

BEFORE THE
PODIATRIC MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)
Against:)
)
Connie Melanie Choy, D.P.M.)
)
Doctor of Podiatric Medicine)
Certificate No. E-5005)
)
Respondent.)

Case No: 500-2022-001257

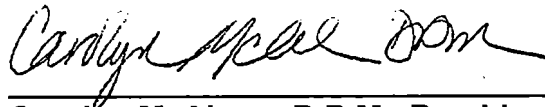
DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Podiatric Medical Board of the Department of Consumer Affairs, State of California, as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on OCT 25 2024.

DATED SEP 26 2024.

PODIATRIC MEDICAL BOARD



Carolyn McAloon, D.P.M., President

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 WENDY WIDLUS
Deputy Attorney General
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Attorneys for Complainant

9
10 **BEFORE THE**
PODIATRIC MEDICAL BOARD
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12
13 In the Matter of the Accusation Against:
14 CONNIE MELANIE CHOY, D.P.M.
15 Specialty MOB – 1st floor Podiatry
16 3600 Broadway
Oakland, CA 94611-5730
17 Doctor of Podiatric Medicine License
18 Number E 5005,
19 Respondent.

Case No. 500-2022-001257
OAH No. 2023090572
**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

20
21 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
22 entitled proceedings that the following matters are true:

23 **PARTIES**

24 1. Brian Naslund (Complainant) is the Executive Officer of the Podiatric Medical Board
25 (Board). He brought this action solely in his official capacity and is represented in this matter by
26 Rob Bonta, Attorney General of the State of California, by Wendy Widlus, Deputy Attorney
27 General.

28 //

1 **CULPABILITY**

2 9. Respondent understands that the charges and allegations in Accusation No. 500-2022-
3 001257, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and
4 Surgeon's Certificate.

5 10. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
7 basis for the charges in the Accusation and that those charges constitute cause for discipline if
8 sustained. Respondent believes that she could present evidence disputing the factual basis for the
9 charges in the Accusation, but she hereby gives up her right to contest that cause for discipline
10 exists based on those charges.

11 11. Respondent agrees that her Podiatrist License is subject to discipline and she agrees
12 to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

13 12. If an Accusation and/or Petition to Revoke Probation is filed against the Respondent
14 before the Board, or Respondent should ever apply or reapply for a new license or certification,
15 and/or file a petition for reinstatement of a license, before the Board or any other health care
16 licensing action agency in the State of California, all of the charges and allegations contained in
17 Accusation No. 500-2022-001257 shall be deemed to be true, correct, and fully admitted by
18 Respondent for the purpose of any Statement of Issues or any disciplinary proceeding seeking to
19 deny, restrict, or revoke licensure or any petition proceeding seeking to reinstate licensure or
20 modify probation.

21 **CONTINGENCY**

22 13. This stipulation shall be subject to approval by the Podiatric Medical Board.
23 Respondent understands and agrees that counsel for Complainant and the staff of the Podiatric
24 Medical Board may communicate directly with the Board regarding this stipulation and
25 settlement, without notice to or participation by Respondent or her counsel. By signing the
26 stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek
27 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
28 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails

1 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
2 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
3 action between the parties, and the Board shall not be disqualified from further action by having
4 considered this matter.

5 14. The parties understand and agree that Portable Document Format (PDF) and facsimile
6 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
7 signatures thereto, shall have the same force and effect as the originals.

8 15. In consideration of the foregoing admissions and stipulations, the parties agree that
9 the Board may, without further notice or formal proceeding, issue and enter the following
10 Disciplinary Order:

11 **DISCIPLINARY ORDER**

12 **IT IS HEREBY ORDERED THAT** Connie Melanie Choy, D.P.M. shall be and is hereby
13 Publicly Reprimanded pursuant to California Business and Professions Code sections 2222 and
14 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation
15 No. 500-2021-001178, is as follows:

16 This Public Reprimand is issued in connection with a Board review regarding Respondent's
17 review of x-rays and care of one patient in June, July, and August, 2019, as set forth in
18 Accusation No. 500-2022-001257.

19 1. **MEDICAL RECORD KEEPING COURSE** Within 60 calendar days of
20 the effective date of this Decision, respondent shall enroll in a course in medical record keeping,
21 at respondent's expense, approved in advance by the Board or its designee. Failure to
22 successfully complete the course during the first 6 months of probation is a violation of probation.

23 A medical record keeping course taken after the acts that gave rise to the charges in the
24 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
25 or its designee, be accepted towards the fulfillment of this condition if the course would have
26 been approved by the Board or its designee had the course been taken after the effective date of
27 this Decision.

28 Respondent shall submit a certification of successful completion to the Board or its

1 designee not later than 15 calendar days after successfully completing the course, or not later than
2 15 calendar days after the effective date of the Decision, whichever is later.

3 2. COST RECOVERY Within 90 calendar days from the effective date of
4 the Decision or other period agreed to by the Board or its designee, respondent shall reimburse
5 the Board the amount of \$22,002.75 for its investigative and prosecution costs. The filing of
6 bankruptcy or period of non-practice by respondent shall not relieve the respondent of her
7 obligation to reimburse the Board for its costs.

8 ACCEPTANCE

9 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
10 discussed it with my attorney, Lindsay M. Johnson. I understand the stipulation and the effect it
11 will have on my Podiatrist License. I enter into this Stipulated Settlement and Disciplinary Order
12 voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the
13 Podiatric Medical Board.

14
15 DATED: 8/26/24 
16 CONNIE MELANIE CHOY, D.P.M.
Respondent

17 I have read and fully discussed with Respondent Connie Melanie Choy, D.P.M. the terms
18 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary
19 Order. I approve its form and content.

