BEFORE THE IOWA BOARD OF PODIATRY

IN THE MATTER OF THE	**)**	**DIA NO. 08DPHPE001**
STATEMENT OF CHARGES AGAINST	**)**	**CASE NO. 06-003**
	)	
NAVIN KUMAR GUPTA, DPM	**)**	**FINDINGS OF FACT,**
	)	**CONCLUSIONS OF LAW,**
Respondent	**)**	**DECISION AND ORDER**

On January 29, 2010, the Iowa Board of Podiatry (Board) found probable cause to file a three count Notice of Hearing and Statement of Charges against Navin Kumar Gupta, DPM (Respondent). The charges are based on Respondent's treatment of a single patient and include allegations of professional incompetency, practice harmful or detrimental to the public, and negligence. Specifically, the charges allege that Respondent failed to provide appropriate preoperative and postoperative care for a patient (AK) who presented with heel pain, failed to maintain appropriate medical records, engaged in inappropriate office surgery, and failed to recognize and perform the appropriate procedures.

The hearing was initially scheduled for April 29-30, 2010 but was continued at Respondent's request. The hearing was held on August 5-6, 2010 in the Lucas State Office Building, fifth floor conference room, Des Moines, Iowa. The state was represented by Assistant Attorney General Theresa O'Connell Weeg. Respondent was represented by attorney Robert Goldstucker. The following Board members presided at the hearing: Denise Mandi, DPM, Acting Chairperson; Kelly Kadel, DPM; Gregory Lantz, DPM; Patsy Hastings and Bridget Maher, Public Members. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was closed to the public, pursuant to Iowa Code section 272C.6 (1) (2009), and was recorded by a certified court reporter. At the outset of the hearing, the Board heard and overruled Respondent's Motion to Complete Deposition of Dr. Stanislav, Renewed Motion to Dismiss the Board's Statement of Charges with Prejudice, and Motion to Strike Portion of Amended Complaint.

After hearing all the evidence and examining the exhibits, the Board convened in closed session, pursuant to Iowa Code section 21.5(1)(f)(2009), to deliberate its decision. The administrative law judge was instructed to prepare the Board's written decision, in accordance with its deliberations.

THE RECORD

The record includes the Notice of Hearing and Statement of Charges; Answer; Respondent's Motion to Dismiss, Resistance, Reply to Resistance, and Ruling Denying Motion to Dismiss; Order Following Prehearing Conference; Motion to Reconsider Ruling/Supplemental Brief, Board's Ruling on Motion for Reconsideration; Respondent Motion to Strike Portion of Amended Complaint, Motion to Complete Deposition of Dr. Stanislav, and Renewed Motion to Dismiss Statement of Charges with Prejudice; State's Resistances to Motion to Strike, Motion to Complete Deposition, and Renewed Motion to Dismiss. The record also includes State Exhibits 1-33 (see Exhibit Index for description) and Respondent Exhibits A-L (see Exhibit Index for description). Respondent's proffer of AK's deposition and his request to subpoena AK during the hearing were both denied. The state presented the testimony of Dr. Andrew Stanislav, DPM, FACFAS. Respondent presented the testimony of Respondent, Dr. Joel Shockley, M.D., and Dr. Allen Jacobs, DPM, FACFAS.

FINDINGS OF FACT

Respondent's Practice and Disciplinary History

1. Respondent graduated from the University of Osteopathic Medicine and Health Sciences College of Podiatric Medicine and Surgery (UOMHS) in June 1990. On October 5, 1990, the Board issued Respondent Iowa license number 00508, which authorized him to engage in the practice of podiatric medicine. Respondent immediately entered private practice in Denison, Iowa and obtained hospital privileges at the local hospital. Respondent did not complete a residency, which was not unusual at that time.

Dr. Daniel Hake, DPM agreed to mentor Respondent by assisting him with his surgeries during his first year of practice. Dr. Hake had previously worked with Respondent when he was a student at UOMHS. Respondent estimates that he performed approximately 100 surgical procedures with Dr. Hake over a 14-month period in 1990-1991. According to Respondent, 80-90% of these surgeries, including three tarsal tunnel releases[1], were performed under local anesthetic. Respondent estimates that he has performed about a dozen tarsal

[1] A tarsal tunnel release surgery is at issue in this case.

tunnel release surgeries using the procedure that Dr. Hake taught him in the early 90's. (Respondent testimony; Respondent Exh. D; State Exh. 10; Answer)

2. On December 8, 1993, the Board filed a Notice of Hearing and Statement of Charges against Respondent charging him with professional incompetency and negligence based on his treatment of three patients during the time period from December 1991-September 1992. Following a hearing, the Board issued its Findings of Fact, Conclusions of Law, and Decision and Order on April 28, 1995. The Board's decision restricted Respondent from performing any podiatric surgery until he complied with certain terms and conditions. The terms and conditions included, in part, successful completion of a surgical residency and successful completion of the written and oral examinations administered by the American Podiatric Association-Board of Surgery. (State Exh. 1, 2)

Respondent and the Board subsequently entered into a Settlement Agreement on January 30, 1996. The Settlement Agreement provided that Respondent would successfully complete a 32 hour continuing education course dealing with surgery and/or the indications and complications of podiatric surgery. Respondent also agreed to be mentored by a diplomat with the American Board of Podiatric Surgery for a period of one year. The mentor would review and approve the written histories and surgical indications prior to all of Respondent's surgeries. Respondent further agreed to become "board eligible" within two years and to become "board certified" by the American Podiatric Medical Association (APMA) within two years of becoming Board eligible. (State Exh. 3)

Respondent successfully completed the continuing education and the monitoring requirement specified in the 1996 Settlement Agreement. The Board approved Dr. Daniel Hake as Respondent's mentor. Respondent had surrendered his hospital privileges after the Board entered its first disciplinary order against him and thereafter has performed all surgeries in his podiatric office. According to Respondent, Dr. Hake reviewed and approved 25-40 of his surgeries, all of which Respondent performed under local anesthesia in his Denison office. (Respondent testimony)

Respondent became board eligible in May 1996 but was unable to pass the ABPS certification examination, despite several extensions. Respondent reports that he passed the written examination on his first attempt but was unable to pass the oral examination. The grandfather clause that permitted board certification without first completing a residency has since expired. (Respondent testimony)

