STATE LICENSURE AND DISCIPLINE OF PODIATRISTS

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INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE AND OBJECTIVES

The overall aim of this inspection was to promote a better understanding of State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists. It sought to identify the extent and type of changes occurring, the major issues being addressed, and the kinds of improvements that might be made. This report, which focuses on the licensure and discipline of podiatrists, is the third in a series of reports to be issued as part of the inspection. Prior reports focused on dentists and chiropractors, and a fourth will focus on optometrists.

BACKGROUND

The inspection follows up on a similar inquiry conducted by the Office of Inspector General in 1985 and 1986 that addressed medical licensure and discipline. It is based primarily on three lines of inquiry: (1) telephone discussions with board members or staff of State licensure and discipline bodies, (2) a review of pertinent literature and data bases, and (3) discussions with representatives of national professional associations.

This report's organization and presentation closely parallel that of the first and second reports of the overall inspection. A number of the findings and recommendations also parallel those set forth in the previous reports.

FINDINGS

- In both the licensure and discipline realms, State board officials tend to feel that they are inadequately funded and staffed, and that, as a result, the effectiveness of both licensure and discipline operations is undermined.

Licensure

- State podiatry board policies concerning licensure by credentials--the practice of granting a license on the basis of one already held in another State--tend to be extremely restrictive. Twenty-three boards will issue licenses in this manner, but 19 of them impose one or more restrictions on the applicant.

- The majority of practicing podiatrists are concerned about this situation because they feel it inhibits their economic opportunity and freedom of interstate movement. Less obvious, but of greater concern to consumers, is that in a number of States this policy appears to constrain access to podiatric services. It is striking that among the 28 States that will not grant licensure by credentials, 20 have podiatrist-to-population ratios below the national average.

- Many board officials, particularly in larger States, feel an increasing sense of concern about the adequacy of the background information they receive on applicants for licensure. This involves both the validity of the credentials being submitted and the completeness of the information being provided.

- A major factor contributing to this concern is the widely perceived inadequacy of the two national clearinghouses that collect and disseminate information on disciplinary actions taken against podiatrists. Most board officials express serious reservations about the extent, quality, and timeliness of the data provided by these clearinghouses.

Discipline

- During the past 3 years, the annual number of State board disciplinary actions against podiatrists has nearly doubled. Between 1984 and 1985, it rose from about 84 to 107. From 1985 to 1986, it jumped from 107 to 159.

- Fifteen State boards took no disciplinary actions against podiatrists from 1984 to 1986.

- The most serious types of disciplinary actions--revocations, suspensions, and probations--accounted for only 35 percent of all the disciplinary actions taken against podiatrists. This represents a drop from 1984, when they represented 44 percent of all actions.

- Disciplinary action rates concerning podiatrists are much higher than those concerning medical doctors, or both dentists and chiropractors, the subjects of the first two reports in this inspection. In 1985, podiatry boards disciplined about 9.7 podiatrists per 1,000 active podiatrists; dental boards, about 5.4 dentists per 1,000 active dentists; chiropractic boards, about 5.3 per 1,000; and medical boards, about 4.2 per 1,000.

- Variation in disciplinary performance is also substantial when State podiatry boards are compared among themselves. These facts stand out:

  - *Over the past 3 years, two boards were disciplining podiatrists at a rate that far exceeded that of any other board. In 1985, one of these boards accounted for about 26 percent of all disciplinary actions taken against podiatrists in the United States.*

  - *There is little variation in the rate of disciplinary activity with respect to the size of States. The most significant variation lies with the medium-sized*

States. These States hold 24 percent of active podiatrists, yet were responsible for 30 percent of all disciplinary actions from 1984 to 1986.

- *The rate of disciplinary action has been disproportionately high in the South and low in the Midwest. Although southern States have only 20 percent of active podiatrists, they accounted for 34 percent of the reported disciplinary actions between 1984 and 1986, whereas in the Midwest, the comparable rates were 26 percent and 9 percent.*

- Comparatively low license renewal fees appear to be closely associated with low rates of disciplinary action. Of the 10 State boards with annual renewal fees of $25 or less in 1987, 5 took no actions at all from 1984 to 1986, and another State disciplined podiatrists at a rate well below the national median for that period.

- Consumer complaints are by far the major source of disciplinary actions against podiatrists. In contrast, relatively few such actions emerge as a result of referrals from State podiatry societies or investigations initiated by the boards themselves.

- State podiatry board officials tend to be supportive of the national data bank to be established under Public Law 99-660. However, they raise a number of concerns associated with its implementation, among them the accuracy, confidentiality, timeliness, and accessibility of the bank's data.

RECOMMENDATIONS

- State governments should ensure that State podiatry boards have sufficient resources to carry out their responsibilities effectively.

- State podiatry boards should join together to establish and use a high-quality, national clinical licensure examination.

- State podiatry boards should shore-up their credential verification processes.

- The Federation of Podiatric Medical Boards (FPMB) should develop guidelines for State podiatry practice acts.

- The FPMB, in consultation with the American Podiatric Medical Association, should accumulate and disseminate, on a regular basis, changes in State practice acts and regulations.

- The FPMB should identify and disseminate to State boards the most effective techniques of credential verification.

- The American Podiatric Medical Association (APMA) should encourage more extensive and effective inter-action between its State societies and State podiatry boards.

- The Public Health Service should assist the FPMB to extend and improve its technical assistance and information dissemination activities.

COMMENTS

The APMA and FPMB were in general agreement with the recommendations directed to them, and in some cases have initiatives underway that address the issues in the report. The PHS and American Association of Colleges of Podiatric Medicine expressed some concerns that the report did not go far enough in some areas. These concerns, as well as all comments received, are addressed in appendix IV of the report.

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INTRODUCTION

In June 1987, the Office of Inspector General undertook an inspection of State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists. The overriding purpose of the inspection was to provide the Federal and State governments and the respective professional communities with a better understanding of these practices. More specifically, it sought to identify the extent and type of changes taking place, the major issues that are surfacing, and the kinds of improvements that might be made. (For more background on why the study was undertaken, see appendix II.)

This report focuses on podiatric medicine and is the third of four reports to be issued as part of the above-noted inspection. It is based on three avenues of inquiry: (1) telephone discussions with board members or staff associated with podiatric licensure and discipline bodies in 48 states; (2) a review of pertinent literature and data bases, including journal articles, studies, prepared speeches, and statistical compilations of public and private organizations; and (3) discussions with representatives of various professional associations. These include the American Podiatric Medical Association (APMA), American Association of Colleges of Podiatric Medicine (AACPM), Federation of Podiatric Medical Boards (FPMB), and the Council on Podiatric Medical Education (CPME). (For more methodological background, see appendix III.)

Podiatric medicine has fewer practitioners than any other health profession[1]; nonetheless, it has an important and growing role in health care. In 1987 there were about 12,400 practicing podiatrists[2] in the United States. Podiatrists are classified as "physicians" under Medicare law, but only with respect to the functions they are legally authorized to perform in the State in which they practice. Thus the services they provide within the scope of their State license are "physician's services" and are reimbursable on a reasonable charge basis under Part B of the Federal Medicare Program. In Fiscal Year (FY) 1985, these expenditures totalled $211.8 million.[3]

In the case of Medicaid, the role of podiatrists and the level of expenditure for which they account are less clear. Statistics are difficult to come by because podiatrists are included in the general category of "Other Physician Services." It is estimated, however, that less than 5 percent of podiatrists' practice income comes from Medicaid.[4]

This report starts with brief overviews of the practice of podiatric medicine and State boards of podiatry. It also examines the major changes and issues affecting licensure and discipline and suggests areas of action directed primarily to State boards of podiatry.

PRACTICE OF PODIATRIC MEDICINE

Much like dentists and chiropractors, podiatrists practice in relative isolation. While increasing numbers of podiatrists have staff privileges at one or more hospitals, office treatment still predominates. By 1983, 73 percent of podiatrists had some type of professional privilege in

hospitals and 58.5 percent had surgical privileges, but less than 15 percent of podiatric physicians treated more than 5 percent of their patients in hospital settings.[5] The vast majority of patients continue to be treated in the podiatrists' offices.

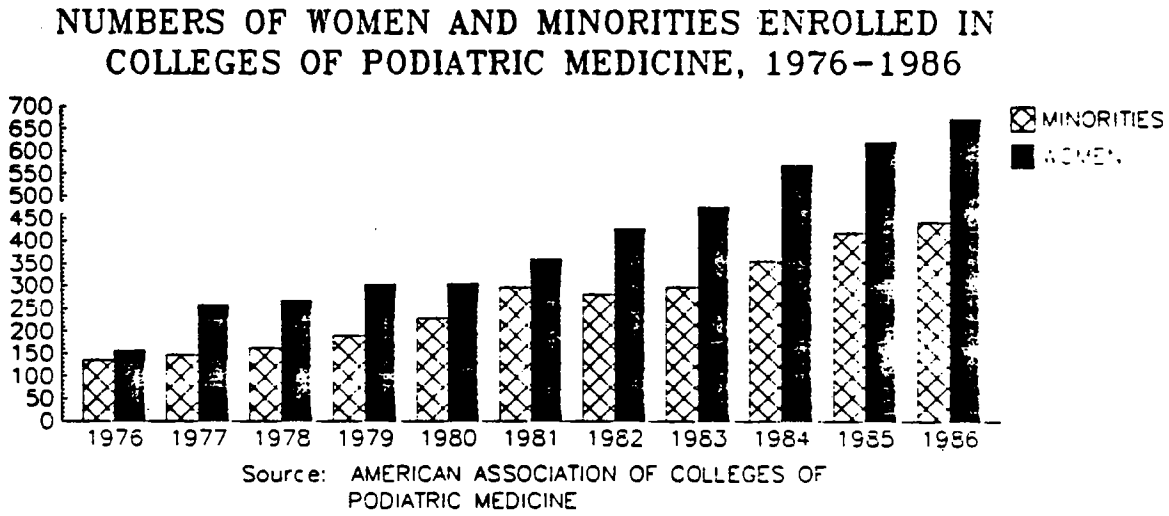
Even in the office setting, most podiatrists work alone. According to a report prepared for the APMA by ELM Services, Inc., in 1985--*The Economics of Foot Care* --about 72 percent of podiatric physicians were in a solo practice, 13 percent were involved in a partnership, 5 percent were in a group practice arrangement, and the remaining 10 percent were either retired, employed by the government or a podiatric medical college, or not in active practice.