20 DATED: 08/27/24 
21 LINDSAY M. JOHNSON
22 Attorney for Respondent
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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Podiatric Medical Board.

DATED: August 28, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



WENDY WIDLUS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 500-2022-001257

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 WENDY WIDLUS
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8

9 **BEFORE THE**
PODIATRIC MEDICAL BOARD
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12
13 In the Matter of the Accusation Against:

Case No. 500-2022-001257

14 **CONNIE MELANIE CHOY, D.P.M.**

15 Specialty MOB-1st floor Podiatry
3600 Broadway
16 Oakland, CA 94611-5730

A C C U S A T I O N

17 Doctor of Podiatric Medicine License No. E-5005,

18 Respondent.

19
20 **PARTIES**

21 1. Brian Naslund (Complainant) brings this Accusation solely in his official capacity as
22 the Executive Officer of the Podiatric Medical Board (Board).

23 2. On June 1, 2012, the Board issued Podiatrist License No. E-5005 to Connie Melanie
24 Choy, D.P.M. (Respondent). That license was in full force and effect at all times relevant to the
25 charges brought herein and will expire on July 31, 2025, unless renewed.

26 **JURISDICTION**

27 3. This Accusation is brought before the Board under the authority of the following
28 laws. All section references are to the Business and Professions Code (Code) unless otherwise

1 indicated.

2 4. Section 2229 of the Code states:

3 (a) Protection of the public shall be the highest priority for the Division of
4 Medical Quality, the California Board of Podiatric Medicine, and administrative law
judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

5 (b) In exercising his or her disciplinary authority an administrative law judge of
6 the Medical Quality Hearing Panel, the division, or the California Board of Podiatric
7 Medicine, shall, wherever possible, take action that is calculated to aid in the
rehabilitation of the licensee, or where, due to a lack of continuing education or other
8 reasons, restriction on scope of practice is indicated, to order restrictions as are
indicated by the evidence.

9 (c) It is the intent of the Legislature that the division, the California Board of
10 Podiatric Medicine, and the enforcement program shall seek out those licensees who
11 have demonstrated deficiencies in competency and then take those actions as are
indicated, with priority given to those measures, including further education,
12 restrictions from practice, or other means, that will remove those deficiencies. Where
13 rehabilitation and protection are inconsistent, protection shall be paramount.

14 5. Section 2222 of the Code states:

15 The California Board of Podiatric Medicine shall enforce and administer this
16 article as to doctors of podiatric medicine. Any acts of unprofessional conduct or
17 other violations proscribed by this chapter [The Medical Practice Act] are applicable
18 to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing
Panel established under Section 11371 of the Government Code is vested with the
19 authority to enforce and carry out this chapter as to licensed physicians and surgeons,
20 the Medical Quality Hearing Panel also possesses that same authority as to licensed
21 doctors of podiatric medicine.

22 The California Board of Podiatric Medicine may order the denial of an
23 application or issue a certificate subject to conditions as set forth in Section 2221, or
24 order the revocation, suspension, or other restriction of, or the modification of that
25 penalty, and the reinstatement of any certificate of a doctor of podiatric medicine
26 within its authority as granted by this chapter and in conjunction with the
27 administrative hearing procedures established pursuant to Sections 11371, 11372,
28 11373, and 11529 of the Government Code. For these purposes, the California Board
of Podiatric Medicine shall exercise the powers granted and be governed by the
procedures set forth in this chapter.

6. Section 2497 of the Code states:

(a) The board may order the denial of an application for, or the suspension of,
or the revocation of, or the imposition of probationary conditions upon, a certificate
to practice podiatric medicine for any of the causes set forth in Article 12
(commencing with Section 2220) in accordance with Section 2222.

(b) The board may hear all matters, including but not limited to, any contested
case or may assign any such matters to an administrative law judge. The proceedings

1 shall be held in accordance with Section 2230. If a contested case is heard by the
2 board itself, the administrative law judge who presided at the hearing shall be present
3 during the board's consideration of the case and shall assist and advise the board.

4 7. Section 2227 of the Code states:

5 (a) A licensee whose matter has been heard by an administrative law judge of
6 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
7 Code, or whose default has been entered, and who is found guilty, or who has entered
8 into a stipulation for disciplinary action with the board, may, in accordance with the
9 provisions of this chapter:

10 (1) Have his or her license revoked upon order of the board.

11 (2) Have his or her right to practice suspended for a period not to exceed one
12 year upon order of the board.

13 (3) Be placed on probation and be required to pay the costs of probation
14 monitoring upon order of the board.

15 (4) Be publicly reprimanded by the board. The public reprimand may include a
16 requirement that the licensee complete relevant educational courses approved by the
17 board.

18 (5) Have any other action taken in relation to discipline as part of an order of
19 probation, as the board or an administrative law judge may deem proper.

20 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
21 medical review or advisory conferences, professional competency examinations,
22 continuing education activities, and cost reimbursement associated therewith that are
23 agreed to with the board and successfully completed by the licensee, or other matters
24 made confidential or privileged by existing law, is deemed public, and shall be made
25 available to the public by the board pursuant to Section 803.1.

26 8. Section 2234 of the Code states in pertinent part:

27 The board shall take action against any licensee who is charged with
28 unprofessional conduct. In addition to other provisions of this article, unprofessional
conduct includes, but is not limited to, the following:

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more
negligent acts or omissions. An initial negligent act or omission followed by a
separate and distinct departure from the applicable standard of care shall constitute
repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically
appropriate for that negligent diagnosis of the patient shall constitute a single
negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or
omission that constitutes the negligent act described in paragraph (1), including, but

1 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
2 licensee's conduct departs from the applicable standard of care, each departure
3 constitutes a separate and distinct breach of the standard of care. . .

