providers of the services shall be accorded great weight in determining whether government regulation is desirable.

5. Professional and vocational regulation which artificially increases the costs of goods and services to the consumer should be avoided.

6. Professional and vocational regulation should be eliminated where its benefits to consumers are outweighed by its costs to taxpayers.

7. Regulation shall not unreasonably restrict entry into professions and vocations by all qualified persons.

We translated these policy statements into the following framework for evaluating the continuing need for the various occupational licensing statutes.

Licensing of an occupation or profession is warranted if:

1. There exists an identifiable potential danger to public health, safety, or welfare arising from the operation or conduct of the occupation or profession.
2. The public that is likely to be harmed is the consuming public.
3. The potential harm is not one against which the public can reasonably be expected to protect itself.
4. There is a reasonable relationship between licensing and protection of the public from potential harm.
5. Licensing is superior to other optional ways of restricting the profession or vocation to protect the public from the potential harm.
6. The benefits of licensing outweigh its costs.

**The potential harm.** For each regulatory program under review, the initial task is to identify the purpose of regulation and the dangers from which the public is intended to be protected.

Not all potential dangers warrant the exercise of the State's licensing powers. The exercise of such powers is justified only when the potential harm is to public health, safety, or welfare. "Health" and "safety" are fairly well understood. "Welfare" means well-being in any respect and includes physical, social, and economic well-being.

This policy that the potential danger be to the public health, safety, or welfare is a restatement of general case law. As a general rule, a state may exercise its police power and impose occupational licensing requirements only if such requirements tend to promote the public health, safety, or welfare. Under particular fact situations and statutory enactments, courts have held that licensing requirements for paperhangers, housepainters, operators of public dancing schools, florists, and private land surveyors could not be justified.<sup>1</sup> In Hawaii, the State Supreme Court in 1935 ruled that legislation requiring photographers to be licensed bore no reasonable relationship to public health, safety, or welfare and constituted an unconstitutional

1. See discussion in 51 *American Jurisprudence*, 2d., "Licenses and Permits," Sec. 14.

encroachment on the right of individuals to pursue an innocent profession.<sup>2</sup> The court held that mere interest in the practice of photography or in ensuring quality in professional photography did not justify the use of the State's licensing powers.

**The public.** The Sunset Law states that for the exercise of the State's licensing powers to be justified, not only must there be some potential harm to public health, safety, or welfare, but also the potential harm must be to the health, safety, or welfare of that segment of the public consisting mainly of consumers of the services rendered by the regulated occupation or profession. The law makes it clear that the focus of protection should be the consuming public and not the regulated occupation or profession itself.

Consumers are all those who may be affected by the services rendered by the regulated occupation or profession. Consumers are not restricted to those who purchase the services directly. The provider of services may have a direct contractual relationship with a third party and not with the consumer, but the criterion set forth here may be met if the provider's services ultimately flow to and adversely affect the consumer. For example, the services of an automobile mechanic working for a garage or for a U-drive establishment flow directly to the employer, but the mechanic's workmanship ultimately affects the consumer who brings a car in for repairs or who rents a car from the employer. If all other criteria set forth in the framework are met, the potential danger of poor workmanship to the consuming public *may* qualify an auto mechanic licensing statute for reenactment or continuance.

**Consumer disadvantage.** The consuming public does not require the protection afforded by the exercise of the State's licensing powers if the potential harm is one from which the consumers can reasonably be expected to adequately protect themselves. Consumers are expected to be able to protect themselves unless they are at a disadvantage in selecting or dealing with the provider of services.

Consumer disadvantage can arise from a variety of circumstances. It may result from a characteristic of the consumer or from the nature of the occupation or profession being regulated. Age is an example of a consumer characteristic which may cause the consumer to be at a disadvantage. The highly technical and complex

2. *Terr. v. Fritz Kraft*, 33 Haw. 397.

nature of the occupation is an illustration of occupational character that may result in the consumer being at a disadvantage. Medicine and law fit into the latter illustration. Medicine and law were the first occupations to be licensed on the theory that the general public lacked sufficient knowledge about medicine and law to enable them to make judgments about the relative competencies of doctors and lawyers and about the quality of services provided them by the doctors and lawyers of their choice.

However, unless otherwise indicated, consumers are generally assumed to be knowledgeable and able to make rational choices and to assess the quality of services being provided them.

**Relationship between licensing and protection.** Occupational licensing cannot be justified unless it reasonably protects the consumers from the identified potential harm. If the potential harm to the consumer is physical injury arising from possible lack of competence on the part of the provider of service, the licensing requirement must ensure the competence of the provider. If, on the other hand, the potential harm is the likelihood of fraud, the licensing requirements must be such as to minimize the opportunities for fraud.

**Alternatives.** Depending on the harm to be protected against, licensing may not be the most suitable form of protection for the consumers. Rather than licensing, the prohibition of certain business practices, governmental inspection, or the inclusion of the occupation within some other existing business regulatory statute may be preferable, appropriate, or more effective in providing protection to the consumers. Increasing the powers, duties, or role of the consumer protector is another possibility. For some programs, a nonregulatory approach may be appropriate, such as consumer education.

**Benefit-costs.** Even when all other criteria set forth in this framework are met, the exercise of the State's licensing powers may not be justified if the costs of doing so outweigh the benefits to be gained from such exercise of power. The term, "costs," in this regard means more than direct money outlays or expenditure for a licensing program. "Costs" includes opportunity costs or all real resources used up by the licensing program; it includes indirect, spillover, and secondary costs. Thus, the Sunset Law asserts that regulation which artificially increases the costs of goods and services to the consumer should be avoided; and regulation should not unreasonably restrict entry into professions and vocations by all qualified persons.



## Chapter 2

### BACKGROUND

Chapter 463E, Hawaii Revised Statutes, authorizes the Board of Medical Examiners to regulate the practice of podiatry in Hawaii. This chapter reviews the occupational characteristics of the podiatry profession, the statutory history of regulation of the profession in Hawaii, and the current provisions of the podiatry practice act.

#### Occupational Characteristics

Podiatry is an autonomous branch of medicine and surgery that is concerned with the prevention, diagnosis, and treatment of diseases, injuries, and defects of the human foot. Podiatrists take patient histories, perform physical examinations of the lower extremities, order X-rays and laboratory tests, and treat patients using a variety of methods including surgery and drug therapy. When they detect symptoms of a disease that affects a part of the body other than the foot, podiatrists refer patients to a physician while continuing to treat the foot condition.

Podiatry is one of only four professions in the United States that are authorized to engage in the independent practice of medicine and surgery. The other three professions include allopathic medicine (M.D.s), osteopathic medicine (D.O.s), and dentistry. Podiatry is similar to dentistry in that both professions practice on a limited part of the body.

In 1984, there were approximately 10,000 active podiatrists in the United States.<sup>1</sup> As of October 1984, 51 podiatrists were licensed to practice in Hawaii,

1. American Podiatry Association, *History and Current Practice of Podiatric Medicine*, Washington, D.C., August 1984, p. I-1.

including 14 podiatrists who reside in the State.<sup>2</sup> Hawaii has one of the lowest ratios of practicing podiatrists to population in the country. In 1974, there were 0.9 active podiatrists per 100,000 resident population in Hawaii compared with an average of 3.4 per 100,000 nationwide.<sup>3</sup> This ratio has not changed significantly during the past decade.

**Development of the podiatry profession.** In the United States, the podiatry profession has its origins in the work of "corncutters" who traveled around the country in the late 1700s. These individuals worked out of such locations as barber shops and promised to remove hardened and thickened skin from the feet. During the 1840s, some corncutters established offices in larger cities and began to call themselves "corn doctors."<sup>4</sup> By the end of the century, individuals who specialized in the treatment of minor foot problems such as corns, callouses, warts, and bunions came to be known as "chiropodists."

In 1895, New York passed the first law regulating the practice of chiropody. This law authorized a professional society composed of chiropodists to issue certificates to qualified practitioners who had passed an examination. It was not very effective, and there were reports of abuses such as chiropodists trying to bilk the public by using impressive but useless electric machines and frightening patients about diabetes. The law was revised in 1912 when regulatory authority was transferred to the state medical board, and chiropodists were required to graduate from a school headed by a medical doctor in order to qualify for licensure.<sup>5</sup>

The National Association of Chiropodists was established in 1912 to gain recognition for the profession.<sup>6</sup> The association began to set standards for the education of chiropodists and to campaign for the regulation of chiropodists by state

2. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*, October 1984.

3. U.S. Public Health Service, National Center for Health Statistics, "Podiatry Manpower: A General Profile, United States 1974," *Vital and Health Statistics*, Series 14, No. 18, Hyattsville, Md., U.S. Government Printing Office, 1978, p. 5.

4. Herbert Lerner, "Steps in the Development of the Profession of Podiatry," *Journal of the American Podiatry Association*, v. 64, no. 5, May 1974, p 279.