On January 26, 2001, the Board filed a second Statement of Charges against Respondent, citing his failure to complete the board certification examination as required by the Settlement Agreement. (State Exh. 4, 5) Respondent and the Board later entered into another Settlement Agreement and an Amended Order to resolve the January 26, 2001 Statement of Charges. Respondent complied with that settlement, which required him to have two Iowa-licensed, board certified podiatrists complete a personalized evaluation of his knowledge and skill in all aspects of podiatry, including clinical practice and infection control. Respondent was also required to complete a twenty-hour clerkship under an infectious disease specialist approved by the Board. Respondent complied with the terms of these orders. (State Exh. 6, 7; Respondent testimony)

3. In 1998, Respondent moved his practice from Denison to Indianola, Iowa. Respondent has not obtained privileges at any hospital. He performs all surgeries under local anesthesia in a surgical suite at his office. Respondent's surgical suite has a power computerized operating table, double overhead operating light, a c-arm fluoroscopy portable x-ray machine, full striker power instrumentation, oxygen tanks, and a crash cart. Respondent estimated that his Indianola office is 20 miles from the nearest acute care facility. Respondent is unable to give blood or establish an IV in his office. Respondent is not currently certified for CPR, although he was CPR certified while working as respiratory therapist prior to becoming a licensed podiatrist. (Respondent testimony)

Respondent's Treatment of Patient AK

4. At times relevant to this decision, Respondent maintained his clinical notes in a SOAP (subjective, objective, diagnosis, treatment) format. Respondent dictated his notes and they were typed by a transcriptionist and then signed by Respondent. (Respondent testimony; Exh. 18)

Patient AK was a 31-year-old patient who initially presented to Respondent's office on March 11, 2005 with complaints of severe pain in both heels. Respondent's clinical note for AK's first visit included the following subjective findings:

- the pain started two months earlier and was keeping AK up at night;
- AK had been taking 800 mg Ibuprofen three times a day for the past 1 ½ months;
- the pain was becoming intolerable;

- she had seen her family physician two days earlier and had been prescribed anti-inflammatory medication (Relafin).

Respondent's clinical note includes the following objective findings on examination:

- AK related severe pain to palpation at the calcaneo-plantar fascial attachment at the central and medial aspect and at the periphery of the heel bilaterally and at the insertion of the sinus tarsi, tarsal tunnel, and Achilles tendon area bilaterally.
- AK was noted to have a lateral calcaneal fibular right sprain although she denied any injuries.
- AK had mild edema in the symptomatic areas.
- No erythema was noted.
- Neurovascular status as noted above.

(Exh. 18, p. 47)

Respondent's initial history form for AK indicates that he examined AK for hair growth, skin pigment, nails, varicosities, temperature, and turgor with no positive findings. The entries further indicate that Respondent took AK's pulses. The entries indicate positive findings bilaterally for paresthesia but no burning. The initial history form includes diagrams of the right and left foot with "x" marks appearing on both heels and ankles. (Exh. 18, p. 7)

Respondent's clinical note states that he diagnosed AK with bilateral plantar fasciitis, bilateral Achilles tendonitis, bilateral sinus tarsi syndrome, bilateral tarsal tunnel syndrome and calcaneal fibular sprain (right ankle).

With respect to treatment, Respondent's clinical note states that:

- he explained his findings to the patient in detail;
- he explained the course of treatment with NSAIDS, ice, ultrasound therapy, taping of the foot and/or orthotics, night splint and steroid injections;
- he explained that surgical treatment could be necessary if the conservative treatments failed to resolve the patient's symptoms; and that
- AK chose to proceed with treatment immediately.

At her first visit, Respondent gave AK bilateral injections at the calcaneo-plantar fascial attachment and ten minutes of ultrasound therapy[2] to both heels. He fitted her for night splints to be worn at time of rest and with Alimed accommodators to be worn at all times. Respondent also fitted AK with a pneumatic walker for her right foot. He prescribed 500 mg naprosyn to be taken twice a day after meals, and he advised AK to apply ice to the symptomatic areas for 10-15 minutes 3-4 times a day. AK was scheduled for a return visit four days later. (Exh. 18, p. 47)

5. AK reported less pain at her next appointment on March 15, 2005. However upon examination, AK had moderate pain to palpation at the calcaneo-plantar fascial attachment and at the central and medial aspects of the heels. She continued to have pain to palpation at the insertion of the Achilles tendon, tarsal tunnel, and STS area, bilaterally. AK reported that she had been icing the foot three times a day and wearing the night splint and pneumatic walker as directed. AK was wearing the accommodator in the right shoe. Respondent documented the same five diagnoses for AK and advised continuing the current treatment. AK was given an ultrasound therapy treatment and asked to return three days later, on March 18, 2005. (Exh. 18, p. 47)

6. AK returned to Respondent's office for follow-up treatment and ultrasound therapy on March 18, March 22, March 25, March 29, April 1, April 5, April 8, April 12, April 15, April 19, April 22, April 26, April 29, May 3, and May 5, 2005. The pain in her right heel had resolved by March 18, 2005 but her left foot had become more painful. Respondent continued conservative treatment, including ultrasound therapy at each visit. (Exh. 18, pp. 40-46)

7. On May 5, 2005, Respondent performed a diagnostic ultrasound (DUS) of AK's left plantar fascia in longitudinal and transverse orientations. Respondent's clinical note indicates that the DUS was consistent with marked inflammation of the plantar fascia (6.9 in the symptomatic area versus 3.1 in the non-symptomatic area of the left heel). He further noted that the left posterior tibial nerve was hyper echoic and enlarged. (Exh. 18, p. 40) Respondent's Ultrasound

[2] Respondent explained at hearing that therapeutic ultrasound works similarly to deep heat massage. Respondent uses therapeutic ultrasound to improve circulation, decrease edema in the soft tissue, and progress healing. Respondent had purchased a Toshiba Diagnostic Ultrasound machine in the fall of 2002 and attended a training seminar to learn how to operate the machine and report the results. Respondent had researched this machine and felt it was a superior product for musculoskeletal ultrasound. (Respondent testimony)

Examination Report states that the findings were suggestive of plantar fasciitis, left foot, and moderate impingement of the posterior tibial nerve, left foot. (Exh. 18, p. 51).