4 9. Section 801 of the Code states in pertinent part:

5 (a) Except as provided in Section 801.01 and subdivisions (b), (c), (d), and (e)
6 of this section, every insurer providing professional liability insurance to a person
7 who holds a license, certificate, or similar authority from or under any agency
8 specified in subdivision (a) of Section 800 shall send a complete report to that agency
9 as to any settlement or arbitration award over three thousand dollars (\$3,000) of a
10 claim or action for damages for death or personal injury caused by that person's
11 negligence, error, or omission in practice, or by his or her rendering of unauthorized
12 professional services. The report shall be sent within 30 days after the written
13 settlement agreement has been reduced to writing and signed by all parties thereto or
14 within 30 days after service of the arbitration award on the parties.

11 COST RECOVERY

12 10. Section 2497.5 of the Code states:

13 (a) The board may request the administrative law judge, under his or her
14 proposed decision in resolution of a disciplinary proceeding before the board, to
15 direct any licensee found guilty of unprofessional conduct to pay to the board a sum
16 not to exceed the actual and reasonable costs of the investigation and prosecution of
17 the case.

18 (b) The costs to be assessed shall be fixed by the administrative law judge and
19 shall not be increased by the board unless the board does not adopt a proposed
20 decision and in making its own decision finds grounds for increasing the costs to be
21 assessed, not to exceed the actual and reasonable costs of the investigation and
22 prosecution of the case.

23 (c) When the payment directed in the board's order for payment of costs is not
24 made by the licensee, the board may enforce the order for payment by bringing an
25 action in any appropriate court. This right of enforcement shall be in addition to any
26 other rights the board may have as to any licensee directed to pay costs.

27 (d) In any judicial action for the recovery of costs, proof of the board's decision
28 shall be conclusive proof of the validity of the order of payment and the terms for
29 payment.(e)(1) Except as provided in paragraph (2), the board shall not renew or
30 reinstate the license of any licensee who has failed to pay all of the costs ordered
31 under this section.(2) Notwithstanding paragraph (1), the board may, in its discretion,
32 conditionally renew or reinstate for a maximum of one year the license of any
33 licensee who demonstrates financial hardship and who enters into a formal agreement
34 with the board to reimburse the board within one year period for those unpaid costs.

35 (f) All costs recovered under this section shall be deposited in the Board of
36 Podiatric Medicine Fund as a reimbursement in either the fiscal year in which the
37 costs are actually recovered or the previous fiscal year, as the board may direct.

DEFINITIONS

1
2 11. "Hallux valgus," commonly referred to as a bunion, is an inflamed swelling of the
3 small fluid-filled sac on the outside of the first joint of the big toe accompanied by enlargement
4 and protrusion of the joint and is comprised of bone and soft tissue. This foot deformity occurs
5 from years of pressure on the big toe joint (the metatarsophalangeal, or MTP, joint). Eventually,
6 the great toe joint gets out of alignment, and a bony bump forms. The medical term for bunions is
7 hallux abducto valgus.

8 12. "Hallux varus" is defined as a big toe joint deformity. As opposed to a bunion which
9 causes the big toe to point toward the other toes, hallux varus causes the big toe to point towards
10 the opposite foot away from the other toes. Hallux varus is a condition characterized by the
11 medial deviation of the hallux relative to the 1st metatarsal bone, most often the result of
12 overcorrection from prior bunion surgery. Hallux varus may be recognized immediately after
13 bunion surgery or may gradually occur in the first few months after surgery.

14 13. A "bunionette" is described as a prominence of the fifth metatarsal bone where it
15 meets the bone of the little toe; it is often associated with the little toe turning inward. Bunionettes
16 are similar to bunions, the protrusions that occur on the inside of the foot below the big toe.

17 14. Hallux varus revision surgery generally involves releasing the tight soft tissues on the
18 inside portion of the joint and possibly re-cutting the metatarsal bone to reposition it back into its
19 normal position.

20 15. The "hallux abductus angle," also known as the first metatarsophalangeal angle, is a
21 preoperative measurement used to assess the presence and severity of the alignment of the first
22 metatarsophalangeal joint on a weight-bearing dorsoplantar radiograph of the foot.

23 16. "Metatarsus adductus" ["metatarsus varus"] is a measurement to describe the degree
24 of metatarsal deviation towards the midline of the body. A measurement greater than 15 degrees
25 is abnormal. This is a common foot deformity noted at birth that causes the front half of the foot,
26 or forefoot, to turn inward. The metatarsus refers to the long bones group of bones in the middle
27 section of the foot. Each foot has five metatarsal bones, each connected to the phalanges of the
28 toes.

1 17. An "angulated fragment" is defined as a specific type of fracture displacement where
2 the normal axis of the bone has been altered such that the distal portion of the bone points off in a
3 different direction.

4 18. Sesamoid bones exist in the feet and bear the additional stress of shock absorption
5 from walking. The tibial sesamoid position is assessed by its relation to the mid-axis of the first
6 metatarsal.

7 19. A "capital fragment" is defined as a fragment of bone avulsed [forcibly torn] from the
8 head of a bone - e.g., of the metatarsus. The capital fragment, when described in an operative
9 report, refers to the distal position, [i.e., further away from the heel bone] portion of bone which
10 is resected from the proximal metatarsal using a power saw so that the capital fragment can be
11 repositioned in a more favorable position.

