BEFORE THE
PODIATRIC MEDICAL BOARD
OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: Michael Bastani, D.P.M Doctor of Podiatric Medicine Certificate No. E 5477 Respondent.	Case No.: 500-2021-001222

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Podiatric Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 21, 2025.

IT IS SO ORDERED: January 23, 2025.

PODIATRIC MEDICAL BOARD OF CALIFORNIA

Daniel Lee, D.P.M., PhD
Board President

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

In the Matter of the Second Amended Accusation Against:

MICHAEL BASTANI, D.P.M.

Doctor of Podiatric Medicine License Number E-5477,

Respondent.

Agency Case No. 500-2021-001222

OAH No. 2023110161

PROPOSED DECISION

Administrative Law Judge Deena R. Ghaly (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on August 19 through 23, 2024, by videoconference.

Deputy Attorney General Wendy Widlus represented complainant Brian Naslund, acting in his official capacity as Executive Officer of the Podiatric Medical Board (Board). Adam B. Brown, Attorney at Law with Brown & Brown, represented respondent Michael Bastani, D.P.M., who was present throughout the hearing.

During the hearing, the ALJ granted the parties' motions to seal Exhibits 7, 9, 4, 6, 13, C through Y, and KK because they contain confidential patient information to an extent that redacting the information is impracticable. In addition, the ALJ ordered that any transcript prepared of the proceedings refer to the patient solely as Patient 1. Consistent with this order, the patient at issue is referred to as Patient 1 in this proposed decision.

Testimony and documentary evidence were received. The record was held open until September 6, 2024, for complainant to submit a second amended accusation, the operative pleading for this matter, and until September 13, 2024, for any response from respondent. Complainant timely submitted the second amended accusation which was marked Exhibit 23 and admitted into the record for jurisdictional purposes. There were no other submissions, and the record closed on September 13, 2024.

SUMMARY

Complainant requests the Board take disciplinary action against respondent's Doctor of Podiatric Medicine License Number E-5477 for alleged gross negligence, repeated negligent acts, failure to maintain accurate records, and general unprofessional conduct in connection with the care and treatment of Patient 1. Complainant also requests an order awarding the Board its costs for investigating and prosecuting the matter. Respondent denies the allegations and asserts the evidence does not support disciplinary action.

Complainant established by clear and convincing evidence respondent's conduct warranted discipline. However, based on respondent's lack of prior discipline, the limited scope of his misconduct, and other rehabilitation evidence, revocation of

his license would be unduly punitive. A two-year period of probation with standard terms is sufficient to protect the public. In addition, respondent shall pay a reduced cost award of $20,000 to the Board.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 12, 2018, the Board issued Podiatrist License Number E-5477 to respondent. The license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2026, unless renewed.

2. After the Board received and investigated a complaint about respondent from Patient 1, complainant issued an Accusation. Respondent timely filed a notice of hearing challenging the charges therein and requesting a hearing. Complainant subsequently issued two additional accusations, the First Amended Accusation and post-hearing, the Second Amended Accusation, which removed some of the allegations charged against respondent. Pursuant to Government Code section 11507, any new or different charges set out in the First and Second Amended Accusations are deemed controverted.

Complainant's Evidence

PATIENT 1'S TESTIMONY

3. In June 2019, Patient 1 consulted with respondent about pain in her right foot from a bunion, which is a fluid-filled sac on the first joint of the big toe. As part of the consultation, Patient 1 filled out a basic patient information form where she wrote

she was experiencing "sharp, throbbing" pain in her foot and that the pain intensified when she stood on it. (Exh. 7, p. A139.)

4. In addition to pain, bunions can also cause misalignment of the big toe. Patient 1 also had a bunion-like swelling on the fifth or pinky toe, which curled in and did not lie flat. After the consultation, respondent recommended three surgical procedures for Patient 1's right foot, a bunionectomy to remove the bunion and realign the big toe, a "bunionette," to remove the bunion-like growth on her pinky toe, and "hammertoe" (also known as arthroplasty) surgery to straighten the pinky toe. The surgery was scheduled for August 16, 2019.

5. Prior to the surgery, on August 2, 2019, respondent met with Patient 1 for a pre-operative visit and to obtain her informed consent. At this visit, Patient 1 signed several pre-printed consent forms and received pre-printed instructions for preparing for surgery. Also, respondent spoke to Patient 1 about the planned surgeries.

6. According to Patient 1, at the pre-operative visit, respondent gave her general information about the planned surgeries but failed to discuss the recuperation period, including how long it would be before she would be able to bear weight on her foot and whether, once Patient 1 could do so, she would be able to walk long distances or drive. Further, Patient 1 maintained respondent did not tell her she should not fly for the first four to six weeks after the operation. Patient 1 had plans to travel to Europe shortly after the scheduled surgeries.

7. Also, Patient 1 did not recall that respondent spoke to her about potential surgical complications during the preoperative visit, including the possibility of encountering cysts (fluid-filled sacs) within the bone during surgery. Patient 1 stated

during the hearing, "I did ask questions but did not receive complete answers. Also, I did not know what I didn't know. For instance, I didn't know there was even a possibility that a joint would be removed."

8. Patient 1 recalled discussing possible scarring from the surgery with respondent and that he told her it would be minimal because of the way he made incisions. She also recalled speaking to respondent about using manuka honey on the incision site to disinfect the wound and promote scarless healing. Patient 1 stated respondent expressed interest in this type of alternative medicine but was noncommittal about whether he would recommend it.