Respondent recommended continuing the conservative treatments but informed AK that surgical intervention may be necessary if the conservative treatments failed to resolve the symptoms. (Exh. 18, p. 51)

8. AK returned to Respondent's office on May 6, 2005 for a cortisone injection and for ultrasound therapy to the symptomatic area of her left foot. (Exh. 18, p. 39) AK returned to Respondent's office for additional ultrasound therapy treatments on May 10, May 13, May 17, and May 20, 2005. AK had another cortisone injection on May 20, 2005. AK had further ultrasound therapy treatments on May 24, May 27, May 31, June 3, and June 7, 2005. (Exh. 18, pp. 35-39)

9. On June 14, 2005 AK informed Respondent that she wanted to go ahead with the surgery for her chronic tarsal tunnel syndrome. Respondent's clinical note states that he explained the surgical procedure to the patient in detail with diagrams and drawings. It further states that he explained the post operative course and care and the possibility of risks and complications. AK chose to proceed with surgery and signed the consent form for tarsal tunnel release on the left foot. The consent form stated that Respondent could, in his sole discretion, perform such other or different procedures if they appear advisable during the course of the operation. Surgery was scheduled for June 29, 2005. (Exh. 18, pp. 35, 53-57) Respondent verbally explained to the patient, in plain language, that he would open the area and free up the nerve from any restriction that he found. (Respondent testimony)

10. According to his operative reports and clinical notes, Respondent performed a tarsal tunnel release and a partial plantar fasciotomy on AK's left foot on June 29, 2005. Both procedures were performed in Respondent's surgical suite in his office and under local anesthesia. Respondent roughly estimated that he has performed 300 surgical procedures under local anesthetic to date. (Respondent testimony; Exh. 21; Exh. 18, p. 34)

11. AK returned to Respondent for follow-up care on July 1, 2005. According to the clinical record, AK's only complaint was mild to moderate pain. Respondent also noted that the surgery site was in satisfactory condition and

progressing with no signs of infection, with minimal drainage, and with moderate normal post-op edema and erythema. Respondent cleaned and dressed the surgery site. (Exh. 18, p. 34)

12. AK returned to Respondent for further follow-up care on July 11, 2005. Respondent's clinical note states:

- AK reports mild to moderate pain, increased swelling, and some tingling;
- the surgery site was healing satisfactorily, there were no signs of infection, and there was minimal drainage on the dressing;
- AK had 2+ edema and mild normal post operative erythema;
- AK reported tingling in the 1st and 2nd MPJ area with mild palpation of the operative area.

Respondent explained to AK that while the surgery released the pressure on the posterior tibial nerve, the nerve still had to heal and she may not be symptom free for some time. Respondent advised AK to continue the same post-operative care, and he gave her some ankle range of motion exercises. (Exh. 18, pp. 34, 32)

13. AK had additional post-operative appointments with Respondent on July 15, July 22, July 29, and August 9, 2005. By August 9, 2005, the surgical site was noted to be fully healed but AK continued to have 2+ edema in the surgical area. Respondent advised AK to try high compression stockings and to ice the surgical area for 20-30 minutes, three times a day. (Exh. 18, pp. 32-33)

14. On August 18, 2005, AK returned for further follow-up. AK continued to have a lot of swelling but planned to return to work. Respondent's clinical note documents AK's report of mild pain to palpation of the tarsal tunnel area of the left foot and mild to moderate tingling about the course of the medial calcaneal nerve course. Respondent diagnosed possible medial calcaneal neuritis and advised AK to continue icing her foot. Respondent fitted AK with a new pair of accommodators to be worn whenever she was on her feet and told her to wear her pneumatic walker if needed. Respondent started AK on ultrasound therapy treatments for the medial calcaneal neuritis. (Exh. 18, p. 31)

15. On August 22, 2005, AK returned for another ultrasound treatment for medial calcaneal neuritis and possible medial calcaneal nerve entrapment in the surgical incision area. (Exh. 18, p. 31) AK returned for further follow-up and ultrasound treatments on August 25, August 29, September 1, September 8,

September 12, September 15, September 19, September 22, September 26, October 3, October 6, October 10, October 13, October 17, October 20, October 24, and October 27, 2005. Respondent recommended a diagnostic ultrasound and x-rays at AK's next visit if her symptoms had not improved. (Exh. 18, pp. 24-30).

16. On November 3, 2005, AK's symptoms had not improved, and Respondent performed a diagnostic ultrasound scan and x-rays of the left foot. (Exh. 18, p. 23) The x-rays were unremarkable except for mild soft tissue edema in the proximal aspect of the medial longitudinal arch. (Exh. 18, p. 49) The diagnostic ultrasound showed an area of hypo-echoic activity, possibly a bursa. The findings were suggestive of chronic edema and/or bursa formation. (Exh. 18, pp. 23, 50)

Respondent documented diagnoses for AK of medial calcaneal neuritis, medial calcaneal nerve entrapment, infra calcaneal bursa, and plantar fasciitis. Respondent administered a steroid injection and advised AK to continue icing the foot, wearing compression stockings, and using the pneumatic walker. AK was given a therapeutic ultrasound treatment to the left foot. (Exh. 18, p.23)

17. AK's condition did not improve, and Respondent continued to document the same four diagnoses. Respondent gave AK additional therapeutic ultrasound treatments on November 7, November 10, November 14, November 21, November 28, December 1, December 8, December 12, December 15, December 19, December 22, and December 27, 2005. (Exh. 18, pp. 18-23)

- On November 14, 2005, Respondent told AK that she appeared to have recurrent plantar fasciitis and that healing was slowed by recurrent edema. Respondent gave AK inferential therapy for 20 minutes, followed by her usual therapeutic ultrasound treatment. Respondent showed AK how to operate the inferential therapy unit and told her to use it at home, two to four times a day for 90 days. (Exh. 18, p. 22)
- On November 21, 2005, Respondent showed AK range of motion exercises to perform 3-4 times a day and adjusted her night splint. (Exh. 18, p. 21)
- On December 8, 2005, Respondent fitted AK with a new pair of Alimeds to be worn in her shoes when she was on her feet and advised her to wear the pneumatic walker as needed. (Exh. 18, p. 20)
- On December 19, 2005, Respondent fitted AK with a new pair of accommodators to be worn in her shoes at all times. (Exh. 18, p. 19)

- On December 22, 2005, Respondent gave AK a cortisone injection. On December 27, 2005, AK reported that the cortisone injection provided some relief but that numbness and tingling had increased in her 1st and 2nd toes over the prior two days. (Exh. 18, p. 18)

18. At her appointment on January 3, 2006, AK reported that she had not worn the compression stocking since December 31, 2005 and that all of her toes had been numb since December 27th after wearing the night splint. She further reported that her 1st and 2nd toes continued to be numb but that the 3rd-5th toes were getting better. Respondent gave AK a therapeutic ultrasound treatment and asked her to return in two days. (Exh. 18, p. 17)

On January 5, 2006, AK reported that she had no pain that morning but had previously had some shooting pain from the heel across the toes. Respondent recommended another steroid injection since the previous injection appeared to have controlled most of her symptoms, and AK agreed. AK had a steroid injection and therapeutic ultrasound at this appointment. (Exh. 18, p. 17)