12 20. An "osteotomy" is defined as a surgical procedure that involves cutting bone and
13 sometimes adding bone tissue, used for changing the angular position of a joint, and is a treatment
14 for problems at the joints, i.e., the area where two bones meet. The procedure is used to correct
15 the angle, bowing or rotation of bones; shorten or lengthen bones; to correct the alignment of a
16 deformed joint; repair a damaged joint or to shift the patient's weight from a damaged area of a
17 joint to an area where there is more normal or healthy cartilage. There are many surgical
18 techniques and variations of osteotomy techniques.

19 21. A "chevron osteotomy," also called an Austin bunionectomy, is a common technique
20 for correcting mild to moderate bunion deformities. The procedure is done on the bone, and the
21 bunion is corrected by relocating or sliding across the top of the first metatarsal bone. The
22 procedure is generally used to correct the bunion by placing the metatarsal head behind the great
23 toe, aligned with lesser toes, and to release a tight tendon that tends the great toe towards the
24 second toe.

25 The osteotomy is performed near the great toe joint and is useful when the distal end of the
26 metatarsal needs to be realigned. There are many different variations of osteotomies. Some
27 osteotomies require immobilization or non-weight-bearing status for four to six weeks and
28 therefore are not popular. The choice of procedure will depend on how much of each of the

1 different bones and soft tissue are involved, as well as the individual surgeon's preferences.

2 Minimally invasive surgery allows the performance of a chevron osteotomy through small
3 percutaneous [needle puncture] incisions. Following the osteotomy, the capital fragment is
4 shifted laterally and fixated with either compression FT screws for the minimally invasive surgery
5 approach or compression PT screws for the traditional open approach.

6 22. A "K wire" [Kirschner wire] is a stainless-steel wire sharpened on one or both sides,
7 used to hold bone fragments together or to provide an anchor for skeletal traction. These wires
8 can be drilled through the bone to hold the fragments in place. The wires can be placed through
9 or be buried beneath the skin. K-wires are often used to stabilize a broken bone and can be
10 removed in the office once the fracture has healed. Some K-wires are threaded, which helps
11 prevent movement or backing out of the wire, although that can also make the wires more
12 difficult to remove. K wires are available in various types, lengths and diameters and are widely
13 used in orthopedics and other types of medical and veterinary surgery.

14 23. Fluoroscopy is a real-time study of moving body structures--similar to an X-ray
15 movie. A continuous X-ray beam is passed through the body part being examined. The beam is
16 transmitted to a TV-like monitor so that the body part and its motion can be seen in detail. As an
17 imaging tool, fluoroscopy enables physicians to look at many body systems, including the
18 skeletal, digestive, urinary, respiratory, and reproductive systems. Fluoroscopy may be
19 performed to evaluate specific areas of the body, including the bones, muscles, and joints.
20 Fluoroscopy is useful in surgery to confirm the alignment of osteotomies, bones, or placement of
21 fixation devices during a surgical procedure.

22 24. "Tightrope" is a device made by an orthopedic implant company used to stabilize the
23 syndesmosis [a joint in which the bones are united by fibrous connective tissue forming an
24 interosseous membrane or ligament] after an injury. This device allows flexible fixation, an
25 improvement over the previously rigid forms of fixation.

26 25. A "surgical curette" is an instrument used for surgical scraping or debridement of
27 human tissue. They come in a range of sizes, forms, and blade types to fit a variety of medical
28 procedures, such as the removal of diseased bone.

1 *American College of Foot and Ankle Surgeons* Fellow, certified in Foot and
2 Rearfoot/Reconstructive Surgery by the *American Board of Foot and Ankle Surgery*, and has a
3 California Radiology and Fluoroscopy Operator permit.

4 35. On or about December 9, 2022, Respondent and her attorney participated in a
5 telephonic, digitally recorded Subject interview with the Investigator and the Board's Medical
6 Consultant.

7 36. On or about March 3, 2023, the Department of Consumer Affairs Division of
8 Investigation Health Quality Investigations Unit Analyst contacted Expert Dr. 1, an approved
9 expert for the Board and confirmed the expert's qualifications to perform an expert review of the
10 case. The Analyst uploaded the electronic case binder with all of the case materials to Expert Dr.
11 1 for his expert review.

12 37. On or about March 13, 2023, the Analyst uploaded additional imaging records of
13 Patient 1 for Expert Dr. 1's expert review.

14 38. On or about March 17, 2023, Expert Dr. 1 provided the Board with his expert report
15 that he prepared on or about March 16, 2023, based on his review of all of the materials the Board
16 provided to him.

17 39. Expert Dr. 1's March 16, 2023, report delineated simple departures from the standard
18 of care for lack of adequate preoperative and postoperative X-ray documentation, lack of
19 adequate preparation in handling a postoperative complication, an inadequate plan for a third
20 surgery without referral to another provider, placing the patient in a splint instead of a short leg
21 cast to limit weight bearing, failure to properly prepare the bone surfaces to insure fusion of the
22 osteotomy site during second and third surgeries, failure to document measurements for the
23 management of hallux valgus based on evaluation of pre and postoperative imaging, and overall
24 treatment.

25 40. Expert Dr. 1's March 16, 2023, report discussed the chronology of Patient 1's various
26 surgeries and outcomes. Per Respondent's records, on June 6, 2019, Patient 1 initially saw
27 Respondent for evaluation of bilateral bunions and a bump on the lateral aspect of her left foot
28 which visit included x-rays and a discussion about surgery. According to Respondent's records

1 the patient had previously undergone unsuccessful non-surgical treatment for her painful feet with
2 other providers.