9. Patient 1 did not recall respondent telling her in detail what the surgical procedure would entail. Patient 1 stated she did not become aware the hammertoe surgery involved the removal of a joint in her pinky toe until after the surgery when, during a post-operative office visit, respondent removed the surgical dressing from her foot and she found she could not move her pinky toe. Patient 1 was surprised and dismayed to find she had lost her ability to move her pinky toe because she had not experienced pain in that region of the foot prior to the surgery and had only agreed to the bunionette and hammertoe surgeries for what she termed cosmetic reasons, i.e., because she understood these procedures would reduce the width of her foot, allowing her to wear a wider variety of shoe styles.

10. Patient 1 did not recall respondent talking to her about possible complications from the surgery or whether she was likely to experience chronic pain. Patient 1 stated she has experienced constant pain since the surgical procedures respondent performed on her over five years ago.

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11. During the surgery, respondent inserted a screw in Patient 1's big toe. Patient 1 found the screw, which turned out to be too long for her foot's anatomy, to be extremely uncomfortable. She asked respondent to remove it as soon as possible. Respondent attempted to but could not remove the screw during a routine post-operative office visit. Patient 1 was subsequently admitted to a hospital where another physician removed the screw.

12. Patient 1 is a professor and she holds a Ph.D. She is articulate and intelligent, but nothing in the record indicates her background includes a medical education.

Board Expert

13. The Board retained Anthony Poggio, D.P.M. to perform an expert review and serve as its expert witness. Dr. Poggio earned his undergraduate degree in biology from the University of California, Berkeley, and his Doctor of Podiatry and Master's Degree in Medical Education from the California College of Podiatric Medicine (CCPM). He completed his residency in podiatric surgery at Pacific Coast Hospital in San Francisco and is dual board certified in both podiatric orthopedics and podiatric surgery. Dr. Poggio has held teaching positions at CCPM since 1988 and has been in private practice for over 40 years.

14. The Board investigator provided Dr. Poggio with Patient 1's certified medical records and a transcript of the investigator's interview with respondent. After reviewing the medical records, Dr. Poggio found respondent departed from the standard of care in several respects. Dr. Poggio prepared a report of his findings (see, Exhibit 20) and testified about these findings at the hearing.

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15. Dr. Poggio was particularly critical of how respondent addressed obtaining informed consent before Patient 1 underwent surgery. Informed consent is commonly understood to mean the process of effectively communicating a patient's condition to the patient and the options for treatment including the risks and benefits of each choice. Dr. Poggio stressed the need to avoid medical jargon in the process. He also stated the physician's communication style and approach must be customized to the patient. For instance, language barriers must be considered when treating patients whose first language is not English. Allowing patients to ask questions is, according to Dr. Poggio, an important component of achieving genuine informed consent, as is drawing pictures and diagrams. Dr. Poggio opined informed consent is essential to meaningful medical care as it allows the patient the opportunity to exercise agency over his or her medical care and body.

16. Dr. Poggio opined respondent's approach and practices regarding obtaining Patient 1's informed consent reflected several deficiencies and constituted gross departures from the standard of care.

17. As part of his analysis, Dr. Poggio reviewed all respondent's charts for Patient 1, beginning with a medical record dated June 26, 2019, which respondent prepared in conjunction with respondent's initial examination of Patient 1. Dr. Poggio opined that, under a section entitled "History of Present Illness," there was insufficient detail. Respondent noted Patient 1 is experiencing pain but did not document when the pain started, whether it was constant or intermittent, or whether it was interfering with Patient 1's daily activities, including those related to her work. Under a section entitled "Physical Examination," respondent used an acronym, "ACC," which Dr. Poggio did not recognize. Dr. Poggio also found the notes insufficiently detailed, including about mechanical problems Patient 1 may have been experiencing such as any limits in

the affected foot's movement and whether the pinky toe was curled or lay flat. Dr. Poggio noted that information on the issue of movement limitation informs treatment options, including whether conservative treatment such as orthotics will suffice or surgery will be necessary. Similarly, Dr. Poggio noted respondent's documentation did not specify the exact degree of the intermetatarsal (IM) angle of Patient 1's big toe. According to Dr. Poggio, the larger the IM angle, the bigger the bunion. Such a measurement is, according to Dr. Poggio, crucial to informing where the bone should be cut during the bunionectomy. Dr. Poggio also opined respondent's failure to note the IM angle measurement raised informed consent issues because the extent of the IM angle is related to the treatment options for bunions and to certain post-operative considerations such as recovery time and conditions (e.g., whether crutches will be necessary and whether the patient will be able to drive).

18. Dr. Poggio also took issue with respondent's entry under a section entitled "Procedure Codes," in the June 26, 2019 record. Respondent wrote "73630 X-RAY FOOT - 3 views," indicating he was ordering x-rays of Patient 1's foot. (Exh. 7, p. A144 [capitalized text in original].) Dr. Poggio stated a "purist" would find the entry incomplete because it did not specify whether the x-rays respondent ordered were under weight-bearing or non-weight-bearing conditions.

19. Dr. Poggio determined from respondent's records that respondent had not ordered weight-bearing x-rays and, as part of a generally deficient pre-operative process, opined that decision also constituted an extreme departure from the standard of care. The scans a physician orders as part of the initial review of a patient's condition are part of pre-operative planning. Dr. Poggio opined respondent should have ordered weightbearing x-rays as part of his pre-operative planning. Dr. Poggio also opined the x-rays respondent had ordered indicated the presence of cystic bones,

the small fluid-filled sacs that sometimes develop inside a bone. Cystic bones can be unstable and may require additional stabilizing hardware when operated upon. Dr. Poggio opined, because there was some indication that Patient 1's first metatarsal showed signs of cysts, respondent should have ordered additional studies, namely CT or MRI scans, to determine whether and to what extent cysts existed in these bones as part of the pre-operative planning process for Patient 1. However, Dr. Poggio also acknowledged Patient 1's x-rays were not clear and CT and MRI scans are particularly expensive and not necessary for every podiatric surgery.