A 1983 survey of podiatrists conducted by the APMA found that increasing numbers of podiatrists are looking to the American Board of Podiatric Surgery (ABPS) and the American Board of Podiatric Orthopedics (ABPO) for certification in these two specialties. According to the survey, in November of 1983, 14.8 percent of active podiatrists were ABPS certified, with 16.5 percent eligible, and 1.9 percent were ABPO certified, with 0.7 percent eligible for board certification.[7]

The greater part of a podiatrist's time is spent on activities that are considered general practice. Although, in recent years an emphasis has been placed on podiatrists' developing skills in surgery and foot orthopedics, this specialty is most often incorporated into their regular practice. Specialization, in the everyday medical sense, is rare.[8]

Podiatry is largely a white male profession, although the numbers of minority and female students enrolled in colleges of podiatric medicine have been increasing, as shown in figure I.

FIGURE I

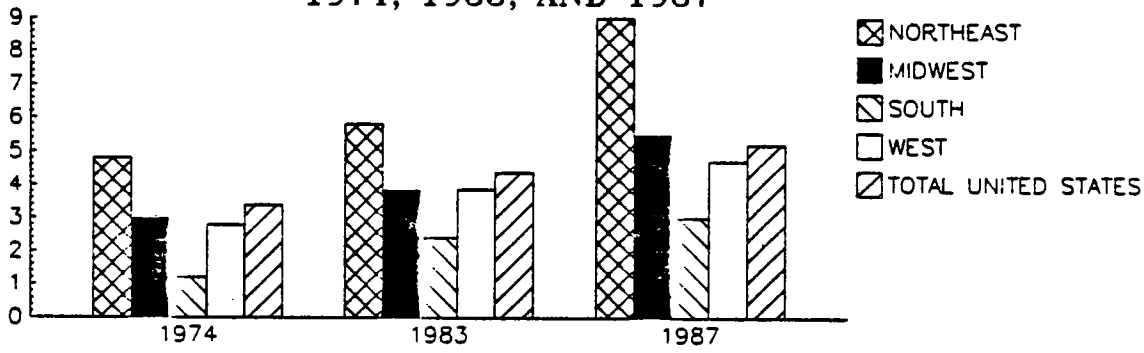


It should be noted, also, that the attrition rate for women and minorities is greater than the overall attrition rate of 12.7 percent. According to data from the American Association of Colleges of Podiatric Medicine (AACPM), minorities in 1985 experienced an attrition rate of 20.8 percent and women 17.2 percent.[9]

The number of all students enrolled in the colleges of podiatric medicine has leveled off after a period of expansion in the late sixties to mid-seventies. The growth at that time was due to increased Federal aid to both schools and students and to the schools' efforts to increase class size. Another general upward trend in enrollment occurred in the 1980's when two new schools opened, the College of Podiatric Medicine and Surgery in Des Moines, Iowa (1982), and the Barry University School of Podiatric Medicine in Miami Shores, Florida (1985).

FIGURE II

PODIATRIST:POPULATION RATIOS SHOWING GEOGRAPHIC DISTRIBUTION OF PODIATRISTS, 1974, 1983, AND 1987



Sources: 1974 Data on Active Podiatrists From National Center for Health Statistics; 1983 Data From APMA; 1987 From State Boards/Census Bureau

Although the number of practicing podiatrists has increased over the past 10 to 15 years, there has been no significant improvement in their geographic distribution when concomitant increases in population are also considered. For example, the data show that from 1974 to 1987, the Northeast had the highest ratio of podiatrist to population as well as the largest per-ratio increase over those years (figure II).[10]

In 1984 the American Podiatric Medical Association (APMA) formed a panel of prominent podiatrists and others to take a look at the profession of podiatric medicine and chart a path for its future. Called the "Project 2000 Commission," its final report was presented to the APMA House of Delegates in 1986. The report cited several major areas of concern identified by the Commission. One of these was the education of podiatrists. "The goal of podiatric medical education," stated the report, "must be to produce a 'comprehensive footcare physician,' a total specialist who is well versed in all areas of his or her field, with a redirection and em-

phasis on non-invasive and biomechanical procedures in patient care." The report, according to former APMA president Dr. Jerry D. Brant, "did not say that podiatric surgery should be abrogated. On the contrary, excellence must be the standard here, because competition among physicians will be most intense in this area. It is critical for the profession to produce all-around foot care physicians."[11]

The report also recommended adoption of a uniform podiatric practice act. It is widely felt that differing State laws confuse not only the public but other practitioners as well. The base of this uniform act would be the scope of practice recommended by the Project 2000 Commission. This calls for an anatomical scope that includes the foot, ankle and soft tissue of the lower leg, distal to the tuberosity (protuberance) of the tibia.

STATE BOARDS OF PODIATRY

Two decades ago, State podiatry boards, like other State licensing boards, were little-noticed entities of State Government. In many cases, because the regulation of podiatry was assigned to the medical boards, it was dominated by medical doctors. Only where independent podiatric licensing boards existed did the profession itself dominate. Most of the boards, whether podiatric or composite, had little operational interaction with other professional boards or even with sister boards in other States. Although their responsibilities typically covered both licensure and discipline, they focused primarily on the former, and in particular on the development and administration of their own licensing examinations. The boards would discipline a podiatrist occasionally, but their authority and readiness to do so were quite limited.

Now the picture has changed somewhat. With the growth in the number of podiatrists, the development of the consumer movement, the widespread use of practice-building techniques (including advertising), the heightened concerns about infectious disease, and the increased attention to the cost and quality of health care, State boards of podiatric medicine function in a more visible environment with a greater degree of accountability to the public. Although the scope and intensity of the changes have not been as great for State medical boards, they nevertheless have been significant.

About 63 percent of State podiatry boards report that they are now part of a centralized State agency, and at least 80 percent have one or more non-podiatrist members on their board of directors.[12] Nearly all the boards (94 percent) have responsibility for both licensure and discipline.[13]

The staff and financial resources available to the boards are not as easily determined. Only three of them report that they have two or more staff members, but in many cases this does not include staff reporting to an umbrella agency that may provide some assistance to a board. Similarly, the budget of a board is often obscured within the budget of a larger agency.

It is clear, however, that in nearly all States the board revenues derive entirely from fees imposed on podiatrists and any other occupational groups covered by the board. These include application, examination, and various other fees. The major source of revenue is the license renewal fee imposed on practicing podiatrists, which in 1987 ranged from $10 to $650 annually; the median was $50. Half the boards with whom we spoke imposed fee increases during the last 2 years or are planning to do so, although one State reported lowering its renewal fee. But, because boards typically are part of the State budget process and subject to the same budgeting and personnel controls as other State agencies, fee increases do not necessarily mean an increase in their resources. Thus, even though the licensure and discipline of podiatrists has grown to become an estimated $2 million-a-year enterprise,[14] many board representatives feel they are seriously underfunded in carrying out their extensive responsibilities.

LICENSURE

Over time, State podiatry boards have come to judge applicants on the basis of four major requirements: (1) graduation from an accredited or approved college of podiatric medicine; (2) passage of the written exam given by the National Board of Podiatric Medical Examiners; (3) passage of a State clinical exam; and (4) in increasing numbers, completion of an approved residency or preceptorship.

Of these four requirements, graduation is the most consistently and formally applied by the States. Almost all have specific written regulations that require an applicant be a graduate of a school approved by the national accrediting body, the Council on Podiatric Medical Education (CPME); if this requirement is not officially spelled out in the statutes or regulations, it is usually the policy of the board nevertheless. Few applicants for podiatric licensure are graduates of foreign schools. Only seven State board representatives reported that they had received inquiries from graduates of foreign schools over the past 3 to 4 years, and of these, only four had received formal applications. Seven States told us that it is possible to be licensed without a degree from a U.S. podiatric medical college, most often because of a lack of specific language in State laws and regulations. Most States said they had never had to deal with such a situation.

The NBPME testing requirement is the second most consistently applied by States, with nearly all specifying that an applicant for licensure must pass the two-part test. Part I, which focuses on the basic biomedical sciences, is usually taken after 2 years of podiatry school; part II, taken during the final year of school, addresses various clinical subjects

According to a Council of State Governments report published in 1986,[15] 20 of the 50 States and the District of Columbia require passage of a practical clinical exam for licensure and 16 require passage of an oral clinical exam. Most States have developed their own, but increasing numbers (eight as of August 1987) are using a clinical exam developed for Virginia by the Local Government Research Corporation of State College, Pennsylvania. It was first used in Virginia in 1982 and is presently under consideration by several States.

