Department of Regulatory Agencies

Office of Policy, Research and Regulatory Reform

2009 Sunset Review: Colorado Podiatry Board

October 15, 2009

Consumer Protection

Department of Regulatory Agencies

Executive Director's Office
D. Rico Munn
Executive Director

Bill Ritter, Jr.
Governor

October 15, 2009

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Colorado Podiatry Board (Board). I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2010 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination….

The report discusses the question of whether there is a need for the regulation provided under Article 32 of Title 12, C.R.S. The report also discusses the effectiveness of the Board and staff in carrying out the intent of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

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Executive Director

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2009 Sunset Review:
Colorado Podiatry Board

Summary

What Is Regulated?
Podiatrists – also known as foot doctors, foot specialists, podiatric physicians or podiatric surgeons – are trained in the medical and surgical treatment of the human foot and ankle.

Why Is It Regulated?
The Podiatry Practice Act protects consumers by ensuring that only qualified podiatrists are practicing in the State of Colorado. Complications that may arise from an unqualified person practicing podiatry include loss of a limb, disfigurement, chronic pain, and death.

Who Is Regulated?
There are 201 licensed podiatrists.

How Is It Regulated?
The Colorado Podiatry Board (Board), which licenses Doctors of Podiatric Medicine, is housed in the Division of Registrations of the Department of Regulatory Agencies. Applicants must be 21 years of age, graduate from an approved four-year podiatric medical school, complete a minimum of one year in an approved hospital-based residency program, and pass a national licensing examination. Further certification is required for podiatrists to perform ankle surgery.

What Does It Cost?
The fiscal year 07-08 expenditure to oversee this program was $51,592, and there were 0.3 full-time equivalent employees associated with this program.

What Disciplinary Activity Is There?
For the period fiscal year 03-04 through fiscal year 07-08, the Board issued 13 disciplinary actions including suspension of licenses, probation or practice limitation, letters of admonition, and an injunction.

Where Do I Get the Full Report?
The full sunset review can be found on the Internet at: www.dora.state.co.us/opr/oprpublications.htm.

Key Recommendations

Continue the Colorado Podiatry Board for nine years, until 2019.
Podiatric treatment performed by an unqualified practitioner could result in serious harm to a patient including deformity, chronic pain, amputation of the foot, and death. Considering the potential for harm, regulation of the profession is necessary.

Amend the definition of the practice of podiatry to clarify that podiatrists may treat the soft tissues below the mid-calf.
While podiatrists clearly have the statutory and regulatory authority to treat non-healing wounds of the foot and ankle, it is not clear that podiatrists have the authority to treat non-healing wounds of the lower leg. Since podiatrists are trained and qualified to treat non-healing wounds on the lower leg, the definition of podiatry should be clarified to include treatment of the soft tissue below the mid-calf.

For podiatrists who have completed a three-year residency program in foot and ankle surgery, repeal the requirement to be board certified in order to perform ankle surgery.
The Podiatry Practice Act requires a podiatrist to be certified by the American Board of Podiatric Surgery (ABPS) in order to perform surgical procedures on the ankle, or be supervised by a podiatrist or orthopedic surgeon who is certified. Podiatrists who participate in a three-year residency receive considerable training in ankle surgery and upon completing the residency are qualified to perform ankle surgery. The requirement to be certified by the ABPS in order to perform ankle surgery should be repealed for those podiatrists who have completed a three-year residency program.

Major Contacts Made During This Review

American Board of Podiatric Surgery
American College of Foot & Ankle Surgery
American Podiatric Medical Association
Colorado Attorney General's Office
Colorado Division of Registrations
Colorado Medical Society
Colorado Orthopedic Society
Colorado Podiatric Medical Association
Colorado Podiatry Board
COPIC Companies
Council on Podiatric Medical Education
Denver Veterans Affairs (VA) Medical Center Podiatric and Medical Surgery Residency Program
Dr. William M. Scholl College of Podiatric Medicine
Highlands Presbyterian St. Luke's Podiatric and Medical Surgery Residency Program
Northern Colorado Podiatric and Medical Surgery Residency Program
NYC College of Podiatric Medicine
Podiatry Insurance Company of America
Samuel Merritt University, Department of Podiatric Surgery

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are Prepared by:
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Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

[1] Criteria may be found at § 24-34-104, C.R.S.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

Regulation, then, has many positive and potentially negative consequences.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. To facilitate input from interested parties, anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.state.co.us/pls/real/OPR_Review_Comments.Main.

The regulatory functions of the Colorado Podiatry Board (Board) relating to Article 32 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2010, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of the Board pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation of podiatrists should be continued for the protection of the public and to evaluate the performance of the Board and staff of the Division of Registrations (Division). During this review, the Board and the Division must demonstrate that the regulation serves to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly.

Methodology

As part of this review, DORA staff attended Board meetings, interviewed Board staff, reviewed Board records and minutes including complaint and disciplinary actions, interviewed officials with state and national professional associations, interviewed healthcare providers, reviewed Colorado statutes and Board rules, and reviewed the laws of other states.

Profile of the Profession

Podiatrists – also known as foot doctors, foot specialists, podiatric physicians, doctors of podiatric medicine, or podiatric surgeons – are trained in the medical and surgical treatment of the human foot and ankle. They treat corns, calluses, ingrown toenails, bunions, heel spurs, arch problems, foot injuries, deformities, and infections.[2] Podiatrists may prescribe drugs and physical therapy, set fractures, and perform surgery. They may also fit corrective shoe inserts called orthotics, design plaster casts and strapping to correct deformities, and design custom-made shoes.

Podiatrists in Colorado are limited to treating the human toe, foot, ankle and tendons that are connected to the foot. While Colorado allows podiatrists to perform ankle surgery, other states, like New York, limit the practice of podiatry to the treatment of the foot. In most states, podiatrists are prohibited from amputating the foot and are limited to administering local anesthesia.

Podiatrists may specialize in sports medicine, geriatrics, pediatrics, dermatology or diabetic foot care.[3] Others may receive advanced training in foot and ankle surgery. Orthopedic surgeons, or orthopedists, are members of another profession that may also provide surgical treatment of the foot and ankle. Orthopedics is a branch of medicine concerned with treating the entire musculoskeletal system, not just the foot and ankle. Orthopedists are licensed by the Colorado Board of Medical Examiners.

Most podiatrists work in small private offices.[4] They may also spend time visiting patients at nursing homes or performing surgery in hospitals or ambulatory surgical centers. Some podiatrists work in groups with orthopedic surgeons. Podiatrists often work on teams with other healthcare professionals to treat patients who suffer from diabetes-related foot problems.
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The profession of podiatric medicine demands a high degree of education and training.[5] For entry into podiatric medical school, applicants are required to have attained at least three years of undergraduate education, including courses in physics, biology, English, and inorganic and organic chemistry. Podiatric medical school requires four years of study. The first two years of podiatric curricula focus on the basic medical sciences, including subjects such as anatomy, biochemistry, pathology, and pharmacology. The last two years of curricula focus on treatment of the foot and ankle, and include clinical rotations in private practices, clinics and hospitals. The degree granted by podiatric medical schools is doctor of podiatric medicine.

[2] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook, 2008-09 Edition.* Retrieved September 17, 2009, from http://www.bls.gov/oco/ocos075.htm
[3] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook, 2008-09 Edition.* Retrieved September 17, 2009], from http://www.bls.gov/oco/ocos075.htm
[4] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook, 2008-09 Edition.* Retrieved September 17, 2009, from http://www.bls.gov/oco/ocos075.htm
[5] United States Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook, 2008-09 Edition.* Retrieved September 17, 2009], from http://www.bls.gov/oco/ocos075.htm

As of October 2008, the Council on Podiatric Medical Education (CPME), the national organization that accredits podiatric medical schools and approves podiatric residency programs, has accredited eight podiatric medical schools, located in or near New York, Chicago, Phoenix, Philadelphia, San Francisco, Cleveland, Miami, and Des Moines.

For licensure in Colorado and in most states, a podiatrist must complete one year of a residency program. Two states require two years, and some do not have residency requirements at all. To perform ankle surgery below the level of the dermis, Colorado requires a licensed podiatrist to be nationally certified by the American Board of Podiatric Surgery, which demands, among other things, completion of a two- or three-year residency program.