5. *Ibid.*, pp. 280-281.

6. *Ibid.*, p. 282.

medical boards. By 1921, 25 states had passed statutes regulating the practice of chiropody,<sup>7</sup> and by 1937, chiropodists were licensed in all states.<sup>8</sup>

The chiropody profession developed in collaboration with the medical profession. Its educational standards were patterned after those adopted by the medical profession, and physicians served on the faculties of chiropody schools. In 1939, the American Medical Association endorsed the practice of chiropody upon finding that it had a scientific basis of treatment and filled a gap in the delivery of medical services that were often neglected by physicians.<sup>9</sup>

By the end of the 1950s, the practice of chiropody included the treatment of serious foot conditions and the use of treatment methods such as injections and surgery. In addition, chiropodists in some states had won the right to serve on hospital medical staffs and jointly admit patients to the hospital with a physician. In 1958, "podiatry" replaced the word chiropody as the name of the practice, and the National Association of Chiropodists changed its name to the American Podiatry Association.<sup>10</sup>

During the 1960s, there was an extensive review of colleges of podiatric medicine in the United States, and reforms were instituted to standardize and upgrade podiatry education. Entrance requirements and basic medical science course requirements were raised to be comparable with medical school programs. Clinical education continued to focus on the diagnosis and treatment of foot conditions and systemic disorders which manifest in the foot.<sup>11</sup>

In 1984, the American Association of Colleges of Podiatric Medicine adopted new uniform objectives for colleges of podiatric medicine which further standardize podiatry education.<sup>12</sup> These objectives require colleges to prepare students to be competent in three major areas prior to graduation: taking patient histories,

7. *Ibid.*, p. 283.

8. Michelle Arnot, *Foot Notes*, Garden City, N.Y., Doubleday and Company, 1980, pp. 73-74.

9. Lerner, "Steps in the Development of the Profession of Podiatry," p. 285.

10. *Ibid.*, p. 287.

11. American Podiatry Association, *History and Current Practice of Podiatric Medicine*, p. I-4.

12. Interview with Paul Scherer, Professor of Biomechanics, California College of Podiatric Medicine, San Francisco, September 18, 1984.

performing physical examinations, and patient management. Patient management is a broad category that includes 11 separate competency areas such as podiatric management, surgery, pharmacology, and physical therapy. All colleges are required to incorporate the new objectives into their educational programs.

Also in 1984, the American Podiatry Association changed its name to the American Podiatric Medical Association (APMA). The APMA has component societies in every state and a total membership of 8,300 podiatrists.<sup>13</sup> Its purposes are to create greater public awareness of the benefits of good foot care, to encourage and initiate programs to meet the foot health needs of an expanding population, and to provide membership services.

**Education of podiatrists in the United States.** Podiatry education in the United States is controlled by the APMA Council on Podiatry Education. This organization accredits colleges of podiatric medicine and approves graduate training programs together with review committees from various podiatric specialty organizations. Currently, there are six accredited colleges of podiatric medicine<sup>14</sup> and 147 teaching hospitals in 30 states that offer approved graduate training programs.<sup>15</sup>

Minimum requirements for admission to a college of podiatric medicine include three years of undergraduate education with course work in chemistry, biology or zoology, physics, mathematics, and English. Applicants must also pass the Medical College Admissions Test which is administered by the Educational Testing Service. Most applicants possess a baccalaureate degree when they apply for admission.<sup>16</sup>

The podiatry curriculum is a four-year program which is based on the medical school model. The first two years include course work in the basic medical sciences of anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology. The third and fourth years include clinical training in general diagnosis,

13. American Association of Colleges of Podiatric Medicine, *Podiatric Medical Education: Information for the Prospective Student 1982-1983*, Washington, D.C., p. 11.

14. American Podiatry Association, *History and Current Practice of Podiatric Medicine*, p. I-5.

15. *Ibid.*, p. I-12.

16. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, 1984-1985 ed., Washington, D.C., April 1984, p. 156.

therapeutics, surgery, anesthesia, and operative podiatry. During the last two years, students are allowed to gradually assume responsibility for direct patient care in a supervised setting, and they acquire the skills and experience necessary to practice podiatric medicine. Graduates are expected to be adequately prepared to serve as primary health care providers in podiatry. Students are awarded a Doctor of Podiatric Medicine or D.P.M. degree when they graduate.

About two-thirds of all current podiatry graduates continue their formal education by entering a graduate program known as a residency program.<sup>17</sup> There are three types of approved residency training programs: rotating podiatric residency or general postgraduate training, podiatric orthopedics residency (relating to the treatment of bone, muscle, and joint disorders), and podiatric surgical residency. All programs must be sponsored by and conducted in an accredited institution such as a hospital or ambulatory health care facility. Rotating and podiatric orthopedics residency programs are 12 months long, and surgical residency programs may be 12 months, 24 months, or longer.

Residency programs are generally designed to instruct podiatrists in the completion of hospital medical records and to develop their ability to utilize information obtained from the patient history, physical examination, and laboratory tests to arrive at an appropriate diagnostic and therapeutic approach. The programs differ substantially in emphasis although each type of residency program covers internal medicine, radiology, rheumatology (relating to medical conditions characterized by inflammation or pain in muscles, joints or fibrous tissue), trauma and emergency medicine, and neurology.

Completion of an approved podiatric orthopedics or surgical residency program qualifies podiatrists to apply for certification in their specialty field. Certification is awarded by private professional organizations and is unrelated to state licensing requirements.

17. American Podiatry Association, Council on Podiatry Education, *Requirements for Approval of Residencies in Podiatric Medicine*, Washington, D.C., August 1983, p. 1.

Upon completing their formal education, most podiatrists in independent practice continue a program of study in order to keep up with new developments in the field of podiatric medicine. Some podiatrists take formal courses of study whereas others arrange their own course of study.

**Licensing.** All states and the District of Columbia require podiatrists to graduate from an accredited college of podiatric medicine in order to be licensed. In addition, eight states require podiatrists to complete one year of an approved residency training program.<sup>18</sup> Due to an insufficient number of residency positions, at least two of the eight states permit podiatrists to substitute a one-year "preceptorship" for the residency training requirement.<sup>19</sup>

All states and the District of Columbia also require podiatrists to pass licensing examinations.<sup>20</sup> Forty-two states use a written examination developed by the National Board of Podiatry Examiners in cooperation with the Educational Testing Service as all or a part of their licensing examination.<sup>21</sup>

### **Statutory History of Regulation**

The practice of podiatry was first regulated in Hawaii in 1941 when Act 87 made it unlawful for persons to practice chiropody without a certificate or permit issued by the Board of Health. The Board of Health was authorized to set standards for the qualifications of chiropodists and to establish grounds for the revocation or suspension of certificates or permits. It was also authorized to revoke certificates or permits upon due notice and an opportunity for a hearing. The purpose of this legislation was to safeguard the public's health.

The law was amended in 1945 and 1957 primarily to improve and strengthen enforcement. In 1959, Act 25 changed the term "chiropody" to "podiatry" in keeping with national trends.

18. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, p. 156.

19. Interview with Jay Levrio, Staff Member, Council on Podiatry Education, American Podiatric Medical Association, Washington, D.C., September 19, 1984.

20. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, p. 156.

21. National Board of Podiatry Examiners, *Bulletin of Information 1984 Examinations*, Princeton, N.J., 1984, p. 14.

In 1973, Act 80 transferred the licensing function from the Department of Health to the Department of Regulatory Agencies (now the Department of Commerce and Consumer Affairs) and authorized the Board of Medical Examiners to issue podiatry licenses. This legislation sought to improve and upgrade the practice of podiatry in Hawaii. It defined the scope of practice for podiatrists, set licensing requirements, and established the grounds for disciplinary action against licensed podiatrists. It also included provisions designed to insure that health care providers and insurers do not discriminate against licensed podiatrists.

In 1978, Act 163 extended the podiatry practice act through 1984 as a result of a sunset review conducted by the Department of Regulatory Agencies.<sup>22</sup> Act 163 also authorized the Board of Medical Examiners to appoint a committee of not less than three licensed podiatrists to assist in the administration of the podiatry practice act because the board's regulatory duties entail or require a substantive knowledge of podiatry.

### **Nature of Regulation**

Chapter 463E, HRS, authorizes the Board of Medical Examiners to regulate the practice of podiatry in the State. The board is established by Chapter 453, HRS, which is the medical practice act. The board is composed of nine members who are appointed by the Governor and confirmed by the Senate. Seven members must be licensed Hawaii physicians, including one physician from each neighbor island county. Two must be public members. The members serve without pay but they are reimbursed for their expenses. The director of the department is authorized to hire a civil service exempt executive secretary to staff the board.