3 41. Respondent scheduled a preoperative evaluation on June 19, 2019, followed by
4 surgery on June 28, 2019, to correct hallux abducto valgus and a bunionette on Patient 1's left
5 foot.

6 42. Non-weight bearing postoperative x rays taken June 28, 2019, in the hospital's
7 postoperative care unit, revealed an angulated capital fragment. In her deposition, Respondent
8 stated she performed intraoperative fluoroscopic confirmation during the surgery, which revealed
9 satisfactory alignment of the surgery site. However, the X-rays also revealed that the capital
10 fragment was in a varus position. The Respondent did not comment on whether the tibial
11 sesamoid was peeking, a common finding in patients with hallux varus. Unfortunately,
12 Respondent stated she did not save the images.

13 43. Respondent was unable to read the X-rays before Patient 1 was discharged so
14 Respondent contacted the patient at her home after the surgery to explain her concerns and gave
15 her the opportunity to immediately return to the operating room to correct the malalignment but
16 Patient 1 declined to do so. Instead, Patient 1 and her husband did return to Respondent's office
17 on July 2, 2019, to review the X-rays and discuss her treatment options.

18 44. On July 3, 2019, Patient 1 underwent a second surgery to allow Respondent to
19 remove the screw, realign the metatarsal head, and re-fixate the metatarsal head osteotomy.
20 Respondent used intraoperative fluoroscopy to confirm the patient's fixation was secure and the
21 metatarsal head was in good alignment. According to Respondent, these intraoperative
22 fluoroscopy images were saved.

23 45. Respondent's July 3, 2019, operative report describes that she removed the screw,
24 which was not loose, and replaced it with a new screw. Respondent's operative report did not
25 describe the status of Patient 1's capsule, tendon, tissue planes, or bone. Nor did Respondent's
26 operative report or deposition testimony describe performing any other procedures, such as
27 capsule and tendon balancing, remodeling the osteotomy site, drilling the bone, or any other
28 measures to stimulate bleeding across the osteotomy site and bone healing. Respondent did not

1 give an explanation why this was not done.

2 46. Significantly, Respondent stated in her deposition that she had no recall of the details
3 of any of the procedures she performed on Patient 1.

4 47. On July 5, 2019, Dr. 2 saw Patient 1 for a postoperative inspection and dressing
5 change.

6 48. On July 18, 2019, Dr. 3, an associate podiatrist in the practice, saw Patient 1 in
7 Respondent's absence. Dr. 3 splinted Patient 1's toe with tape to maintain rectus alignment while
8 the soft tissue and bone healed and placed the patient on non-weight bearing status. In the
9 medical records, Dr. 3 noted Patient 1's complaints of painful weight bearing, hallux in slight
10 varus rotation to hallux.

11 49. On July 25, 2019, Dr. 3 saw Patient 1 and reported that the patient said she felt less
12 pulling in her toe. Patient 1 reported burning and tingling on the bottom of her foot, and Dr. 3's
13 examination revealed hallux rectus or "straight toe." Dr. 3's records state the patient was
14 instructed to continue to wear a postoperative, non-weight bearing shoe and splint the toe.

15 50. According to Patient 1 she also visited a non-Kaiser podiatrist for a second opinion
16 and fusion of the joint as well as other procedures that were discussed during that visit.

17 51. On August 2, 2019, Respondent evaluated Patient 1 for a preoperative visit in which
18 her records stated she found Patient 1 had an angular rotation of hallux. Respondent's note stated
19 she planned to remove and replace Patient 1's hardware and have the patient continue her non-
20 weight bearing status.

21 52. During her deposition, Respondent stated Patient 1 was not fully compliant with
22 regard to her non-weight bearing status. During this visit, the patient's great toe appeared
23 straight, but an X-ray confirmed that Patient 1's capital fragment had rotated and become angled.
24 During this visit, Respondent recommended a third surgery to stabilize the fragment and prevent
25 it from moving. Respondent explained to Patient 1 this problem, if untreated, would result in
26 early arthritis in the great toe joint. Respondent did not comment on any other X-ray findings
27 including a common finding in patients with hallux varus, the tibial sesamoid position after
28 surgery.

1 53. Patient 1 agreed to another surgery if Dr. 3 assisted, and Respondent agreed to this
2 request. Respondent ordered Patient 1 to undergo blood tests for calcium and Vitamin D to
3 determine if inadequate levels of those nutrients were preventing Patient 1's bone from
4 consolidating. Before the surgery date, when Respondent determined Patient 1's Vitamin D
5 levels were below normal, Respondent placed Patient 1 on vitamin D and ordered a bone
6 stimulator to enhance healing. After that, Patient 1 became ill, which resulted in her surgery
7 being postponed for two weeks.

8 54. On August 21, 2019, Patient 1 underwent her third surgery during which Respondent
9 removed the previous screw. Respondent encountered difficulty stabilizing the metatarsal head
10 on the metatarsal. Respondent used a K-wire and two screws to fixate Patient 1's metatarsal
11 head. Respondent considered using Tightrope to secure the hallux on the lateral aspect of the
12 joint but decided it was not necessary.

13 55. Respondent's August 21, 2019, operative report did not describe the procedure
14 performed in sufficient detail to enable another person to understand her thought process, the
15 problems Respondent encountered and Respondent's treatment plan. Respondent failed to
16 include any description of Patient 1's soft tissue, capsule, tendon and bone. Respondent did not
17 describe resurfacing the osteotomy surfaces to stimulate bleeding, nor did she indicate she drilled
18 Patient 1's bone to stimulate bleeding.

