

SUNSET REVIEW
OF
THE COLORADO PODIATRY BOARD

Submitted by
The Colorado Department of Regulatory Agencies
Office of Policy & Research
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The Honorable Vickie Agler, Chair
Joint Legislative Sunrise/Sunset Review Committee
State Capitol Building
Denver, CO 80203

Dear Representative Agler:

The Colorado Department of Regulatory Agencies has completed the evaluation of the Colorado Podiatry Board. We are pleased to submit this written report, which will be the basis for my office's oral testimony before the Joint Legislative Sunrise/Sunset Review Committee. The report is submitted pursuant to Section 24-34-104 (8)(a), of the Colorado Revised Statutes, which states in part:

"The Department of Regulatory Agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...

The Department of Regulatory Agencies shall submit a report and such supporting materials as may be requested, to the Sunrise and Sunset Review Committee created by joint rule of the Senate and House of Representatives, no later than July 1 of the year preceding the date established for termination..."

The report discusses the question of whether there is a need for the regulation provided under 12-32-101, et. seq. C.R.S. The report also discusses the effectiveness of the board and staff in carrying out the intention of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Joseph A. Garcia
Executive Director

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EXECUTIVE SUMMARY

The Department of Regulatory Agencies has completed its review of the Colorado Podiatry Board. It has found that the regulation of podiatry practice and the licensure of podiatrists should continue. The Board should also continue independently since it has been able to efficiently deal with complaints and administer disciplinary action when appropriate. Recent litigation costs have resulted in higher renewal fees for podiatrists. However, the Division of Registrations has implemented a plan to minimize fee fluctuations in the future. Therefore, this review finds no reason to alter the existing regulatory framework based solely on the issue of high renewal fees.

It is necessary to regulate podiatrists because they are practitioners who function independently using techniques that are invasive and life-threatening to consumers of their services or could result in permanent injury. They make decisions independently, either with or without consultation with other medical practitioners, that directly affect the health, safety, welfare, and quality of life of such consumers. It is unlikely that consumers would have access to the kinds of information needed to make reasonable choices between incompetent and competent practitioners. Therefore, state regulation provides a needed element of consumer protection by ensuring that only qualified podiatrists are allowed to practice in Colorado.

BACKGROUND

THE SUNSET PROCESS

The Colorado Podiatry Board in the Division of Registrations of the Department of Regulatory Agencies shall be terminated on July 1, 1995, unless continued by the General Assembly (24-34-104(19)(c)). During the year prior to this date, it is the duty of the Department of Regulatory Agencies to conduct an analysis and evaluation of the Board's regulation of podiatrists and the practice of podiatry in the State of Colorado pursuant to 24-34-104(9)(b).

During this review, the Board must demonstrate that there is still a need for the licensure of podiatrists and the regulation of podiatry practice and that its regulation is the least restrictive regulation consistent with the public interest. The Department's findings and recommendations are submitted to the Sunrise and Sunset Review Committee of the General Assembly. (Statutory criteria used in sunset reviews may be found in Appendix A.)

This sunset review process included an analysis of the statute and rules, interviews with Board members, licensees, staff, assistant attorneys general, professional associations, and other industry representatives. The Department makes every effort to elicit information and comment from all interested parties.

HISTORY

The practice of podiatry was originally called chiropody and the degree granted by medical schools to a graduate was called a doctor of surgical chiropody (D.S.C.). In 1958, the term chiropody was officially changed to podiatry by the national association, the American Podiatric Medical Association. In 1973, the practice in Colorado became statutorily known as podiatry and the practitioner became known as a doctor of podiatric medicine (D.P.M.).

Podiatry was first regulated in 1915 under the Colorado Board of Medical Examiners. In 1943, a podiatry advisory Board was created to advise the Medical Board on podiatry issues. This Board consisted of three members and was called the Colorado Chiropody Board. In 1973, it was renamed the Colorado Podiatry Board and increased to five members.

Under the advisory Podiatry Board, licensure and disciplinary matters were taken up by the Board for review and a recommendation would be made to the Board of Medical Examiners. The Board of Medical Examiners reviewed the cases leading to the submitted recommendations and made its own decision as to the disposition of

the case or application. Such cases became prioritized with other Medical Board cases.