The level of skill among podiatrists varies greatly depending on when a podiatrist graduated from podiatric medical school. Some graduated at a time when there were only a few residency programs, so many went on to licensure without completing any residency training. As residency programs proliferated, more and more graduates were able to secure placement, but programs varied in length from one to three years. Recently, CPME changed its standards so that residency programs must span either 24 or 36 months in order to be approved. The one-year podiatric residency no longer exists, and the 24-month programs are also being phased out.

Colorado has three podiatric residency programs. All three are 36-month programs:

- Highlands Presbyterian St. Luke's Podiatric and Medical Surgery Residency Program (Highlands) started in 1976. Highlands' residents work out of two clinics and one wound care center. The residents also perform rotations in eight hospitals and six surgical centers in the Denver area.

- Denver Veterans Affairs (VA) Medical Center Podiatric and Medical Surgery Residency Program started in 1982. The VA program was the first 36-month podiatric residency program in Colorado to be approved by CPME. The Denver VA Medical Center is a 162-bed hospital. Also on campus is a 60-bed Nursing Home Care Unit. Additionally, the Medical Center supports a primary care clinic in Aurora at the former Fitzsimons Army Medical Center and a primary care clinic in Lakewood.

- Northern Colorado Podiatric and Medical Surgery Residency Program started in 1991 in Greeley. The North Colorado Medical Center offers a full range of clinical services.

Legal Framework

History of Regulation

The practice of podiatry was originally called chiropody, and the degree granted by medical schools to a graduate was called a doctor of surgical chiropody. In 1958, the term chiropody was officially changed to podiatry by the American Podiatric Medical Association. In 1973, the practice in Colorado became statutorily known as podiatry and its practitioners became known as doctors of podiatric medicine.

In Colorado, podiatry was first regulated in 1915 under the Colorado Board of Medical Examiners (BME). In 1943, a podiatry advisory board was created to advise the BME on podiatry issues. In 1985, the advisory board was separated from the BME and became an independent, policy autonomous board, the Colorado Podiatry Board (Board).

Podiatry has been a constantly changing medical profession. These changes can be illustrated by the evolution of the statutory definitions of the scope of practice. These definitions reflect expansions in training and education that resulted in new directions in the treatment of the human foot and in manifestations of systemic diseases in the foot.

In 1915, a podiatrist had the statutory authority to surgically treat abnormal nails, corns, warts, calluses of the feet, and the superficial treatment of bunions. A podiatrist was able to give local anesthetics incidental to this treatment, but could not give anesthetics that would enable such person to make an incision below the true skin (the layer of skin below the epidermis or the outermost layer formed of connective tissue containing lymphatics, nerves, and nerve endings, blood vessels, sebaceous and sweat glands, and elastic fibers—also known as the dermis).

As of 1937, a podiatrist could diagnose and treat through external medical, surgical, mechanical, manipulative, and electrical procedures ailments of the foot and leg that were external to the superficial fascia (the sheet of fibrous tissue beneath the surface of the outer skin or epidermis) of the foot and leg, and the external treatment of deformities and functional disturbances of the foot. A podiatrist, however, could not treat communicable and internal diseases, fractures or dislocations, and was limited to the use of local anesthesia.

In 1947, a podiatrist could diagnose and treat through the use of medical, surgical, mechanical, or manipulative procedures, but could not perform amputations. A podiatrist could only give local anesthesia, and surgery was limited to minor ailments and could not be done on the bony structure or ligamentous tissues of the foot or beneath the skin or superficial fascia on the leg. A podiatrist could use electrical treatment of external ailments of the leg between the knee and ankle.

The statute was amended again in 1967, and until 1985, no further changes occurred in the definition of podiatry. A podiatrist could diagnose and medically and surgically treat any part of the toes and foot but could not amputate the foot or toes nor remove any bone within the foot.

In 1985, podiatry was redefined to include diagnosis and the medical, surgical, mechanical, manipulative, and electrical treatment of disorders of the human toe and foot, including the ankle and tendons that insert into the foot. A podiatrist was prohibited from amputating the foot and was limited to the use of local anesthesia. Surgery performed on the ankle below the skin level was required to be performed in a licensed hospital. To perform ankle surgery, a podiatrist was required to be certified by the American Board of Podiatric Surgery or perform the surgery under the direct supervision of a licensed podiatrist who was so certified or under the direct supervision of a licensed physician who was certified by the American Board of Orthopedic Surgery or the American Board of Osteopathic Orthopedic Surgery.

As a result of a sunset review in 1994, a number of other changes were made to the Podiatry Practice Act. Licensed podiatrists who perform surgical procedures were required to maintain professional liability insurance of at least $500,000 per claim and $1.5 million per year for all claims. The Board was authorized to promulgate rules establishing financial responsibility requirements for podiatrists who do not perform surgical procedures and rules regarding the reinstatement of a license that has been delinquent for more than two years.

Since 2001, applicants for licensure are required to complete an approved residency program, which consists of:

- At least one year in a hospital conforming to the minimum standards established by the Council on Podiatric Medical Education; or
- That has been approved by the Board.

Summary of Current Laws

In Colorado, the laws that govern the regulation of podiatry are known as the Podiatry Practice Act (Act). These statutes are housed in Article 32, Title 12, Colorado Revised Statutes (C.R.S.). The Colorado Podiatry Board (Board) regulates the practice of podiatry.[6]

The Governor appoints the members of the Board and may remove members for misconduct, incompetency or neglect of duty.[7] The Board consists of five members: four podiatrists and one public member, each serving four-year terms.[8] The members elect a president, vice-president and a secretary of the Board every two years.[9]

[6] § 12-32-104(1), C.R.S.
[7] § 12-32-103(1), C.R.S.
[8] § 12-32-103(1), C.R.S.
[9] § 12-32-103(2), C.R.S.

The Board is authorized to exercise the following powers and duties:[10]

- Promulgate rules;
- License qualified applicants;
- Conduct disciplinary hearings;
- Discipline licensees; and
- Approve podiatric medical schools.

The Board also has investigative subpoena authority and may prosecute or seek injunction against those violating the Act.[11] Although the Board may take disciplinary action against a licensee, the Board does not have the authority to arbitrate or adjudicate fee disputes.[12]

Practice of Podiatry

The practice of podiatry is restricted by statute to persons who hold either a podiatry license issued by the Board or a medical license issued by the Colorado State Board of Medical Examiners, with the exception of those serving in residency programs.[13] The Act does not prohibit the practice of podiatry by any regularly commissioned surgeon of the U.S. Army, Navy, Marines or U.S. public health service.[14]

The title "podiatrist" is protected; only persons licensed by the Board may use the title. Other protected titles under the Act are "foot specialist," "foot correctionist," "foot expert," "practipedist," and "podologist."[15] The Act, however, does not require a license for retail dealers and manufacturers who recommend, advertise, fit, adjust, or sell corrective shoes, arch supports, or similar mechanical appliances and foot remedies.[16]

Unlike a medical license, a podiatry license is restricted to the treatment of the foot and ankle, and a podiatrist is prohibited from using "Doctor" or "Dr." before his or her name unless he or she follows it with "podiatrist," "Doctor of Podiatric Medicine," or "DPM." The title "podiatric physician" is also prohibited unless it is followed by the phrase "practice limited to treatment of the foot and ankle."[17]

[10] § 12-32-104(1), C.R.S.
[11] Ibid
[12] § 12-32-104.5, C.R.S.
[13] § 12-32-102(1), C.R.S.
[14] § 12-32-109(5), C.R.S.
[15] § 12-32-109(2), C.R.S.
[16] § 12-32-109(6), C.R.S.
[17] § 12-32-109(3), C.R.S.

The Act's definition of the practice of podiatry is comprehensive and includes:[18]

> Suggesting, recommending, prescribing, or administering any podiatric form of treatment, operation, or healing for the intended palliation, relief, or cure of any disease, ailment, injury, condition, or defect of the human toe, foot, ankle, and tendons that insert into the foot, including complications thereof consistent with such scope of practice, with the intention of receiving, either directly or indirectly, any fee, gift, or compensation whatsoever.

While the Act limits a podiatrist to the treatment of the human toe, foot, ankle and tendons that are connected to the foot, by Board rule, a podiatrist may perform proximal measures incidental to a procedure.[19] However, these measures must be:

- For the treatment of the human toe, foot, ankle and tendons that insert into the foot;
- Reasonable and necessary; and
- Within the generally accepted standards of podiatric medicine.