19 56. Respondent's August 21, 2019, operative report for this third repeat surgery did not
20 contain an extensive description of the surgery plan, the quality of the patient's tissue Respondent
21 encountered during the performed procedure, or whether Respondent's original treatment plan
22 was carried out or needed modification.

23 57. During her September 4, 2019, visit with Respondent two weeks after the August 21,
24 2019, surgery, Patient 1 explained to Respondent she felt her great toe pulling into a varus
25 position. X-rays confirmed the capital fragment was unchanged but Patient 1's toe was drifting in
26 a medial direction. Respondent review of the X-ray did not comment on whether the tibial
27 sesamoid was peeking, although this is a common finding in patients with hallux varus. The
28 radiologist's report provided very little useful information. Respondent simply reassured Patient

1 1 and splinted her toe.

2 58. Respondent saw Patient 1 on September 11, 2019, and Patient 1 reported mild nerve
3 pain and that she was elevating her legs. Patient 1 had finished her pain and antibiotic
4 medications. Patient 1 stated she was feeling a pulling and experienced pain at K-wire pin site.
5 The X-rays showed that the surgical correction was maintained without displacement.

6 59. At her five weeks postoperative visit on September 30th, the osteotomy on X-ray
7 appeared fused, but Patient 1 was having pain which Respondent determined was from the
8 screws. Respondent did not comment on any other X-ray findings, including the presence or
9 absence of tibial sesamoid peeking.

10 A fourth surgery was discussed to remove the screw and place the tight rope fixation to
11 prevent the toe from tilting into hallux varus. Patient 1 was hesitant to undergo another surgery
12 and was instead sent to physical therapy which resulted the patient experiencing increased pain
13 due to the range of motion exercises.

14 60. On Patient 1's follow-up exam on October 15, 2019, following a course of physical
15 therapy, Respondent noted crepitus in the joint and rotation or angulation of the capital fragment
16 on X-ray. Respondent stressed the importance of bringing Patient 1 back to the operating room to
17 fix the deformity with Tightrope to prevent progression of the deformity and eventual arthritis
18 requiring joint fusion.

19 61. Patient 1's last visit with Respondent was on October 15, 2019. Thereafter Patient 1
20 was seen by Dr. 4 and underwent two more surgeries including a metatarsal joint fusion by Dr. 4.

21 **DEPARTURES FROM THE STANDARD OF CARE**

22 62. With regard to surgical procedures to correct hallux varus, the standard of care is to
23 fixate the capital fragment securely to allow for "bony healing" to take place.

24 63. Expert Dr. 1's analysis states that a chevron osteotomy is one of the most common
25 surgical procedures utilized to correct a hallux valgus deformity. A radiologist read and
26 interpreted Patient 1's preoperative and postoperative X-rays and described normal findings. A
27 surgeon is expected to review the X-rays and provide the surgeon's impression of the images.

28 64. The most common causes of hallux varus after performing a bunioneectomy include

1 excessive bone resection (aka staking the metatarsal head) of the metatarsal head, over-aggressive
2 medial capsulorrhaphy (aka tightening the medial capsule too much) or lateral capsulotomy (aka
3 aggressive release of the lateral structures). The cause can also be an aggressive plantar lateral
4 release, an adductor tendon transfer, a fibular sesamoidectomy or any procedure such as moving a
5 capital fragment too much that can lead to a negative intermetatarsal angle. A chevron osteotomy
6 performed on a metatarsus adductus foot type can more easily lead to hallux varus. "Acquired
7 (i.e., as a result of a surgical complication) hallux varus occurrence" varies but it occurs one to
8 two percent of the time.

9 65. It is very important for the foot surgeon to demonstrate an understanding of both
10 preoperative and postoperative issues. Expert Dr. 1's review found that the Respondent did not
11 possess this understanding. Expert Dr. 1's review found no evidence in Respondent's medical
12 records indicating Respondent's recognition that a complication had occurred that would result in
13 hallux varus deformity. Respondent's preoperative and postoperative lack of adequate X-ray
14 documentation represents a simple departure from the standard of care for a podiatric surgeon.

15 66. Regarding Patient 1's postoperative complication following Respondent's July 3,
16 2019, second surgery, the standard of care requires the surgeon to understand why and how a
17 surgical complication occurred. Information on the probable causes of a hallux varus
18 complications following surgery is part of a foot surgeon's training and is readily available. A
19 foot surgeon can also consult with colleagues and/or obtain second opinions to prepare for a
20 patient's second surgery adequately.

21 67. Expert Dr. 1's review found Respondent failed to seek an explanation for why the
22 hallux varus complication occurred. Respondent's documentation of the second surgery is
23 minimal. There was no indication Respondent had any plans for the second surgery other than to
24 remove and replace a single screw. Respondent's documentation did not contain an analysis of
25 Patient 1's X-rays, any comment on Patient 1's tibial sesamoid position, nor a detailed operative
26 report explaining Respondent's findings of the soft tissue and bone. Expert Dr. 1 stated that the
27 causes of post-surgical hallux varus are well known but Respondent's documentation did not
28 discuss these causes nor Respondent's plans to address those causes. The depositions of the

1 Respondent's and t Patient 1, seen in light of the actual procedure Respondent performed,
2 demonstrate that Respondent was not adequately prepared for the first surgery's complication nor
3 how she planned to proceed in the second surgery. Respondent's failure to understand why and
4 how the surgical complication occurred and her failure to plan how she would remedy the
5 complication represents a simple departure from the standard of care for a podiatric surgeon.