Each of the practical exams seeks to assess the clinical readiness of candidates, and in so doing requires them to conduct procedures on patients. Yet the contents of the tests vary as do the determinations of acceptable performance.

The fourth major requirement--completion of an approved residency or preceptorship--is gaining prominence among the States. Ten of the 17 States that reported major legislative or regulatory changes in licensure requirements over the past 3 to 4 years named the instituting of a residency/internship/ preceptorship requirement. While this was the most common licensure change, two other issues were also mentioned: licensure by credentials--the practice of issuing a license to a podiatrist on the basis of a license held in another State--and the adequacy of background information provided on applicants for licensure.

LICENSURE BY CREDENTIALS

The policies of State boards in granting licensure by credentials are extremely restrictive and severely limit the ability of podiatrists to move freely from one State to another. States usually have adopted three approaches to the question of recognizing a license from another State.

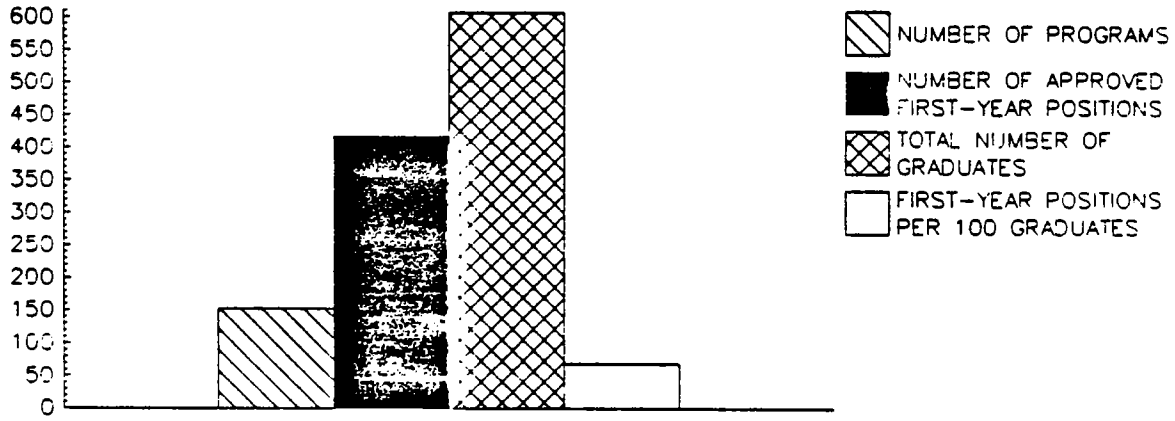
The first of these is simple non-recognition of such a license--the current practice in 10 States. All applicants must meet the same criteria as a new graduate of podiatric medical school seeking licensure for the first time. This usually means they must pass the current licensing exam, which can pose a problem for those who are not recent graduates. Moreover, increasingly they must fulfill a requirement for some kind of post-graduate training.

The second approach is the granting of a license by reciprocity. That is, the State recognizes the licenses of practitioners only from States with which they have formal reciprocal agreements. Currently, 18 States grant licenses in this manner, but only 3 do so without imposing further restrictions. The most common of these restrictions are the stipulations that the practitioner must have taken a clinical practical exam and, increasingly, that they must have completed a residency program in order to have been licensed initially.

The third approach adopted by some States is endorsement or credentialing. This shifts the focus to the individual qualifications of the applicant. Endorsement is a unilateral decision by a State to admit licensed individuals from another State to practice without examination.[16] Although 23 States grant licenses by endorsement, 19 of them impose one or more restrictions on the applicant, in effect limiting the true meaning of endorsement.[17] There is a need to simplify and broaden the whole process. It is believed by some in the licensing community that a national clinical examination is one key to the achievement of universal licensing by endorsement.

FIGURE III

PODIATRIC RESIDENCIES AVAILABLE TO GRADUATES OF COLLEGES OF PODIATRIC MEDICINE, ACADEMIC YEAR 1984-85



Source: Fifth Report to the President and Congress on the Status of Health Personnel in the U.S., March 1986

But owing to an increasing number of States requiring that an applicant complete a residency for licensure (and residencies are limited, as shown in figure III) and that they pass whatever exam the State recognizes, the mobility of podiatrists remains restricted.

ADEQUACY OF BACKGROUND INFORMATION

During the early 1980s, State medical boards were severely shaken by scandals involving fraudulent credentials from two Caribbean medical schools and by breaches of security on some medical licensure examinations. State podiatry boards have not had to face comparable developments. Yet among many of them, particularly those in the larger States and in States where podiatry is handled by the medical board, there seems to be a growing uneasiness about the quality of the background information provided to boards on applicants for licensure, whether these applicants are already licensed in another State or seeking their initial license. The validity of any credentials cited in an application is not seen as a problem, as much as the completeness of the information bearing on an applicant's professional conduct. The following comment from a State board representative illustrates this concern vividly:

> "States sometimes lie when it comes to inquiring about applicants. I think sometimes a State may really want to get rid of a bad practitioner, so they will probably not give the whole picture about the applicant."

Boards usually now require more extensive documentation with an application for licensure. Yet the processing times for applications have increased significantly in only 20 percent of the States. Two States, in fact, report that the processing time has decreased mainly because of administrative improvements. Seventy percent of those States reporting increases cite more in-depth background checks as the cause for the delay. The remaining 30 percent cite an increase in the number of applicants as the reason for the longer processing time.

About 10 percent of the State boards report that in the past 3 to 4 years they have implemented changes that call for more detailed information on application forms and/or more vigorous efforts to verify the credentials of applicants. Other boards are also planning changes of this sort. Most of the changes involve the revision of applications to provide a fuller accounting of the applicants' past and to require disclosure of any disciplinary problems they may have had. To limit opportunities for submitting altered records, a number of States now require that colleges send transcripts and other States send any licensing and disciplinary history directly to the board. A few boards undertake more diligent verification through telephone inquiries, fingerprinting, and even Federal Bureau of Investigation checks.

Overall, however, the scope of these changes is limited and, many board officials suggest, inadequate. The major reason cited by the boards for their failure to take more substantial action is the lack of sufficient resources. Their staffs are simply inadequate to do a job properly. The result, a significant number of boards report, is that the backgrounds of many individuals are checked superficially, if at all, and the boards are compelled to rely too heavily on the assumption that applicants are telling the truth. They add that this situation seems to present a particular vulnerability in the case of applicants who are already licensed in other States.

A second factor that inhibits more effective board action in reviewing applicant backgrounds is the widely perceived inadequacy of the national disciplinary action clearinghouses maintained by the Federation of Podiatric Medical Boards (FPMB) and the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR). Although 60 percent of the boards report that they use one or both of these clearinghouses,[18] the majority of them feel that their usefulness is limited. Primarily, this is due to the fact that neither of them comes close to having a complete listing of all the disciplinary actions taken by the 51 States. Other reasons bear on the insufficient data held by the clearinghouses on podiatrists who have been disciplined and the time involved in sending data to the boards. Several States noted, however, that the regular reports sent to the boards by FPMB are helpful.

Nevertheless, the unease generated by the limitations of clearinghouses is especially significant in States that endorse previously held licenses and thus are more likely to be reviewing applications from podiatrists licensed in other States. But it is felt to a considerable degree in most other States as well. Expressing much frustration over the deficiencies of the current system, one board representative told us, "We need all the help we can get."

DISCIPLINE

Over the years, the authority of State boards to discipline podiatrists has been increasing gradually, with respect to both the grounds upon which they can take disciplinary action and the type of action they can take. During the past 3 to 4 years, about 35 percent of the boards have experienced some legislative or regulatory change concerning their disciplinary authority, three-fourths of it increasing that authority and none of it serving to decrease it. Most often, the changes have involved an expansion of their range of disciplinary actions.

As of 1984, the latest year for which aggregate data are available, all the boards had the power to discipline podiatrists by suspending or revoking their license upon proof of a punishable violation. Other types of disciplinary actions that could be imposed were limited, however: 19 had the authority to assess probations, 17 to issue reprimands, 13 to restrict podiatric practice, 9 to impose censure, and 5 to impose fines of up to $1,000. Two States had the authority to require a course of education or training, and one could require a licensee to perform up to 100 hours of public service.

Since 1984, these numbers have increased, with more States gaining a greater range of disciplinary options. Yet many still lack a full complement of options as well as other basic authorities, such as the power to issue subpoenas or to summarily suspend the license of a podiatrist who poses a clear and present danger to the public.

INCIDENCE AND TYPE OF DISCIPLINARY ACTIONS

How many and what type of disciplinary actions are being taken against podiatrists in the United States? Although this question is basic, it is one we learned could not be answered. The existing information bases were too limited to provide even reasonable estimates.

Accordingly, in our discussions with representatives of the State boards, we asked them to indicate the number and type of disciplinary actions imposed on podiatrists during each of the past 3 calendar years. We received the data from all 48 States with whom we were able to speak. The result is an essentially complete picture of the extent and nature of disciplinary actions taken in 1984, 1985, and 1986. The data provided by the State boards are summarized in figure IV.

During a period when the numbers of podiatrists steadily increased and national concern about the quality of health care grew, it is not surprising that the total number of disciplinary actions taken against podiatrists by State boards also increased, by nearly 100 percent from 1984 to 1986. The figure rose from 84 actions in 1984 to 107 in 1985, an increase of almost 30 percent, and reached 159 actions in 1986, a further increase of about 50 percent.

