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

In the Matter of the Second Amended Accusation Against: **PETER REDKO, DPM** North Bay Foot and Ankle Center 1400 Professional Drive #102 Petaluma, CA 94954 Doctor of Podiatric Medicine License E4517 Respondent.	Case No. 500-2016-000338 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Brian Naslund (Complainant) brings this Second Amended Accusation solely in his official capacity as the Executive Officer of the Podiatric Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 22, 2003, the Board issued Doctor of Podiatric Medicine License E4517 to Peter Redko, DPM (Respondent). The Doctor of Podiatric Medicine license was in full force and effect at all times relevant to the allegations brought herein and will expire on July 31, 2025, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2222 of the Code states:

"The California Board of Podiatric Medicine shall enforce and administer this article as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by this chapter are applicable 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 authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.

The Board may order the denial of an application or issue a certificate subject to conditions as set forth in Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 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.'

5. Section 2229 of the Code makes public protection the Board's highest priority.

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 shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the administrative

law judge who presided at the hearing shall be present during the board's consideration of the case and shall assist and advise the board."

7. Section 2234 requires that the Board take action against any licensee charged with unprofessional conduct, which includes, but is not limited to:

"(b) Gross negligence.

(c) Repeated negligent acts.

". . . ."

8. Section 2236 of the Code provides that the conviction of any offense substantially related to the qualifications, functions, or duties of a licensee constitutes unprofessional conduct.

9. Section 2239 of the Code provides that the use of dangerous drugs or alcoholic beverages to the extent, or in such a manner, as to be dangerous or injurious to the licensee, or to another person, or to the public constitutes unprofessional conduct.

10. Section 2266 of the Code provides that failure to maintain adequate and accurate medical records pertaining to patient care provided by the licensee constitutes unprofessional conduct.

COST RECOVERY

11. Section 2497.5 of the Code states:

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

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

"(c) When the payment directed in the board's order for payment of costs is not made by the licensee, the board may enforce the order for payment by bringing an action in any appropriate

court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

"(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

"(e)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

"(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for those unpaid costs.

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

12. Respondent is subject to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts] of the Code, in that Respondent was grossly negligent and/or repeatedly negligent in his care and treatment of Patient One.[1] The circumstances are as follows:

13. Patient One, a 51-year-old female, was first seen in Respondent's Petaluma office[2] on December 9, 2014. Patient One reported that she hurt her left foot approximately five to six months previously while running and it hurts constantly. A previous physician ordered an MRI and diagnosed the patient with two torn tendons (a split tear of the peroneus brevis at the ankle level and a complete tear of the lateral hemi-tendon at the distal fibular tip, between the ankle and

[1] The subject patients are referred to herein as Patient One up to and including Patient Four to preserve patient confidentiality. The patients' full names will be produced to Respondent upon request.

[2] Respondent is in solo practice and has offices in Petaluma and Sonoma.

the fifth metatarsal base.)[3] According to Patient One, Respondent reviewed only the MRI report and advised her to undergo surgery. Respondent also informed the patient that she would be able to run again within six months after surgery.

14. Respondent noted on the progress note[4] that the patient was allergic to aspirin and sensitive to sulfa and ceftin medications. He also noted that she was on methadone for restless leg syndrome and another medication for migraines. Respondent did not conduct or document any further information about the patient's methadone use or substance abuse history. Respondent did not review the MRI itself, but only the report, and did not review any medical records from other physicians, including the prior physician to determine what other conservative treatment methods had been tried. Additionally, Respondent's physical examination is cursory and does not document the patient's range of motion or that he considered the possibility of anterior cavus.[5]

15. According to the "Plan" noted on the progress record, Respondent wrote that he discussed the diagnosis with the patient along with the "conservative and surgical treatment options. I discuss with the patien[t] in detail the surgical procedure itself, the indications, the risks, the possible complications, and alternative treatment options. I gave no guarantees reguarding [sic] the outcome." Respondent did not document what the non-surgical treatment methods, the conservative treatment options, or what the alternative treatment options were that he offered Patient One. Respondent further wrote "the risks of the procedure including but not limited to sepsis, hemorrhage, pain, and failure to achieve the stated goals of the procedure were

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[3] "There are two peroneal tendons that run along the back of the fibula. The first is called the peroneus brevis. The term "brevis" implies short. It is called this because it has a shorter muscle and starts lower in the leg. It then runs down around the back of the bone called the fibula on the outside of the leg and inserts (i.e. connects) to the fifth metatarsal. This is in the side of the foot. The peroneus longus takes its name because it has a longer course. It starts higher on the leg and runs all the way underneath the foot to insert or connect on the first metatarsal on the other side. Both tendons, however, share the major job of everting or turning the ankle to the outside. The tendons are held in a groove behind the back of the fibula and have a roof made of ligamentous-type tissue over the top of them called a 'retinaculum.'" http://www.aofas.org/footcaremd/conditions/ailments-of-the-ankle/Pages/Peroneal-Tendonitis.aspx

[4] Respondent uses an electronic medical record in the SOAP format to document his appointments. He also uses another form that appears to contain medical coding and billing information.