For example, to fix an ankle fracture, a common surgical procedure for a podiatrist to employ is the application of an external fixator, in which pins may be inserted into the shin bone and an external frame is then secured outside the leg to hold the bones in place and to allow the joint to heal. Although the tibia and fibula above the ankle joint are outside the scope of practice, the use of an external fixator is a common podiatric procedure necessary to fix an ankle fracture. A podiatrist may also take a patient history and a physical examination as long as they are required to treat conditions of the human toe, foot, ankle, or tendons that insert into the foot. Finally, in an emergency situation, a podiatrist is authorized by Board rule to take measures necessary to stabilize a patient until an appropriate provider is able to intervene.

The Act prohibits the amputation of the foot and the administration of an anesthetic other than a local anesthetic.[20] According to Board rule, a podiatrist may perform a partial amputation of the foot but may not disarticulate between the talus and the tibia.[21]

To perform ankle surgery, a podiatrist must be certified by the American Board of Podiatric Surgery (ABPS), or be supervised by either a podiatrist who is ABPS-certified or by an orthopedic surgeon certified by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery.[22]

[18] § 12-32-101(3)(a), C.R.S.
[19] Board Rule 290 § 5 (3 CCR 712-13)
[20] § 12-32-101(3)(b), C.R.S.
[21] Board Rule 290 § 3 (3 CCR 712-13)
[22] § 12-32-101.5, C.R.S.

Podiatrists may delegate podiatric tasks to licensed physician assistants, but they are limited to the supervision of two physician assistants unless they obtain Board approval.[23] Prescriptions written by physician assistants must be countersigned by the supervising podiatrist.

Licensure

In the state of Colorado, a podiatrist may obtain licensure either by examination or by endorsement.

To be licensed by examination, statute demands the applicant meet the following minimum qualifications:[24]

- Be at least 21 years of age;
- Graduate from a podiatric medical school;
- Complete an approved hospital-based residency; and
- Pass an examination in the basic and clinical sciences and other subjects limited in scope to the treatment of the human foot.

Any podiatrist may apply for licensure by endorsement, if he or she has:[25]

- A license to practice podiatry in another jurisdiction;
- Credentials and qualifications substantially equivalent to those required for licensure in Colorado;
- No disciplinary or adverse action imposed in another jurisdiction; and
- Been engaged in the active practice of podiatry during the five years preceding the application, three of which must be consecutive in one jurisdiction.[26]

In order to establish competency, the Board established, in Rule 100, that an applicant must provide proof that during the 24 months preceding the date of the application, he or she has been:

- Enrolled in podiatry school;
- Enrolled in a residency program;
- Engaged in the active practice of podiatry; [27] or that
- He or she has passed the required examination.

The Board also requires all applicants to be certified in Cardiac Pulmonary Resuscitation.[28]

[23] §§ 12-32-109.3 (1) and (2), C.R.S.
[24] § 12-32-105, C.R.S.
[25] § 12-32-108, C.R.S.
[26] Board Rule 100 § 2(i) (3 CCR 712-1)
[27] The Board defines the active practice of podiatry as "engaged in the practice of podiatry at least 20 hours per week during the preceding 24 months with no more than six months absence from the practice of podiatry." Board Rule 100 (3 CCR 712-1) § 2(j)

Once the Board has determined that an applicant is qualified and has paid the fee, the Board will issue a license to practice podiatry.[29] If it is determined that the applicant does not have the necessary qualifications, the Board may refuse to issue a license.

The Board established guidelines, in Rule 130, for participation in a podiatric residency program. Residents must complete an application establishing acceptance into a program and the dates of participation. Residents, without a license to practice in Colorado, may not practice podiatry outside of the residency program. A residency program may be one or two years in length and must be based in a hospital.

Podiatrists renew their licenses annually. To renew, a licensee must fill out a Board-approved renewal form[30] and a questionnaire designed to determine if the licensee has violated the Act.[31] Any licensed podiatrist who fails to self-disclose any violations of the Act or criminal convictions may be disciplined for unprofessional conduct. Licensees are also required to fulfill a minimum of 10 hours of continuing education each year.[32] Upon renewal, the Board requires licensees to sign a form attesting that they have fulfilled the continuing education requirement.

The Board also created guidelines, in Rule 120, for the reinstatement of an expired or inactive license. If a license is expired or is inactive for more than two years, the licensee must demonstrate continued professional competence by providing documentation of the following:

- A current license in another jurisdiction;
- The active practice of podiatry in that jurisdiction;
- Letters from three licensed podiatrists or physicians attesting to the applicant's competence; and
- Completion of the continuing education requirements.

If a license is expired for more than five years, the licensee must demonstrate continued professional competence by providing documentation of the above requirements and by demonstrating passage of the National Board of Podiatric Medical Examiners Part III Examination (formerly known as the PMLEXIS).

If a license has expired or is inactive and the Board receives a complaint against the licensee, the Board may wait to reinstate or reactivate a license until the Board has issued a final order.[33]

[28] Board Rule 100 § 1(c) (3 CCR 712-1)
[29] § 12-32-107(1), C.R.S.
[30] § 12-32-115(2)(a), C.R.S.
[31] § 12-32-115(2)(b), C.R.S.
[32] Board Rule 110 (3 CCR 712-2)
[33] Board Rule 120 § 3 (3 CCR 712-3)

Disciplinary Action

The Board may refuse to issue or renew a license, revoke or suspend a license, issue a letter of admonition, or place on probation any licensee who is guilty of unprofessional conduct.[34]

The grounds for unprofessional conduct include, among others:[35]

- Resorting to fraud, misrepresentation, or deception, or making a misleading omission, in applying for a license or in taking the examination;
- Having been convicted of a felony or any crime that would constitute a violation of the Act, including a plea of *nolo contendere* or the imposition of a deferred sentence;
- Suffering from habitual intemperance or excessively using of any habit-forming drug or any controlled substance;
- Engaging in any act or omission which fails to meet generally accepted standards of the practice of podiatry;
- Violating the Act, any rule or regulation promulgated by the Board, or any final agency order;
- Administering, dispensing, or prescribing any habit-forming drug or any controlled substance other than in the course of legitimate professional practice relevant to the scope of podiatric medicine;
- Having been convicted of a violation of any federal or state law regulating the possession, distribution, or use of any controlled substance;
- Suffering from any physical or mental disability that renders the licensee unable to perform podiatry with reasonable skill and safety to the patient;
- Committing a fraudulent insurance act;
- Engaging in a sexual act with a patient during the course of patient care or during the six-month period immediately following the termination of such care;
- Performing any procedure beyond the podiatrist's training and competence;
- Administering, without clinical justification, treatment which is demonstrably unnecessary;
- Failing to obtain consultations or perform referrals when failing to do so is not consistent with the standard of care for the profession; and
- Falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records.

Any disciplinary action imposed in any other jurisdiction is considered proof of unprofessional conduct in Colorado, as long as the reasons for the discipline were based on acts that would be defined as unprofessional conduct in Colorado.[36]

[34] § 12-32-107(2), C.R.S.
[35] § 12-32-107(3), C.R.S.
[36] § 12-32-107(3.5), C.R.S.

The Board may require a licensee to be evaluated by physicians if it finds a possible condition of excessive drinking or drug use, or a possible condition of physical or mental disability that may render the podiatrist unable to practice safely.[37]

The Board may conduct disciplinary hearings or use an administrative law judge to conduct disciplinary hearings.[38] Any person who fails to respond to a subpoena or process of the Board or an administrative law judge may be ordered to do so by a district court.[39] Failure to comply with the order of the court is punishable by contempt of court. All disciplinary investigations and examinations are exempt from open records and open meetings laws.[40]

The Board may send a letter of admonition if it finds that although a complaint does not merit formal action, it does reveal a case of misconduct that should not be dismissed.[41] The licensee has 20 days after the receipt of the letter of admonition to request adjudication. If the licensee requests adjudication, the letter is vacated and the formal disciplinary proceedings begin.

The Board may dismiss a complaint if it finds that it is without merit or that there is no reasonable cause to justify further action.[42]

Professional Service Corporations

Licensed podiatrists may organize professional service corporations created exclusively for the purpose of conducting the practice of podiatry.[43] All shareholders of the corporation must be licensed podiatrists who are actively engaged in the practice of podiatry, and the president and director of the corporation must be shareholders.