20. Documentation from the August 2, 2019 pre-operative visit is comprised of: (i) an Informed Consent for Minor Procedure form (see Exh. 7, pp. A166-A167); (ii) a graph with multiple drawings of the foot from various angles annotated with respondent's notes and initialed by Patient 1 (*Id.* at p. A168); (iii) a form listing the pre-operative diagnoses and planned surgical procedures and additional pre-printed information about possible adverse outcomes (*Id.* at p. A169); (iv) an additional consent form signed by Patient 1, respondent, and a witness (*Id.* at p. A170); (v) respondent's clinic's cancellation policy signed by Patient 1 and a witness (*Id.* at p. A171); and (vi) a form entitled "Foot and Ankle Surgery Information" which addresses pre-surgery instruction regarding such matters as avoiding smoking and discontinuing certain medications prior to surgery, recovery room procedures, postoperative instructions, and conditions under which patients should contact their treating physician post-surgery (*Id.* at pp. A172-A175).

21. Dr. Poggio opined respondent's use of a diagram during the informed consent process is generally considered an effective process for obtaining informed consent; however, in this case, the text respondent hand-wrote next to one of the drawings of a foot was unreadable and was not placed near where the planned

surgeries would actually take place. Regarding the form setting out the diagnoses and the proposed surgery at Exhibit 7, page A169, respondent had hand-written the proposed surgeries as follows: "Bunionectomy, correction of bunionette, 5th digit hammer toe correction." Dr. Poggio found respondent's notes to be too jargon-laden, particularly the use of the term "bunionette." While he found the preprinted informed consent form on the following page to be generally acceptable, in the instant case Dr. Poggio found it insufficient because it references back to the proposed surgery language and therefore, reading the two forms together, there is no clarification in layperson language describing the proposed surgeries.

22. Dr. Poggio also found the post-operative instructions in the Foot and Ankle Surgery Information form at Exhibit 7, pages A172 through A175, to be inadequate and falling short of the standard of care. In particular, Dr. Poggio was critical of the instructions regarding weightbearing status, which provide as follows:

> Following some foot and ankle surgeries, patients may be allowed to bear weight on the operated limb in a post-op shoe. In other cases, absolutely no weight bearing will be allowed on the operated limb for up to 2 months after the surgery. I will discuss the weight bearing requirements of your procedure with you before surgery.

(Exh. 7, p. A173.)

23. Dr. Poggio found the range of outcomes for weightbearing status as they are expressed in the Foot and Ankle Surgery Information form to be virtually meaningless since it encompasses all outcomes from no limitation on bearing weight on the treated foot to an extended period where the patient would be unable to bear

weight on the treated foot. Dr. Poggio determined respondent's failure to discuss recuperation time and question Patient 1 about her lifestyle, work responsibilities, and post-surgery plans, as established by his failure to document such communications, constituted an extreme departure from the standard of care.

24. A summary of Dr. Poggio's findings regarding respondent's approach to establishing informed consent is as follows:

> The chart lists a consent form which shows markings on it of all the surgical sites. There is mention of screws being used. There are pre- and post-instructions given to the patient. Most of the forms are rather templated and generic for surgeries in general. Each surgery has inherent risks. Informing the patient of reasonable risks is part of the informed consent. Use of hardware should also be included in the discussion. It is expected that the doctor speak in layman's language explaining what is (*sic*) procedures being contemplated. This would include removing bone in the joint as is the issue with the fifth digit surgery.
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> The patient's contention is that she did not consent to this particular procedure on the fifth toe because she apparently did not understand that part of the joint was going to be removed. But more importantly it is her contention that there was no pain associated with the digit. She also felt this was done on a more cosmetic basis. Whether it was cosmetic or otherwise . . . needs to be clearly delineated.

> The more documentation there is the better the ability to determine what the doctor told the patient vs what the patient may have remembered.
>
> Conclusion
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> Not explaining a surgery in terms that the patient can understand is an extreme departure from the standard of care . . . .

(Exh. 20, p. A376. [underlined text in original].)

25. Respondent scheduled post-operative visits with Patient 1 starting three days after surgery and documented each of these visits in Patient 1's medical records. Dr. Poggio found fault with respondent's documentation of a post-surgery office visit that took place on August 28, 2019 (Exh. 7, p. A152), 12 days after respondent performed surgery on Patient 1. Dr. Poggio noted that, as with the pre-surgery examination, respondent did not document whether he had measured the range of motion of the toes upon which he had operated. Similarly, Dr. Poggio noted respondent's documentation of Patient 1's next post-surgery office visit, on September 13, 2019 (Exh. 7, p. A157), did not address Patient 1's toes' range of motion.

26. As noted above, during Patient 1's surgery, respondent had inserted a screw to secure a joint in place. The screw was long for the joint, protruding out from the surgical site. Respondent's documentation does not reflect this development until his notes for Patient 1's September 13, 2019 office visit, where he writes: "pt was told that after starting to ambulate the screw might cause pain in that case it needs to be romved (*sic*). pt expressed verbal understanding."(Exh. 7, p. A158.)

27. During the September 13, 2019, visit Patient 1 disclosed to respondent that she had been walking on the treated foot and driving with it, both against respondent's orders. She also disclosed her plans to fly to Europe. Respondent's documentation of his response to this information is as follows: "pt was once again advised not to drive on the R foot and refrain from excessive walking. . . pt was also advised that being on the plane will cause more swelling in the limb and it needs to be avoided if possible." (Exh. 7, p. A158.)