Section 463E-12, HRS, requires the board to adopt rules in accordance with Chapter 91, HRS, for the administration of the podiatry practice act. Section 463E-12.5, HRS, authorizes the board to delegate certain regulatory duties to a committee of not less than three licensed podiatrists and requires the board to ratify the actions of this committee. The board may not delegate its authority to adopt rules or take final disciplinary action against licensed podiatrists.

<sup>22</sup> In 1982, Act 110 extended the podiatry practice act through 1985 in a general revision of the sunset review schedule.

Section 463E-1(5), HRS, defines the practice of podiatry as:

“. . . the medical, surgical, mechanical, manipulative, and electrical diagnosis and treatment of the human foot, including the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot, but does not include any amputation, treatment of systematic conditions, or the use of any anesthetic except local anesthetic.”

Except as otherwise provided for by law, no person may practice podiatry either gratuitously or for pay or use the term “podiatrist” or “foot specialist” without a valid podiatry license.

**Licensing requirements.** The board is empowered to issue licenses to podiatrists who meet the following requirements: (1) graduate from a college of podiatry approved by the American Podiatry Association and the board, (2) complete a board approved college residence course of professional instruction in podiatry, (3) demonstrate good moral character, and (4) pass examinations in podiatry and related sciences administered by the board.

The board’s examinations must encompass the following subjects:

“. . . anatomy, histology and embryology, physiology, biochemistry, hygiene and public health, pathology, bacteriology, dermatology, syphilology, surgery and anesthesia, podiatry, therapeutics, physical medicine, podiatric medicine, pharmacology, materia medica, roentgenologic technique, and radiation safety.”<sup>23</sup>

The board’s written examination must be developed and graded by the National Board of Podiatry Examiners. Applicants who are certified by the national board may apply for a waiver of the written examination requirement. The board’s oral examination must be taken and recorded on tape and the tapes held for one year. A practical examination is also required.

In addition to fulfilling initial licensing requirements, all podiatrists are required to take 40 hours of continuing podiatry education every two years in order to renew their licenses.

23. Section 463E-4(a), HRS.

**Disciplinary authority over licensees.** Section 463E-6, HRS, authorizes the board to revoke or suspend podiatry licenses for the following acts or conditions:

1. Employing "cappers" or "steerers" to solicit patients;
2. Obtaining any fee on the assurance that a manifestly incurable disease can be permanently cured;
3. Willfully betraying a professional secret;
4. Advertising one's podiatry business with any untruthful and improbable statement;
5. False or fraudulent advertising;
6. Being habitually intemperate;
7. Habitually using any habit-forming drug;
8. Procuring a license through fraud, misrepresentation, or deceit;
9. Using the titles "DR." or "M.D." with the intent to imply that one is a practitioner of medicine or surgery;
10. Professional misconduct, gross carelessness, or manifest incapacity; and
11. Exceeding the authorized scope of practice.

**Availability of podiatric medical care.** Section 463E-14, HRS, provides that public agencies, clinics, medical services, insurance carriers, and boards administering relief under the laws of the State may not deny recipients the freedom to choose podiatric care or services which are within the scope of activities of a licensed podiatrist. Section 463E-15, HRS, provides that programs financed by public funds or administered by any public agency for aid to the indigent, the aged, the legally blind or any other group or class must allow recipients the freedom to choose either a licensed physician or a licensed podiatrist whenever services are within the scope of activities of a licensed podiatrist.



## Chapter 3

### EVALUATION OF THE REGULATION OF PODIATRISTS

This chapter contains our evaluation of the regulation of podiatrists under Chapter 463E, Hawaii Revised Statutes. It includes our assessment of the regulatory operations of the Board of Medical Examiners with respect to the practice of podiatry and our recommendations on continued regulation of the profession.

#### Summary of Findings

We find as follows:

1. There is a danger to the public's health, safety, and welfare in the practice of podiatry, and therefore, podiatrists should continue to be licensed.

2. The Department of Commerce and Consumer Affairs (DCCA) has been remiss in carrying out its responsibilities for a valid and fair examination program, thereby exposing the State to the possibility of license appeals and lawsuits.

3. Some licensing requirements are overly difficult to enforce or outdated. These include provisions relating to continuing podiatry education, good moral character, and fees. In addition, a one year residency training requirement is not needed at this time.

4. The statutes relating to the podiatry disciplinary program are inadequate. Amendments are needed to strengthen the grounds for disciplinary action, the types of disciplinary action that may be taken by the board, and information reporting requirements.

5. Podiatrists should be required to conform with the provisions of the informed consent law.

6. There is a shortage of podiatrists in Hawaii. This is partly because podiatrists are not permitted to apply for clinical privileges and medical staff membership in many hospitals.

7. The Board of Medical Examiners has neglected the podiatry licensing program, allowing the program to operate without rules and without compliance to various statutory requirements.

### **Need for Regulation**

The practice of podiatry poses a risk to the public's health, safety, and welfare. Podiatrists diagnose and treat a wide variety of medical conditions relating to the foot, and they are authorized to perform foot surgery and prescribe dangerous drugs. Incompetent diagnosis, failure to refer patients with general medical conditions to physicians, and incompetent treatment may all result in irreversible physical, emotional, and financial harm.

Consumers are at a disadvantage in choosing and relying on podiatrists. They often lack sufficient knowledge to make judgments about the competence of podiatrists or to assess the quality of care provided by them. For these reasons, the State must intervene to ensure that applicants are qualified to enter podiatric medical practice and that they are competent in the performance of their podiatric duties.

Our examination of podiatry complaint files illustrates the need to protect the public from possible harm. Although there are only 14 podiatrists practicing in Hawaii, eight complaints were filed with the department's Regulated Industries Complaints Office (RICO) between May 19, 1979 and May 18, 1984. Four of these complaints were fee disputes, two alleged medical malpractice or unprofessional conduct, one related to a narcotics violation, and one related to a Medicaid fraud conviction.

Licensing is the most appropriate form of regulation for podiatry because it permits the State to enforce minimum standards of competency for entry into podiatric medical practice and oversee the ongoing quality of care provided by podiatrists. All states and the District of Columbia currently require podiatrists to be licensed in order to practice podiatry.<sup>1</sup>

1. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, 1984-1985 ed., Washington, D.C., April 1984, p. 156.

## The Licensing Program

**Examinations.** The law requires applicants to pass written, oral, and practical licensing examinations. The written examination is developed by the National Board of Podiatry Examiners (NBPE), and it is administered on the mainland. The board may accept a certificate issued by NBPE as equivalent to the written examination requirement.

The current NBPE examination has two parts. Part I tests knowledge of the basic medical sciences of anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology. Part II tests knowledge of the clinical sciences of dermatology, medicine, orthopedics-biomechanics, podiatric medicine, radiology, and surgery-anesthesia. This part also includes questions on community health and jurisprudence, and hospital protocol.<sup>2</sup> In cooperation with the Educational Testing Service, NBPE is now developing a test for "clinical competency" which is the ability of an individual to *transfer knowledge* of the basic medical and clinical sciences into safe and effective practice.

The oral and practical examinations are local examinations. The board has established a podiatry examining committee (PODEC) to assist in the development, administration, and grading of these examinations. Until recently, PODEC included four licensed podiatrists. However, in October 1984, the board accepted the resignation of one podiatrist and appointed a physician board member to PODEC.

The oral and practical examinations have been combined into a single examination that has three parts. Part I tests knowledge of various podiatric conditions, and Part II requires applicants to evaluate foot X-rays. Part III includes several questions relating to the treatment of podiatric conditions and requires applicants to perform a physical examination, develop a treatment plan, and perform a non-invasive podiatric procedure. By law, the board must administer the oral-practical examination twice a year on or about the 15th of January and the 15th of July. The oral examination must be recorded on tapes which are held for one year.

2. National Board of Podiatry Examiners, *Bulletin of Information 1984 Examinations*, Princeton, N.J., 1984, pp. 16-55.

The oral-practical examination program is seriously flawed. There is no evidence that the current examination is valid or reliable, procedures for test administration are deplorable, and grading is subjective and arbitrary.

DCCA continues to fail in its responsibility to ensure a valid and fair testing program. Our 1982 evaluation of the department's licensing program noted serious deficiencies in the development and administration of local licensing examinations. Among these were deficiencies in test development resulting in outdated, invalid, and unreliable exams, a lack of objectivity in oral and practical exams, a failure to protect the anonymity of applicants, and nonuniform grading practices. We also noted that these problems were largely due to a failure of the boards to recognize that tests must meet professional testing standards and a failure of the department to provide adequate technical assistance to the boards.<sup>3</sup>

The State has already been faced with one federal lawsuit challenging the administration of the local practical examination for dental licensing applicants. As a result of this case, which cost the State more than \$475,000, substantial changes were made in the dental board's examination procedures. Unfortunately, the department has neglected to follow through and make changes in the examination programs of other boards with similar problems.

Although licensed professionals can provide valuable input into the content of local examinations, DCCA is responsible for providing the technical testing expertise to ensure that these examinations do indeed assess competency in occupational performance and that they are properly administered and graded. In particular, the department's licensing examiner has the primary responsibility for test development, administration, and grading.