A professional service corporation is prohibited from conducting itself in any way which would violate the standards of professional conduct as outlined in the Act for licensed individuals.[44]

Professional Liability Insurance

A podiatrist who performs surgery is required to maintain professional liability insurance at a minimum of $500,000 per claim and $1.5 million per year for all claims.[45] According to Board Rule 220, a podiatrist who does not perform surgery must maintain professional liability insurance of $200,000 per claim and $600,000 per year for all claims.

[37] § 12-32-108.3(11)(a), C.R.S.
[38] § 12-32-108.3(6), C.R.S.
[39] § 12-32-108.3(7)(b), C.R.S.
[40] § 12-32-108.3(12), C.R.S.
[41] § 12-32-108.3(2)(c)(III), C.R.S.
[42] §§ 12-32-108.3(2)(c)(I) and (II), C.R.S.
[43] § 12-32-109.5(1), C.R.S.
[44] § 12-32-109.5(2)(a), C.R.S.
[45] § 12-32-102(2)(a), C.R.S.

Program Description and Administration

All states, the District of Columbia and Puerto Rico regulate the practice of podiatry. The Colorado Podiatry Board (Board) is authorized to regulate Doctors of Podiatric Medicine in the State of Colorado. The five-member Board meets quarterly to approve licenses, review complaints, take disciplinary action, promulgate rules, and make policy decisions.

Agency Fiscal Information

The Department of Regulatory Agencies (DORA) Division of Registrations (Division) performs the administrative and operational functions of the Board. The following table illustrates the Board's expenditures and staffing over the last five fiscal years.

Table 1
Agency Fiscal Information

Fiscal Year	Total Program Expenditure	FTE
03-04	$40,915	0.2
04-05	$39,628	0.2
05-06	$33,561	0.2
06-07	$28,125	0.2
07-08	$51,592	0.3

The full-time equivalent (FTE) employees listed in Table 1 do not include staffing in the centralized offices of the Division. Centralized offices include the Director's Office, Office of Investigations, Office of Expedited Settlement, Office of Examination Services, Office of Licensing, and Office of Support Services. However, the cost of those FTE is reflected in the Total Program Expenditures. The Board pays for those FTE through a cost allocation methodology developed by the Division and DORA's Executive Director's Office.

The Board-dedicated staff in fiscal year 07-08 includes a program director (0.2 FTE General Professional VI) and a program assistant I (0.1 FTE). The program director is responsible for managing the administration of the program and Board meetings, communicating with the Board, and responding to inquiries. The program assistant is the primary staff support responsible for analyzing and processing renewal questionnaires, preparing hearing records for cases on appeal, preparing the Board agenda, ensuring compliance with final agency orders and stipulations, and updating national regulatory databases with Board disciplinary actions.

Since the Board oversees a small program, the program expenditures vary considerably from year to year depending on the legal fees and investigative costs. In fiscal year 07-08, the program expenditure grew nearly $23,500 as a result of an increase in legal services and the addition of 0.1 FTE, incurring $14,000 in additional personnel costs and $4,000 in additional leased space.

The Board is cash-funded by the fees collected for licensure shown in Table 2.

Table 2
Podiatry Board Fees
Fiscal Year 08-09

Fee Type	Amount
Original License by Examination	$200
Original License by Endorsement	$200
Renewal Active License	$177
Renewal Inactive License	$160
Late Fee (for renewals after the expiration date)	$15
Reinstatement	$192
Reactivate Inactive License	$25
Duplicate Computer License	$5

Licensing

In Colorado, it is illegal to practice podiatry without either a license issued by the Board or a license issued by the Colorado State Board of Medical Examiners.

Applicants for licensure by the Board must submit a completed application with the fee and the required documentation to the Office of Licensing in the Division. A licensing specialist reviews the completed application and documentation, and if the application is without issues, a license may be administratively issued. Applications that are incomplete are kept on file for one year. After a year, an applicant must submit a new application, the required documentation, and pay the fee again.

All podiatry licenses expire on May 31 and must be renewed annually. In order to renew, licensees must sign a form attesting that they have fulfilled 10 hours of continuing education in the previous year. In the past five years, the Division has not performed any audits of the continuing education attestations.

The number of licensed podiatrists in Colorado has remained fairly consistent over the last five fiscal years as Table 3 demonstrates.

Table 3
Licensing Information

Fiscal Year	Examination	Endorsement	Reinstatement	Renewal	Total
03-04	5	3	Not available*	179	204
04-05	7	0	0	187	201
05-06	6	2	1	178	201
06-07	7	2	1	180	199
07-08	8	1	1	186	201

* For fiscal year 03-04, the Division is unable to provide a breakdown of the number of licenses issued by reinstatement because, previously, reinstatements were not tracked separately from renewals.

In Table 3, the figures for the various types of license acquisition do not equal the figures in the "total" column due to a number of circumstances, including computer system anomalies. Many of these anomalies can be attributed to the date on which various reports are pulled, as well as when data are entered into the system.

In Colorado, a podiatrist has the option to change the status of his or her license to inactive. Table 4 breaks down the number of active and inactive podiatry licenses in Colorado over the last five fiscal years.

Table 4
Licenses by Status

Fiscal Year	Active	Inactive	Total
03-04	194	10	204
04-05	192	9	201
05-06	191	10	201
06-07	190	9	199
07-08	195	6	201

A podiatrist may choose to inactivate a license when he or she is not actively practicing. The benefit of inactivating a license is minimal since the difference in licensing fees is almost negligible ($17 in fiscal year 08-09). However, a podiatrist is not required to fulfill the continuing education requirements while his or her license is inactive.[46] When a podiatrist returns to active status, then he or she must comply with any continuing education requirements.

[46] § 12-70-101(1), C.R.S.

Examinations

To be licensed in Colorado, an applicant must pass a national examination developed and administered by the National Board of Podiatric Medical Examiners (NBPME). The examination is administered in three parts. Parts I and II are completed prior to graduation from podiatric medical school, and passage of Part III is used by most states, including Colorado, and the District of Columbia as a condition of licensure. All parts of the examination are written.

Parts I and II of the NBPME examination are developed by faculty members from podiatric medical schools to test whether a candidate possesses the knowledge necessary to practice as a minimally competent entry-level podiatrist. Part I tests knowledge of the basic sciences and is taken after the second year of podiatric medical school. Part II tests clinical knowledge of general medicine, dermatology, radiology, orthopedics, biomechanics, surgery, anesthesia, hospital protocol, community health, and jurisprudence. Part II is generally taken near the end of the fourth year.

Part III is developed by practicing podiatrists and is taken after graduation to determine whether a candidate has the knowledge and skills to safely practice podiatry. Six states and Puerto Rico do not require passage of Part III for licensure: Alaska, Arkansas, Idaho, Mississippi, New Jersey, and Oklahoma. Instead, these states administer a state licensing examination. Wyoming requires passage of Part III and a state examination.

The fee for each part of the national examination is $900. The examinations are administered by Prometric, Inc. Part I and Part II are given twice a year in or near cities with podiatric medical schools: Chicago, Cleveland, Des Moines, Miami, New York, Philadelphia, Phoenix, and San Francisco. The Part III examination is given twice a year. In Colorado, candidates may take the test at one of four centers located in Denver, Longmont, Colorado Springs, and Grand Junction.

Table 5 illustrates the number of Part III examinations taken nationally and the pass rates over the last five years. Examination statistics specific to Colorado were not available.

Table 5
NBPME Part III Examination

Fiscal Year	Number of Written Examinations Given	Pass Rate
03-04	407	91%
04-05	349	91%
05-06	342	93%
06-07	351	91%
07-08	376	91%

Complaints/Disciplinary Actions

The Board receives complaints from patients and their families, healthcare professionals, and governmental and public safety agencies. The Board may also initiate a complaint on its own motion. The Board may take the appropriate disciplinary action if it determines that the licensee has violated the Podiatry Practice Act (Act) or the Board rules.

Complaints citing standard of practice issues are by far the most common type of complaint filed with the Board (see Table 6). To prove a standard of care complaint, the Board must determine that the care would be considered substandard by a reasonable and prudent podiatrist.