AK returned to Respondent for additional therapeutic ultrasound on January 9, January 12, January 16, and January 19, 2006. (Exh. 18, pp. 15-16) On January 19, AK reported that the area of pain had lengthened and her toes were still numb and had gotten worse. Respondent recommended a third steroid injection and advised her that if it did not resolve the symptoms she may need to consider additional surgery for additional plantar fasciotomy and/or bursa removal. AK asked to defer the steroid injection to her next appointment because she was going to Las Vegas and would be doing a lot of walking. Respondent warned AK that excessive walking could worsen her symptoms. (Exh. 18, p. 15)

AK returned to Respondent on January 23, 2006 for the cortisone injection and for therapeutic ultrasound. AK had additional therapeutic ultrasound treatments on February 6, and February 9, 2006. She continued to have moderate pain and tingling in her toes. (Exh. 18, pp. 13-14)

19. Respondent's clinical record for AK contains very few objective findings based on physical examination and few findings to support his multiple diagnoses. Based on these records, it does not appear that Respondent performed any gait, biomechanical, neurological, or musculoskeletal examinations of AK. AK's pulse is recorded only one time in more than 100 office visits. Respondent's records fail to document or explain his thought

process in evaluating AK's symptoms and in determining what treatments to recommend. The records do not include any treatment plans. Respondent only documented what treatment he provided at each visit. (Exh. 18; Dr. Stanislav testimony)

Second Opinion and Subsequent Treatment of AK by Dr. Bratkiewicz

20. On February 16, 2006, AK's family physician referred her to Dr. K. Linda Bratkiewicz, DPM, FACFAS for a second opinion. Respondent provided AK with a copy of her clinical record and with her x-rays and diagnostic ultrasounds. AK did not return the x-rays and diagnostic ultrasounds to Respondent and did not return to Respondent for further care after she consulted Dr. Bratkiewicz. (Exh. 18, pp. 58-60; Exh. 26)

The hearing record does not include Dr. Bratkiewicz's clinical record for AK but does include Dr. Bratkiewicz's letter to the Board dated April 26, 2006 (Exh. 26), a copy of an MRI ordered by Dr. Bratkiewicz on February 22, 2006 and the MRI report (Exh. 27, 28), and photographs from a surgery that Dr. Bratkiewicz performed on AK on April 18, 2006. (Exh. 26A) Dr. Bratkiewicz did not testify at hearing.

In her letter to the Board, Dr. Bratkiewicz reported that AK was very frustrated about her medical condition and felt that her pain was much worse than prior to Respondent's surgery. Dr. Bratkiewicz reported and described the results of her cardiovascular, dermatological, neurologic, gait, and musculoskeletal examinations of AK. Dr. Bratkiewicz assessed the patient as having failed tarsal tunnel release with chronic foot pain. She discussed her treatment plan with AK, which included an MRI of the tarsal canal to further evaluate AK's superior and inferior retinaculums. If the retinaculum appeared released on the MRI, then Dr. Bratkiewicz planned to order an EMG (electrodiagnostic) study for further diagnostic testing. (Exh. 26)

21. On February 22, 2006, AK had the MRI of her left foot, which was read by a radiologist, by Dr. Bratkiewicz, and by Dr. Bratkiewicz's partner, Dr. Eric Barp, DPM, FACFAS. All three of them concluded that AK's flexor retinaculum appeared intact. (Exh. 16, 26, 28) The MRI findings will be described and discussed later in this decision. Based on the MRI findings and on AK's report of pain (9 on a scale of 1-10), Dr. Bratkiewicz recommended revisional tarsal tunnel release surgery. AK agreed. (Exh. 26)

22. On March 10, 2006, AK filed a complaint with the Board alleging that Respondent did not perform the tarsal tunnel release surgery as he claimed, based on the information provided to her by Dr. Bratkiewicz. According to the complaint, Dr. Bratkiewicz told AK that both retinacula were completely intact, that it was extremely uncommon to perform a tarsal tunnel release in an office setting, and that it was unlikely and difficult to visualize the branches that are mentioned in Respondent's operative report. (Exh. 12, 13)

AK also filed a civil lawsuit against Respondent in Warren County District Court. The lawsuit was resolved by an Arbitration Decision issued on June 11, 2008, which found that Respondent did not breach the standard of care during his treatment of AK. (Exh. H)

23. On April 18, 2006, Dr. Bratkiewicz performed the revisional tarsal tunnel release for AK at a surgery center. On April 26, 2006, Dr. Bratkiewicz sent a letter to the Board describing her treatment of AK and the April 18, 2006 surgery. Dr. Bratkiewicz later provided photographs that she took during the surgery. Dr. Bratkiewicz reported intraoperative findings consistent with an intact superior retinaculum, inferior retinaculum including the extension around the abductor hallucis muscle and porta pedis entry. Dr. Bratkiewicz took photographs, which she felt confirmed her intraoperative findings. During surgery, Dr. Bratkiewicz released the superior and inferior retinaculums, along with the expansion to the abductor hallucis and porta pedis. Dr. Bratkiewicz noted that Respondent's operative report stated that he identified the posterior tibial nerve along with the medial and lateral plantar nerve branches. Dr. Bratkiewicz commented that she was not able to visualize the medial and lateral plantar nerve branches and has never been able to visualize them in any previous tarsal tunnel surgery that she had performed. Dr. Bratkiewicz reported that AK was doing well post surgery and reported less pain. (Exh. 26, 26A)

Board Investigation/Peer Review Report

24. Andrew C. Stanislav, DPM, FACFAS agreed to conduct a peer review of Respondent's care and treatment of AK at the Board's request. After graduating from podiatry school in 1997, Dr. Stanislav completed a two-year surgical residency under Dr. Dan Hake before entering private practice. Dr. Stanislav reviewed Respondent's treatment records for AK, the billing records, operative notes, and pre-operative testing materials. Dr. Stanislav was not able to review

Respondent's diagnostic ultrasounds or his radiograph of AK's foot because AK never returned them to Respondent. (Exh. 18, pp. 58-59)

In his peer review report submitted on May 2, 2008, Dr. Stanislav concluded that Respondent's treatment of AK violated 645 IAC 224.2(2)"c" and "d," which defines professional incompetency to include but not be limited to:

> c. A failure to exercise the degree of care which is ordinarily possessed and applied by the average practitioner acting in the same or similar circumstances; and
>
> d. Failure to conform to the minimal standard of care of acceptable and prevailing practice of a podiatrist in this state.