Over this 3-year period, in stark contrast to dentists and chiropractors (subjects of the first two reports in this inspection), tier 1 actions--the more serious ones involving license revocation, suspension, or probation--regularly accounted for less than half of the disciplinary actions

taken by State boards, and as little as a third (figure V). For dentists and chiropractors such actions composed roughly two-thirds of all disciplinary actions. Tier 2 actions, such as reprimands and fines (designated in figure V as "other") represent no more than 44 percent of total actions in any one year. The tier 2 actions identified by board representatives can be broken down as follows: 81 letters of reprimand, 73 consent agreements (which can include a variety of stipulations agreed to and signed by the licensee), 5 decrees of censure, 2 restraining orders or restrictions on practice, and 63 unspecified "other" actions.

FIGURE IV

NUMBER AND TYPE OF DISCIPLINARY ACTIONS TAKEN BY STATE BOARDS OF PODIATRIC MEDICINE AGAINST PODIATRISTS, 1984–1986

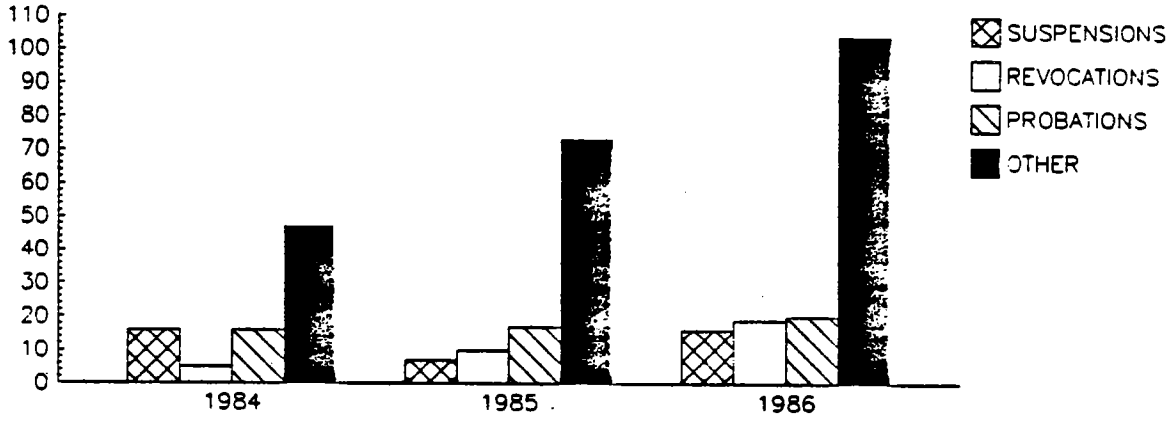
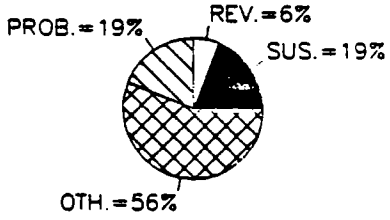
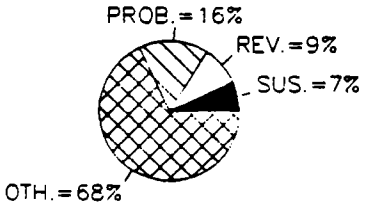


FIGURE V

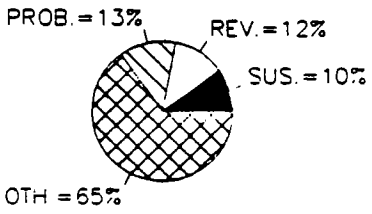
PERCENT DISTRIBUTION OF DISCIPLINARY ACTIONS TAKEN AGAINST PODIATRISTS BY STATE BOARDS, BY TYPE OF ACTION, 1984–1986



1984



1985



1986

Sources: State Boards as Reported to the Office of Inspector General, 1987

When the performance of State boards of podiatry is compared to that of State medical, dental, and chiropractic boards, some notable differences emerge concerning both the incidence and type of disciplinary actions. First, the podiatry boards have been far more active than the other three in disciplining members of the profession. In 1985, for example, podiatry boards disciplined 9.7 podiatrists per 1,000 licensees, dentists 5.4 per 1,000, chiropractors 5.7, and medical doctors 4.2.[20]

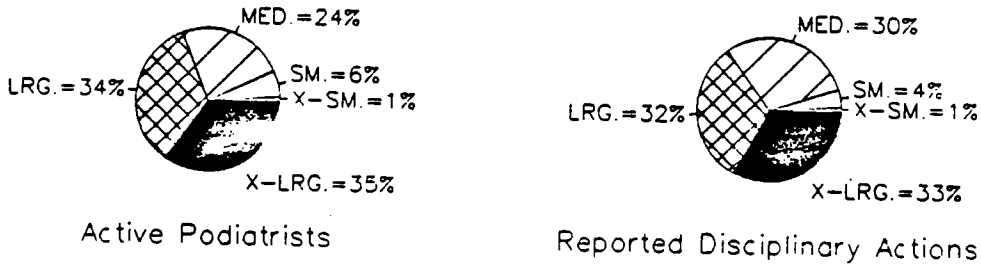
A second noticeable difference among the four types of boards involves contrasting trends in the proportionate emphasis given to the more severe, tier 1 disciplinary actions. Although such actions have been increasing as a share of all disciplinary actions taken by dental boards against dentists, they have essentially remained constant for chiropractors (65 percent average), and they are declining for both medical doctors and podiatrists. For the latter, tier 1 actions composed 44 percent of all actions taken in 1984; by 1986 the figure had dropped to 35 percent after reaching a low of 32 percent the year before. Similarly, for medical doctors, tier 1 actions dropped from 63 percent of total actions in 1982 to 53 percent in 1985.

From 1984 to 1986 there was a steady decrease in probations as a percentage of all actions taken by the State podiatry boards, and the percentage of suspensions dropped by almost 50 percent from 1984 to 1986 after reaching a low of 7 percent of all actions in 1985. Overall, tier 1 actions accounted for only 36 percent, or 126 of the 350 total actions over the 3-year period. It is important to note, however, that from 1984 to 1986 the percentage of revocations--the most serious action possible--imposed on podiatrists by State boards doubled. They rose from 6 percent of total actions in 1984 to 12 percent in 1986.

The variations in disciplinary performance are no less apparent when State podiatry boards are compared among themselves rather than with the other three boards. Over a 3-year period, for instance, two State boards, Arizona and Florida, disciplined podiatrists at a rate that far exceeds that of any other board. In fact, Florida's alone accounted for about 26 percent of all disciplinary actions taken by State podiatry boards in the United States in 1986, and 17 percent in 1984 and 1985.

FIGURE VI

PERCENT DISTRIBUTION OF ACTIVE PODIATRISTS (1987) AND OF REPORTED DISCIPLINARY ACTIONS (1984-1986), BY SIZE RANKING OF STATES



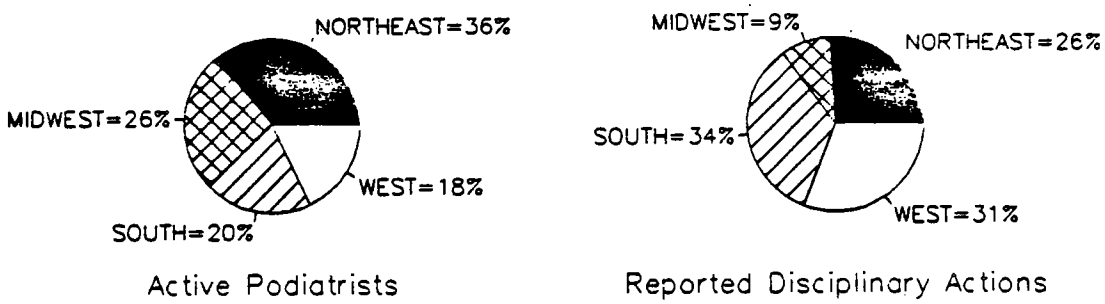
Sources: Fifth Report to the President and Congress on the Status of Health Personnel in the U.S. and State Boards as Reported to OIG

Slight variations among the boards are also apparent when their rate of disciplinary activity is correlated with the variable of size of podiatrist population in a State. Since year-to-year fluctuations in this regard may be misleading, we have aggregated and analyzed the data over the 3-year period from 1984 to 1986 (see figure VI above).

Out of this comparative examination, it can be seen that the most significant variation existed in States classified as medium-sized. While those States had 24 percent of active podiatrists, they were responsible for 30 percent of all disciplinary actions from 1984 to 1986. Three of the other four categories--small, large, and extra large--produced only slightly fewer actions in relation to the number of podiatrists in those areas. When compared with respect to regional divisions, however, the results are quite different (figure VII).

FIGURE VII

PERCENT DISTRIBUTION OF ACTIVE PODIATRISTS (1987) AND OF REPORTED DISCIPLINARY ACTIONS (1984–1986), BY CENSUS REGION



Sources: Fifth Report to the President and Congress on the Status of Health Personnel and State Boards of Podiatry as reported to OIG

The rate of disciplinary action was highest in the South and lowest in the Midwest. Although the Southern States had about 20 percent of the active podiatrists licensed in the United States, they were responsible for 34 percent of the reported disciplinary actions. Likewise, for the Midwestern States, the figures were 26 percent and 9 percent.

Why was the rate of disciplinary action higher in some States than in others? Was it because practicing podiatrists in some States were more incompetent, dishonest, or unprofessional than in others? Or because levels of board commitment to take action varied? Or because boards were constrained by inadequate authority or insufficient resources? Each of these factors may be explanatory to some extent, but, in the case of one--insufficient resources--we have some data to suggest an association.