Our sunset reviews of occupational licensing boards have repeatedly noted deficiencies in local examination programs, and we have repeatedly recommended that DCCA make the needed improvements. Despite these recommendations, the podiatry oral-practical examination program still has serious deficiencies that make

3. State of Hawaii, Legislative Auditor, *Evaluation of the Professional Vocational Licensing Program of the Department of Regulatory Agencies*, Report No. 82-1, January 1982, pp. 39-43.

licensing decisions questionable. These deficiencies also expose the State to the possibility of license appeals and lawsuits filed by applicants who fail the examination.

*Problems with testing format.* The requirement that the board administer an *oral* licensing examination is seriously flawed. Oral interviews permit judgments to be made on the basis of personal characteristics other than the knowledge and skills of an applicant, and there is no evidence that they are a sound and fair technique to discriminate between competent and incompetent applicants.

PODEC members have not been briefed on the objectives of the oral test. Members report that the purpose of the oral examination is to see if they can “trust” an applicant, to see what kind of person an applicant is, and to make sure that the applicant does not discredit the profession. However, a determination of the character of an applicant is not an appropriate objective for a licensing examination, and perception of this as a legitimate function introduces bias and subjectivity into the examination program.

The requirement that the board administer a *practical* licensing examination also has serious drawbacks. Practical examinations are used to evaluate completed assignments and to evaluate the process followed in carrying out a task. This testing format is valid and reliable only if a great deal of attention is given to the development, administration, and grading of examinations. Because practical testing programs are very expensive, most national testing firms use written examinations for the health professions. The revised NBPE examination for clinical competency will be a written test.

*Problems in test development.* Table 3.1 outlines the steps that should be taken to construct a valid and reliable licensing examination. The current oral-practical examination does not satisfy these guidelines.

The examination does not have clearcut objectives, and it is not based on an analysis of the podiatry occupation to identify critical job skills that need to be tested to ensure safe and effective practice at the entry level. In addition, the examination largely duplicates the national board’s tests on medicine, podiatric medicine, and radiology.

Table 3.1  
Steps in Proper Test Development

- 
1. Analyze the occupation to isolate critical elements that need to be tested.
  2. Develop specifications for the test to increase the likelihood that each form of the test will be consistent with a definite plan and include all significant topics.
  3. Write test questions which are not ambiguous or have more than one answer.
  4. Write clear directions for the test.
  5. Develop answer keys to facilitate accurate scoring.
  6. Develop clear guidelines for judges of performance tests.
  7. Set appropriate passing scores to ensure safeguarding of the public's health, welfare, and safety.
  8. Analyze test items to determine the ones which discriminate the qualified candidates from the unqualified candidates.
  9. Analyze the reliability and validity of the test.
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Source: State of Hawaii, Legislative Auditor, *Evaluation of the Professional Vocational Licensing Program of the Department of Regulatory Agencies*, Report No. 82-1, January 1982, p. 38.

There are no test specifications to ensure that different versions of the oral-practical examination are consistent with a definite plan. Moreover, there is only one version of the examination which has reportedly been used continuously since January 1981. This means that applicants can pass the exam simply by becoming familiar with it since unlimited retakes are allowed. It also compromises the integrity of the exam because information on test questions can be circulated among applicants prior to the testing sessions.

Test questions are ambiguous, and they do not provide enough information for applicants to use in formulating responses. Many questions require more than one answer, and there is often more than one correct answer to each part of a question. In addition, the open-ended nature of test questions requires applicants to formulate narrative or essay type responses that are difficult to evaluate.

The answer keys for questions on Parts I and II of the exam do not include all possible correct answers. This means that applicants can be penalized for giving correct answers if graders stick to the answer keys. And if graders award points for correct answers not on the keys, an element of subjectivity is introduced into the examination program.

More seriously, there is *no* answer key for four questions on Part III of the exam, and there are *no* criteria or guidelines for graders to use in evaluating applicants' work on the performance questions. In addition, there are no guidelines for the selection of patients used on Part III. Some applicants are given patients with serious and complex medical problems while others are given patients with minor foot problems or no medical problem at all.

*Problems in test administration. Lack of uniform testing procedures.* The department has not routinely trained podiatry examiners or required them to follow uniform testing procedures. A review of tapes of the examinations and observation of the July 1984 testing session revealed numerous deficiencies in the testing process. Podiatry examiners did not always read instructions and test questions *verbatim* to applicants, and they did not always permit applicants to complete their responses. In addition, podiatry examiners occasionally prompted some but not all applicants, and they asked some applicants to perform more podiatric procedures than others.

*Failure to provide for maximum anonymity.* The department has also failed to provide for maximum anonymity in the testing process. Although identification numbers were used during the July 1984 testing session, the podiatry examiners were permitted to see and talk to applicants throughout the testing session. Since the answers to all test questions were taped for grading at a later date, the examiners could correlate identification numbers and voices on the tapes with the names and faces of applicants. This introduced a tremendous potential for bias and subjectivity into the examination program, especially since the examiners were personally acquainted with some of the applicants.

*Logistical problems.* DCCA's sloppy approach to the testing program is illustrated by the many logistical problems encountered during the July 1984 examination. All three parts of the examination were administered at a private podiatry clinic. Although seven applicants were scheduled to take the examination, only one staff member was assigned to oversee the testing process. This staff member registered applicants, gave them identification numbers, and then went behind closed doors to administer Part I of the exam. As a result, applicants were permitted to sit in an unsupervised conversational grouping in the clinic's waiting room throughout the testing session. This presented an opportunity for applicants

who had completed different parts of the exam to share information on test questions with others who were waiting to begin.

Although PODEC requested the department to provide two tape recorders for the testing session, only one machine was available at the start of the day. After a telephone call, a second tape recorder was brought over at midmorning. The lack of adequate equipment unnecessarily delayed the testing session because Part I of the exam could not begin until the second tape recorder was brought to the clinic.

All seven applicants were required to appear at the clinic at eight in the morning. Each applicant was required to complete Part III of the exam before taking Part I. And Part II of the exam was not begun until each applicant completed Part I. The testing process was delayed when one applicant had to *retake* Part I because her answers were inaudible on the tapes. It was further delayed because Part II of the exam could not be administered until the tape recorder used for Part III became available.

Due to the problems in test administration, some applicants had to wait until two in the afternoon to finish their tests. At least one applicant complained that his performance was adversely affected by the long waiting period and lack of a lunch break. In addition, the responses of three applicants were not recorded at all during Part II of the examination.

*Arbitrary grading practices.* PODEC did not meet to grade the July 1984 examinations until one month after they were administered. No valid reason was given for the delay in grading. One committee member said it simply took that long for all the examiners to get together. This unnecessarily delayed the licensing process as successful applicants had to wait more than a month to be licensed and begin practice. It also made the grading process more suspect as it was based on recall.

The examiners did not receive adequate training from the department on how to grade the July 1984 oral-practical examination, and the department did not adequately supervise the grading session. This resulted in the use of questionable grading practices which diminished the effectiveness of the examination program. For example, the examiners discussed applicants' responses prior to allocating points on test questions. Although the grading of each examination was technically done

individually, the discussion of responses introduced an element of subjectivity into the grading process.

More seriously, there was no relationship between the grades awarded on some parts of the exam and the applicants' actual performance on those parts. On Part III, the examiners decided to award perfect scores to all seven applicants without listening to the tape recorded responses. This was done even though one examiner was not even present when Part III was administered, and more than a month had passed since the exam was given. One examiner said that this decision was made because the group agreed that each applicant's performance had been "adequate." However, a review of records for examinations administered between January 1983 and January 1984 reveals that this approach was not used in the past.

On Part II, the examiners graded the taped responses of four applicants and discovered that the responses of three applicants had not been recorded. Only two of the four examiners were present when Part II was administered, and they expressed concern that they could not adequately recall the three applicants' responses. In discussing the problem, the committee discovered that one applicant's performance on Part I was so poor that he would fail the exam if points were deducted from Part II—even though he had been give a perfect score on Part III. The committee felt that it could not justify failing this applicant if he filed a license appeal or lawsuit because it did not have a record of his responses. As a result, three of the four examiners awarded him a perfect score, and he passed the exam. The same scores were also awarded to the other two applicants whose responses had not been recorded, and they also passed the exam.

The committee's decision on these three cases was arbitrary because the two examiners who were absent when Part II was administered had no basis for their grading decisions, and the two examiners who were present could not clearly recall the applicants' responses. It was also unfair to the other four applicants who had been graded on the basis of their taped responses. The board should have been notified about this problem in order to make a determination on how to proceed with licensing the applicants. However, neither the board nor the department's licensing examiner was notified of the problem by the committee.