In Dr. Stanislav's opinion, Respondent's treatment of AK was professionally incompetent in the following respects: failure to perform appropriate studies, substandard clinical note taking, excessive number of office visits, and inappropriate office surgery. (Dr. Stanislav testimony; State Exhs. 30, 31)

25. On September 22, 2009, the Board sent Dr. Stanislav a copy of Dr. Bratkiewicz's letter describing her treatment of AK, as well as her intraoperative photographs. The Board also sent Dr. Stanislav x-rays and investigative information concerning ten additional patients of Respondent whose care Dr. Stanislav had not previously reviewed. The Board asked Dr. Stanislav to review this additional information and to provide an addendum report by October 1, 2009. On October 6, 2009, the Board received Dr. Stanislav's addendum report, which reaffirmed the opinions in his prior report. Dr. Stanislav further concluded that the intraoperative photographs take by Dr. Bratkiewicz confirmed that AK's superior and inferior retinaculums were still intact at the time of the April 18, 2006 revisional surgery. Dr. Stanislav made no findings with respect to the ten additional patient cases. (Dr. Stanislav testimony; Exh. 31, 32)

Summary and Resolution of the Conflicting Expert Opinions at Hearing

26. Respondent retained Allen M. Jacobs, DPM, FACFAS as his expert witness to review AK's treatment and to prepare a written report. Dr. Jacobs also testified on Respondent's behalf at the 1994 Board hearing. (Exh. 2). After graduating from podiatry school in 1973, Dr. Jacobs completed a two-year

residency before entering private practice. Dr. Jacobs has taught podiatric residents since 1975, has published numerous professional articles and textbook chapters, and is a frequent speaker on various topics related to podiatry practice. (Exh. E)

Dr. Jacobs reviewed Dr. Stanislav's peer review report and Respondent's treatment records for AK. He also reviewed medical and podiatric literature relevant to the evaluation and management of AK's complaints and concerns. Dr. Jacobs prepared a written report, dated February 9, 2009, and also provided testimony at hearing. In Dr. Jacobs' opinion, Respondent provided acceptable care to AK that was far beyond the minimal standard of care called for in 645 IAC 224.2(2)"c" and "d." In summary, Dr. Jacobs concluded that Respondent provided appropriate preoperative and postoperative studies to AK for those complaints and concerns for which she sought care. He further concluded that Respondent adequately performed a tarsal tunnel surgery, provided adequate documentation, did not provide excessive preoperative or postoperative care, and provided adequate facilities for the performance of a tarsal tunnel release surgery. (Dr. Jacobs testimony; Exh. E)

Failure to perform appropriate studies

Radiographs

27. Respondent primarily relied on diagnostic ultrasound to substantiate his diagnoses. (Exh. 18, pp. 50-51; Respondent testimony). Respondent did not obtain a radiograph of AK's foot until four months after surgery. (Exh. 18, p. 49) When asked what basis he had for ordering the x-ray (radiograph), Respondent replied that he did not have a specific basis for ordering the x-ray, he just did it "for the heck of it." Respondent did not order an MRI of AK's foot pre or post surgery. (Respondent testimony; Exh. 18; 27, 28)

In Dr. Stanislav's opinion, Respondent should have performed additional appropriate studies (i.e., radiographs, MRIs, and electrodiagnostic studies) both preoperatively and postoperatively. (Dr. Stanislav testimony; Exh. 30) Dr. Stanislav believed that Respondent should have obtained radiographs prior to surgery when AK's heel pain was recalcitrant to all of the conservative treatments that are usually successful in relieving plantar fasciitis symptoms. In his opinion, radiographs would have been beneficial to rule out other possible causes of AK's heel pain such as calcaneal stress fracture, arthritic conditions

(Reiters Syndrome, Psoriatic Arthritis, Ankylosing Spondylitis) or calcaneal tumors/cysts.

Dr. Jacobs disagreed, noting that AK had none of the conditions mentioned by Dr. Stanislav and that any pathology that would have been demonstrated on x-ray would also be demonstrated on diagnostic ultrasound. He further noted that diagnosis of these conditions is based on history and clinical examination, particularly on the presence of unusual signs and symptoms. In Dr. Jacobs' opinion, x-rays were not required because they would not demonstrate the plantar fascia (a soft tissue structure), the posterior tibial nerve, the flexor retinaculum, or any structure within the tarsal tunnel. Although the Board generally agreed that x-rays were an appropriate option to rule out other diagnoses, they were not persuaded that the failure to obtain x-rays pre-operatively violated minimum standards of care.

MRIs v. Diagnostic Ultrasound

Dr. Stanislav was also critical of Respondent's reliance on diagnostic ultrasound to substantiate his diagnoses of plantar fasciitis and tarsal tunnel syndrome and of Respondent's failure to obtain an MRI, both preoperatively and postoperatively. Dr. Stanislav does not order diagnostic ultrasounds in his practice and prefers to order MRIs. Dr. Stanislav relies on a radiologist to read the MRI, although he may also review the MRI image himself. Dr. Stanislav concedes that he has no special expertise in reading MRIs.

Dr. Stanislav conceded that both diagnostic ultrasound and MRI are used in podiatric practice to diagnose soft tissue injuries like tarsal tunnel syndrome and plantar fasciitis. Dr. Stanislav estimates that 90% of patients get better utilizing conservative treatments for plantar fasciitis while tarsal tunnel is less common than plantar fasciitis and more difficult to treat. The three major causes of tarsal tunnel syndrome are trauma, space occupying lesions, and foot deformity. In Dr. Stanislav's opinion, it was important for Respondent to identify the cause of the tarsal tunnel, if possible, prior to proceeding to surgery. In Dr. Stanislav's opinion, MRI imaging is superior to diagnostic ultrasound as a method to investigate for the presence and extent of space occupying lesions such as tumors, ganglion cysts, varicosities or tensynovitis of adjacent tendon causing tarsal tunnel symptoms. In his testimony, Dr. Stanislav cited to Berquist, "Radiology of the Foot and Ankle", 2000, 2nd Edition, for the proposition that MRI is superior to diagnostic ultrasound to identify soft tissue and neuro

abnormalities. Dr. Stanislav further asserted that MRI was also indicated postoperatively to confirm Respondent's diagnosis of infracalcaneal bursa as well as to identify possible scar tissue or incomplete release of the flexor retinaculum.