We found that of the 10 State boards with annual renewal fees of $25 or less in 1987, 5 had no actions at all and another fell well below the median rate of disciplinary actions of the State boards.[21] Additionally, if the comparison is extended to States with renewal fees of $50 or less, we find 11 States with no actions and 5 more below the median rate; 3 of the 5 had less than half the median rate for disciplinary actions. At the other end, the association, although not as strong, was nevertheless significant. Of the 18 States with annual renewal fees of $75 or more, 7 had a 3-year rate below the median, with 3 that took no disciplinary actions at all; and of the 11 States that fell above the median rate of disciplinary actions, 3 were within one percentage point of it. And so we found that although a comparatively high renewal fee is no guarantee in itself of a higher level of disciplinary activity, it seems to have helped increase the activity of podiatry boards in a number of States.

Finally, it is important to recognize that State boards are not the only forum for disciplining podiatrists. Another, as noted in appendix I, is the Office of Inspector General (OIG), which can impose sanctions on professionals who have committed fraud or abuse. During the past 5 years, OIG sanctions against podiatrists have averaged about 3 percent of all the OIG sanctions imposed, ranging from 1 percent in FY 1985 to 5.4 percent in FY 1982.

TYPE OF VIOLATION

Unlike our previous studies of medical doctors and of dentists and chiropractors, this study found there is no one type of violation that stood out among the bases for disciplinary actions taken by State podiatry boards. Of the 33 States that reported having taken at least one disciplinary action from 1984 to 1986, relatively equal numbers said that clinical misjudgment, unprofessional conduct, self-abuse of alcohol or drugs, inappropriate prescription writing, and violations of advertising laws were their primary causes for disciplining podiatrists. Six of the 33 States said they could not identify any primary cause for discipline because they took too few actions. One large State did report that for the period from 1984 to 1986, "The majority of our disciplinary actions (total 80 actions) have been for poor clinical performance or inadequate clinical judgment." Of these 80 disciplinary actions, 69 were only the less severe tier 2 actions, and of the 11 tier 1 actions, 4 were revocations, and the other 7 were probations.

Only one-third of the States said that they had disciplined at least one podiatrist because of poor clinical performance over the past 3 to 4 years. Of the two-thirds that had not, the reasons most often given were much the same as those cited by medical doctors in our earlier study: (1) the complexity, length, and cost of such cases, (2) the substantial burden of proof required, and (3) the considerable variation in what constitutes acceptable practice. A significant number of board officials expressed the belief that one reason that helps account for the small number of actions based on poor clinical performance is that the old boy network within the State podiatric societies "takes care of their own" before a State board ever hears of the problem. Indeed, some board officials said they prefer it this way because it lessens the burden on their shoulders. Given their limited staffs and resources, the boards felt that it does not hurt the profession if such issues are left up to the State societies to resolve. If the societies fail, then the board will hear about it and disciplinary proceedings can take place.

Some of the States to whom we spoke also identified continuing education efforts as a factor in keeping cases of poor clinical performance to a minimum. According to a Council of State Governments report,[22] 33 States in 1986 required some continuing education for license renewal, with an average requirement of 19.4 hours annually.

Thus far, the most visible and consequential of the early intervention efforts intended to correct problems before they lead to violations are the rehabilitation programs directed to impaired podiatrists. In our review, two-thirds of the boards indicated that such programs were available. They were most often administered by the State medical societies, but podiatrists had access to them. In a small number of States, the programs were available under the auspices of the board itself. In a few other States, Massachusetts, for instance, the programs were run by a peer review committee within the State podiatric medical society.

SOURCE OF DISCIPLINARY ACTIONS

Complaints from consumers were the major source of disciplinary actions against podiatrists in almost two-thirds of the States. This pattern held regardless of a State's size or region. In contrast, few disciplinary actions appear to have been based on referrals from State podiatry societies. No State cited the societies as the most common source of complaints, and only two cited them as even the second most common source. Again, the opinion that State societies "take care of their own" unless there is a serious problem was widely expressed by the board representatives with whom we spoke.

Individual practicing podiatrists have been among the least frequent sources of referral. Recently, though, their tendency to refer cases of possible violations to the State boards seems to be on the rise. Two factors are seen as providing the impetus for this increase: mandatory reporting laws, which exist in a number of States, and the increasingly competitive environment characterizing the practice of podiatric medicine. A third factor may well become more prominent in the near future. The language in the Health Care Quality Improvement Act of 1986 that extends immunity to practitioners who make referrals for good cause may increase the number of direct referrals by podiatrists.

More than half of the States have laws or regulations calling for other agencies to report cases involving possible violations to the podiatry boards. Most often these laws require hospitals and insurance companies to report malpractice cases, but some States have extended these laws to require practitioners as well as State podiatry associations to report possible violations to the board. Even when these types of provisions exist, however, many cases still go unreported. As one board official put it, "We'll never be able to catch all the ones that fall through the cracks. It's impossible."

THE ADMINISTRATIVE PROCESS

Over the past 3 to 4 years there seem to have been measurable improvements in the backlog of cases awaiting investigation. Although five States cited an increase in their backlogs during

this period (most often attributable to a lack of staff), more States said there has been a decrease and several others stated they have no backlog of cases that need to be investigated.

Board representatives from 19 States reported they had made changes in the recent past with the intent of expediting their boards' investigatory and review activities. More than half of these involved increases in investigative staffing, appointment of a hearing officer to help with complaints, and creation of new investigative offices. In one State, where there is no backlog and there have been no recent changes, a board official told us, "We don't need to make any changes. There hasn't been anything to expedite."

Another comment--"It takes almost an act of God to get a restraining order to protect consumers from bad practitioners"--came from a board official in one of the States with the largest number of practicing podiatrists. It typified the frustration expressed by many officials with whom we spoke. In about half the States, board representatives told us that there are weaknesses in the disciplinary process and that there are constraints that hinder improvements in it. The most often cited weaknesses were underfunding and lack of appropriate staff to adequately address discipline matters.

Much of the frustration expressed also resides in the delays associated with due process protections. A representative in one State noted that such delays were largely responsible for the fact that it takes a little over two and a half years to process a case, with the podiatrist typically continuing to practice during that time. But a board official in another State viewed the situation from a broader perspective, commenting as follows:

> "Some might see weaknesses, but I view the discipline process as one that is fully endowed with protections for the licensee; this sometimes slows things down, but it is palatable to other authorities such as the courts, attorneys, civil libertarians, etc."

INFORMATION SHARING

Over 85 percent (41) of the States regularly send notice of disciplinary actions to a national clearinghouse. Thirty indicated that they send the information to the clearinghouse operated by the Federation of Podiatric Medical Boards (FPMB) only; 9 send notice of actions to the Clearinghouse on Licensure, Enforcement and Regulation (CLEAR); and 4 States send notice to both FPMB and CLEAR. In addition, a small number of States that have composite boards also send notice of actions to the Federation of State Medical Boards. The comments we heard in our review indicate that confidence in the FPMB and CLEAR clearinghouses is lacking, mainly because of the incompleteness of their data bases. Most States, although they send notice of actions to the clearinghouses, prefer to rely on communication among themselves to obtain accurate and timely information.

Many factors severely limit the effectiveness of the two clearinghouses. State boards typically do not report on licensure denials or on informal actions. Many do not report in a timely manner, sometimes waiting for months before sending the data to a clearinghouse. When they do

report, the data provided on disciplined podiatrists are limited, often not including the name of their podiatric college, their social security number, or even their date of birth. And, while their reports do specify the type of disciplinary action taken, they reflect widespread inconsistencies in how the underlying violations are described and, indeed, on the type of disciplinary action imposed for a particular type of violation. Within their individual States, only 11 boards told us they have a clearly defined set of guidelines for determining the appropriate level of disciplinary action.

The executive director of a State podiatry board commented as follows about the new national disciplinary action data bank to be established under P.L. 99-660, the Health Care Quality Improvement Act of 1986:

- "This clearinghouse must be the best kept secret anywhere. We are sitting on the edge of our chairs waiting to see what the regulations will require us to do. And the clearinghouse will be of limited use if past actions are not included in the data bank."

Many other board officials in other States voiced similar concerns.

During our discussions, held in the Fall of 1987, many State board officials were unaware that podiatrists would be included in this data bank as a result of P.L. 100-93, the Medicare and Medicaid Patient and Program's Protection Act of 1987. When told that the reporting requirements would apply to podiatrists, most were generally enthusiastic.

Among the specifically noted concerns raised about the prospective national clearinghouse, those expressing the need for a common language for violations and disciplinary actions were prominent. Among the other questions raised were the following:

- How accurate will the data be? What steps will be taken to ensure its accuracy?

- Will the confidentiality of the data be maintained? Might State laws assuring confidentiality be compromised?

- How quickly will the data be accessible? What will be done to ensure that the system does not bog down because of administrative overload?

- How extensive will the reporting demands placed on State podiatry boards be? Will all the boards be able to meet these demands? Will there be any Federal financial help?

- Will the national data banks produce aggregate data summaries that will facilitate an understanding of trends and help shape risk management efforts?

- Will podiatry be associated with medicine in a way that might be to the disadvantage of the profession? Will the uniqueness of its practice setting be recognized?