In April 1984, the department's hearings officer issued findings on a license appeals case filed by an applicant who failed the oral-practical examination in

July 1979. The hearings officer found that the grading of one part of the applicant's examination was deficient and that the applicant had in fact passed this part of the exam. He further stated that:

"In the Hearings Officer's view there are problems with the way that the oral examination was evaluated and with in particular with the third question that was asked of Petitioner. This at least raises a possibility (unproven by the record before us) that Petitioner was not fairly evaluated."<sup>4</sup>

Although the oral-practical examination has been revised since 1979, the problems that led to the license appeals case are still present in the current examination program. This means that the State is still exposed to the possibility of license appeals and lawsuits.

**Improvements needed.** DCCA recently became aware of some of the problems with the oral-practical examination, and the department's licensing examiner has recommended that the board consider switching to a written multiple choice format for its exam. The board has indicated a willingness and desire to switch to a written exam and has brought PODEC into the discussion process.

In order to facilitate improvements in the examination program, the law should be amended to delete the requirements for oral and practical licensing examinations and to require instead a written test of clinical competency. This will enable the board to adopt the revised NBPE examination when it becomes available and to take interim steps to improve the testing program. The law should also be amended to give more flexibility to DCCA in scheduling the examination.

The board is considering using a written clinical competency examination that was developed by a national testing firm for the Virginia Board of Medicine. The examination is an all-day, four-part test that includes questions on general podiatric medicine, therapeutics, clinical photographs, and patient management problems. This may be a feasible alternative to developing an entirely new written examination.

4. State of Hawaii, Department of Commerce and Consumer Affairs, Hearings Office, "Hearings Officer's Findings of Fact, Conclusions of Law, and Recommended Order," POD-LIC-83-1, April 25, 1984, p. 12.

The department should provide adequate technical expertise to assist the board in improving the podiatry examination program. This includes evaluating the feasibility of alternative approaches to the development of a written examination and ensuring that any examination used is valid and reliable. If the board decides to develop its own examination, the department should make sure that the steps listed in Table 3.1 are followed.

If the board decides to continue to use the oral-practical examination pending the adoption of a written test, the department should closely supervise all aspects of the testing program to ensure that applicants are treated fairly and equitably.

**Other licensing requirements.** Some of the board's licensing requirements are overly difficult to enforce or outdated. These include provisions relating to continuing podiatry education, good moral character, and fees. In addition, a one-year residency training requirement should not be added at this time.

**Continuing education.** Section 463E-5, HRS, requires podiatrists to take a minimum of 40 hours of postgraduate work or continuing education in podiatry every two years. Podiatrists must submit written proof that they have fulfilled this requirement when they renew their licenses.

The board has not adopted rules to implement this requirement, and it does not review documents submitted by podiatrists. Instead, DCCA routinely sends these documents to the Hawaii Podiatry Association (HPA) for its review and approval. This is an inappropriate delegation of a licensing function to a private professional organization.

HPA handles the approval of continuing education credits very informally and does not follow any specific criteria or guidelines. It will approve any activity that relates to podiatry. This means that attending HPA meetings or learning how to manage a podiatry practice qualify for credits on the same basis as attending hospital medical staff meetings or improving surgical skills. Thus, there is no assurance that credits are awarded only for activities that are directly related to continuing competence in the practice of podiatric medicine.

The Council on Podiatry Education of the American Podiatric Medical Association (APMA) has adopted criteria and guidelines for the national approval of continuing education organizations and programs. However, as of September 1984,

only a few organizations in the United States had applied for or received approval under this program, and only 30 to 40 individual programs had been approved.<sup>5</sup> There are no nationally approved continuing education organizations or programs in Hawaii, and the small number of podiatrists in the State make it unlikely that such programs will become available in the near future.

The present informal approach to the approval of continuing education credits by HPA should be discontinued. Since the current national approval program is not widespread at this time, and it is not reasonable to require podiatrists to travel to the mainland in order to take nationally approved courses, the statutes should be amended to delete the postgraduate work or continuing education requirement in podiatry. There are a number of licensed health care professions which do not have any continuing education requirements, including osteopaths, dentists, dental hygienists, nurses, and pharmacists.

*Good moral character.* Section 463E-3(3), HRS, requires podiatrists to demonstrate good moral character to qualify for licenses. This requirement serves little purpose since most applicants can supply personal references which provide no real assurance of good character. Since DCCA no longer requires podiatrists to submit letters of reference with their license applications, and the board has removed this provision from the medical practice act, this requirement should be deleted from Chapter 463E, HRS.

*Fees.* Section 463E-5, HRS, requires podiatrists to pay a \$25 examination fee when they apply for licenses and a \$10 renewal fee every two years. In 1980, Act 92 authorized the director of DCCA to increase or decrease fees charged by boards and commissions in order to maintain a reasonable relation between the revenue derived from the fees and the cost or value of services rendered. In 1983, DCCA adopted rules that adjusted the fees of 25 boards and commissions. The department has not yet reviewed the appropriateness of podiatry licensing fees. Since these fees appear to be low, DCCA should review them and make adjustments to ensure that there is a reasonable relation between the revenue derived and the cost or value of services rendered.

5. Interview with Jay Levrio, Staff Member, Council on Podiatry Education, American Podiatric Medical Association, Washington, D.C., September 19, 1984.

*Residency training.* Because of the subjectivity of the oral-practical examination, the board's former executive secretary suggested that HPA consider drafting legislation to abolish the exam and replace it with a one-year residency training requirement. Although HPA proposed such legislation in 1982, the board has not acted on its recommendation.

There appears to be no justification for adding a one-year residency training requirement at this time. Students in accredited colleges of podiatric medicine are permitted to gradually assume responsibility for direct patient care in a supervised setting,<sup>6</sup> and they are expected to be adequately prepared to serve as primary health care providers when they graduate.<sup>7</sup> APMA has not recommended a fifth year of training for podiatrists.

Only eight states require podiatrists to complete one year of residency training in order to be licensed.<sup>8</sup> A few of these states permit podiatrists to substitute a one-year "preceptorship" with a licensed podiatrist for the residency training requirement.<sup>9</sup> This alternative pathway was found to be necessary because *one-third* of all current graduates cannot be accommodated in approved residency training programs due to a lack of residency positions nationwide.

According to guidelines issued by the APMA Council on Podiatry Education, preceptorships should be sponsored by accredited colleges of podiatric medicine or hospitals with approved residency training programs.<sup>10</sup> These guidelines stress that preceptorships are not a substitute for residency training, and the council does not approve preceptorship programs at this time. Hawaii does not have an accredited college of podiatric medicine or a hospital with an approved residency training program that can sponsor preceptorship programs.

6. American Podiatry Association, *History and Current Practice of Podiatric Medicine*, Washington, D.C., August 1984, p. I-8.

7. American Podiatry Association, Council on Podiatry Education, *Criteria and Guidelines for Colleges of Podiatric Medicine*, Washington, D.C., August 1980, p. 2.

8. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, p. 156.

9. Interview with Jay Levrio, September 19, 1984.

10. American Podiatry Association, Council on Podiatry Education, *Guidelines for Preceptorship Programs in Podiatric Medicine*, Washington, D.C., August 1983, p. 1.

The lack of national policy recommending a fifth year of training for podiatrists, the limited number of states that presently require one year of residency training for podiatrists, the absence of an adequate number of residency positions nationwide, the untested nature of the preceptorship option, and the lack of sponsoring institutions for preceptorship programs in Hawaii, indicate that a residency requirement is not appropriate at this time.

**Name change.** In 1984, the American Podiatry Association changed its name to the American Podiatric Medical Association. Section 463E-3, HRS, and Section 463E-4, HRS, should be amended to reflect this name change.

### **Enforcement Program**

The statutes relating to the podiatry disciplinary program have not been amended since 1973. During the past eight years, the Board of Medical Examiners has gained considerable experience in identifying and disciplining physicians whose conduct jeopardizes the public's health, safety, and welfare. Based on this experience, various statutes have been amended to improve the medical disciplinary program. Some of these changes would also benefit the podiatry program.

**Grounds for disciplinary action.** Section 463E-6, HRS, lists 11 grounds for disciplinary action against licensed podiatrists. Most of these provisions were taken from the medical practice act as it was written in 1973. Since that time, the medical practice act has been amended to facilitate the prosecution of complaints filed against licensed physicians. Some of these amendments would substantially improve the podiatry practice act.

For example, the board must now prove that a licensed podiatrist committed "professional misconduct" in violating the Uniform Controlled Substance Act in order to discipline the licensee. The board must simply prove that the controlled substance act was violated in order to discipline a licensed physician. This is a more effective and efficient approach.

Table 3.2 includes a list of grounds for disciplinary action that should be incorporated into the podiatry practice act.