Table 6
Complaint Information

Nature of Complaints	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Standard of Practice	13	7	11	15	12
Physical/Mental Disability	0	0	0	1	0
Scope of Practice	4	0	0	0	0
Substance Abuse	0	1	2	1	1
Application Fraud/ Misrepresentation	1	0	0	2	0
Conviction of a Crime	2	1	1	0	0
Other	2 (insurance fraud) 1 (advertising)	1 (liability insurance)	0	0	2 (stipulation violations)
TOTAL	**23**	**10**	**14**	**19**	**15**

If the Board determines that the complaint is within its jurisdiction and credible, it will initiate an investigation and send a letter requesting that the podiatrist respond to the complaint. The Board may also request copies of patient records, direct the Division staff to interview witnesses, or send the case to be reviewed by an expert.

If the Board determines that a podiatrist has violated the Act, then the Board may pursue disciplinary action including: revocation or suspension of a license, probation or practice limitation, a stipulated agreement, or a letter of admonition. If the Board finds that a podiatrist did not violate the Act, then the Board may dismiss the complaint. In cases where the Board is concerned about the patient care but the conduct of the podiatrist does not rise to the level of unprofessional conduct as defined by statute, then the Board may dismiss the complaint and send the podiatrist a letter of concern.

Table 7 charts the Board disciplinary actions and dismissals over the last five fiscal years.

Table 7
Final Agency Actions

Type of Action	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Revocation/Surrender/ Voluntary Relinquishment	0	0	0	0	0
Suspension	0	0	1	0	1
Probation/Practice Limitation	0	1	1	2	4
Letter of Admonition	0	0	1	0	1
License Denied	0	0	0	0	0
Other (Please specify)	0	1 (injunction)	0	0	0
Total Board Actions	**0**	**2**	**3**	**2**	**6**
Dismiss	7	7	5	15	7
Letter of Concern	4	1	4	0	2
Total Dismissals	**11**	**8**	**9**	**15**	**9**

Analysis and Recommendations

Recommendation 1 – Continue the Colorado Podiatry Board for nine years, until 2019.

Podiatrists perform medical and surgical treatments on the human foot and ankle. Podiatric treatment performed by an unqualified practitioner could result in serious harm to a patient including deformity, chronic pain, amputation of the foot, and death. Podiatrists often work with vulnerable populations like the elderly, who may not be in a position to make an informed choice about selecting a qualified podiatrist. Considering the potential for harm, regulation of the profession is necessary to protect the interests of the public.

The last sunset review of the Podiatry Practice Act (Act) was completed in 1995. The practice of podiatry has changed considerably over the last fifteen years and it will most likely continue to evolve; therefore, it would be advisable to schedule less time before the next podiatry sunset review. For these reasons, the Colorado Podiatry Board (Board) should be continued for nine years.

Recommendation 2 – Amend the definition of the practice of podiatry to clarify that podiatrists may treat the soft tissues below the mid-calf.

Podiatrists often work with persons who have diabetes and who suffer from chronic or non-healing wounds of the foot and ankle. Patients who have venous insufficiency[47] suffer from non-healing wounds on the foot, ankle, and lower leg. While podiatrists clearly have the statutory and regulatory authority to treat non-healing wounds of the foot and ankle, it is not clear that podiatrists have the authority to treat non-healing wounds of the lower leg.

By statute, the definition of the practice of podiatry is comprehensive and includes:[48]

> Suggesting, recommending, prescribing, or administering any podiatric form of treatment, operation, or healing for the intended palliation, relief, or cure of any disease, ailment, injury, condition, or defect of the human toe, foot, ankle, and tendons that insert into the foot, including complications thereof consistent with such scope of practice.

[47] Venous insufficiency is a condition in which the veins have problems sending blood from the legs back to the heart. Medline Plus, Medical Encyclopedia. *Venous insufficiency.* Retrieved August 3, 2009, from http://www.nlm.nih.gov/medlineplus/ency/article/000203.htm

[48] § 12-32-101(3)(a)(II), C.R.S.

By Board rule, podiatrists may take proximal measures that are reasonable and necessary to treat the foot and ankle as long as they are within the standard of podiatric care. For example, a podiatrist may place pins or screws into the shin bone to repair an ankle fracture because it is a proximal measure that is reasonable and necessary to repair an ankle fracture, and within the standard of podiatric care. However, venous insufficiency affects the foot, ankle and lower leg, and although podiatrists may perform proximal measures to treat the foot and ankle, treating the leg is not within the scope.

Because podiatrists may treat the tendons that insert into the foot, the Act appears to allow podiatrists to work on the soft tissue below the mid-calf. In order to treat the tendons that insert into the foot, a podiatrist must work on the soft tissues above the ankle. Amending the statute to state that podiatrists may treat the soft tissues below the mid-calf (i.e., where the tendons that lead into the foot connect to the muscles of the lower leg) would clarify this. Fifteen other states include the leg in the scope of practice for podiatrists. Both Maryland and North Carolina clearly allow podiatrists to work on the soft tissues below the mid-calf. Clarifying the Act in this way would permit podiatrists to treat non-healing wounds above the ankle and below the mid-calf.

Podiatric medical students and residents receive sophisticated training and education in treating non-healing wounds. Additionally, because many states, like Florida and Georgia, include the leg in the podiatric scope of practice, podiatric medical schools include treatment of the leg in the curricula. In Florida, where the scope of practice includes the leg, podiatrists may medically treat the thigh and may perform surgical procedures below the knee. In Florida, the primary work podiatrists do on the leg is treat non-healing wounds.

Podiatrists who treat non-healing wounds work on teams with other healthcare providers, such as: vascular surgeons, general surgeons, plastic surgeons, infectious disease specialists, internists and nurses. Treating non-healing wounds involves wound debridement, compression and dressing the wounds. Authorizing podiatrists to work on the soft tissues above the ankle would allow the teams more flexibility in coordinating patient care. Hospitals and wound care clinics would be able to determine competency and assign the appropriate practitioner for a procedure.

Further, podiatrists are prohibited by statute from performing procedures beyond their own training and competence.[49] A podiatrist who has not received advanced training in wound healing would still be prohibited from performing any such procedures, even if the scope of practice were to allow it.

Allowing podiatrists to treat non-healing wounds below the mid-calf would improve access to qualified healthcare in the state. Preventing professionals who are otherwise qualified and competent from performing such procedures is not in the public interest. Since podiatrists are trained and qualified to treat non-healing wounds on the lower leg, the definition of podiatry should be clarified to include treatment of the soft tissue below the mid-calf.

[49] § 12-32-107(3)(t), C.R.S.

Recommendation 3 – For podiatrists who have completed a three-year residency program, repeal the requirement to be board certified in order to perform ankle surgery.

Currently, the Act requires a podiatrist to be certified by the American Board of Podiatric Surgery (ABPS) in order to perform surgical procedures on the ankle below the level of the dermis, or be supervised by a podiatrist or orthopedic surgeon who is certified. This requirement was implemented in 1985. In 25 years, podiatric training has changed considerably.

In 1985, not all graduating podiatric medical students were able to secure placement in a residency program. Since that time, podiatric residency programs have proliferated. At the time one-year residency programs were the standard. Today, all programs must be two or three years in length, and the two-year programs are being phased out.

The three-year podiatric residency approved by the Council on Podiatric Medical Education (CPME) provides considerable training in ankle surgery. In 2008, podiatric residents in Colorado completed an average of 168 reconstructive rearfoot[50] and ankle surgeries by the time they finished their training and an average of 917 total surgeries.[51] These numbers do not include surgeries in which the resident was observing a surgery or assisting another surgeon; only those surgeries in which the resident performed the majority of the work are included.

Colorado is one of the few states where podiatrists who perform ankle surgery are required to be certified. Of the 34 states that allow podiatrists to perform surgery on the ankle, only six require certification by the ABPS.

Typically, Colorado does not require healthcare professionals to be certified by a national board since that would be delegating a governmental function to a private entity, and a private entity may change the requirements for certification at any time without public scrutiny, act in ways that are discriminatory, or create a high barrier to entry into the profession in an attempt to restrict competition.

The second sunset criterion asks whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest.[52] Licensing requirements should be designed to ensure the professional has the qualifications and competency to perform at the entry level. Any requirements beyond the entry-level, therefore, are overly restrictive; they create an unnecessary barrier for entry into the profession.

[50] Rearfoot is comprised of the heel and ankle bones.
[51] Total surgeries include digital, first ray, other soft tissue foot, other osseous foot and reconstructive rearfoot and ankle surgeries. This data was provided by the program directors of the Colorado podiatric residency programs.
[52] § 24-34-104, C.R.S.