28. Dr. Poggio found respondent's documentation about screw placement and the need to remove it, as well as his instructions reiterating she should not walk, drive, or fly to be inadequate. Dr. Poggio stated there should have been a "wrap up sentence" in the notes about these issues.

29. Beginning shortly after Patient 1's surgery, she and respondent began texting back and forth about her condition, a form of communication Dr. Poggio stated was becoming increasingly the norm and therefore he was "agnostic" about whether this communication method meets the standard of care. However, Dr. Poggio opined the discussion of manuka honey in the texts (see, Exh. 7, pp A222-A223), indicated there were unresolved issues in Patient 1's mind and therefore further supported Dr. Poggio's opinion that respondent's pre-operative session had not fully explored and addressed respondent's post-operative needs.

Respondent's Evidence

RESPONDENT'S TESTIMONY

30. Respondent attended college at the University of Houston, leaving before graduating to attend New York College of Podiatric Medicine where he received his Doctor of Podiatry degree. He completed residencies in rear foot and

ankle surgery and in surgery at the New York College of Podiatric Medicine, Metropolitan Hospital, Lincoln Hospital, and Harlem Hospital. Respondent has been a licensed podiatric surgeon in California since 2018. He works at two clinics, Irvine Foot and Ankle, where he is an owner, and Orange County Foot and Ankle, where he is an associate.

31. Respondent's record-making procedures involve a combined effort with clinic staff. Staff complete the areas calling for general patient information and also take and record standard vital signs. Respondent speaks to the patient during the office visit and then, after completing the examination, goes to his office and inputs all the information on his laptop computer. Respondent believes his memory is strong so he can input everything his patients tell him even though he does not take contemporaneous notes. Respondent uses some abbreviations including "ACC," which respondent stated stands for "area of chief complaint."

32. Respondent maintained he evaluated Patient 1's muscle power during the initial consultation, rating her as having five out of five, the highest rating, in four directions. The test is done by asking the patient to push her foot down as though she is pushing on a car's gas pedal.

33. Respondent maintained his standard informed consent method and the one he used when treating Patient 1, is to explain all options and advise surgery should be a last resort. He stated he always keeps a foot model in his hand as he explains procedures and uses it to help the patient understand his surgical plans. Respondent recalled explaining the hammertoe surgery to Patient 1 and that she asked questions about it though he does not remember specifically what she asked.

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34. In general, respondent's recollection of the discussions he had with Patient 1 at the pre-operative meeting was that they were "extensive" and Patient 1 asked many questions. Respondent explained the darkened shading he drew on the diagram of the foot (see, Exh. 7, p A209) indicates where he planned to cut Patient 1's bone for the bunionectomy, the words he wrote on the left side are "scar," "pin," "AP," and "screw." "AP" stands for arthroplasty. Regarding the preprinted forms listing surgical complications, respondent stated these are provided as part of informed consent procedures in his clinic and noted many of these complications are out of the medical providers' control. With respect to helping the patient plan for post-surgical limitations, respondent believes his procedures are, if anything, more thorough than other practitioners. For instance, he offers a crutch training session in advance of surgery, something Patient 1 did not attend. Regarding her travel plans, respondent stated Patient 1 not only failed to reveal them to him before surgery but did not mention them until the third post-operative visit on September 13, 2019.

35. Respondent disagrees with Dr. Poggio that his pre-operative testing was insufficient. The x-rays he ordered were "partial," not non-weightbearing. Regarding whether he should have ordered CT or MRI studies to determine whether Patient 1 had cystic bones, respondent stated he did not do that because there were no signs of cystic bones pre-surgery. When he observed "cystic changes" in the head of the first metatarsal bone during surgery, he noted it in the operative report.

36. Respondent stated he stresses open and ready communication with his patients post-surgery and that is why he provides them with a cell number with which they can text him anytime. The number is a Google number that forwards calls and messages to his personal cell phone. He also generally schedules five post-surgery office visits to monitor his patients' progress and healing.

37. Respondent considers Patient 1 to be more headstrong than most patients he sees and that she came to the initial consultation already adamant she would undergo surgery, perhaps because he was not the first doctor she consulted.

38. After her surgery, respondent described Patient 1 as noncompliant. He disagrees that he allowed or encouraged her idea to use manuka honey on her wound, stating "I do not experiment on my surgical patients." His routine practice is to personally change surgical dressings until they are no longer needed yet, in a picture Patient 1 sent to him, he saw she was using a dressing type he does not use. Her disclosures to him that she had been walking and driving before he cleared her for these activities further underscored for him that she was not heeding his advice.

39. Despite his disagreements with some of the findings stemming from the disciplinary action against his license, respondent maintained he has seen the process as a learning opportunity and made some changes to his practice including using a new, clearer diagram of the foot and leaving out all medical jargon in his explanations of procedures to patients. Additionally, respondent stated he now exclusively orders weightbearing x-rays for all his patients.

Respondent's Expert

40. Respondent retained Babak Baravarian, D.P.M. as his expert consultant and witness. Dr. Baravarian obtained his undergraduate degree from the University of Southern California and his Doctor of Podiatry degree from CCPM. He is dual board-certified in forefoot surgery and in hindfoot/ankle surgery. He has been in private practice for over 24 years, including 10 years when he also taught at the University of California, Los Angeles (UCLA). Dr. Baravarian formerly served as the chief of podiatric foot and ankle surgery at Santa Monica/UCLA Medical Center and is the current

section chief at Providence St. John's Medical Center. He has written multiple books, book chapters, and published articles on topics related to foot and ankle surgery. In addition to his private practice, Dr. Baravarian supervises podiatry fellows at the University Foot and Ankle Institute.