In 1985, the Board was separated from the Board of Medical Examiners and became an independent policy autonomous board. The two-tiered regulatory system was found to be ineffective and non-productive.

Scope of practice changes. Podiatry has been a constantly changing medical occupation. These changes have been reflected in statutory definitions of the scope of practice since the practice was first regulated. The changes have reflected expansions in training and education that resulted in new directions in the treatment of the human foot and in manifestations of systemic disease in the foot.

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

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

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

The statute was amended again in 1967 and until 1985, no further changes occurred in the definition of podiatry. The podiatrist could diagnose and medically and surgically treat any part of the toes and foot except for amputation of the foot or toes and except for the removal of any bone of the foot.

In 1985, podiatry was redefined to include diagnosis and the medical, surgical, mechanical, manipulative, and electrical treatment of disorders of the human toe and foot, including the ankle and tendons that insert into the foot. Podiatrists may not amputate the foot and may use only local anesthetic. Surgery performed on the ankle below the skin level must be performed in a licensed hospital. To perform ankle surgery, the podiatrist must also be licensed and certified by the American Board of Podiatric Surgeons or perform the surgery under the supervision of someone who is so certified or under the supervision of a licensed physician who is certified by the American Board of Orthopedic Surgery.

In 1989, the Podiatry Board underwent sunset review resulting in numerous changes and updates to the law. For instance, the practice of podiatry was clarified and the podiatric surgery requirement was expanded.

SUMMARY OF STATUTE

Definition. Podiatry is defined as the diagnosis and the medical, surgical, mechanical, manipulative, and electrical treatment of disorders of the human toe and foot, including the ankle and tendons that insert into the foot. Podiatry does not include amputation of the foot or the administration of other than a local anesthetic (12-32-101, C.R.S.). To perform surgical procedures of the ankle below the skin, the podiatrist must be certified by the American Board of Podiatric Surgeons or perform the surgery under the supervision of someone who is so certified or licensed to practice medicine in the state and certified by the American Board of Orthopedic Surgery. (12-32-101.5, C.R.S.)

Protected titles under section 12-32-109(2) include "podiatrist", "foot specialist", "foot correctionist", "foot expert", "practipedist", and "podologist". If a podiatrist calls himself or herself a podiatric physician, the title must be followed by the phrase "practice limited to treatment of the foot". He or she may not use the prefix doctor without following it with the term "podiatrist" or "podiatric medicine".

Exceptions to licensure. Anyone practicing podiatry must be licensed to do so with the exception of those in residency programs. All residents are required to register with the Board and attend a program in a hospital that the Board has determined to have met minimum standards for residency training. (12-32-102)

The statute does not require licensure of military podiatrists, nor does it require licensed physicians or osteopaths to obtain a podiatry license to practice on the human foot. Dealers and retailers of corrective shoes, arch supports, or similar mechanical appliances and foot remedies are not required to be licensed. Persons such as physician extenders who work under the personal and responsible direction of a licensed podiatrist are also exempt. (12-32-109(5) and (6), C.R.S.)

Board. The Podiatry Board has five members, four podiatrists and one public member. The Governor may remove members for misconduct, incompetency, or neglect of duty. (12-32-103)

The Board has the power to promulgate rules and regulations, examine and license applicants, renew licenses, conduct investigations, and conduct disciplinary hearings. The Board has investigative subpoena authority and can prosecute or seek injunction against those violating the podiatry law. (12-32-104)(1)

Licensure requirements. An applicant for a podiatry license must be a graduate of a school of podiatry which requires at least a two-year, pre-podiatry curriculum and a four-year podiatry curriculum. The program must be approved by the Podiatry Board. The applicant must pass an examination on the treatment of the human foot given by the Podiatry Board and an examination in the basic sciences given by the National Board of Podiatry Examiners. (12-32-105)

The Board must administer and score the examination and determine a passing score. If the applicant fails the first examination, he or she may be re-examined at the next administration. If the person fails the examination a second time, he or she must wait one year before re-taking it. (12-32-106)