Certification implies advanced training beyond entry-level competency. Requiring certification creates a barrier that prevents professionals from doing work that they are qualified, competent and trained to perform, and such a requirement impedes access to healthcare services.

Licensed podiatrists who have completed a three-year surgical residency program approved by the CPME should not be required by the state to be certified by the ABPS in order to perform ankle surgery.

On the other hand, podiatrists who have not completed a three-year surgical residency program should still be required to be certified by the ABPS. A one- or two-year residency program may not provide enough training to ensure that a podiatrist has the experience and qualifications to competently perform ankle surgery without further supervision. Requiring certification is not generally recommended. However, since the training of podiatrists has changed considerably over the last 25 years, the skill level and competency varies considerably depending upon when a podiatrist graduated from podiatric medical school. For this reason, the certification requirement should not be eliminated entirely.

Additionally, when section 12-32-101.5(1)(a), Colorado Revised Statutes (C.R.S.), was enacted, the ABPS only offered one certification, Foot and Ankle Surgery. Consequently, the statute does not specify a type of certification, but since 1991, ABPS has offered two types of certification: 1) Reconstructive Rearfoot/Ankle Surgery, and 2) Foot Surgery. As the statutory requirement refers to ankle surgery and not foot surgery, the statute should be amended to reflect this. As the statute is currently written, a podiatrist who is certified only in Foot Surgery would be permitted by statute to perform ankle surgery. This does not seem to be the intention of the statute.

Some podiatrists who were certified prior to 1991 may still have the former certification of Foot & Ankle Surgery, so the statute should include this certification as well as the Reconstructive Rearfoot/Ankle Surgery certification in the requirement.

In consideration of all this, the requirement to be certified by the ABPS in order to perform ankle surgery should be repealed for those podiatrists who have completed a three-year residency program. However, those podiatrists who have not completed a three-year residency program should still be required to be certified by the ABPS in order to perform ankle surgery. Additionally, the requirement should be amended to specify certification in Reconstructive Rearfoot/Ankle Surgery, or Foot and Ankle Surgery.

Recommendation 4 – For a podiatrist who performs surgical procedures, increase the minimum level of professional liability insurance to $1 million per incident and $3 million annual aggregate per year.

Professional liability insurance is vital to protecting Colorado consumers. In many instances, it is the only avenue by which an injured consumer can seek redress in an attempt to be made whole.

Establishing the appropriate minimums for coverage, then, is equally important. Minimums that are too low will fail to accomplish the desired goal. Minimums that are too high may result in excessive premiums, forcing podiatrists to leave practice, leave Colorado or run the risk of practicing without insurance.

Section 12-32-102(2)(a), C.R.S., requires each podiatrist who performs surgical procedures to maintain professional liability insurance of at least $500,000 per incident and $1.5 million annual aggregate per year. This requirement should be increased to a minimum of $1 million per incident and $3 million aggregate per year.

The same increase is being recommended for physicians licensed by the Colorado State Board of Medical Examiners in the sunset report of that board. As podiatrists practice a subset of medicine, it is reasonable for their liability insurance minimums to match those required for physicians, especially for those podiatrists who perform surgical procedures. Those podiatrists who primarily perform surgeries on the foot and ankle operate similar to orthopedic surgeons who specialize in the foot and ankle.

The increases for physicians are justified by the fact that verdicts in medical malpractice cases continue to rise. According to one source, in 1991, the average malpractice payment was $284,896, but that number climbed to $461,524 in 2005.[53] According to another source, the median in 2001, for medical malpractice claims paid by non-surgeon physicians was $511,000 and $575,000 for surgeons.[54]

Both of the sources above confirm the fact that Colorado's minimums for physicians in medical practices are woefully inadequate. Similarly, the minimums for individual physicians are either just above the national average as of a few years ago, or have already been surpassed by them.

Since 1987, medical costs in general have increased by 113 percent, but the amount spent on professional liability premiums has increased just 52 percent.[55]

[53] Consumer Injury Lawyers. *Medical Malpractice Verdicts*. Retrieved August 3, 2009, from www.consumerinjurylawyers.com/catastrophic-medical-malpractice/jury-verdicts.html
[54] Thomas H. Cohen, "Medical Malpractice Verdicts and Trials in Large Countries, 2001," MedicalMalpractice.com (April 2004). Retrieved August 3, 2009, from www.medicalmalpractice.com/medical-malpractice-verdicts.cfm
[55] Resource4MedicalMalpractice. *Medical Malpractice Facts.* Retrieved from www.resource4medicalmalpractice.com/topics/medicalmalpracticefacts.html

COPIC Companies (COPIC) utilizes a single rating classification for podiatrists regardless of their performance of surgical procedures. Of the 12 podiatrists insured by COPIC, three carry limits of liability of $2 million per incidence and $4 million annual aggregate per year, and the remaining nine carry limits of liability of $1 million per incidence and $3 million annual aggregate per year. COPIC does not write any policies for podiatrists at the statutory minimum.

Despite requests, Podiatry Insurance Company of America Group, a professional liability insurance company devoted to podiatrists, did not provide liability coverage data. However, anecdotal evidence suggests that podiatrists in Colorado typically carry liability insurance of $1 million per incident and $3 million annual aggregate per year. As a result, the proposed mandate should have minimal impact on practitioners.

For those podiatrists who do not perform surgery, the Board is authorized in statute to establish financial responsibility rules. Currently, the minimum required by Board rule is $200,000 per incident and $600,000 aggregate per year. The Board should continue to be granted this authority so that podiatrists who do not perform invasive procedures are not required to maintain more liability insurance than necessary.

For these reasons, the General Assembly should amend section 12-32-102(2)(a), C.R.S., to require podiatrists who perform surgical procedures to carry at least $1 million per incident and $3 million annual aggregate per year in professional liability insurance.

Recommendation 5 – Prohibit the public member of the Board from being a licensed healthcare professional or being employed in or benefiting financially from the healthcare industry.

> Public members are appointed precisely because they are not members of the profession. Public members are supposed to challenge and complement board decision-making from a critical, non-professional perspective; they are the 'social conscience' of a board.[56]

Currently the Act does not prohibit the public member of the Board from being a licensed healthcare provider. It only provides for one member from the public at large.[57] Both the Medical Practice Act[58] and the Nurse Practice Act[59] have provisions that limit the public member from having a financial interest or being employed in healthcare.

[56] *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century,* Pew Health Professions Commission (1995), p. 15, citing GG Rockwell (Spring 1993), "The Role and Function of the Public Member," Federation Bulletin, p. 42-4.
[57] § 12-32-103(1), C.R.S.
[58] § 12-36-103(1)(a), C.R.S.
[59] § 12-38-104(1)(a)(III), C.R.S.

Technically, the Act allows the public member to be from another licensed healthcare profession. As the member is licensed by another a healthcare profession, the role of the public member may be weakened because the interests of the Board member tie in closely to the interests of the profession.

Although a public member who is a licensed healthcare professional has expertise that a lay member does not have, a public member is not included on the Board for his or her expertise. A member of the public benefits the Board by ensuring the Board protects the interests of the public and not the interests of the profession. A member who is a licensed healthcare professional may not bring the objective eye necessary to maintain this balance. In order to ensure the Board is abiding by the law and to ensure public protection, the integrity of the public seat should be preserved.

Consequently, the public member of the Board should not be a licensed healthcare professional, employed in or benefit financially from the healthcare industry.

Recommendation 6 – Repeal the office of the secretary from the Board officers.

Section 12-32-103(2), C.R.S., requires the Board to elect a president, vice president and a secretary. Under the current Board structure, the secretary has no duties. Any duties that might have once been performed by the Board secretary are performed by the Board staff. As the role of secretary is obsolete, the requirement for the Board to elect such an officer should be repealed.

Recommendation 7 – Create a volunteer license to be provided at a reduced fee, for those podiatrists who are no longer charging for services.

Podiatrists have a tradition of working with indigent populations. In school and in residency training, podiatrists often work in clinics that provide free or reduced-cost podiatric care to underserved populations. Podiatrists in Colorado who are closing their practice often call the Division to request a license at a reduced fee because they are interested in giving back to the community by providing podiatric care at clinics for the indigent or the working poor. However, there is no such license type available.