41. In reviewing respondent's case, Dr. Baravarian read the Board's accusation, its investigation file including a transcript of the Board's interview of respondent, Patient 1's medical records and related documents, Dr. Poggio's report, and respondent's curriculum vitae.

42. Dr. Baravarian noted the standard of care means the "median" standard, not the optimal or absolute best practice. Applying this standard, Dr. Baravarian stated he does not agree with Dr. Poggio's findings that respondent's record-keeping did not meet the standard of care. On the contrary, Dr. Baravarian having observed small variations in spelling, abbreviations and the like in respondent's entries under the prefilled template headings, opined these demonstrated respondent customized his notes to the specific circumstances of his patients, an indication of valid record-keeping.

43. Dr. Baravarian also disagreed with the extent of documentation Dr. Poggio opined was necessary for record-keeping to be within the standard of care. Dr. Baravarian opined such detailed documentation was incompatible with the time pressures and competing demands of physicians. He further opined the standard of care for record-keeping allowed for discrepancies and variations. As Dr. Baravarian expressed in his report:

> [I]t is my experience there is a wide variety of medical record documentation. In the busy office setting, medical

> record documentation is often abbreviated and limited to the significant facts presented at the time of the office visit. While electronic medical records have improved the legibility, the templates used create medical records that do not reflect all of the details of the physician/patient interaction.

(Exh. LL, p. B282.)

44. Thus, Dr. Baravarian disagrees not only with Dr. Poggio about the protocol required for standard of care medical record-keeping but also about whether medical records necessarily capture everything that occurred or was or was not communicated during the office visit. According to Dr. Poggio, because of the importance documentation has become to the medical profession and how it works to protect both patient and provider, it is a safe assumption that, if something is not included in the medical records, it did not happen. Dr. Baravarian believes, particularly under the stress of a busy practice, it is possible that medical records "do not reflect all of the details of the physician/patient interaction."

45. Dr. Baravarian found respondent's documentation of Patient 1's informed consent during the preoperative office visit to not only meet but exceed the standard of care. In particular, during the hearing, Dr. Baravarian pointed out respondent's use of a diagram to constitute exceptional care as, in his view, it provided very clear and complete information about respondent's surgical plan. Dr. Baravarian did not find respondent's handwriting to be illegible. In his report, Dr. Baravarian summed up his evaluation of respondent's efforts to obtain informed consent as follows:

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> In this case, the patient was seen twice prior to surgery. She had an initial visit with appropriate documentation of her problems, a discussion of her foot issues, and discussion of treatment options. The patient was then seen at another in-office visit to review and discuss the surgical consent prior to surgery. This visit again detailed her foot problems, provided her with a comprehensive informed consent, including risks, potential complications, options, pre and post operative treatment plans, and an image of the foot with markings of the procedures and the screw fixations being used. I believe this consent is not only an excellent example of a consent form, but also a comprehensive example of a proper consent from. I also believe the patient had multiple opportunities to meet with the doctor and ask questions and be involved in the full decision-making process prior to undergoing surgery. She was given full disclosure of the procedures.

(Exh. LL, p. B287.)

46. Dr. Baravarian vociferously disagreed with Dr. Poggio's conclusion that respondent's preoperative planning, as reflected in his documentation of his pre-operative office visit with Patient 1, constituted an extreme departure from the standard of care, calling Dr. Poggio's opinion in this regard "completely irrational." (Exh. LL, p. 288.) Dr. Baravarian addressed the main three deficiencies Dr. Poggio found in respondent's pre-operative planning - failure to order weightbearing x-rays, failure

to order CT or MRI scans to determine whether Patient 1 had cystic bones, and failure to question Patient 1 about her post-surgery plans - as follows:

> Weight bearing x-rays are often considered at academic institutions to be best practice for foot and ankle care. However, there is no reason that doing a non-weight bearing x-ray is below the standard of care. At UCLA and within the orthopedic community, non-weight bearing x-rays are more often done than weight bearing x-rays. It is commonly done in the community by reasonable practitioners. Furthermore, there is no reason that proper diagnosis and radiographic examination of the foot and ankle cannot be performed without weight bearing x-rays.
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> The [preoperative] evaluation of a bone cyst is not standard of care on all foot and ankle cases, not on all bunions. If a cyst is considered a high likelihood, a CT or MRI may be necessary, but if a cyst is mildly suspected, standard x-rays are within the standard of care. Furthermore, if MRI and CT [imaging] were used on all suspected cases of a cyst, the insurance industry would have problems with excessive spending under that standard of care.
>
> [Respondent] noted a possible cyst, and my review of the radiographs showed the bone quality to be within the norms of a healthy woman of the patient's age. I do not believe advanced imaging was required as the standard of care at this level of care. I believe that this type of problem

> can be found in many cases of osteotomy and needs to be dealt with at the time of surgery, as [respondent] clearly did very well.
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> Finally, the idea that a physician needs to be sure to plan the patient's daily activities, trips and full schedule prior to care is not within the standard of care. . . . It is my opinion that the onus of surgical planning is partly on the doctor and partly on the patient. In this case, I believe [respondent] clearly discussed the surgery, detailed the preoperative and post operative timeline in his informed consent with adequate instructions, and considering the extensive time he spent texting and caring for the patient in a very timely manner, [respondent] was thorough and valued the patient's wellbeing.

(Exh. LL, p. B289.)

47. Dr. Baravarian also found nothing suggesting practices outside the standard of care in the text message exchanges regarding Patient 1's questions about using manuka honey on her surgical site and her travel plans, including respondent's direction to avoid both. As noted above, Dr. Baravarian does not share Dr. Poggio's opinion that physicians are required to engage in in-depth questions about a patient's post-operative plans as part of the preoperative process.