[5] Cavus means a high arched foot.

all fully discussed, understood, and accepted by the patient and I consider the patient fully consented." Respondent did not order any pre-surgical lab work or testing, nor did he have the patient sign an informed consent form in his office during that appointment.

16. On December 16, 2014, Respondent performed out-patient surgery on Patient One at Petaluma Valley Hospital. Before the surgery, Patient One completed a general two-page consent form that filled in the blanks with the type of surgery ("left peroneal tendon repair") and the name of the surgeon ("Redko"). There was no explanation on the hospital consent detailing the specifics about the surgery or the risks and benefits of the specific surgery being performed by Respondent, including the risk of sural nerve[6] entrapment or alternative treatment options.

17. According to Respondent's Operative Report, he excised the tears, debrided the surgical site, and repaired the tendons. Respondent also utilized staples as part of the repair. Respondent wrote that the patient tolerated the procedure well and subsequently discharged her home following a brief period in the recovery room. The post-operative instructions ordered Patient One to keep the dressings dry, to remain non-weight bearing on the left foot for the next two weeks, to ice and elevate the left foot, and to take pain medication as needed. The patient was placed in a below the knee Cam boot. [7]

18. Patient One suffered from significant pain the night of the surgery. She felt like the staples were pushing against the wound while she was using the Cam boot. Respondent advised the patient to remove the boot and take the pain medication he prescribed.

19. On or about December 23, 2014, the patient returned to Respondent's office for her first post-surgical follow-up appointment. The patient reported that she was still in a lot of pain, there was still a large amount of swelling and discoloration, and her foot was hot to the touch. Respondent informed the patient that this was normal, but he did not document the patient's complaints. The patient requested the staples be removed but Respondent said his office would be closed for the holidays and he would remove them in January. Respondent did not use his SOAP note progress note to document this visit with Patient One. Rather he made a handwritten

[6] The sural nerve is a sensory nerve running up the back of the calf.
[7] A CAM walker/boot is also referred to as a walking boot.

note on the coding and billing form that is almost impossible to read. During Respondent's interview with investigators for the Board he read his note as: "Surgical site well coapted, mild edema, staples intact, dressing changed, non-weight bearing in air cast, follow up 2 weeks, Rx for Xartemis #20, ï po q. 12 ° [1 pill by mouth every 12 hours]."[8]

20. On January 5, 2015, Patient One contacted Respondent's office for an earlier appointment than previously scheduled because she was in so much pain from the surgical staples. Respondent's office was able to schedule an appointment for that day. According to Respondent's SOAP progress note for the visit, the patient was healing well but still had edema to the left foot. During this visit Respondent removed the staples from the left foot, kept her in the CAM boot, and advised her to use it at all times when ambulating. Physical therapy was performed and Respondent also referred the patient for additional physical therapy sessions (twice per week for six weeks).

21. Patient One went to 11 physical therapy sessions, two of which were documented in Respondent's records. Patient One was able to walk again with less pain and regain more mobility; however, she reported that the physical therapist continued to comment on the swelling and heat from her left foot, along with "pitting."

22. On or about February 17, 2015, Patient One returned to Respondent's office for another follow-up appointment. According to Patient One, Respondent told her for the first time during this appointment that her recovery could take up to a year and the swelling, heat, and pain were normal. Respondent documented on the SOAP progress note that Patient ONE was doing well, wearing sandals, not using pain medications, and continuing with physical therapy. During the physical examination portion of the progress note, Respondent reported that the surgical site looked good, there was "thickening with tenderness over the left peroneal tendons," mild edema in the ankle, and that the Patient's gait revealed abnormal pronation.[9] He determined that along

[8] Xartimis XR is the trade name also known as Percocet, containing both oxycodone and acetaminophen. Oxycodone is an opioid pain reliever. It is a Schedule II controlled substance as defined by Health and Safety Code section 11055(b)(1)(M).