Podiatrists who have retired their practice no longer have an income from that practice, and the cost of a full license could deter them from volunteering. Because it is a small profession in terms of the number of licensees, podiatry licenses tend to be more expensive than other licenses. Reducing the license fee could encourage more podiatrists to volunteer upon retirement.

Allowing podiatrists a new license type at a reduced fee could increase access to healthcare services for the indigent and underserved populations. Podiatrists work with diabetics and the elderly, and these populations would benefit from podiatry services provided by a volunteer. Homeless persons and the working poor often have serious foot conditions from spending so much time on their feet, and treating these conditions can improve their quality of life significantly.

Other licensed healthcare professionals, such as dentists[60] and nurses,[61] can obtain a retired-volunteer status license. Both regulatory boards require the applicant to attest that he or she will no longer earn an income from his or her profession. These licensees are subject to the same discipline as full license types and are offered the retired-volunteer status license at a reduced fee. Dentists must maintain liability insurance, and nurses are granted civil liability immunity.

COPIC has a program where it waives the premiums for liability insurance for those physicians and podiatrists who have retired their practice, but are still providing medical services at no cost. These providers are restricted from charging for services, performing invasive surgery, and the number of hours they are allowed to work is limited.

For all these reasons, a new license type should be created and provided at a reduced fee for podiatrists who are no longer charging for services. Podiatrists with a volunteer license should still be required to have the same qualifications, maintain the same liability insurance, and be subject to the same regulatory oversight as a podiatrist with a full license.

Recommendation 8 – Create a training license for podiatric residents.

Podiatrists are currently required to complete a residency program of at least one year before they can obtain a full license. Before the one-year requirement was imposed, podiatrists were fully licensed when they started their residency program.

Currently, the Act requires the Division to maintain records of podiatric residents who are training in Colorado. The Board staff is not enforcing this requirement nor is it maintaining the required information. While there are only an average of 18 podiatric residents in the state in any given year, the Board should know who they are and where they are training. However, as licensure is not required, the Board does not have any oversight over these residents.

[60] § 12-35-123, C.R.S.
[61] § 12-38-112.5, C.R.S.

As podiatrists practice a subset of medicine, the state is condoning podiatric residents to practice medicine without a license. While podiatrists are among a number of healthcare professions exempted from licensing requirements in the Medical Practice Act,[62] the other exempted professions, such as dentists, optometrists, chiropractors, nurses, and acupuncturists, have no residency requirements for licensure.[63] Those other healthcare professions are able to obtain a full license before starting any postgraduate training program.

Further, anyone enrolled in a medical postgraduate training program is required to obtain a medical training license, and a podiatric resident in Colorado is required to complete medical rotations similar to someone in a medical postgraduate training program. In their first and second years, podiatric residents in Colorado complete medical rotations that include: anesthesiology, internal medicine, infectious disease, pathology, radiology, general surgery, emergency medicine, vascular surgery, orthopedic surgery, and plastic surgery. As podiatric residents are required to complete medical rotations similar to those in medical postgraduate training programs, it follows that the state should require the same oversight of podiatric residents as it does of those in medical postgraduate training programs.

It is recognized in all states and U.S. jurisdictions that regulation of the practice of medicine is necessary for the health, safety and welfare of the public. Regulation of podiatric medicine is necessary because podiatric treatment performed by an unqualified practitioner could result in serious harm to a patient including deformity, chronic pain, amputation of the foot, and death. The Board should have oversight over podiatric residents as the potential for harm is high.

Therefore, podiatric residents should be required to obtain a training license. Training licenses should be granted to persons who have:

- Graduated from a podiatric medical school approved by CPME;
- Passed Part I and Part II examinations by the National Board of Podiatric Medical Examiners; and
- Been accepted into a podiatric residency program in Colorado.

As required of the physician training license in section 12-36-122(4), C.R.S., the Board should be required to issue a training license upon receipt of a statement, signed by the residency director, from an approved residency program in Colorado stating that the applicant meets the necessary qualifications and that the residency program accepts responsibility for the applicant's training while in the program. The residency director should be required to submit the statement to the Board at least 30 days prior to the date the applicant begins the residency, and the applicant should be required to submit a completed application on or before starting the residency program. If a completed application is not received by the Board within 60 days after the date the applicant begins the residency, then the license should expire.

[62] §12-36-106(3), C.R.S.
[63] §§12-35-117(1), 12-40-108(1), 12-33-111(1)(a), 12-38-111(1), and 12-29.5-104(3), C.R.S.

Additionally, the Board should have the authority to reject the applications of those persons who:

- Do not have the necessary qualifications;
- Have engaged in unprofessional conduct as defined in the Act; or
- Have been disciplined by a licensing board in another jurisdiction.

The podiatric training licensee should be limited to practice podiatric medicine only under the supervision of a licensed podiatrist or a physician licensed to practice medicine within the residency program. A podiatric training licensee should not have the authority to delegate podiatric or medical services to anyone who is not licensed to practice podiatry or medicine, and should not have the authority to supervise physician assistants.

The training license should expire:

- After three years with no option to renew;
- If the licensee is no longer participating in the sponsoring residency program; or
- Upon obtaining a full license to practice podiatry.

Licensed podiatrists responsible for the supervision of residents should be required to report to the Board no later than 30 days after a resident who holds a training license resigns or is terminated from the program.

Finally, the Board should have the authority to discipline a podiatric training licensee for unprofessional conduct as it is defined in the Act.

Recommendation 9 – Amend licensure qualifications to require completion of one year of an approved residency and allow the Board to promulgate rules to define an approved residency.

In sections 12-32-105(1)(c) and (3), C.R.S., the Act requires completion of an approved residency program and defines an approved residency to be a program of at least one year. The language should be amended to reflect current standards in the profession of podiatry and the current practice of the Board.

Currently no podiatric residency programs are one year in length. All residency programs for podiatrists take two or three years to complete. The language in statute implies that a podiatrist should complete a residency in order to be licensed. In practice, the Board requires completion of one year of a residency for full licensure but not completion of the residency program itself.

Requiring podiatrists to complete a two- or three-year residency to fulfill entry-level requirements for full licensure would be overly restrictive. Although it is standard in the profession for podiatrists to complete a two- or three-year residency program, residents typically obtain a full license after the first year. Residency directors and hospitals prefer that second- and third-year residents obtain a full license so that they may practice with more independence than unlicensed residents. Second- and third-year residents are still supervised, but they have more responsibility and independence than first-year residents. Increasing the levels of responsibility and independence is an important part of podiatric medical training. Although two states require podiatrists to complete a full residency program, and two other states require podiatrists to complete two years of a residency, most states require one year.

Further, the Board should be permitted to define an approved residency in rule rather than to define it in statue to allow for more flexibility as the standards of podiatry and podiatric residencies evolve and change.

For these reasons, the licensure requirements in section 12-32-105(1)(c), C.R.S., should be amended to require completion of one year of an approved residency program, and section 12-32-105(3), C.R.S., should be amended to allow the Board to promulgate rules defining an approved residency program.

Recommendation 10 – Amend the qualifications for initial licensure and licensure by endorsement to require the applicant to demonstrate engagement in the active practice of podiatry during the previous two years.

In the Board rules regarding the qualifications for initial licensure, in addition to other qualifications, an applicant must provide proof that during the previous two years he or she:

- Has been enrolled in podiatric medical school or in a residency program; or
- Has taken the national examination; or
- Has been engaged in the active practice of podiatry.

In the Board rules regarding qualifications for licensure by endorsement, in addition to other qualifications, an applicant must provide proof that he or she has been engaged in the active practice of podiatry for the previous five years with at least three consecutive years in one jurisdiction.

The purpose of these requirements is to prevent podiatrists who have been out of practice for significant periods of time, and thus, presumably are no longer competent to practice, from being granted a license.

However, for licensure by endorsement or initial licensure, the Board does not have the statutory authority to require a podiatrist to demonstrate that he or she has been engaged in the active practice of podiatry. The Act itself is inconsistent because, upon renewal of a license, 12-32-111(2), C.R.S., requires a podiatrist whose license to practice has been delinquent[64] for more than two years to demonstrate continued professional competence.

Potentially, a podiatrist could be licensed in another state but not have practiced for ten years. If he or she otherwise satisfied the statutory requirements for licensure and requested a license in Colorado, the Board would be required to grant him or her a license by endorsement.