CHARACTER REFERENCES

48. Respondent enjoys the professional support of colleagues and patients, including Jonathan Bennet, a fellow podiatrist who owns four podiatry clinics including

one where respondent has worked. Dr. Bennet, who both testified at the hearing and wrote a letter of support, is familiar with the disciplinary charges against respondent. He considers respondent to be an outstanding professional and someone who exercises good judgment in his practice. Mahadi Bahara, Esq. is a personal injury attorney who has known respondent for several years and was treated by him after injuring his foot. Despite reading the disciplinary charges against him, Mr. Bahara remains supportive of respondent and would not hesitate to return to him if he needed further treatment. Mark Wardenburg is a chiropractor and the owner of a clinic, Irvine Physical Medicine and Rehabilitation. Dr. Wardenburg routinely works with respondent, referring patients to him. Respondent recently operated on Dr. Wardenburg's daughter, performing complicated surgery to repair ligaments and tendons after she was injured playing volleyball. Despite reading the disciplinary charges brought against respondent, Mr. Wardenburg does not hesitate to continue referring patients to respondent.

49. In addition to the character witnesses who testified at the hearing, multiple current and former patients, all of whom espoused their knowledge of the charges brought against respondent, wrote letters of support uniformly expressing their satisfaction with, and trust in, respondent's care as their physician. (See, Exhs. AA through JJ.)

COSTS

50. Complainant incurred $4,740 in investigative costs, $20,888.75 in prosecutorial costs, and expert fees of $975 for Dr. Poggio's services, a total of $26,603.75. This amount is deemed reasonable given the scope and complexity of the case. Respondent did not present any evidence regarding his financial circumstances and whether they prevented him from paying the Board's costs.

LEGAL CONCLUSIONS

General Provisions

1. Business and Professions Code section 2222 (further statutory cites are to the Business and Professions Code unless otherwise designated) gives the Board the authority to enforce the Medical Practice Act (commencing with section 2000) as to doctors of podiatric medicine. This authority includes revocation, suspension, or other restriction of any certificate of a doctor of podiatric medicine. Pursuant to section 2497, the Board may discipline a podiatric medicine certificate for any of the causes set out in Article 12 (commencing with section 2220).

2. Section 2229 states:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
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> (b) In exercising his or her disciplinary authority, an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric 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 reasons, restriction on scope of practice is inaction, to order restrictions as are indicated by the evidence.

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

Burden and Standard of Proof

3. As the moving party, complainant bears the burden of proof. (Evid. Code, § 500.) The applicable standard of proof is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Causes for Discipline

GROSS NEGLIGENCE

4. As a first cause for discipline, complainant charged respondent with gross negligence in violation of section 2234, subdivision (b). Gross negligence is "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. (Id. at 1054.)

5. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Podiatric Medical Board v. Superior Court of City and County of San Francisco* (2021), 62 Cal.App.5th 657; *Elcome v. Chin* (2003) 110 Cal.App.4th 310,317). It is often a function custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

6. In the operative pleading, the Second Amended Accusation, complainant references generally the 37 paragraphs of factual allegations underlying the grounds for discipline and highlights five - respondent's "failure to accurately edit Patient 1's chart notes;" respondent's failure to explain Patient 1's recommended surgeries in layperson terms; respondent's failure to document the language he used to explain the recommended surgeries; respondent's failure to order preoperative weightbearing x-rays; and respondent's failure to appropriately assess the timing of Patient 1's proposed surgery in light of her postoperative schedule - in support of complainant's gross negligence charge.

7. As to the first highlighted factual allegation, failure to accurately edit Patient 1's chart notes, "accurate editing" was not a phrase that appeared in any of the expert reports or other exhibits and was not discussed or explained during the hearing. As such, nothing in the record supports a finding that this allegation was substantiated. Therefore, there is insufficient evidence to find respondent committed gross negligence based on failing to accurately edit medical charts.

8. As to the second and third highlighted factual allegations regarding properly explaining and documenting the proposed surgeries, as set out in Factual Findings 15 to 24, Dr. Poggio opined he found respondent's pre-operative discussions

with Patient 1 too jargon-laden and unclear to fully inform her about the procedure, and its benefits and risks. Dr. Poggio relied primarily on respondent's documentation of the discussions in his charting of the two office visits Patient 1 attended before the surgery. At the hearing, as set out in Factual Findings 6 to 11, Patient 1's testimony also supported a finding that respondent's explanation fell short of the mark and left her surprised and unprepared for the post-operative changes to her foot. Even respondent's own testimony regarding Patient 1's attitude and his sense she knew what she wanted before his initial consultation with her (see Factual Finding 37) support Dr. Poggio's opinion that respondent's explanations were somewhat rushed and incomplete as she seemed, as least according to respondent, already familiar with the information and set on proceeding with surgery.

9. In his expert testimony, set out at Factual Findings 45, Dr. Baravarian categorically disagreed with Dr. Poggio, stating informed consent is a shared responsibility and that, if a physician gives at least a basic overview of the surgery and the patient sufficient time and opportunity to ask questions, the standard of care in this regard has been met. Similarly, Dr. Baravarian did not find anything amiss in respondent's record-keeping, noting his use of diagrams was exceptionally useful and thorough.

10. Looking beyond the exact wording respondent used or documented, however, the overall picture of respondent's pre-operative process supports a finding that respondent explained the proposed surgeries without giving Patient 1 the information she needed to understand their components and ramifications. Contrary to Dr. Poggio's findings, "bunionette" and even "arthroplasty" are not necessarily entirely inappropriate, especially when speaking to an educated patient such as Patient 1. But, unless the patient has been through the process before or is herself medically

trained, she is unlikely to understand what the words mean for her own experience. In that sense, respondent did not meet Patient1's needs to understand what will happen, how she will feel after surgery and what, if anything, is likely to change in her ability to ambulate and move her foot. Respondent's failure to explain these issues appear in both the evidence of the actual communications between respondent and Patient 1 and in the diagrams, short-hand notes, and templated pre-printed information sheets Patient 1 received as part of the pre-operative process.