Disciplinary action-unprofessional conduct. Under section 12-32-107, the Podiatry Board may refuse to issue or renew a license, issue letters of admonition without a hearing, place licensees on probation, or revoke or suspend a license. The grounds for disciplinary action or unprofessional conduct are fairly standard for a regulatory statute and include:

- Resorting to fraud, misrepresentation, or deception in obtaining a license or in taking the examination;
- Conviction of a felony or pleading guilty or nolo contendere to a felony;
- Habitual intemperance or excessive use of a habit-forming drug or controlled substance;
- Aiding and abetting in the unlicensed practice of podiatry or aiding and abetting the practice of a podiatrist who is suspended;
- Any act or omission which fails to meet generally accepted standards of practice;
- Physical or mental disability that makes the licensee unable to provide podiatric services with reasonable skill and safety;
- Misleading, deceptive, or false advertising;
- Abuse of health insurance prohibited by section 18-13-119;
- Engaging in any sexual contact with patient; and,
- Revocation or suspension by any other state, territory, or country.

(12-32-107)

Other disciplinary matters. The Board may enlist the help of other podiatrists or physicians in the discharge of its duties. Licensees must report to the Board any podiatrist that such licensee knows to have violated the podiatry law. The Board is required to conduct an investigation if disciplinary action is taken by a hospital to revoke or suspend the hospital privileges of a podiatrist or if a hospital has allowed the podiatrist to resign for reasons of unprofessional conduct. The Board must also conduct an investigation if a professional review committee takes disciplinary action, or if a malpractice settlement or judgment has been entered against a podiatrist. (12-32-108.3) The Board, through the Attorney General, may seek to enjoin those who violate the provisions of the act. (12-32-113)

Investigations. The Board is allowed to keep confidential or close to public scrutiny investigations of cases until such time as the Board decides to take action against the podiatrist. Records, resulting from proceedings in which a podiatrist charged with habitual intemperance or drug use and has stipulated by agreement to treatment in a rehabilitation program approved by the Board may be closed to public scrutiny and the entire record kept confidential. If the Executive Director of the Department of Regulatory Agencies receives complaints about a podiatrist, he or she may order the Podiatry Board to conduct an investigation. (12-32-108.3)

Review of proceedings. The Board may reconsider any action taken against a licensee or reduce or modify the severity of any order. Upon such a request, the Board may ask the Attorney General to conduct an investigation and may in its sole discretion hold a hearing to determine the facts of the matter (12-32-108.5).

Appeals of Board decisions are heard by the Court of Appeals (12-32-108.7).

Violations. A violation of the Podiatry Act by persons, associations, or corporations is a Class 3 misdemeanor. However, any person presenting a diploma, license, certificate, or credentials that are false or practices under a false name or impersonates a licensee of like or different name commits a Class 6 felony. (12-32-109)

Professional Corporations. Professional corporations may be organized for the purposes of conducting podiatry practice by licensees actively engaged in the practice of podiatry. Lay directors and officers may not exercise any authority in professional matters. The corporation must be insured against liability for damages resulting from the licensee's practice or from acts of non-professional employees. (12-32-109.5)

SUNSET ANALYSIS

The primary question answered by the sunset review is whether or not regulation of an occupation should continue.

The practice of podiatry is a specialty within the practice of medicine. The practice affects the entire human body, as well as the patient's overall health and well-being. Negligent or incompetent podiatric practice could result in death or permanent injury. The fact that podiatrists administer drugs further exposes the patient to significant risk.

It is not reasonable to expect that patients have the knowledge to discern competent from incompetent practitioners. Therefore, patients cannot make informed choices on podiatric treatment. Since the ability to practice at a minimum level of competency and with reasonable skill and safety is critical to a patient's life and well-being, the state, through examination, licensing, and discipline, is the best entity to protect the consumer.

The next level of analysis in the sunset review questions if the present regulatory structure is the most efficient. In terms of the instant case, this raises a discussion on the merits of the Podiatry Board's independent policy-making status. After various configurations, the Podiatry Board was separated from the Board of Medical Examiners in 1985.