In Dr. Jacobs' opinion, however, the standard of care did not require Respondent to order MRI studies, either preoperatively or postoperatively. Respondent also offered testimony from Dr. Joel Shockley, M.D., whom is a radiologist specializing in the foot and ankle. (Exh. F) Dr. Jacobs and Dr. Shockley both testified that diagnostic ultrasound has become much more widely used in the past ten years and that both MRI and diagnostic ultrasound will show anything external to the bony structures, including a space occupying cyst or lesion. (Dr. Shockley; Dr. Jacobs testimony)

Dr. Jacobs cited to several articles appearing in peer reviewed journals in the past five years that describe diagnostic ultrasound as equivalent or superior to MRI in managing tarsal tunnel syndrome, visualizing peripheral nerve pathology, investigating musculoskeletal disorders of the lower extremity, and evaluating entrapment neuropathies and tumors. Although Dr. Jacobs was unable to review the actual ultrasounds in this case, he noted that the findings in the preoperative ultrasound report confirmed Respondent's clinical impression that AK demonstrated signs and symptoms consistent with both tarsal tunnel syndrome as well as plantar fasciitis. The diagnostic ultrasound demonstrated hypoechoic activity at the insertion of the plantar fascia and abnormal thickening of the plantar fascia. The diagnostic evaluation of the tarsal tunnel demonstrated compression and constricture of the posterior tibial nerve. (Dr. Jacobs testimony; Exh. L, pp. 6-7)

After reviewing the opinions and reports of all three experts, the Board was not persuaded that Respondent's failure to order MRI studies preoperatively and postoperatively violated minimum standards of care.

Electrodiagnostic Studies

In Dr. Stanislav's opinion, electrodiagnostic studies were also indicated to evaluate compression of the posterior tibial nerve and its branches. However, Dr. Stanislav conceded that these studies remain somewhat controversial for detecting possible tarsal tunnel syndrome. (Dr. Stanislav testimony; Exh. 30, p. 3) Dr. Jacobs asserted that electrodiagnostic studies would not have provided

Respondent any further direction in his diagnosis of tarsal tunnel syndrome than what he had already obtained by history, clinical examination, and supportive ultrasonography. In addition, studies have shown that electrodiagnostic studies have a high rate of false positives and false negatives. In the face of history and physical evidence suggestive of tarsal tunnel syndrome, surgery is not contraindicated in the presence of a false-negative test. Dr. Jacobs further noted that electrodiagnostic studies are expensive and very painful, if performed properly. (Dr. Jacobs testimony; Exh. L, p. 8) The Board agreed that minimum standards of care did not require Respondent to conduct electrodiagnostic studies prior to proceeding to surgery.

Substandard clinical note taking

In Dr. Stanislav's professional opinion, Respondent failed to conform to the minimal standard of care for note taking. With respect to note taking, Dr. Stanislav observed that on her initial visit, AK's chief complaint was bilateral heel pain. Respondent diagnosed AK with bilateral plantar fasciitis, Achilles tendonitis, sinus tarsi syndrome, tarsal tunnel syndrome, and sprain of the right calcaneal fibular. Dr. Stanislav found that Respondent's clinical note did not document:

- any patient complaint of right ankle pain or injury;
- any objective findings of ankle instability or pain, edema, or ecchymosis around the calcaneal fibular ligament;
- any of the classic symptoms of bilateral tarsal tunnel syndrome, such as burning, tingling, intermittent numbness or worsening of symptoms with prolonged standing or ambulating;
- any physical exam findings (such as sensorimotor alteration) to substantiate the diagnosis of tarsal tunnel syndrome, including Tinel's and Valleix sign by tapping lightly over the nerve on the affected limb, motor deficit of the short flexors or abductor hallucis atrophy, assessment of the deep tendon reflexes to determine if there is proximal causation, and inspection of patient's stance and gait for excessive pronation or valgus deformities of the rearfoot.

(Dr. Stanislav testimony; Exh. 30, pp. 3-5)

Dr. Stanislav also testified that Respondent's clinical chart for AK failed to document many of the standard physical examinations that comprise the

minimum standard of care for a patient presenting with her symptoms. He testified that Respondent's clinical record lacked documentation of vascular status, a gait exam, dermatological exam, musculoskeletal exam, or a neurological exam. However, on cross examination, Dr. Stanislav conceded that Respondent's initial history form for AK (Exh. 18, p. 7) did indicate that Respondent checked the patient's hair growth, skin pigment, nails, pulses, varicosities, parasthesias, temperature, turgor, edema, and burning at her initial visit.

Dr. Stanislav apparently overlooked the initial history form in his review of the records. Nevertheless, Dr. Stanislav did not concede that this additional form made Respondent's clinical record adequate. Dr. Stanislav observed that Respondent's narrative does not include any description of his examinations or findings at the initial visit. It is unclear from the record whether the patient or Respondent made the "x" marks on the diagrams of the patient's feet or what the "x" marks signify. Dr. Stanislav thought it was likely that the "x" marks indicated the locations of the patient's reported pain. However, there were no "x" marks in the areas of the tarsal tunnel or the Achilles tendon.

Dr. Stanislav further noted the following unexplained discrepancies in the clinical record:

- Although Respondent diagnosed AK with *bilateral* tarsal tunnel on 3/11/2005 (Exh. 18, p. 47), on 4/12/2005 Respondent diagnosed her with tarsal tunnel, right foot. (p. 43) Three days later Respondent's diagnosis is tarsal tunnel, left foot, with no explanation for the change. (p. 42) Even assuming that the designation of "right" on 4/12/2005 was just an error and should have been "left," it would be unusual for bilateral tarsal tunnel to have resolved on one side in approximately one month's time. Respondent's clinical note does not explain or support the change in his diagnosis.
- From the patient's sixth visit, on 3/29/05, until her thirteenth visit, on 4/29/05, Respondent's objective findings do not include any description or mention of pain to palpation of the tarsal tunnel. (pp. 41-45) Beginning on 4/29/2005, Respondent's clinical note does describe pain on palpation of the tarsal tunnel.
- Based on AK's description of her post operative pain in her complaint to the Board, Dr. Stanislav had concerns that Respondent was not fully

documenting the extent of AK's reported post operative pain. (Exh. 12, 13; Exh. 18, pp. 14-34)

- Although Respondent performed and charged AK for both a tarsal tunnel release of the left foot and a partial plantar fasciotomy of the left foot, the written consent signed by AK was only for the tarsal tunnel release. (Exh. 18, pp. 3, 53)

Dr. Jacobs agreed that the clinical record should reflect the podiatrist's thought process in providing a diagnosis and planning treatment. Dr. Jacobs also agreed that Respondent's record did not include any documentation of a biomechanical examination of the patient's foot function, although he did not agree that the standard of care required a biomechanical examination in this case. Dr. Jacobs further agreed that Respondent's clinical record was "less than optimal" and that, in hindsight, it would have been better if Respondent had included more detail. Nevertheless, Dr. Jacobs felt that Respondent's clinical records were similar to other private practice records that he has reviewed. In his opinion, Respondent's clinical records did not fall below the standard of care and did not have a negative impact on the patient's care.