Finally, it is important to recognize that the information sharing that occurs within a State is also of significance. In this sphere, podiatry boards are becoming somewhat more open, sometimes because of legislative mandate, in disseminating information within the State on disciplinary actions taken against podiatrists. The vehicle for this dissemination is most often a newsletter sent to the State podiatry society, State Medicaid Fraud Control Units, State insurance agencies, and other State or local entities. In only a relatively few States is an active effort made to share the information with the general public through general circulation newspapers or other popular media outlets.

RECOMMENDATIONS

Given the situation described in the previous pages, our central recommendation is the following:

- State governments should ensure that State podiatry boards have sufficient resources to carry out their responsibilities effectively.

In most States, this is not now the case. In both the licensure and discipline realms, resource limitations (mainly staff limitations) are undermining the capacity of the boards to do their jobs. With the forthcoming implementation of the national data bank and the additional responsibilities it will place on the State boards, the strains generated by the current resource shortfall are likely to become even greater.

Since most of the revenue of the State boards derives from renewal fees charged to practicing podiatrists, they are probably the best source for generating additional revenue. As noted earlier, the median annual renewal fee in 1987 was only $40.

In addition to our central recommendation concerning resources, we have a number of more specific ones directed to the State podiatry boards, the Federation of Podiatric Medical Boards, the American Podiatric Medical Association, and the U.S. Public Health Service.

State Podiatry Boards

In many States, the boards must have a fuller range of disciplinary options available to them and a greater degree of enforcement authority; it is particularly important that they be able to issue subpoenas and be able to suspend immediately the license of a podiatrist who poses a clear and present danger to the public. But even more important is that they carry out existing enforcement authorities more rigorously. This means that they must not only react swiftly and effectively to complaints and referrals but also assume a more active investigatory role of their own.

Such a strengthening is important primarily because it will help boards protect the public from those few podiatrists who perform in an unprofessional, incompetent, or fraudulent manner. Not to be overlooked, however, is that it will also support the case for licensure by credentials. If State boards have more confidence in one another's enforcement and discipline efforts, they will have all the more reason to enact policies that allow for licensure by credentials.

- State podiatry boards should join together to establish and use a high-quality national clinical licensure examination.

Among State podiatry board officials, this is a very sensitive topic because it involves States rights and prerogatives. Yet, from a 51-State perspective, the current situation--with the presence of several separate State clinical examinations, a small number of States using one

exam--and some States without any clinical examination at all--has become increasingly counter-productive. It restricts mobility of practicing podiatrists. It suggests that the professional community cannot agree on the minimum level of knowledge and skills necessary to practice podiatry. It results in a duplication of resources devoted to testing. And it diverts State board attention and resources that might otherwise be devoted to enforcement and discipline activities. Other professional boards have successfully established a national clinical licensure examination; it would appear to be constructive for State podiatry boards to do the same.

- State podiatric licensing boards should shore-up their credentials verification procedures.

A number of boards have already moved in this direction. But, as many State board officials indicate, more must be done in terms of the extent and type of (1) information requested of licensure applicants and (2) verification undertaken by board officials. Without such additional safeguards, many boards will remain too vulnerable to irregularities that could result in some undeserving individuals receiving a podiatry license and in an undermining of public confidence in the entire licensure process.

Federation of Podiatric Medical Boards

For more than a half-century, the Federation of Podiatric Medical Boards (FPMB) has provided a forum for State podiatry board officials to address common concerns and chart directions that are in their mutual interest. In the last 2 years, these officials have used the FPMB to help develop a national clearinghouse of disciplinary actions and to work on many other projects that have benefited podiatric medicine. It is important, we feel, for the FPMB to supplement these actions by taking initiatives that will help individual State boards move in the directions recommended above. Given that the FPMB recently received a grant from the U.S. Public Health Service to more fully develop its clearinghouse on disciplinary actions and that many State boards must clearly improve their enforcement and disciplinary efforts, we feel it is particularly important for FPMB to exert leadership that will encourage and support such efforts. Our specific recommendations follow:

- The FPMB, in consultation with the American Podiatric Medical Association, should develop guidelines for State podiatry practice acts.

As noted earlier the Project 2000 Commission formed by the APMA called for the establishment of a uniform podiatric practice act. Such an act or set of guidelines could promote greater State-to-State uniformity not only in the definition of podiatric practice but also in the grounds upon which disciplinary action might be taken and the procedures for enforcement. In this regard, it could serve as a useful reference point for State reforms, much as *A Guide to the Essentials of a Modern Medical Practice Act*, issued by the Federation of State Medical Boards, does for State medical boards.

- The FPMB should accumulate and disseminate, on a regular basis, changes in State practice acts and regulations.

Information dissemination of this kind would be extremely useful to the State boards. It would enable them to stay more fully abreast of developments in other States and to assess what if any significance such developments have for their own States. It would serve as a valuable, more comprehensive supplement to the interaction that now occurs by word of mouth.

- The FPMB should identify and disseminate to State boards the most effective techniques of credential verification.

Because this is not now a crisis area, it is an easy one to overlook. Yet it does involve a potential danger that should be addressed. The FPMB can help individual boards in this regard by identifying and distributing information about some of the best practices undertaken by member boards.

The American Podiatric Medical Association

- The American Podiatric Medical Association (APMA) should encourage more extensive and effective interaction between its State societies and State podiatry boards.

Such action is important because most State societies make few referrals to State podiatry boards and because the societies' own peer review efforts are often quite limited. There is a need to strengthen the peer review system, to identify practice that is substandard, and to take steps to help these practitioners improve their technical skills or behavior.

The Public Health Service

- The Public Health Service (PHS) should assist the FPMB to extend and improve its technical assistance and information dissemination activities.

The PHS has long provided such assistance to professional bodies, and its recent grant to the Federation is a very important and positive step in providing much needed assistance to the national body that is most closely associated with the individual State licensing boards. Now is an opportune time to extend whatever support is possible to FPMB to help it play an even more effective leadership role vis à vis its member boards. This is particularly important with respect to the enforcement and discipline areas, where the need for such leadership is compelling.

APPENDIX I

NOTES

1. U.S. Department of Health and Human Services, Public Health Service, *Fifth Report to the President and Congress on the Status of Health Personnel in the United States*, March 1986, p. 71.

2. Here, and elsewhere in the report, unless otherwise noted, the data are derived from our survey of 48 of the 50 States. See appendix III.

3. Data obtained by phone from the Health Care Financing Administration.

4. *Fifth Report to the President*, p. 7-8.

5. Data from the American Podiatric Medical Association as presented in the *Fifth Report to the President*, p. 18.

6. ELM Services, Inc., for the American Podiatric Medical Association, *Economics of Foot Care*, p. 18.

7. *Fifth Report to the President*, p. 7-5.

8. Data from the Council on Podiatric Medical Education as presented in the *Fifth Report to the President*, p. 7-8.

9. Data from the American Association of Colleges of Podiatric Medicine.

10. *Fifth Report to the President*, p. 7-3.

11. Prepared remarkes before the House of Delegates of the American Podiatric Medical Association, 1986.

12. The Council of State Governments, State Credentialing of the Health Occupations and Professions, pp. 174-196.

13. Ibid.

14. We developed the $2 million estimate as follows. For each State we multiplied the total number of licensed podiatrists in 1987 by the renewal fee for that year. That resulted in a total of 1.35 million. We then assumed that renewal fees accounted for two-thirds of overall fee income from podiatrists, and, accordingly, added one-third to the above needed total. This resulted in a new total of $2 million.

15. State Credentialing of the Health Occupations and Professions, pp. 174-196.

16. Benjamin Shimberg, *Occupational Licensing: A Public Perspective*, 1982, p. 66.

17. Data are a combinations of information obtained in our survey of State licensing boards and data contained in the CSG report, *State Credentialing of the Health Occupations and Professions*, pp. 174-196.

18. Of the 29 boards that indicated they regularly check with a clearinghouse when a person applies for licensure, 18 said they use FPMB only, 7 use CLEAR only, and 4 noted that they use both.

19. The national data bank now being established under title IV of the Health Care Quality Improvement Act of 1986 will provide a basis for answering this question in the years ahead.

20. See our previous inspection reports, *Medical Licensure and Discipline: An Overview, State Licensure and Discipline of Dentists*, and *State Licensure and Discipline of Chiropractors*, for more detailed information.

21. Using 1985 as the standard, we found that the median rate at which podiatrists were disciplined by State boards was 13.36 per 1,000 licensees.

22. *State Credentialing of the Health Occupations and Professions*, pp. 174-196.

APPENDIX II

BACKGROUND

The licensure and discipline of health care professionals is a traditional function of State Government. It dates back to the pioneering efforts of the American colonies in the 1600's. But it did not gain permanence until the late 1800's, when Texas passed the first modern medical practice act (1873) and the U.S. Supreme Court upheld West Virginia's act as a valid exercise of State police powers (1889).

In recognition of this traditional State role, Congress, when it established the Medicare and Medicaid programs in 1965, left it to the States to determine whether physicians and other health care professionals were legally authorized to participate in these programs. Subsequently, Congress has empowered HHS and its predecessor (HEW) to impose sanctions on those professionals (and other provider groups) who have abused or defrauded these programs. However, the Federal Government has continued to depend on the States to serve as the disciplining agent for transgressions that do not directly relate to the Medicare or Medicaid programs.

Thus, States have been providing an important front line of protection for beneficiaries of these two federally funded programs. This protection has been at no cost to the Federal Government and at only minimal cost to State Government. Nearly all the costs have been covered by licensure fees imposed on the health care professionals.