The consumer protection role of the Board is the fundamental measure of the Board's success. That role is largely, though not exclusively, defined by the Board's ability and willingness to discipline podiatrists who have harmed patients. The following chart shows complaint and disciplinary actions conducted by the Podiatry Board since FY 90/91. In addition to these actions, the Board issued eight Letters of Admonition, a less serious disciplinary response by the Board.

	90/91	91/92	92/93	93/94
Complaints	7	8	20	38
Dismissals	6	4	7	17
Stipulations	0	1	0	2
Revocations	0	0	0	1

Prior to the creation of an autonomous Podiatry Board in 1985, the Podiatry Board was advisory and the Medical Board was required by statute to seek the advice of the advisors board. Problems, such as duplication of effort, conflict over examination issues, and disagreement over proper discipline all contributed to a less efficient program. These problems have been essentially solved by the creation of the autonomous Podiatry Board.

Another measure of the Board's effectiveness concerns general administrative duties such as licensing functions, examinations, and an overall sense of even-handedness by the Board towards consumers as well as licensees.

This sunset review found that the Board's administrative functions are carried out efficiently and effectively. In particular, interviews with podiatrists and their professional association reveal that the present administration of the regulatory program is functioning smoothly and offers significant protection to consumers without imposing burdensome and unnecessary regulation on practicing podiatrist.

One issue that does bear some examination is the fee to renew the podiatry license. Presently, that fee is \$709.00 which is quite higher than previous fees. There are a couple of factors that have created this situation.

The primary cause of the fee increase is the extensive litigation required in several cases recently. When these costs are spread among the approximately 120 licensees, the resulting high fees are unavoidable.

The Division of Registrations has established a plan to counteract such fluctuations. Essentially, the Division will attempt to establish and maintain a fund balance of 35-40% of estimated expenditures of the Podiatry Board. Presently, the Division attempts to balance revenues (license fees, and examination fees, for instance) with estimated expenditures to achieve a zero to near-zero fund balance each year. The creation of a surplus will provide a significant buffer against heavy costs of litigation which will probably continue given the nature of some cases now being evaluated.

Other ideas to combat high fees have been considered. They include:

- Returning the regulation of podiatry to the Board of Medical Examiners. If this were to be implemented, it would be reasonable to expect the same problems with complaint prioritization that existed prior to 1985, to surface again.
- Return the regulation of podiatry to the Board of Medical Examiners but give an autonomous panel of podiatrists disciplinary authority. This would solve the high fees for podiatrists but would do so by shifting the costs to Colorado physicians.
- The Podiatry Board could be eliminated and the program administered by DORA (as with physical therapy). This would create significant problems in administration and evaluation of the practical examination, in particular.

It appears that the solution pursued by the Division of Registrations is the most prudent course at this time and the one with the greatest potential of success. Next year's renewal fees will be \$500 which is a more reasonable amount and will still allow the fund balance surplus to be initiated although it will take some time to build a cushion of 35-40% of expenditures.

It would be somewhat unrealistic to expect such a small population of licensees in a medical specialty not to encounter these types of problems in administering a regulatory scheme. However, these types of issues should not engender an overreaction or restructuring of the regulatory program. This review finds that the autonomous Podiatry Board should continue.

The Podiatry Board underwent sunset review in 1989. Many changes in the statute were made at that time and the program is operating smoothly. Therefore, this review recommends that the Sunrise/Sunset Committee consider establishing the maximum period of time before the next sunset review.

RECOMMENDATION 1: THE GENERAL ASSEMBLY SHOULD CONTINUE THE REGULATION OF PODIATRY THROUGH THE PODIATRY BOARD.

STATUTORY RECOMMENDATIONS

This section of the review contains recommended changes to the Podiatry Practice Act if the General Assembly continues the present form of regulation.

RECOMMENDATION 2: THE PODIATRY ACT SHOULD BE AMENDED BY REPEALING SECTION 12-32-107(F) AND ADDING LANGUAGE UPDATING THE PROHIBITION AGAINST ALCOHOL AND DRUG ABUSE.

Section 12-32-107(f) defines as unprofessional conduct the habitual intemperance or excessive use of habit-forming drugs or controlled substances.