11. Because informed consent bears on important issues such as agency and bodily integrity, Dr. Poggio's determination that a failure to meet the necessary standard of care in obtaining it constitutes an extreme departure is credited. By operation of law, such an extreme departure necessarily constitutes gross negligence.

12. Regarding whether respondent committed an extreme departure from the standard of care and therefore is liable for gross negligence for failing to order weightbearing x-rays, Dr. Poggio and Dr. Baravarian again arrive at opposite conclusions. As set out in Factual Finding 19, Dr. Poggio opined respondent's decision represented an extreme departure from the standard of care. As set out in Factual Finding 46, Dr. Baravarian described weightbearing x-rays as more commonly used in academic institutions and fall into the category of best practices not within the community standards the standard of care is intended to encompass. Here, Dr. Poggio's opinion is more persuasive, particularly because, as set out in Factual Finding 3, Patient 1 wrote on her patient information form presented at the initial consultation that she experienced increasing pain when standing.

13. Complainant's allegation that respondent's failure to affirmatively inquire into Patient 1's post-operative travel plans and schedule surgery to accommodate them constitutes gross negligence is supported by Dr. Poggio's opinions. As set out in

Factual Findings 23, he believes the standard of care requires all of the responsibility to understand a patient's circumstances falls on the physician to ascertain through close questioning. Here, though, Dr. Baravarian's view of shared responsibility, as set out in Factual Findings 45 through 47, is more persuasive. While, as noted above, Patient 1 may not have the medical knowledge to know what questions to ask about the procedures, their potential complications and risks, etc., she is in a far better position to affirmatively share with her physician the specifics of her life, including such things as travel plans. Patient 1's decision not to share this information pre-surgery cannot be deemed a failing on respondent's part. Thus, no finding of gross negligence is made based on respondent's failure to question Patient 1 about her post-operative plans.

REPEATED NEGLIGENT ACTS

14. As a second cause for discipline, complainant charged respondent with repeated negligent acts in violation of section 2234, subdivision (c). Pursuant to section 2234, subdivision (c), "[t]o 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."

15. As set out in Legal Conclusions 8 through 12, multiple acts of negligence were established. Thus, they also establish that respondent engaged in more than two acts of negligence. Cause therefore exists to discipline respondent's license pursuant to section 2234, subdivision (c), for repeated acts of negligence.

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FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS

16. The Third Cause for Discipline seeks to discipline respondent's license for failure to maintain accurate and adequate medical records pursuant to section 2266. As noted above, respondent's medical documentation was, in places, vague and incomplete such as where it did not fully reflect Patient 1's location and degree of pain (Factual Finding 17), failed to comprehensively include information regarding respondent's range of motion both pre and post-surgery (Factual Findings 17 and 25) and to timely document surgical complications related to a screw which had been implanted as part of Patient 1's bunionectomy and was causing her pain (Factual Finding 26). Under these circumstances, cause exists to discipline respondent's license pursuant to section 2266.

UNPROFESSIONAL CONDUCT

17. The Fourth Cause for Discipline seeks to discipline respondent's license for general unprofessional conduct, which courts have defined as "that conduct which breaches the rules or ethical code of conduct which is unbecoming a member in good standing of a profession." (*Shea v. Bd of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.) In violating sections 2334, subdivisions (b) and (c) and 2266, respondent has violated such rules and therefore is subject to discipline on that ground.

The Appropriate Degree of Discipline

18. Section 2227 provides in pertinent part as follows:

> (a) A licensee whose matter has been heard by and administrative law judge of the Medical Quality Hearing

Panel . . . may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the [B]oard.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the [B]oard.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the [B]oard.

(4) Be publicly reprimanded by the [B]oard. The public reprimand may include a requirement that the licensee complete relevant educational coursed approved by the [B]oard.

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

19. California Code of Regulations, title 16 (Regulation or Reg.), section 1399.710 provides that the Board shall consider the disciplinary guidelines entitled "Manual of Disciplinary Guidelines with Model Disciplinary Orders" [revised September 2005] when determining the appropriate penalty after a finding of grounds for license discipline. "Deviation from these guidelines and order, including the standard terms of probation, is appropriate where the board in its sole discretion determines that the facts of the particular case warrant such a deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems." (Reg., § 1399.710)

20. Regulation section 1360.1 sets out the criteria for determining appropriate penalties. The criteria and their application to the instant case are as follows:

(a) The nature and severity of the act(s) or offense(s) - Respondent's acts underlying the instant disciplinary action are serious. Respondent's failure to comprehensively and successfully complete the pre-operative stage of Patient 1's treatment, including obtaining her informed consent did not allow her a full opportunity to make knowing decisions about her treatment.

(b) The total criminal record - This criterion is not applicable.

(c) The time that has elapsed since commission of the act(s) or offense(s) - It has been approximately five years since respondent treated Patient 1, a substantial period of time.

(d) Whether the licensee, certificate or permit holder has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person - This criterion is not applicable.

(e) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code. This criterion is not applicable.

(f) Evidence, if any, of rehabilitation submitted by the licensee, certificate, or permit holder. Respondent has changed his methods, including avoiding medical jargon and using clearer diagrams when educating his patients about the procedures he recommends to them, and uniformly utilizing weightbearing x-rays, in an effort to improve and evolve as a medical practitioner. This is an especially positive criterion.