Likewise, a podiatrist could have let his or her license expire in another state and may not have practiced for many years. If he or she requested an initial license in Colorado and was otherwise qualified, the Board would have to grant him or her a license regardless of the fact that he or she may no longer be safe to practice.

Adopting a requirement for podiatrists to demonstrate that they have been actively practicing podiatry or can otherwise demonstrate that they are safe to practice is in the best interests of the public because it ensures that those who are licensed in Colorado are safe to practice.

Other practice acts that have similar requirements include medical,[65] dental,[66] physical therapy,[67] and chiropractic.[68]

Therefore, section 12-32-105, C.R.S., should be amended to require an applicant for initial licensure to demonstrate, in addition to other qualifications, that during the previous two years immediately preceding the date of the application he or she has been enrolled in podiatric medical school or in a residency program, or has passed the national examination, or has been engaged in the active practice of podiatry as defined by the Board, or can otherwise demonstrate competency as determined by the Board.

Additionally, section 12-32-108, C.R.S., should be amended to require an applicant for licensure by endorsement to demonstrate, in addition to other qualifications, that during the previous two years immediately preceding the date of the application he or she has been engaged in the active practice of podiatry as defined by the Board, or can otherwise demonstrate competency as determined by the Board.

[64] In Board Rule 120 (3 CCR 712-3), the Board interprets a “delinquent” license to be synonymous with an expired or lapsed license.
[65] §12-36-116(1)(d), C.R.S.
[66] §12-35-117(2)(a), C.R.S.
[67] §12-41-109(3)(b), C.R.S.
[68] §12-33-113(1)(c), C.R.S.

Recommendation 11 – Require licensees to report within 30 days any adverse action taken against the licensee.

In section 12-32-107(3)(bb), C.R.S., licensees are required to report to the Board any adverse action taken by another licensing agency in another state, territory, or country, any peer review body, any healthcare institution, any professional or medical society or association, any governmental agency, any law enforcement agency, or any court for acts of conduct that would constitute grounds for action as described in the Act. However, the Act is silent as to the timing of this report to the Board.

Requiring licensees to report to the Board within 30 days any adverse action against the license, including criminal charges or convictions, to the Board would alleviate this issue. The Board would be able to consider the facts behind the adverse actions and determine if the licensee had violated the Act. A 30-day reporting requirement would help protect public health and safety by allowing the Board to act quickly to suspend or revoke a license when a licensee is unsafe to practice.

Licensees should be required to report to the Board within 30 days any adverse actions against a licensee, including criminal charges or convictions.

Recommendation 12 – Increase the time podiatrists have to respond to complaints from 20 days to 30 days.

Podiatrists are currently provided 20 days to respond to a complaint.[69] While podiatrists endeavor to meet this deadline, it may not be a reasonable amount of time to gather all the necessary records, consult with an attorney, and draft an explanation of the alleged violations. Considering other healthcare professions, such as nurses, physicians and mental health providers, are granted 10 additional days, the Act should be changed to harmonize with requirements of other healthcare providers. Allowing podiatrists the same amount of time to respond to a Board complaint as other healthcare professions should not negatively impact the interests of the public. Therefore, section 12-32-108.3(2)(a), C.R.S., should be amended to provide podiatrists 30 days to respond to complaints.

[69] § 12-32-108.3(2)(a), C.R.S.

Recommendation 13 – Add language to the Act authorizing the Board to suspend a license for not complying with an order of the Board.

At this time, the Board must initiate a new complaint against a podiatrist who does not comply with a Board order, by for example failing to submit to an examination of his or her mental condition or failing to take courses deemed necessary to correct deficiencies. Initiating a new complaint proves to be a time consuming and costly practice. Allowing the Board to suspend the license of a podiatrist who does not comply with a Board order would be a more efficient use of legal resources.

Upon the failure of the licensee to comply with any conditions imposed by the Board, the Board should be authorized to suspend the license until such time as the licensee complies with such conditions.

Recommendation 14 – Include in the definition of unprofessional conduct, failure to respond to a complaint.

Currently, the Board does not have any provision to discipline a podiatrist for failing to respond to a complaint. This is inconsistent with the Medical Practice Act, section 12-36-117(1)(gg), C.R.S., which requires a response to a complaint issued pursuant to section 12-36-118(4), C.R.S. In order to effectively regulate the practice of podiatry, the Board should have a similar provision and the clear authority to discipline a podiatrist for such a violation. Therefore, failing to respond in an honest, materially responsive, and timely manner to a complaint issued pursuant to section 12-32-108(3), C.R.S., should be included in the definition of unprofessional conduct.

Recommendation 15 – Amend the language that includes "habitual intemperance" as unprofessional conduct.

In section 12-32-107(3)(f), C.R.S., the Act defines unprofessional conduct to include: "Habitual intemperance or excessive use of any habit-forming drug or any controlled substance." Habitual intemperance is obscure language that could be more clearly stated as habitual or excessive use or abuse of alcohol. As the persons most affected by this Act are the licensed professionals, there is no reason to obscure the meaning behind this prohibition. Making it clear to the professionals that habitual or excessive use or abuse of alcohol or any habit-forming drug or controlled substance is grounds for discipline would be preferable to using language that obstructs clarity. This provision should be amended to simply prohibit the "habitual or excessive use or abuse of alcohol or controlled substances."

Recommendation 16 – Add language to the Act authorizing the Board to impose a fine on a licensee.

Currently the Board does not have the authority to impose a fine on a licensee. The Colorado State Board of Medical Examiners,[70] the Board of Chiropractic Examiners,[71] and the Board of Nursing[72] have the authority to impose fines for violations of their respective practice acts. As podiatrists practice a limited scope of medicine and many podiatrists who perform surgery on the foot and ankle perform the same surgical procedures as orthopedic surgeons who specialize in the foot and ankle, it follows that the Board should have the same disciplinary options as the Colorado State Board of Medical Examiners.

Allowing the Board to impose fines would improve the Board's ability to regulate the profession of podiatry by adding another instrument that it may use when other means of discipline including suspension, revocation, or probation are not appropriate. A violation that is administrative rather than below the standard of care would be an appropriate use for a fine. An example of this could be a podiatrist who fails to renew his or her license within the grace period and practices for a short time without a license.

In order to effectively and efficiently regulate the practice of podiatry, the Board should be authorized to impose a fine on a licensee for a violation of the Act. A fine should be no more than $5,000 per violation, and all collected fines should be transferred to the state treasurer and credited to the General Fund.

Recommendation 17 – Amend the provision that exempts from the Act any regularly commissioned surgeon of the United States Army, Navy, or Marines to exempt any regularly commissioned surgeon of the armed forces of the United States of America.

Section 12-32-109(5), C.R.S., exempts from the provisions of the Act any regularly commissioned surgeon of the U.S. Army, Navy, or Marines. Missing from this list is the U.S. Air Force. Instead of listing each individual military service, it would be simpler to exempt any regularly commissioned surgeon of the armed forces of the United States of America.

[70] §12-36-118(5)(g)(III), C.R.S.
[71] §12-33-117(1.5), C.R.S.
[72] Senate Bill 09-239

Recommendation 18 – Delete the word "chiropodist" in the statute that requires certain persons to report suspected child abuse or neglect.

Section 19-3-304, C.R.S., requires persons, such as physicians and teachers, to report suspected child abuse or neglect to the authorities. Among this list is the profession chiropodist or podiatrist. The term "chiropodist" is an archaic term for podiatrist. It has not been in use for 50 years, and it should be deleted from statute to avoid confusion and to make it clear that podiatrists are required to report cases of child abuse or neglect to the authorities.

Administrative Recommendation 1 – Seek to amend the sunset review bill to include any technical changes necessary to the Act.

During the course of the sunset review, both the Division and researchers found several places in the Act that need to be updated and clarified to reflect current practices, conventions, and technology. For example, section 12-32-103(2), C.R.S., authorizes the president of the Board to call a special meeting on 24-hour notice by telephone or telegraph. As the telegraph is no longer in use, the word may be deleted and this provision updated with existing means of communication.

Recommendations of this nature do not rise to the level of protecting the health, safety, and welfare of the public, but an unambiguous law makes for more efficient implementation. The entire Act, including every one of its provisions, is commonly only examined by the General Assembly during a sunset review. Therefore, the Board and the Division should review the whole Act and prepare an omnibus amendment to the sunset review bill which will rectify all identified technical problems.