6 68. Expert Dr. 1 analyzed the standard of care regarding Respondent's decision to
7 perform a third surgery on August 21, 2019, for a repair of the hallux varus complication which
8 resulted from her first surgery on Patient 1. The standard of care requires that a surgeon who
9 performed a second surgery with a suboptimal outcome that required a third surgery would either
10 bring in or refer the case to a more experienced surgeon. Respondent never acknowledged the
11 almost immediate failure of the first two procedures. Moreover, neither Respondent's
12 documentation nor deposition reflected a surgical plan to ensure that the third surgery would
13 resolve the complications from the previous surgeries. Under these facts, Respondent's failure to
14 obtain a second opinion and/or a possible referral to a more experienced provider represents a
15 simple departure from the standard of care for a podiatric surgeon.

16 69. Although Respondent claimed during her deposition that Patient 1's lack of
17 postoperative compliance may have contributed to her poor outcome, expert Dr. 1's analysis of
18 Patient 1's surgeries found Respondent failed to provide appropriate postoperative treatment.
19 Expert Dr. 1's reports states Patient 1's unstable fracture required non-weight-bearing status and
20 cast immobilization. A short leg cast limits the patient from weight bearing instead of a splint,
21 that is less protective than a short leg cast. Neither Respondent nor her associate Dr. 3 placed
22 Patient 1 in a short leg cast and chose to merely splint Patient 1's toe with tape. Respondent's
23 failure to treat Patient 1 by requiring a short leg cast for Patient 1 is a simple departure from the
24 standard of care.

25 70. Expert Dr, 1 analyzed the standard of care regarding proper preparation of the bone
26 surfaces to ensure fusion of the osteotomy site necessary during the second and third surgeries.
27 When a repeat osteotomy is performed it is important to "freshen" the bone edges, i.e., to create
28 bone bleeding by perforating the bone at the osteotomy site. Without bleeding bone, the bones'

1 failure to fuse is much more likely to occur. The standard of care when perforating the bony
2 fusion sites requires the surgeon to use a saw, curette, or drill to "freshen" the bone edges.
3 Respondent's failure to use a saw, curette or drill to perforate the bony fusion sites to properly
4 prepare the bone surfaces to ensure fusion of the osteotomy site during second and third surgeries
5 were simple departures from the standard of care.

6 71. Expert Dr. 1 analyzed the standard of care regarding Respondent's performance of
7 Patient 1's July 3, 2019, second surgery when Respondent replaced the screw in the capital
8 fragment. The standard of care for preparation for a repeat surgery to remove a screw found to be
9 "not loose" and "tightly" replace the screw required the surgeon to have a preoperative plan and
10 seek consultations, literature review or consider alternative surgical procedures which are
11 different than the original procedure. As a result of Respondent's lack of recall and her limited
12 operative report detail Expert 1 found no evidence Respondent competently performed the
13 procedure within the standard of care for a foot surgeon performing a repeat surgery for a
14 complication. Respondent's failure to perform the second surgery competently resulted in a
15 simple departure from the standard of care.

16 72. Expert Dr. 1 analyzed the standard of care regarding Respondent's performance of
17 Patient 1's third surgery on August 21, 2019, to remove a screw and replace the screw with two
18 larger screws and a K-wire in an attempt to have the bones heal correctly. This surgery was
19 essentially the same as the previous surgery except for adding oral vitamin D to Patient 1's diet
20 and using a bone stimulator prior to the surgery, and it ultimately failed. Multiple surgeries can
21 result in chronic inflammation and nerve pain and in this case led to Patient 1's eventual joint
22 fusion. For that reason, Expert Dr. 1 found Respondent's performance of Patient 1's third surgery
23 to be a simple departure from the standard of care.

24 73. Expert Dr. 1 analyzed the standard of care for a surgeon's documentation of the
25 treatment plan, record keeping, lack of peer review, and memory regarding the treatment of
26 complications that arise from surgical procedures to correct hallux valgus deformity. Expert Dr.
27 1 determined that Respondent's records did not explain her treatment plan adequately.
28 Respondent's inability to recall any details about this case combined with the fill-in-the-blanks

1 pre-populated charting system Respondent used, poor record keeping, and lack of peer review
2 demonstrated that Respondent failed to fully understand the complexity of the complications
3 resulting in Respondent's simple departures from the standard of care in her documentation of her
4 performance of each of Patient 1's second and third surgeries.

5 74. Expert Dr. 1 analyzed the standard of care for surgical management of hallux valgus
6 which requires the surgeon to evaluate the X-ray films preoperatively and postoperatively and
7 document the findings. The preoperative evaluation should include the findings regarding the
8 measurement of hallux abductus angle, metatarsus adductus angle, tibial sesamoid position, and
9 metatarsal protrusion. The postoperative evaluation of the X-ray measurements should include
10 the tibial sesamoid position, hallux abductus angle, and capital fragment alignment. Patient 1's
11 medical records did not reflect that Respondent performed either preoperative or postoperative
12 evaluations of Patient 1's X-rays and Respondent's failure to do so represents a simple departure
13 from the standard of care.

14 75. Expert Dr. 1 analyzed Respondent's entire treatment of Patient 1. That analysis found
15 Respondent demonstrated she possessed the training, certification, and expertise to meet the
16 standard of care for a podiatric surgeon performing chevron osteotomy for correction of hallux
17 valgus.

18 76. Expert Dr. 1's review of Patient 1's X-rays demonstrated Respondent's issues with
19 preoperative patient evaluation of X-rays as well as a lack of X-ray measurements which could
20 have predicted the problems Respondent experienced during the repeated surgeries. The second
21 and third surgeries demonstrated Respondent's overall lack of understanding of treating a surgical
22 complication such as hallux varus.