As Medicare and Medicaid expenditures have grown to a point where they now account for more than one-fourth of U.S. health care expenditures, Federal interest in the effectiveness of State licensure and discipline practices has increased. For the most part, this heightening interest has focused on those practices concerning medical doctors. In essence this is because they are the most prominent of the health care professionals and because they account for a larger share of Medicare and Medicaid expenditures than any of the other groups. More specifically, serious concerns about the adequacy of State medical licensure and discipline practices were raised by General Accounting Office reports, media investigations, and scandals involving fraudulent medical credentials from two Caribbean medical schools.

Accordingly, in 1985 and 1986, the Office of Inspector General (OIG) conducted an inspection examining the activities of State medical boards. Based primarily on visits to 14 State boards and telephone discussions with the executive directors of another 10, the inspections sought to provide an overview of the major developments and issues facing the boards. The final report, issued in June 1986, received widespread publicity and helped generate reforms to improve the effectiveness of State medical boards, particularly with respect to their disciplinary practices.

Given the positive response and effects of that inspection, the OIG decided that a similar one directed to other health care professionals eligible for Medicare or Medicaid reimbursement

would also be warranted. For these other professionals no less than for medical doctors, State licensure and discipline boards offer a vital front line of protection for the beneficiary.

We chose dentists, podiatrists, chiropractors, and optometrists as a focus because, like medical doctors, they are direct care professionals who have diagnosing and prescribing responsibilities, who can receive direct Medicare reimbursement, and who, overall, represent a major presence on the health care scene. Dentists, podiatrists, chiropractors, and optometrists, together with doctors of medicine and osteopathy are the six groups of health care professionals defined as "physicians" under Medicare law.

Recognizing the value of obtaining a better national picture of the licensure activities of these and other health care professions, HHS (through the Public Health Service) awarded a 3-year contract in July 1984 to the Council of State Governments (CSG) and the National Clearinghouse on Licensure Enforcement and Regulation (CLEAR) to develop a composite State-by-State information system on the credentialing of health professions. The project generates informational reports on the various professions, drawing primarily on State practice acts and State board regulations. The reports present data in separate tables that address such matters as the organizational pattern of the State boards, the administrative and enforcement functions of the boards, the types of examinations required, and the fees imposed. Overall, the descriptive information provided focuses more on licensing than on disciplinary activity. The CSG and CLEAR have published reports on each of the four groups to be addressed in this inspection--chiropractors (1986), podiatrists (1986), dentists (1987), and optometrists (1987).

The CLEAR, which is composed of State officials involved with occupational licensing and regulation issues, also runs the National Disciplinary Information System (NDIS). This is an interstate service that provides participating State agencies with bimonthly reports on disciplinary actions taken against licensed professionals in a number of professional disciplines. Dentists, podiatrists, chiropractors, and optometrists are among the occupation groups included in the system. The disciplinary actions taken against these and other groups are sent to NDIS on a voluntary basis and at this point involve only 32 States. The Federation of State Medical Boards operates a similar but more detailed and complete system that focuses on disciplinary actions taken against medical doctors.

Two recent congressional actions provide an important stimulus toward the further sharing of data on disciplinary actions. First of all, the Health Care Quality Improvement Act, (P.L. 99-660), passed in 1986, calls for the establishment of a national data bank to be run by the HHS Secretary (or a designee thereof). It stipulates that entities making malpractice payments associated with the work of physicians and other licensed health care professionals must report pertinent information concerning those payments to the data bank. Similarly, it mandates the reporting of disciplinary and peer review actions taken against medical doctors, osteopaths, and dentists. The information maintained in the data bank is to be available, upon request, to State licensure and discipline boards, health care entities, attorneys who filed a malpractice complaint with a court against a specific practitioner, and individuals interested in records on themselves.

The second pertinent congressional action (P.L. 100-93) is the Medicare and Medicaid Patient and Program Protection Act. Passed in 1987, this legislation includes a provision that would extend the national reporting responsibility of State licensure and discipline boards to encompass disciplinary actions taken against podiatrists, chiropractors, optometrists, and other licensed health care practitioners.

Thus, on the basis of the authority provided by these two acts, State boards will be able to draw upon a national data bank to determine if any disciplinary actions have been taken against an applicant for licensure. It is expected that this data bank will be operating in 1988.

Finally, with respect to podiatrists, on whom this report focuses, it is important to add that since 1985, the Federation of Podiatric Medical Boards (FPMB) has operated a national clearinghouse on disciplinary actions taken by State podiatry boards. Forty State boards are members of the clearinghouse, but with widespread anticipation of the establishment of the national data bank, participation in the FPMB clearinghouse has dropped in 1987. The information in the FPMB clearinghouse is available to members upon written request and over the telephone. Those States that issue licenses on the basis of credentials have tended to be the most active users.

APPENDIX III

METHODOLOGICAL NOTES

We held discussions with representatives from 48 State boards. (We were unable to speak with a representative from DC, WY, or ND.) Usually we talked with the executive director of the board or with a chairman or other member of the board. Our aim was to obtain information and discuss issues with a board representative who was well informed about board activiities both at present and over the past 3 to 4 years.

The major area in which we sought quantitative information from these officials concerned the disciplinary actions taken by the boards against podiatrists in 1984, 1985, and 1986. Here, we asked for the number of formal actions taken and a breakdown of the types of actions--designated as revocation, suspension, probation, or other.

All 48 of the boards with whom we spoke were able to provide us with the numbers of disciplinary actions taken in each of the 3 years. We cannot confirm that the information is all-inclusive or completely accurate. However, we did stress that we sought all board disciplinary actions against podiatrists and often checked back when we suspected there might be errors. The board officials, typically, were quite responsive in checking their records and providing the data in a timely fashion.

In analyzing the differential performance of the States in disciplining podiatrists, we decided to aggregate the disciplinary data over the 3-year period. We felt that comparisons over only a 1- or 2-year period would be of questionable value because of the distortions that might be associated with year-to-year fluctuations.

In this context, we treated performance as a dependent variable and considered two major independent variables: size and region. With respect to size, first of all, we identified the number of active podiatrists in each State and, then, using variance analysis, identified five clusters of States differentiated on the basis of the number of active podiatrists. The clusters and associated States are as follows:

(1) extra small (AK, HI, ID, MS, MT, SD, and VT);
(2) small (AL, AR, DE, KY, ME, NE, NH, NM, NV, OK, RI, SC, UT, and WV);
(3) medium (AZ, CO, CT, GA, IA, IN, KS, LA, MA, MD, MN, MO, NC, OR, TN, VA, WA, and WI);
(4) large (FL, IL, MI, NJ, OH, and TX); and extra large (CA, NY, and PA).

With respect to region, we used U.S. Bureau of the Census categorizations to identify four regions of the country. The categorizations and associated States are as follows:

(1) Northeast (CT, ME, MA, NJ, NH, NY, PA, RI, and VT);

(2) South (AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, and WV);
(3) Midwest (IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD, and WI); and
(4) West (AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, and WY).

APPENDIX IV

COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE

Within the Department of Health and Human Services, we received comments on the draft report from the Public Health Service and the Health Care Financing Administration. In addition, we received comments from a number of organizations outside the department: the Federation of Podiatric Medical Boards (FPMB), the American Podiatric Medical Association (APMA), the American Association of Colleges of Podiatric Medicine (AACPM), and the National Commission for Health Certifying Agencies (NCHCA). Their comments are contained below, in their entirety. The OIG response to all comments follows.

FPMB COMMENTS

A few comments on the recommendations of the report are in order; comments on disciplinary data reporting follow.

Recommendations:

Page iv, National Clinical Licensure Examination

The Federation, the National Board of Podiatric Medical Examiners, and LGR Examinations (State College, Pennsylvania) have formed a consortium to respond to a request for proposals issued by the State of Virginia relating to their licensing examination. Already, 15 States have contracted to deploy the "Virginia Examination." If the podiatry/LGR consortium wins the competition, States will have a direct role in the further development of a licensing examination which is already a proven success.

Approximately 60% of the 1988 graduating class took the "Virginia Examination" during the last administration cycle. The podiatry/LGR consortium will be able to promote the examination further.

Page iv, Guidelines for State Practice Acts

At the Federation Board of Directors' meeting in August, the Board approved a motion to establish a subcommittee of the board to develop a model for State podiatric medical practice legislation. The committee has begun its work; it will reference the recommendations of the APMA "Project 2000" report as they pertain to the definition of practice and appropriate education. It will draw from the recommendations of existing State law models for other professions (i.e., medicine, etc.). We expect to present recommendations to our membership in August, 1989, at our Annual Meeting in Boston, on the 18th and 19th.

Information on Changes in State Practice Acts

FPMB already has a library of State laws and regulations relating to podiatric medical practice, and we have an index for the compilation. We communicate regularly with State podiatric medical associations through our newsletter, *Federation News*.

APMA/State Association Interaction with FPMB

At the August, 1988 meeting of the American Podiatric Medical Association House of Delegates, a resolution was adopted (1) designating the Federation as the central disciplinary repository for State licensing board actions, and (2) encouraging APMA and its affiliates to support the Federation's efforts in data collection and handling.

Report Findings - Page 9 - Last Paragraph

Since mid-1987, the Federation has made dramatic improvements in its data collection and reporting system. A new report form, engineered in mid-1988, enables States to summarize their reports while they meet all of the content requirements set by law through PL 99-660 and PL 100-93 in regard to data reporting.