This language should be changed and updated because it is confusing and potentially difficult for the board to prove. The General Assembly should amend 12-32-107(f) by the addition of the following language:

"is addicted to or dependent on alcohol or habit-forming drugs or is a habitual user of controlled substances, as defined in section 12-22-303(7) or other drugs having similar effects"

RECOMMENDATION 3: AMEND SECTION 12-32-107(C) TO INCLUDE A DEFERRED SENTENCE AS GROUNDS FOR DISCIPLINE.

This section addresses the Board's authority to discipline a licensee when he has committed a felony. The section does not speak to deferred sentence situations. Such a situation would involve a defendant that pleads guilty to a felony offense in return for which he successfully completes time in public service ordered by the court.

The Board should have the authority to discipline podiatrists who are accepting deferred sentences for felonies. The Board could use the plea in the deferred sentence as proof of a criminal act which merits consideration of discipline. This would end the incentive for any podiatrist to accept a deferred sentence in order to avoid action on their license, as well as hold the podiatrist accountable for his behavior.

OPR recommends that the following language be amended to read:

"Conviction of a felony or conviction of any crime that would constitute a violation of the Podiatry Act. For purposes of this subsection, a conviction shall include a plea of guilty, a plea of nolo contendere or a deferred sentence."

RECOMMENDATION 4: UPDATE CONDITIONS FOR REINSTATEMENT OF A LICENSE.

Section 12-32-115(3) addresses renewal of the podiatric license. The last sentence of (3) speaks to situations in which a licensee has allowed his license to lapse for more than two years. The statute requires that the licensee, in arrears, apply for and receive a new license. A two year lapse in practice can be a problem. The podiatrist's skills and knowledge may have deteriorated if he has not been in active practice. In some cases, the Board might choose to require a licensee to be re-examined and demonstrate that he is qualified to practice. There may be some cases, however, in which the Board would impose requirements somewhat short of re-licensure.

The Board should have more flexibility to deal with these cases. This can be given to the Board by amending 12-32-115(3) to read:

"No license to practice podiatry which has been delinquent for more than two years shall be reinstated unless the applicant fulfills and meets all requirements and conditions required by the Board. The Board shall establish by rule and regulation the requirements for a relicensure or renewal of an elapsed license after two years."

RECOMMENDATION 5: UPDATE LANGUAGE PROHIBITING SECURING A LICENSE BY FRAUD.

C.R.S. 12-32-107(x) defines as unprofessional conduct:

"Misstating or omitting a material fact in procuring or attempting to procure a license or in taking the examination provided for in this article."

This situation has been challenged on grounds that it does not apply to renewal of a license to practice podiatry and also does not apply to innocent omissions.

Given the severity of harm that may result from incompetent practice in medical fields (death or serious injury) it is reasonable to conclude that the General Assembly intended for applicants, whether applying for an initial license or renewing an existing license, to disclose all appropriate information that might have a bearing on that individual's ability to practice safely. Further, it is then reasonable to believe that the legislative intent is that the Podiatry Board consider all of this information and make appropriate determinations within its public protection duties.

The statute should be made more comprehensive by repealing C.R.S. 12-32-107(x) and replacing it with the following:

"Resorting to fraud, misrepresentation, misleading omission, material deception in applying for, securing, renewing, or seeking reinstatement of a license or in taking the examination provided for in this article."

RECOMMENDATION 6: UPDATE SEXUAL MISCONDUCT AS GROUNDS FOR DISCIPLINE

C.R.S. 12-32-107(s) prohibits engaging in a sexual act with a patient in the course of patient care. This prohibition is being updated in all medical regulatory statutes. Because of the severe potential for abuse of patients in any relationship with a health care provider or medical professional in a position of trust, it is appropriate that a "cooling-off" period be observed before a sexual relationship is initiated. The statute should be amended to repeal (s) and replace with the following language:

"Engaging in a sexual act with a patient during the course of patient care or during the period of six months following the termination of the podiatrist/patient relationship. "Sexual act" as used in this paragraph means sexual contact, sexual intrusion, or sexual penetration as defined in section 18-3-401, C.R.S."

RECOMMENDATION 7: REMOVE OUTDATED PROVISION CONCERNING COMPLAINTS.