23 77. Expert Dr. 1's review identified Respondent's ample opportunities to seek
24 consultations, literature review, and second opinions which Patient 1 urged her to do.

25 78. Expert Dr. 1's review identified Respondent's documentation was poor, particularly
26 when Respondent faced complications resulting from her first surgery. Expert Dr. 1 found that
27 the "populate the blank space template driven" operative report Respondent utilized works poorly
28 when used by a surgeon facing a non-standard procedure such as dealing with a surgical

1 complication from the initial surgery. Respondent's lack of recall compounded this problem.

2 The standard of care for surgeons regarding documentation of surgery complications requires that
3 the surgeon dictate notes with details that explain the surgeon's thoughts, concerns, and
4 alternative procedures for adequate preparation for all possibilities. Respondent's operative
5 reports lacked this significant information.

6 79. Patient 1 underwent five surgeries, including a salvage procedure to fuse her great toe
7 joint. Patient 1 has continued pain in her left foot and can no longer wear shoes with a heel
8 greater than one inch. Expert Dr. 1's review identified Respondent's care as contributing to
9 Patient 1's outcome.

10 80. Expert Dr. 1's review found that despite Respondent's knowledge and training,
11 Respondent demonstrated multiple simple departures from the standard of care during her
12 treatment of Patient 1. The accumulation of Respondent's multiple simple departures from the
13 standard of care represents a simple departure from the standard of care.

14 **FIRST CAUSE FOR DISCIPLINE**

15 (Repeated Negligent Acts)

16 81. Respondent is subject to disciplinary action under section 2234, subdivision (c), of
17 the Code in that she was negligent in her care and treatment of Patient 1. The circumstances are
18 as follows:

19 A. Respondent's June 28, 2019, lack of adequate X-ray documentation
20 preoperatively and postoperatively represents a simple departure from the standard of care for a
21 podiatric surgeon.

22 B. Respondent's failure to understand why and how the June 28, 2019, surgical
23 complication occurred and her failure to plan to remedy the complication during the July 3, 2019,
24 second surgery represents a simple departure from the standard of care for a podiatric surgeon.

25 C. Respondent's failure to associate with or to refer the case to another, more
26 experienced surgeon for the third surgery on August 21, 2019, after the July 3, 2019, second
27 surgery's sub-optimal outcome represents a simple departure from the standard of care for a
28 podiatric surgeon.

1 D. Respondent's failure to treat Patient 1 by requiring her to be in a short leg cast
2 represents a simple departure from the standard of care for a podiatric surgeon.

3 E. Respondent's failure to use a saw, curette or drill to perforate the boney fusion
4 sites to properly prepare the bone surfaces to ensure fusion of the osteotomy site during second
5 and third surgeries represents a simple departure from the standard of care for a podiatric surgeon.

6 F. Respondent's failure to perform the second surgery competently represents a
7 simple departure from the standard of care for a podiatric surgeon.

8 G. Respondent's failure to perform the third surgery competently represents a
9 simple departure from the standard of care for a podiatric surgeon.

10 H. Respondent's lack of documentation of her performance of each of Patient 1's
11 second and third surgeries represents a simple departure from the standard of care for a podiatric
12 surgeon.

13 I. Respondent's failure to perform either preoperative or postoperative evaluations
14 of the patient's X-rays represent a simple departure from the standard of care for a podiatric
15 surgeon.

16 J. The accumulation of Respondent's multiple simple departures from the
17 standard of care represents a simple departure from the standard of care for a podiatric surgeon.

18 82. Respondent's acts and/or omissions as set forth in paragraphs 27 through 61 above,
19 whether proven individually, jointly, or in any combination thereof, constitute repeated negligent
20 acts, pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

21 SECOND CAUSE FOR DISCIPLINE

22 (Failure to Maintain Adequate and Accurate Records)

23 83. Respondent is subject to disciplinary action under Code section 2266, in that She
24 failed to maintain adequate and accurate records relating to the services she provided to Patient 1.
25 The circumstances are as follows:

26 84. Complainant refers to and, by this reference, incorporates paragraphs 27 through 61,
27 above, as though set forth fully herein.

28 //

1 **THIRD CAUSE FOR DISCIPLINE**

2 (Unprofessional Conduct)

3 85. Respondent is subject to disciplinary action under section 2234 of the Code in that
4 Respondent engaged in unprofessional conduct. The circumstances are as follows:

5 86. The allegations of the Second and Third Causes for Discipline are incorporated herein
6 by reference as if fully set forth.

7 87. Respondent's acts and/or omissions as outlined in paragraphs 27 through 61, whether
8 proven individually, jointly, or in any combination thereof, constitute unprofessional conduct.

9 **PRAYER**

10 **WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged,
11 and that following the hearing, the Podiatric Medical Board issue a decision:


12 1. Revoking or suspending Podiatrist License No. E-5005, issued to Connie Melanie
13 Choy, D.P.M.;

14 2. Ordering her to pay the Podiatric Medical Board the reasonable costs of the
15 investigation and enforcement of this case, pursuant to Business and Professions Code section
16 2497.5;

17 3. Ordering Connie Melanie Choy, D.P.M., if placed on probation, to pay the costs of
18 probation monitoring; and,

19 4. Taking such other and further action as deemed necessary and proper.

20
21 DATED: AUG 01 2023

22 
23 **BRIAN NASLUND**
24 Executive Officer
25 Podiatric Medical Board
26 Department of Consumer Affairs
27 State of California

28 *Complainant*

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