In January, 1988, State boards received copies of the "1987 FPMB Year-end Report," with an accompanying alphabetical index. The names of twenty-three persons whose licenses were subjected to revocation, suspension, probation, (or other miscellaneous action) were listed; the alphabetical index listed the names and dates of all of the more than two hundred actions reported to FPMB since 1982.

The report generated so much comment that those boards that had not already sent in reporting sheets and copies of findings of fact and written orders, did so in February and March. Consequently, a revised report was issued in April, 1988; that report listed 48 separate license actions.

The Federation of State Medical Boards reported 2,302 disciplinary actions in 1986 (FSMB "Federation Bulletin", February, 1988, p. 46). The 48 actions reported by FPMB amount to just less than one-half of one percent of the total number of podiatrists nationwide (approximately 11,000); the 2,302 actions reported by FSMB also amount to just less than one half of one percent of the total number of MD's and DO's nationwide (approximately 500,000).

Since January, 1988, 25 case actions have been reported to the FPMB data bank. We are operating under a rule of thumb wherein if the number of new cases reported exceed twenty we will produce a report and circulate it to the State boards. We will produce another year end report in January, 1989; we will include alphabetical and date indices for all names reported to the FPMB data bank at the same time. With the active fall months to come, we expect more than forty case actions will appear on the 1988 year end report.

The FPMB disciplinary reports are issued to the State government staff assigned to the eleven combined medical/podiatric licensing boards, and to the staff of the 41 free standing boards as well. Copies are also provided to the presidents/chairs of these boards, the vice-chairs, the member (podiatrist) secretaries, State legal staff, and the podiatrist members seated on the boards of medicine in eight of the eleven States mentioned above. We are just now exploring the conditions and terms for sharing this information with third party carriers, and with the OIG as well. By the time you receive this, we will have initiated communication with Mr. James Patton in that regard. This information is ready now even as we prepare our State boards for full participation in the Federal data bank programs mandated by PL 99-660 and 100-63.

On page 18 of your report, you mention that only eleven States are using a clearly defined set of "guidelines for determining the appropriate level of disciplinary action." Presumably, that figure relates to the eleven combined medical/podiatric boards, which are already familiar with the "Guidebook on Medical Discipline" developed by the Federation of State Medical Boards.

This May, FPMB was awarded a purchase order to develop and implement (1) a nationwide standard disciplinary action classification system, (2) guidelines for determining State licensing board disciplinary actions, and (3) a program to educate the boards in the use of the classification and guidelines. The first meeting of the FPMB Committee on Classification and Disciplinary Guidelines took place in Washington, DC, September 9 and 10, and the project is well under way. A draft classification and guidelines will be available to State boards by the end of 1988, and final version guidelines will be available in mid-1989.

You and your staff are to be commended for the excellent draft report. The document will have far-reaching impact on the profession and the public we all serve. It will promote meaningful quality assurance in a most constructive way.

APMA COMMENTS

With regard to your letter of July 22, when you transmitted to the Association a draft copy of the report, "State Licensure and Discipline of Podiatrists," I take this means to applaud that effort. Our compliments go to Dr. Mark Yessian, who directed a thorough and constructive report.

For your added information and files, I am enclosing a copy of APMA's *Peer Review Guidelines and Procedures Manual.* We hope you will find this helpful in understanding the function we perform in this critically important area.

You should also be aware that APMA has been working closely and will continue to do so with the Federation of Podiatric Medical Boards as it seeks to extend and improve its technical assistance and information dissemination activities. We have extended both time and resou-

rces in support of the Federation to assure that it may play an effective role in helping to launch the national data bank established by Public Law 99-660.

We look forward to receiving your final report.

AACPM COMMENTS

I requested the Deans of the Colleges of Podiatric Medicine to review and comment on the draft copy of the "State Licensure and Discipline of Podiatrists."

The Deans think it is a useful document which comprehensively examines a very sensitive subject. However, they have some concerns. They are the

(1) potential misuse of aggregate disciplinary data on podiatrists by other professions, although there is support for the development of a data base.

This issue could be resolved during the design phase of the clearinghouse.

(2) constraints which are imposed upon podiatric physicians in moving from State to State, particularly as they relate to assuring adequate care to podiatric patients in states where demand for foot care has increased.

The seriousness of these constraints must be more fully explored before completing the final report.

(3) absence of sufficient resources to enable State licensure boards to effectively perform even their basic legal responsibilities as a licensing authority.

The Department of Health and Human Services, in collaboration with the State licensure boards, must identify sources of revenues to enable these boards to exercise this authority.

Podiatric Medicine is seriously exploring the introduction of a Part III Clinical Examination under the auspices of the National Board of Podiatric Medical Examiners that will be available nationally for all podiatric physicians.

This Association is pleased to note that the podiatric licensing boards have been in the forefront in adhering to a code that insures quality health care to all U.S. populations. For this reason, the Association believes that every effort should be made to continue this exemplary service to the nation's public.

Thank you for the opportunity to review and comment on the report.

NCHCA COMMENTS

Thank you for providing the National Commission for Health Certifying Agencies (NCHCA) with an opportunity to comment on the draft report entitled "State Licensure and Discipline of Podiatrists." This draft report was well prepared and provides a good summary of critical licensing issues affecting podiatrists.

The National Commission for Health Certifying Agencies is in agreement with the recommendations made to improve the licensing of podiatrists. We are particularly concerned with the finding that State podiatry boards have insufficient resources to carry out their responsibilities effectively. The increasing costs and personnel demands involved in operating effective licensing programs are becoming a problem in many professions and consumers may ultimately suffer from this trend. It is particularly unfortunate since the public expects that State licensure efforts will "weed out incompetent practitioners" and conduct thorough and comprehensive disciplinary actions when appropriate. Unfortunately, this expectation appears to be the exception rather than the norm in many areas of professional licensing.

The National Commission for Health Certifying Agencies supports efforts to improve public awareness of the appropriate means of dealing with incompetence in licensed professionals. Perhaps licensure fees could be increased to support increased public information programs about licensure and additional funds could also be used to improve the verification process and provide increased support for podiatry boards.

We also strongly support the concept of State podiatry boards joining together to establish and use a high quality, national clinical licensure examination.

Our certification programs use national certification examinations and this eliminates the problem of practitioners having to deal with different requirements from one part of the country to another. We appreciate the opportunity to comment on this draft report and we would like to receive a copy of the final report.

PHS COMMENTS

Licensure of Podiatrists

We agree that the National Practitioner Data Bank established under Public Law 99-660 and amended by Public Law 100-93, when implemented, will be useful to State boards in learning of adverse action experiences of podiatrists seeking licensure by credentials.

Federation of Podiatric Medical Boards (Federation)

The three recommendations to the Federation are good, but may be unrealistic, because the Federation has a very limited staff and, therefore, would be unable to comply adequately. These recommendations call for the Federation to develop guidelines for State podiatry prac-

tice acts, accumulate and disseminate changes in State practice acts and regulations, and identify and disseminate to State boards the most effective techniques of credential verification.

Role of the American Association of Colleges of Podiatric Medicine (Association)

We believe that there should be some reference in the report to the Association and the role of podiatry schools in preparing licensure applicants. The Association should be consulted about the types of training needed to meet State or national standards, and how best to meet existing standards. Accordingly, we suggest the following recommendation be considered for inclusion in the OIG report.

> The American Association of Colleges of Podiatric Medicine should encourage more extensive and effective interaction between the podiatry schools and State podiatry boards.

Public Health Service Assistance

With regard to the OIG recommendation that PHS should assist the Federation to extend and improve its technical assistance and information and dissemination activities, the Health Resources and Services Administration, PHS, awarded a contract to the Federation last May. The contract is to (1) develop a classification of disciplinary actions and guidelines for determining the actions to be taken, and (2) implement a program to educate the State boards in the use of the classification and guidelines. This project is intended to improve the uniformity of licensure disciplinary actions against podiatrists and will contribute to the value of disciplinary action data when it is submitted to the National Practitioner Data Bank.

PHS recognizes that there are other areas in which the Federation needs assistance and will continue to provide such technical assistance. In addition, PHS will continue to work with the podiatric profession to enhance the education and practice of its professionals.

HCFA COMMENTS

We have reviewed the draft report which focuses on State licensure and discipline practices concerning podiatrists. The major finding in the report is that in both licensure and discipline realms, State board officials tend to feel that they are seriously understaffed and, as a result, the effectiveness of both licensure and discipline operations is compromised. Since no recommendations in the report require action by HCFA, we have no specific comments to offer.

We concur with the report's findings and recommendations, and we support the efforts of the OIG to improve the current State practices. Thank you for the opportunity to comment on this report.

OIG RESPONSE TO ALL COMMENTS

We are pleased with the positive responses to the report and indications of progress in addressing issues raised in it.

At the same time, we must note that continued progress could be jeopardized if State governments do not act to assure that State boards have sufficient resources to carry out their responsibilities effectively. The same applies with respect to FPMB. We applaud the actions it has taken, yet, we agree with PHS that additional staff capacity is needed to carry out the more substantial role we have defined.

With respect to AACPM's concerns about the constraints imposed upon podiatric physicians in moving from State to State, we must note that these constraints were not often mentioned during our discussions with the State boards. On page 8 of the report, however, we do address that the mobility of podiatrists remains limited.

Finally, in regard to PHS's suggestion that we consider an additional recommendation urging the American Association of Colleges of Podiatric Medicine to encourage "more extensive and effective interaction between the podiatry schools and State podiatry boards," we share its concern about the importance of such interaction. However, because this issue was not addressed or raised in our study, we feel that it is beyond the scope of our recommendations.