12-32-108.3, C.R.S. empowers the Executive Director of the Department of Regulatory Agencies to order the Podiatry Board to conduct an investigation if the Executive Director has received a complaint. This is an outdated provision. The Podiatry Board is autonomous in conducting investigations and administering discipline, subject to due process requirements. In actual practice, the Executive Director refers all complaints against podiatrists to the Board for review.

The General Assembly should amend 12-32-108.3, C.R.S. by repealing subsection (14)(a), (b), and (c).

RECOMMENDATION 8: REQUIRE PODIATRISTS TO HAVE MALPRACTICE INSURANCE.

Section 12-32-109.5(1)(g), C.R.S. speaks to malpractice insurance for professional corporations. However, there is no requirement imposed on podiatrists who are not practicing within such a corporation.

Protection of the public would be enhanced by requiring malpractice insurance of all podiatrists. While it is likely that few podiatrists choose to accept the risk that accompanies lack of malpractice insurance, the requirement should be in law where violations would constitute grounds for discipline.

It is reasonable to set the limits for a malpractice insurance requirement at the same level now required of the professional corporation where podiatry is practiced. Presently, that level is set at the amount of \$50,000 for each claim and an aggregate top limit of liability per year for all claims of \$150,000.

The General Assembly should amend the Podiatry Act to require that all podiatrists carry malpractice insurance in the above amounts.

RECOMMENDATION 9: CLARIFY THAT LETTER OF CONCERN IS CONFIDENTIAL

In section 12-32-108.3(2)(c)(V), the General Assembly has empowered the Podiatry Board to issue a letter of concern when a complaint reveals conduct by a podiatrist that does not warrant formal action but that could lead to harm to a patient if continued. The letter of concern is clearly distinguished from the letter of admonition, which is the least serious disciplinary action available to the Board.

Inasmuch as the letter of concern does not allege a violation of the Practice Act, it makes sense that the letter ought to be confidential. This is in keeping with the intent of 12-32-108.3(12) which exempts investigations and examinations of the Board from public scrutiny. This provision protects the podiatrist from damage to his reputation which could result from unsubstantiated complaints. The Board makes all formal actions public, of course.

Another reason supporting the confidential letter of concern is the provision of 12-32-108.3(V), C.R.S. prohibiting the Board from issuing a second letter of concern for a second or subsequent actions of the same or a similar nature. This prevents abuse of the letter of concern. Without this, the letter of concern could be used to gloss over bad podiatric practice and prevent the public from having access to that information.

The General Assembly should amend 12-32-108.3(V) by adding "confidential" to the two references to a letter of concern so that the statute refers to a "confidential letter of concern" in both instances.

RECOMMENDATION 10: REPEAL THE PODIATRIC CONTINUING EDUCATION REQUIREMENT

This sunset review recommends that the podiatric continuing education requirement be repealed. The shortcomings of state mandated continuing education have been thoroughly discussed by DORA in the past as well as addressed by numerous national organizations.

Briefly, one of the most significant flaws in state mandated continuing education is that there is no requirement that a participant conduct any type of needs assessment before commencing training. In other words, participants may take course work not related to his area of practice. Instead, he may attend a particular course because it sounds interesting or because it is near his home, or in Hawaii, or because he needs to complete a certain number of hours before renewal deadline in which case he may take whatever course is convenient.

This sunset review strongly supports the position that pursuit of education by professionals is worthwhile and benefits consumers when the individual seeks that training for self improvement. However, requiring such pursuits by law contributes to a myth of competency that ultimately may deceive the public.

If the educational and stringent examination requirements of the Colorado Podiatry Board are not sufficient to establish the competency of a podiatrist, it is doubtful that the minimal hours of continuing education required can significantly alter the practitioners ability to safely practice.

APPENDIX A

SUNSET STATUTORY EVALUATION CRITERIA

- I. Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- II. If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- III. Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices of the Department of Regulatory Agencies and any other circumstances, including budgetary, resource and personnel matters;
- IV. Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- V. Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- VI. The economic impact of regulation and, if national economic information is available, whether the agency stimulates or restricts competition;
- VII. Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- VIII. Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;
- IX. Whether administrative and statutory changes are necessary to improve agency operations to enhance public interest.