21. The Board's Manual of Disciplinary Guidelines with Model Disciplinary Orders (Guidelines)[revised September 23, 2011] set forth the following range for discipline for the conduct in this matter. For gross negligence, repeated negligent acts, failure to maintain adequate medical records, and general unprofessional conduct, and failure to maintain adequate and accurate medical records the minimum range of discipline is five years' probation with terms and condition requiring "preferably as a condition precedent" that the licensee take and pass a written examination, successfully complete a clinical training program, medical record keeping course, ethics course and/or a prescribing practice course, be subject to areas of practice from which he or she is prohibited, incur a period of suspension, have his practice monitored; and not engage in solo practice. The maximum range of discipline for this conduct is revocation.

22. As complainant's counsel herself argued, the particular circumstances of respondent's case do not warrant the five-year probation period called for in the Guidelines and do not require imposition of the optional probation terms for the violations at issue. The grounds for discipline in respondent's case are limited to his treatment of a single patient and occurred almost five years ago. Nothing in the record indicates he had any previous disciplinary history nor has there been any subsequent complaints or other indication respondent continues to engage in the deleterious practices underlying the instant action. On the contrary, respondent has taken the initiative to improve his practice and consider the disciplinary process a learning experience. Under these circumstances, a shortened probationary period of two years and conditions limited to the standard probation terms pursuant to the Guidelines is warranted and consistent with public safety.

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Costs

23. Pursuant to section 2497.5, subdivision (a), the Board may direct a licensee found guilty of unprofessional conduct "to pay to the [B]oard a sum not to exceed the the actual and reasonable costs of the investigation and prosecution of the case."

24. In evaluating a request for costs, the administrative law judge must consider whether complainant's investigation was "disproportionately large" compared to the violation, and whether the licensee committed some misconduct but "used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed;" had a "'subjective good faith belief in the merits of his or her position;'" raised a "'colorable challenge'" to the proposed discipline; and "will be financially able to make later payments." (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.)

25. Here, the costs requested by complainant are reasonable. Respondent has used the hearing process to avoid the most severe penalty and to raise colorable challenges to the proposed discipline. Under the circumstances, a modified reduction of the cost request to $20,000 is warranted.

ORDER

Doctor of Podiatric Medicine License Number E-5477 issued to respondent Michael Bastani, D.P.M. is revoked; however revocation is stayed and respondent is placed on probation for two years upon the following terms and conditions:

1. NOTIFICATION

Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision(s) and Accusations(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of podiatric medicine, including all physicians and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carriers.

2. PHYSICIAN ASSISTANTS

Prior to receiving assistance from a physician assistant, respondent must notify the supervising physician of the terms and conditions of his probation.

3. OBEY ALL LAWS

Respondent shall obey all federal, state, and local laws, all rules governing the practice of podiatric medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. QUARTERLY DECLARATIONS

Respondent shall submit quarterly declarations under penalty of perjury forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. PROBATION UNIT COMPLIANCE

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b). Respondent shall not engage in the practice of podiatric medicine in respondent's place of residence. Respondent shall maintain a current and renewed California doctor of podiatric medicine's license. Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts or is contemplated to last, more than thirty days.

6. INTERVEW WITH THE BOARD OR ITS DESIGNEE

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without notice throughout the term of probation.

7. RESIDING OR PRACTICING OUT-OF-STATE

In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in Business and Professions Code section 2472.

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All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey all Law; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing podiatric medicine in another state in the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. FAILURE TO PRACTICE PODIATRIC MEDICINE - CALIFORNIA RESIDENT

In the event respondent resides in the State of California and for any reason respondent stops practicing podiatric medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of nonpractice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in Business and Professions Code section 2472.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code section 2472.

9. COMPLETION OF PROBATION

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 days prior to the completion of probation. Upon successful completion of probation, respondent's certificate will be fully restored.

10. VIOLATION OF PROBATION

Failure to fully comply with any terms or conditions of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out any disciplinary order that was stayed. In an Accusation or Petition to Revoke Probation or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. COST RECOVERY

Within 90 calendar days from the effective date of the Decision or other period agreed to by the Board or its designee, respondent shall reimburse the Board the

amount of $20,000 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve respondent of his obligations to reimburse the Board for its costs.

12. LICENSE SURRENDER

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificates to the Board or its designee and respondent shall no longer practice podiatric medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent reapplies for a podiatric medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. PROBATION MONITORING COSTS

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Board of Podiatric Medicine and delivered to the Board or its designee within 60 days after the start of the new fiscal year. Failure to pay costs within 30 calendar days of this date is a violation of probation.

14. NOTICE TO EMPLOYEES

Respondent shall, upon or before the effective date of the Decision, post or circulate a notice which recites the offenses for which respondent has been disciplined and the terms and conditions of probations to all employees involved in his practice. Within fifteen days of the effective date of this Decision, respondent shall cause his employees to report to the Board in writing, acknowledging the employees have read the Accusation and Decision in the case and understand respondent's terms and conditions of probation.

15. CHANGES OF EMPLOYMENT

Respondent shall notify the Board in writing, though the assigned probation officer, of any and all changes of employment, location, and address within thirty days of such change.

16. COMPLIANCE WITH REQUIRED CONTINUING MEDICAL EDUCATION

Respondent shall submit satisfactory proof biennially to the Board of compliance with the requirement to complete fifty hours of approved continuing medical education and meet continuing competence requirements for re-licensure during each two-year renewal period.

DATE: 10/14/2024

Deena R. Ghaly
Deena R. Ghaly (Oct 14, 2024 15:55 PDT)

DEENA R. GHALY
Administrative Law Judge
Office of Administrative Hearings