Table 3.2

Grounds for Disciplinary Action from the  
Medical Practice Act (Chapter 453, HRS)  
that Should Be Included in the Podiatry Practice Act

<i>Statute</i>	<i>Grounds for Disciplinary Action</i>
Section 453-8(a)(4), HRS, (Act 167, SLH 1977)	Being habituated to the excessive use of drugs or alcohol; or being addicted to, dependent on, or a habitual user of a narcotic, barbituate, amphetamine, hallucinogen, or other drug having similar effects.
Section 453-8(a)(5), HRS, (Act 219, SLH 1976)	Practicing medicine while the ability to practice is impaired by alcohol, drugs, physical disability, or mental instability.
Section 453-8(a)(6), HRS, (Act 219, SLH 1976)	Knowingly permitting an unlicensed person to perform activities requiring a license.
Section 453-8(a)(8), HRS, (Act 219, SLH 1976, as amended by Act 227, SLH 1982)	Negligence or incompetence, including, but not limited to, the consistent use of medical service which is inappropriate or unnecessary.
Section 453-8(a)(11), HRS, (Act 227, SLH 1982)	Revocation, suspension, or other disciplinary action by another state of a license for reasons as provided in this section.
Section 453-8(a)(12), HRS, (Act 227, SLH 1982)	Conviction, whether by nolo contendere or otherwise, of a penal offense substantially related to the qualifications, functions, or duties of a physician, notwithstanding any statutory provision to the contrary.
Section 453-8(a)(13), HRS, (Act 22, SLH 1983)	Violation of Chapter 329, Uniform Controlled Substance Act, or any regulation promulgated thereunder.
Section 453-8(a)(14), HRS, (Act 16, SLH 1984)	Failure to report disciplinary action taken against the licensee in another jurisdiction.

**Types of sanctions.** Section 463E-6, HRS, permits the board to discipline podiatrists by revoking or suspending their licenses. The medical practice act has been amended to include several additional types of sanctions which enable the board to ensure that licensed physicians practice medicine under conditions that do not pose a threat to the public. Table 3.3 includes a list of sanctions that should be incorporated into the podiatry practice act.

Table 3.3  
Types of Sanctions that Should Be  
Included in the Podiatry Practice Act

<i>Statute</i>	<i>Type of Sanction</i>
Section 453-8(a), HRS	Limitation of practice.
Section 453-8.2(1), HRS	Place the licensee on probation, including such conditions of probation as requiring observation of the licensee by an appropriate group or society of licensed physicians.
Section 453-8.2(4), HRS	Limit the license by restricting the fields of practice in which the licensee may engage.
Section 453-8.2(5), HRS	Fine the licensee, including assessing the licensee for the costs of the disciplinary proceedings.
Section 453-8.2(6), HRS	Temporarily suspend the license for not more than 30 days without a hearing when the board finds the practice probably constitutes an immediate and grave danger to the public.
Section 453-8.2(7), HRS	Require further education or training or require proof of performance competency.

**Information reporting requirements.** Several statutes require the reporting of cases involving medical malpractice and unprofessional conduct by licensed physicians to the department. Many of these same reporting requirements should be applied to cases involving licensed podiatrists. For example:

- Section 329-44, HRS, requires state court clerks and judges to report cases involving physicians who have been convicted of violating the Uniform Controlled Substance Act to the department.
- Section 453-8.7, HRS, requires state court clerks and uninsured physicians to report cases involving death or personal injury caused by negligence, error or omission in practice, or the unauthorized rendering of services to the department.
- Section 671-3, HRS, defines informed consent and requires physicians to comply with board standards in obtaining informed consent from patients. Since the practice of podiatric medicine is substantially the same as the practice of medicine, the statute should be amended to include licensed podiatrists.

Section 671-5, HRS, requires insurance companies and self-insured physicians to report insurance settlements, arbitration awards, and adjudicated judgments involving professional negligence, the rendering of professional services without informed consent, or an error or omission in practice which proximately causes death, injury, or other damage to a patient to the Insurance Commissioner. The statute also requires the Insurance Commissioner to forward copies of these reports to the department.

The above reporting provisions should be extended to include cases involving licensed podiatrists.

### Access to Hospital Facilities

Hawaii has one of the lowest ratios of practicing podiatrists to population in the nation. In 1974, there were 0.9 active podiatrists per 100,000 population in Hawaii compared with an average of 3.4 per 100,000 nationwide.<sup>11</sup> This ratio has not changed significantly during the past decade.

Podiatrists report that one of the reasons for the small number of practicing podiatrists in the State is that they have difficulty obtaining access to hospital facilities and therefore cannot practice up to their level of training. This is borne out by national statistics which show that 90 percent of licensed podiatrists practice in states which allow them to function as full members of a hospital's medical staff.<sup>12</sup> Although recent figures from the American Hospital Association show that approximately one-half of U.S. hospitals provide staff privileges to podiatrists,<sup>13</sup> only one hospital in Hawaii currently has a podiatrist on its medical staff.

Podiatrists report that they have been denied the opportunity to *apply* for hospital privileges in some Oahu hospitals. One podiatrist reported applying for privileges at a private hospital whose bylaws permitted podiatrists to serve on the

11. U.S. Public Health Service, National Center for Health Statistics, "Podiatry Manpower: General Profile, United States 1974," *Vital and Health Statistics*, Series 14, No. 18, Hyattsville, Md., U.S. Government Printing Office, 1978, p. 5.

12. American Podiatry Association, Department of Governmental Affairs, *Podiatric Medicine, A Point of Reference*, Washington, D.C., March 1982, p. 6.

13. American Podiatry Association, *History and Current Practice of Podiatric Medicine*, p. II-3.

medical staff. Instead of reviewing this individual's credentials to determine if he had adequate training, experience, competence, and professional judgment to practice podiatric medicine in the hospital, the board of directors amended the hospital bylaws to exclude podiatrists from membership on the medical staff. Another podiatrist attempted to apply for privileges at a private hospital whose bylaws did not include podiatrists on the medical staff. He was told that his application would not be considered because orthopedic surgeons on the staff could take care of any patients with foot problems.

We find no reason for hospitals to deny privileges to qualified licensed podiatrists. The Joint Commission on the Accreditation of Hospitals recently approved new medical staff standards that became effective on July 1, 1984.<sup>14</sup> These standards call for a single organized medical staff that has overall responsibility for the quality of professional services provided by individuals with clinical privileges. According to the standards, the medical staff may include licensed nonphysicians (including podiatrists) who are permitted by law and the hospitals to provide patient care independently.

The American Medical Association has also approved guidelines that permit health professionals of all types to be eligible to apply for hospital privileges as long as they are licensed. According to these guidelines, hospitals are free to reject applications from unqualified practitioners, and they can still limit clinical privileges.<sup>15</sup>

The exclusion of qualified podiatrists from hospital practice can have several adverse effects. It limits the type of care available to the public. It may force podiatrists to refer patients to physicians even though they are capable of providing proper care. It also means that surgical procedures may be performed in private offices without the benefit of hospital quality control and peer review mechanisms. And, it may dissuade potential practitioners from locating in the State if they want to maintain their level of competence in hospital practice.

14. "JCAH Board Approves New Medical Staff Standards," *JCAH Perspectives*, v. 4, no. 1, January/February 1984.

15. "JCAH Change Would Open Hospital Staffs to Nonphysicians," *Health Planning and Manpower Report*, v. 12, no. 21, October 19, 1983, p. 5.

As of September 1983, 19 states had enacted laws, adopted rules, or established policies that require hospitals to consider applications for clinical privileges and medical staff membership submitted by licensed podiatrists.<sup>16</sup>

In Hawaii, dentists are permitted to apply for hospital privileges since they are licensed to practice oral surgery independently. Because podiatrists are also licensed to practice independently, they should be permitted to apply for hospital privileges. Chapter 463E, HRS, should be amended to add a new section that requires hospitals to consider applications for clinical privileges and medical staff membership submitted by licensed podiatrists and to review these applications on a case-by-case basis in accordance with the same rules and procedures that are established for other licensed individuals who are authorized by law to practice independently.

### **Board Operations**

The board has largely neglected the podiatry licensing program. Board members report that the press of business relating to the medical practice act prevents them from devoting much time to the podiatry program. They also report that they are not familiar with the details of the podiatry profession and that the small number of podiatrists justifies a minimum amount of time spent on podiatry business. The department has also neglected to provide adequate support to the podiatry program. This has caused serious problems which diminish the effectiveness of the licensing program.

**Failure to adopt rules.** The board has never adopted rules to implement the podiatry practice act. Although it requested a group of podiatrists to draft rules in 1974, there is no evidence that this was done. In 1978, the State Ethics Commission published a report noting the lack of rules but the board did not take any corrective action.<sup>17</sup>

16. "Hospital Staff Privileges for Limited License Practitioners," *State Health Legislation Report*, v. 11, no. 2, May 1983, pp. 25-30; and "Staff Privileges," *State Health Legislation Report*, v. 11, no. 3, August 1983, p. 21.