Dr. Jacobs also disagreed that Respondent's failure to include plantar fasciotomy on the surgical consent form constituted a failure to conform to the standard of care. In his opinion, the release of a portion of the plantar fascia was not an isolated procedure but was incidental to and part of the tarsal tunnel decompression, i.e. release of the branches of the posterior tibial nerve. (Dr. Jacobs testimony; Exh. L pp. 11-12)

Respondent testified that the reason he did not specifically include the plantar fasciotomy on the consent form was because he did not plan to perform the procedure unless it became necessary during the course of the surgery. However, the Board did not find this testimony credible, based on its review of Respondent's operative report and the manner in which incision was made to allow approach of the plantar fascia. Although Respondent's broadly worded consent form may constitute sufficient legal consent to cover plantar fasciotomy, Respondent should have specifically documented the plantar fasciotomy on the consent form.

Respondent conceded that plantar fasciitis and tarsal tunnel are frequently caused by biomechanical abnormalities. Respondent conceded that he did not perform or document a biomechanical evaluation in this case but claimed that he

was unable to perform one because AK was in too much pain and was unable to relax her joints sufficiently for him to perform an accurate examination. This was not a reasonable explanation for failure to perform and document a biomechanical examination. The patient's pain is not adequately documented in the record and the presence of pain does not preclude performance of a biomechanical examination. At a minimum, Respondent's documentation needed to include an explanation of why he did not perform this very basic examination.

The Board fully agrees with Dr. Stanislav's opinion that Respondent's clinical note taking and documentation failed to meet minimum standards. Except for the very limited entries on the initial history form, Respondent's clinical notes contain few objective findings to support his diagnoses. There is no documentation of any injury to substantiate the initial diagnosis of an ankle sprain, even though Respondent claims that the patient reported an injury to him. There are no objective findings to support the initial diagnoses of bilateral Achilles tendonitis or bilateral sinus tarsitis. Respondent's clinical notes contain no documentation of a gait exam, biomechanical exam, or muscoskeletal exam, all of which should have been performed and documented. The patient's pulse was documented only at the initial examination and was never documented in any of the subsequent visits. Respondent's clinical notes state what treatment was performed at a particular visit but they completely fail to reflect Respondent's thought process in formulating his diagnoses or his treatment plan.

This is particularly concerning when Respondent's own testimony at hearing raised serious questions about his clinical judgment and reasoning.[3] Respondent assured the Board that his records were adequate to allow him to properly treat the patient, but the Board does not see how this could be true when so much vital information is missing from the records. Moreover, the records were inadequate to provide a subsequent treating podiatrist with sufficient history to assume care of the patient.

The Board does not doubt that there are podiatrists whose documentation is worse than the Respondent's documentation in this record, as Dr. Jacobs suggested. However, the standard of care is what the average podiatrist would do acting in the same or similar circumstances, not what the worst podiatrist

[3] As an example, Respondent volunteered that in about 1993 he performed an ankle fusion, by himself, when he had never performed the procedure before. (Testimony of Respondent)

would do. Respondent's clinical record for AK does not meet that standard. The documentation deficiencies in this case are not isolated. Respondent repeatedly fails to include essential information and findings throughout this 11 month record of bi-weekly patient visits. The record fails to reflect his thought process in formulating diagnoses or his treatment planning. Moreover, Respondent readily conceded at hearing that his "records were not up to par" and may not provide him a sufficient defense in a malpractice case.

Respondent claimed that he took steps to address his deficient records by terminating the employment of his transcriptionist. Obviously, the transcriptionist is not responsible for Respondent's poor records and only transcribes what Respondent dictates or provides. Respondent has signed each of his record entries. Respondent further reports that he is in the process of implementing an electronic medical record system to allow him to document more efficiently. Irrespective of what record keeping system is used, Respondent is ultimately responsible for entering adequate information and findings into the patient's record. The preponderance of the evidence established that Respondent does not understand the importance of thorough documentation of his examination, findings, assessment, and formulation of his treatment plan. The Board has not seen any evidence that Respondent's documentation methods have improved since this record was created and maintained.

Excessive Number of Office Visits

Dr. Stanislav notes that AK underwent a total of 29 ultrasound treatments prior to her surgery and 75 office visits in less than a year. In his opinion, Respondent should not have continued providing the therapeutic ultrasound treatments for as long as he did. Dr. Stanislav also felt that Respondent charged the patient an excessive amount of money ($9,238.83) for these treatments and visits. (Dr. Stanislav testimony; Exh. 30, pp. 5-6)

Dr. Jacobs disagreed and asserted that the length of time that Respondent provided nonoperative management to AK is supported by the medical literature. Dr. Jacobs noted that Myerson's Textbook of Foot and Ankle Surgery states that nonoperative management of tarsal tunnel syndrome is generally administered from 3 to 6 months prior to surgical intervention due to the potential complications of the operation and the potential to irritate the nerve and aggravate the condition. Respondent's length of conservative treatment prior to surgery was at the lower end of this range. Dr. Jacobs also cited Speed

(Rheumatology 2001), which recommended ultrasound following surgery as effective in the reduction of postoperative pain, reduction of postoperative inflammation, increasing blood flow to the surgical area, and speeding tissue healing. No minimum or maximum length of treatment was suggested. (Dr. Jacobs testimony; Exh. L, pp. 9-11)

Although Respondent saw AK in his office at an unusually high frequency over a period of approximately one year, the Board was not convinced that the number of visits was excessive under the circumstances or that the number of visits or treatments was motivated by monetary considerations.

Inappropriate Office Surgery

In Dr. Stanislav's opinion, the surgery that Respondent performed on AK should have been performed at a surgical center or at a hospital under general or spinal anesthetic, and not under local anesthetic. This opinion was not based on any evaluation of Respondent's surgical facilities. Dr. Stanislav conceded that he did not know if Respondent had a surgical suite in his office. (Dr. Stanislav testimony; Exh. 30, p. 6)

While Dr. Jacobs conceded that it would not be his first choice to perform tarsal tunnel surgery under local anesthetic in the surgical suite of a private office, he disagreed that it was outside the acceptable standard of care if the patient was otherwise healthy. Dr. Jacobs cited to Myerson's Textbook on Foot and Ankle Surgery, which states that tarsal tunnel release surgery may be performed under local anesthetic *in competent hands.* He also mentioned that Myerson recently published an article concerning an ankle surgery that was performed under local anesthetic.