17. State of Hawaii, State Ethics Commission, *State Ethics Commission Report on the Professional and Vocational Licensing Boards in the Department of Regulatory Agencies*, 1979, p. 5.

PODEC members are virtually unaware that they are public officials acting on behalf of the State, and they tend to conduct their business as a subcommittee of HPA rather than as a public agency. If rules were adopted to formally establish and structure the podiatry licensing program, the board and PODEC would have a more official basis upon which to act.

**Failure to comply with the State Sunshine Law.** PODEC has not been required to comply with the provisions of the State Sunshine Law. As a result, the committee has not held public meetings, given written public notice of its meetings, and kept minutes recording the substance of its deliberations. PODEC members report that they get together to discuss state business at HPA meetings, and the committee seems to function more as an arm of HPA than as a public agency. This pattern may change somewhat due to the addition of a physician board member to the committee. However, PODEC should be required to comply with the requirements of the sunshine law in the future.

The board has also failed to comply with the requirement of Act 168, SLH 1984, that it hold its meetings in public places. In response to a board request that he look for a public meeting place to hold night meetings of the board, the former executive secretary reported that he was unable to find such a meeting room. He also reported that DCCA is renovating facilities that will include a conference room which can be used by the board. In the meantime, the board has continued to meet in the private conference rooms of the Hawaii Medical Association.

We found when we reviewed this matter in October 1984 that public meetings could be held in the Senate conference rooms at the State Capitol, in the Department of Health board room, and in public libraries near the downtown area. Use of these rooms would require some advanced planning and reservations by the board. In some cases, such as the Department of Health board room, arrangements would have to be made to turn on the air conditioning and post someone at the front door to let people into the building. People attending meetings at the State Capitol would have to park underneath the building, enter through the Punchbowl Street doors, and use the one elevator that is kept open at night. The board may reserve rooms in public libraries up to 90 days in advance of its meetings. Since DCCA is not sure when its new conference room will be available, the executive secretary should proceed more aggressively to obtain public facilities for the board's meetings.

**Apparent violation of the State Ethics Code.** The department has not informed the board and PODEC about provisions in the State Ethics Code that apply to licensing examination programs. This has led to at least one instance where there appears to have been unfair treatment and a possible conflict of interest in the administration of the oral-practical examination. This case involves a mother who helped to design the examination, personally administered the exam to her son and six other applicants, and participated fully in the grading of all seven examinations. At issue here is not only the personal relationship between the examiner and examinee which gives an appearance of unfair treatment for all applicants, but possible financial interests between the mother and son which might have affected the grading of the examinations.

When the licensing examiner learned about this case, he reviewed exam records and determined that grading was done independently because the scores were not identical for each applicant. He also rescored the son's examination without the mother's grades and determined that the son would have passed the examination anyway. The board decided to issue a license to the son and send a letter of reprimand to his mother. In discussing this case, board members expressed the sentiment that the mother "should have known better" than to participate in the examination. However, neither the department nor the board contacted the State Ethics Commission for its opinion on the case.

DCCA should request the ethics commission to review this case and seek the commission's advice on how to avoid such problems in the future. In addition, the department, with assistance from the ethics commission, should summarize the provisions of the ethics code that apply to examination programs and circulate this information among members of all boards and commissions.

**Failure to establish channels of communication.** PODEC has had little formal communication with the board or the department. For example, two new committee members who were appointed in June 1984 were not sent letters of appointment or given any formal orientation to their work and responsibilities. Consequently, they were forced to rely on the advice and guidance of more experienced committee members in administering and grading the July 1984 oral-practical examination.

The experienced committee members told the new members that they did not have to listen to the taped responses of applicants on Part III of the examination and that perfect scores should be awarded to all applicants because their performance had been "adequate." This faulty advice was followed even though committee members were not all present when Part III was administered, and perfect scores had never been awarded to all applicants in the past.

There is no official channel of communication between the board and podiatrists. Board members report that they are unaware of the provisions of the podiatry practice act and unfamiliar with developments in the podiatry profession. Podiatrists report that they have been frustrated in their attempts to communicate their concerns to the board.

For example, in 1982, HPA submitted a proposal to the board recommending changes in the licensing law. This legislative proposal was shelved with only a cursory discussion by the board. PODEC was not asked to comment on the proposal or rework it with the assistance of staff, although the board did circulate the proposal to the Hawaii Medical Association, the Hawaii Hospital Association, and the Hawaii Orthopedics Association for their comments. Podiatrists report that their efforts to have the board review the proposal in 1983 were rebuffed by the former executive secretary, and in 1984, they were told to wait for the sunset evaluation report to be issued.

The department has also failed to establish a channel of communication with podiatrists. Consequently, podiatrists are not routinely informed about developments that affect their profession. They are not informed about correspondence received by the board relating to the podiatry licensing program. They do not know about the new RICO setup or how complaints are processed by the department. And they are unaware of the distribution of staff responsibilities for the licensing program within the department.

It is hoped that the appointment of a physician board member to PODEC will result in more effective communication between the board and PODEC. This physician member must serve as the liaison between PODEC and the board in developing rules for the committee. He must also help to insure that committee members have timely and substantive input into discussions affecting the podiatry profession.

It is also the responsibility of the executive secretary to assist in this effort and to make sure that PODEC is informed of correspondence and other matters affecting the podiatry licensing program.

### ***Recommendations***

*We recommend the following:*

1. *Chapter 463E, Hawaii Revised Statutes, be reenacted to continue the regulation of podiatry. In reenacting the statute, consideration should be given to the following changes:*

- . deleting the requirements for oral and practical licensing examinations and adding instead a requirement for a written test of clinical competency;*
- . deleting specific references to the dates when the licensing examination should be administered;*
- . deleting the requirements for postgraduate work or continuing education in podiatry and good moral character;*
- . updating Section 463E-3, HRS, and Section 463E-4, HRS, to reflect the American Podiatry Association's recent name change;*
- . incorporating the grounds for disciplinary action listed in Table 3.2 and the sanctions listed in Table 3.3 into the statute;*
- . requiring state court clerks and uninsured podiatrists to report cases involving death or personal injury caused by negligence, error or omission in practice, or the unauthorized rendering of services to the department;*
- . adding a requirement that hospitals must consider applications for clinical privileges and medical staff membership submitted by licensed podiatrists, and review these applications on a case-by-case basis in accordance with the same rules and procedures that are established for other licensed individuals who are authorized by law to practice independently.*

2. *The Department of Commerce and Consumer Affairs work with the Board of Medical Examiners to determine whether to purchase Virginia's examination or develop a new written examination. Should the board decide to develop its own examination, the department should provide professional technical expertise to ensure that the new examination will be valid and reliable and administered fairly.*

3. *The department request the State Ethics Commission to review the case involving the July 1984 oral-practical examination and advise on how problems involving conflict of interest can be avoided in the future. In addition, the department should summarize the provisions of the ethics code that apply to testing programs and circulate this information among members of all boards and commissions.*

4. *The department review and adjust podiatry licensing fees to ensure that there is a reasonable relation between the revenue derived and the cost or value of service rendered.*

5. *The department's executive secretary work closely with the podiatry examining committee (PODEC) and the physician representative to PODEC to insure that committee members have timely and substantive input into the development of rules for the podiatry licensing program and that podiatry committee members are kept fully informed of matters affecting the program.*

6. *The board adopt rules to implement Chapter 463E, HRS, to establish a formal basis for the podiatry licensing program and make sure that PODEC members are fully informed about their responsibilities under the State Ethics Code and the State Sunshine Law.*

7. *The board use public facilities for its meetings.*

8. *The following statutes be amended to strengthen the disciplinary program:*

- . Section 329-44, HRS, to require state court clerks and judges to report cases involving podiatrists who are convicted of violating the Uniform Controlled Substance Act.*
- . Section 671-3, HRS, to include podiatrists in the informed consent law.*
- . Section 671-5, HRS, to require insurance companies and self-insured podiatrists to report cases to the Insurance Commissioner, and to require the Insurance Commissioner to forward copies of these reports to the department.*

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APPENDIX

RESPONSES OF AFFECTED AGENCIES

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## COMMENTS ON AGENCY RESPONSES

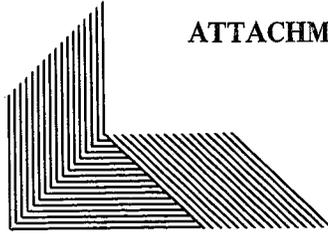
A preliminary draft of this Sunset Evaluation Report was transmitted on December 7, 1984 to the Board of Medical Examiners and to the Department of Commerce and Consumer Affairs for their review and comments. A copy of the transmittal letter to the board is included as Attachment 1 of this Appendix. A similar letter was sent to the department. The responses from the board and the department are included as Attachments 2 and 3.

The board agrees with all of our recommendations relating to the podiatry licensing program except for the recommendations on continuing education and hospital privileges. The board says that although there may be difficulties involved in accumulating 40 hours for continuing education every two years, it is important for podiatrists to keep abreast of scientific and administrative advancements in the field. The board opposes our recommendation on hospital privileges for podiatrists, because the board believes it should not be involved in enforcing a statute that forces private hospitals to grant clinical privileges to podiatrists.

The department acknowledges that there have been substantial problems with the podiatry licensing examination. It says that it has been moving to address these problems. The department says that the report raises a number of issues which should be addressed by the Legislature, and it agrees that sections of the podiatry statute should conform with complementary sections in the medical practice act.

ATTACHMENT 1

THE OFFICE OF THE AUDITOR  
STATE OF HAWAII  
485 S. KING STREET, RM. 500  
HONOLULU, HAWAII 96813



CLINTON T. TANIMURA  
AUDITOR

December 7, 1984

*COPY*

Dr. Ben K. Azman, Chairperson  
Board of Medical Examiners  
Department of Commerce and  
Consumer Affairs  
State of Hawaii  
Honolulu, Hawaii 96813

Dear Dr. Azman:

Enclosed are 13 preliminary copies, numbered 4 through 16, of our *Sunset Evaluation Report, Podiatrists, Chapter 463E, Hawaii Revised Statutes*. These copies are for review by you, other members of the board, members of the podiatry examining committee, and your executive secretary. This preliminary report has also been transmitted to Russel Nagata, Director, Department of Commerce and Consumer Affairs.

The report contains our recommendations relating to the regulation of podiatrists. If you have any comments on our recommendations, we would appreciate receiving them by January 7, 1985. Any comments we receive will be included as part of the final report which will be submitted to the Legislature.

Since the report is not in final form and changes may possibly be made to it, access to this report should be restricted solely to those officials whom you might wish to call upon to assist you in your response. We request that you exercise controls over access to the report and ensure that the report will not be reproduced. Should you require additional copies, please contact our office. Public release of the report will be made solely by our office and only after the report is published in its final form.

We appreciate the assistance and cooperation extended to us.

Sincerely,

Clinton T. Tanimura  
Legislative Auditor

Enclosures

ATTACHMENT 2

GEORGE R. ARIYOSHI  
GOVERNOR



RUSSEL S. NAGATA  
DIRECTOR

DICK H. OKAJI  
LICENSING ADMINISTRATOR

BOARD OF MEDICAL EXAMINERS

STATE OF HAWAII  
PROFESSIONAL & VOCATIONAL LICENSING DIVISION  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

P. O. BOX 3469

HONOLULU, HAWAII 96801

January 4, 1985

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OFF. OF THE AUDITOR  
STATE OF HAWAII

The Honorable Clinton T. Tanimura  
Legislative Auditor  
Office of the Auditor  
465 South King Street, #500  
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

The Board of Medical Examiners discussed your preliminary Sunset Evaluation Report, Podiatrists, Chapter 463E, Hawaii Revised Statutes at its meeting on December 19, 1984.

The members of the Board found the report most informative with regard to the process involved in sunset evaluation in Chapter 1 and the background information of the practice of podiatry in the United States and in Hawaii in Chapter 2.

The Board has the following comments to make on the recommendations in Chapter 3.

1. The Board agrees that Chapter 463E, Hawaii Revised Statutes, be re-enacted to continue the regulation of podiatry.

The report recommends seven amendments to Chapter 463E, HRS. The following is our response to those recommendations:

- a. The Board agrees that the requirements for oral and practical licensing examinations be deleted and the requirement for a written test for clinical competency be added.
- b. The Board agrees to the deletion of specific dates when licensing examinations should be administered.

- c. The Board does not agree to the recommendation for the elimination of the continuing education requirements for podiatrists.

The Board recognizes there may be difficulties involved in accumulating forty hours of post-graduate work or continuing education in podiatry every two years, however, this will be researched further. Hawaii is a popular destination for continuing education courses for podiatry. For example, the Ohio Podiatry Association will be here in February, 1985, offering fifteen hours of CME, and the California College of Podiatric Medicine will be here July 30, - August 6, 1985, and, of course, accredited audio-visual tapes are available from the national leader in continuing education, the Pennsylvania Podiatric Medical Association.

The Board does not accept as valid argument that continuing education requirements should be eliminated because osteopaths, dentists, dental hygienists, nurses and pharmacists are not required to have continuing education. To the contrary, in these changing times, it is more important than ever to keep abreast of scientific and administrative advancements to offer patients quality foot care and cost containment.

- d. The Board agrees that Section 463E-3, HRS, and Section 463E-4, HRS should be updated to reflect the American Podiatry Association's recent name change.
- e. The Board agrees that grounds for disciplinary action listed in Table 3.2 and the sanctions listed in Table 3.3 should be incorporated in the statute.
- f. The Board agrees that state court clerks and uninsured podiatrists must be required to report cases involving death or personal injury caused by negligence, error or omission in practice or unauthorized rendering of service to the department. Failure by an uninsured podiatrist to make such a report should make the practitioner subject to the sanction in Section 463-6, HRS, as amended per e. above.
- g. The Board opposes adding a requirement to chapter 463E, HRS, that hospitals must consider applications for clinical privileges and medical staff membership

submitted by licensed podiatrists, and review these applications on a case-by-case basis in accordance with the same rules and procedures that are established for other licensed individuals who are authorized by law to practice independently. Since the Board's primary purpose is licensing physicians and podiatrists, the Board should not be involved in enforcing a statute that forces private hospitals to grant clinical privileges to podiatrists. Among other negative consequences, such an action by the Board may expose the Board to civil liability.

2. The Board agrees with recommendation No. 2 and is already moving in the direction of developing a new examination which will be valid and reliable and will be administered fairly. The department has cooperated in this work.
3. Recommendation No. 3 calls for the department to request the State Ethics Commission to review the case involving the July 1984 oral-practical examination. The board's position is that this matter is moot. Immediately upon learning of the incident, the board sent a letter of reprimand to the involved person, who has since resigned.

The Board, however, does agree that the State Ethics Commission should summarize the provisions of the ethics code that apply to testing programs and make this information available to the department for circulation to all members of the boards and commissions which conduct testing programs.

4. The Board agrees with recommendation No. 4., i.e. that the department review podiatry licensing fees.
5. The Board agrees with recommendation No. 5 and is carrying out the recommendation that its executive secretary provide more effective coordination between the board and the podiatry examining committee with respect to the development of rules for the podiatry licensing program.
6. The Board agrees with recommendation No. 6. that rules be adopted to implement Chapter 463E, HRS, and that PODEC members be more fully informed about their responsibilities under the State Ethics Code and the State Sunshine Law.
7. The Board agrees with recommendation No. 7. that public facilities be used for its meetings.
8. The Board agrees with recommendation No 8. that the statutes

The Honorable Clinton T. Tanimura  
Page 4  
January 4, 1985

be amended to strengthen the disciplinary program;  
including Sections 329-44, 671-3, and 671-5, Hawaii  
Revised Statutes.

The Board thanks your staff for the thoroughness of the  
report and the many recommendations which can only improve the  
Board's responsiveness to the public and the professions.

Sincerely yours,



George Goto, M.D.  
Chairman  
Board of Medical Examiners

ATTACHMENT 3



GEORGE R. ARIYOSHI  
GOVERNOR

RUSSEL S. NAGATA  
Director  
COMMISSIONER OF SECURITIES

STATE OF HAWAII  
OFFICE OF THE DIRECTOR  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS  
1010 RICHARDS STREET  
P. O. BOX 541  
HONOLULU, HAWAII 96809

ROBERT A. ALM  
DEPUTY DIRECTOR

December 19, 1984

RECEIVED

DEC 21 8 52 AM '84

OFF. OF THE AUDITOR  
STATE OF HAWAII

Mr. Clinton T. Tanimura  
Legislative Auditor  
465 S. King Street, Room 500  
Honolulu, Hawaii 96813

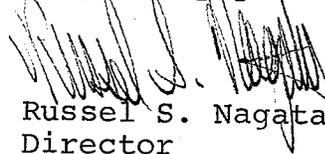
Dear Mr. Tanimura:

We appreciate the opportunity to review and comment on your sunset evaluation of podiatrists.

As the report details, there have been substantial problems with the podiatry licensing examination. As the report also discusses, the department has been moving to address those problems and will continue to do so in the coming months. In this context we note the Governor's Budget for the 1985-87 Biennium will include a request that a professionally trained occupational examination specialist be added to the Examination Branch. We believe that the branch has performed admirably given limited resources and an immense workload but we hope that the addition of this specialist will permit the branch to do much more.

As for the other comments, we look forward to discussing the specific proposals you have made with our subject matter committees. And while we would take issue with the tone of some sections, we believe that the report raises a number of issues which should be addressed by the Legislature and specifically we agree that conforming many sections of the podiatry statute to complementary sections in the medical practice statute would be both appropriate and useful.

Very truly yours,

  
Russel S. Nagata  
Director