Dr. Jacobs reported that he visited Respondent's surgical facilities and felt that if Dr. Stanislav had seen the facility he would find them to be "most adequate" for the provision of soft tissue surgery such as tarsal tunnel release, or limited plantar fasciotomy. Dr. Jacobs denies that the office setting presented any greater risk to the patient than a surgical center so long as it is properly equipped. He pointed out that neither setting has a vascular surgeon or neurosurgeon readily available in case of complications requiring such intervention. Dr. Jacobs' review of the medical literature did not reveal any articles disapproving of performing such surgeries in the office setting, and

many other medical specialists, such as dermatologists and plastic surgeons, regularly perform surgery in their office surgical suites.

Based on the evidence in this record, the Board was not persuaded that Respondent violated minimum standards of care by performing AK's surgery in his office under local anesthetic. Nevertheless, the Board has serious concerns about the wisdom of performing rear foot surgery in an office setting and about Respondent's ability to handle complications when he is not currently CPR certified and is unable to start an IV or give blood. A surgery center would be equipped with nurses and staff who could provide valuable assistance to the podiatric surgeon in an emergency, including assisting with CPR, starting IVs, and providing blood transfusions.

Failure to Perform Tarsal Tunnel Release

Dr. Bratkiewicz concluded, based on AK's MRI and on her observations during surgery on April 18, 2006, that Respondent did not actually perform the tarsal tunnel release procedure described in his operative note. However, Dr. Bratkiewicz did not testify at hearing. (Ex. 16, 26, 26A, 27, 28) Dr. Stanislav reviewed Dr. Bratkiewicz's written report to the Board and the MRI and also concluded that Respondent did not perform the tarsal tunnel release. (Dr. Stanislav testimony; Exh. 26, 27, 32)

Dr. Jacobs disagreed with both of them, based on his review of the MRI and the operative reports. Dr. Joel Shockley also reviewed the MRI and concluded that Respondent had performed a tarsal tunnel release as described in his operative report. Both of them observed that the MRI shows scar tissue both superficial and deep to the flexor retinaculum with thickening of the flexor retinaculum, which is a typical postoperative finding for a patient who underwent tarsal tunnel release with incision of the flexor retinaculum nine months earlier. In addition, Dr. Jacobs reviewed the Dr. Bratkiewicz's surgical photographs and compared them to the MRI. In his opinion, it was evident that Dr. Bratkiewicz had performed surgery on a different portion of the flexor retinaculum from where Respondent had performed his surgery. (Dr. Jacobs; Dr. Shockley testimony; Exh. K, L)

Upon review of the operative reports, the expert testimony and opinions, and based upon its own review of the MRI, the Board was persuaded that Respondent did in fact perform a tarsal tunnel release for AK on June 29, 2005.[4]

CONCLUSIONS OF LAW

Count I- Professional Incompetency

645 IAC 224.2(2) provides, in relevant part:

> **645-224.2(149,272C) Grounds for discipline.** The board may impose any of the disciplinary sanctions provided in rule 645-224.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:
> ...
> **224.2(2)** Professional incompetency. Professional incompetency includes, but is not limited to:
> *a.* A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.
> *b.* A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting under the same or similar circumstances.
> *c.* A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.
> *d.* Failure to conform to the minimal standard of acceptable and prevailing practice of a podiatrist in this state.

The preponderance of the evidence established that Respondent's clinical documentation violated the professional competency standards established by 645 IAC 224.2(2)"c" and "d." Respondent failed to exercise that degree of care which is ordinarily exercised by the average practitioner, acting in the same or similar circumstances and he failed to conform to the minimal standard of acceptable and prevailing practice of a podiatrist in this state. Proper documentation is a very basic element of competent practice. Without proper documentation in the patient record, it is impossible to determine whether

[4] Although it was not at issue in this hearing, the Board was uncertain, based on this record, whether Respondent in fact performed the plantar fasciotomy.

Respondent is in fact performing the appropriate examinations and assessments of the patient. In addition, it is impossible to understand or evaluate his thought process in formulating a treatment plan for the patient.

Count II- Practice Harmful or Detrimental to the Public

Pursuant to Iowa Code sections 147.55(3), 272C.10 (3) and 645 IAC 224.2(3) the Board is authorized to discipline a licensee for engaging in practices that are harmful or detrimental to the public. Proof of actual injury need not be established. The preponderance of the evidence established that Respondent engaged in a practice that was potentially harmful or detrimental to the public, i.e. failure to conform to the minimum standards of practice with respect to clinical documentation.

Count III- Negligence

Pursuant to 645 IAC 224.2(11), the Board is authorized to discipline a licensee for negligence in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession. The preponderance of the evidence established that Respondent was negligent in his practice of podiatry by failing to exercise due care with respect to his clinical documentation for patient AK.

DECISION AND ORDER

IT IS THEREFORE ORDERED that License Number 00508, issued to Respondent Navin Kumar Gupta, DPM, is hereby placed on PROBATION for an indefinite period, effective immediately upon issuance of this decision. IT IS FURTHER ORDERED that Respondent's probation is subject to the following terms and conditions:

A. Within ninety (90) days of issuance of this Decision and Order, Respondent shall attend the Patient Documentation Seminar offered by the Center for Personalized Education for Physician (CPEP) in Denver,

Colorado. All costs of attending the seminar are to be paid by Respondent.

B. Respondent shall also participate in CPEP's six-month follow-up program to the Patient Documentation Seminar, which provides on-going chart review and feedback to the participants in order to help them apply the principles of appropriate documentation in their practice.

C. Respondent shall remain on probation for a period of six months following his completion of the CPEP follow-up program. During this time, Respondent's patient charts shall be subject to random review to ensure his implementation of appropriate standards of documentation.

Upon successful completion of the terms of probation, Respondent's license will be restored to its unrestricted status.

IT IS FURTHER ORDERED that if Respondent does not fully comply with the requirements of this Decision and Order, the Board may take further disciplinary action, pursuant to Iowa Code section 272C.3(2)(a)(2009).

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6, that Respondent shall pay $75.00 for fees associated with the disciplinary hearing and $660.00 for the court reporter fees. The total fees of $735.00 shall be paid within thirty (30) days of receipt of this decision.

This findings of fact, conclusions of law, decision and order is approved by the board on October 8, 2010.