[9] Pronation happens when the foot rolls in and the arch of the foot flattens.

with continued edema the patient also had peroneal tendinitis.[10] Under the "Plan" section of the note, Respondent documented that he suggested the patient obtain custom molded orthotics and he taped the patient's left foot and ankle using the low-Dye strapping technique.[11]

23. Patient One's last appointment with Respondent occurred on March 13, 2015. Patient One reported to Respondent that she completed the prescribed course of physical therapy. According to the SOAP progress note, Respondent only documented dispensing the custom orthotics. Respondent requested follow up with the patient in two months.

24. On or about April 19, 2015, the patient sent an email to Respondent requesting another MRI, but Respondent replied that it was not necessary and healing could take up to one year after surgery.

25. On or about May 16, 2015, Patient One had another appointment with Respondent, but it was cancelled by Respondent's staff. Patient One decided to find another physician and obtain a second opinion.

26. On or about May 23, 2015, another physician ordered a new MRI, which showed that Patient One had a longitudinal tear to the peroneus brevis tendon and peroneus longus tendon. This second physician recommended a second surgery to repair the tendon.

27. Continued email and telephone contact between Respondent and Patient One occurred. Respondent continued to repeat the need for time for the injury to heal and that he did not recommend a second surgery. He suggested that Patient One undergo more physical therapy and continue wearing a brace. Respondent did not document or maintain any copies of his patient communications.

28. Patient One underwent two additional revision/repair surgeries to the area that Respondent operated on in December 2014 by two different physicians. The operative report from the second surgery (first repair surgery) conducted on June 17, 2015, indicated that there was significant scar tissue adhesions and loss of tissue planes to the surgical area. Additionally,

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[10] Peroneal tendinitis is enlargement and thickening with swelling to the peroneal tendon. This injury is common in runners such as Patient One.

[11] Low-Dye strapping is a commonly used technique in patients with injuries or pain associated with pronation.

there were large nylon sutures intertwined within the peroneus brevis tendon indicating that they were not properly anchored and interweaved. The third and final surgery required removing a tendon from Patient One's hamstring to replace the tendon in the ankle and to reconstruct the peroneal brevis tendon. Patient One was later diagnosed with chronic regional pain syndrome of her left foot and ankle.

29. Respondent is subject to discipline under section 2234, and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts] of the Code by reason of the following acts or omissions:

a. Respondent failed to provide proper pre-surgical evaluation and management in that he did not review prior medical records to determine what other treatment methods had occurred previously, he did not evaluate the patient's use of methadone, he did not conduct a complete and thorough physical examination of the patient's ankle, he failed to obtain pre-surgical x-rays, and he failed to obtain pre-operative lab-work.

b. Respondent failed to use the proper surgical technique in the repair of Patient's One's peroneal brevis tendon tear.

c. Respondent failed to properly manage Patient One's post-surgical issues, which should have included ordering imaging studies to reassess and reassure the patient on the effectiveness of the surgery. Additionally, Respondent ordered conservative care post-surgically when those treatment methods were more appropriate prior to the surgery.

SECOND CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping)

30. Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to keep adequate and accurate medical records related to the care and treatment of Patient One as alleged in paragraphs 12 through 29, which are herein incorporated by reference, as if fully set forth below.

a. Respondent failed to document a thorough evaluation of Patient One's peroneal tendon tears, including documenting an adequate history, substance abuse history (including

evaluation of Patient One's use of methadone), and documenting the patient's ankle range of motion and status of the patient's anterior cavus.

b. Respondent failed to document the previous and conservative treatment methods utilized by prior physicians to Patient One's peroneal tendon tears.

c. Respondent did not document what the non-surgical treatment methods, the conservative treatment options, or what the alternative treatment options were that he offered the patient.

THIRD CAUSE FOR DISCIPLINE

(Excessive and Injurious Use of Alcohol)

31. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2239 of the Code, in that Respondent used alcoholic beverages to the extent or in such a manner as to be dangerous or injurious to himself, or to another person, or to the public. The circumstances are as follows:

32. On June 16, 2019, Respondent was arrested by Sonoma County law enforcement officers after he crashed his car into another, causing injuries to the other driver. Blood alcohol testing established that Respondent's blood alcohol percentage some hours after the accident was .20%.

33. A criminal complaint entitled *People v. Peter Redko*, Case No. SCR-729239, was filed in Sonoma County Superior Court on July 10, 2019, charging Respondent with driving under the influence and causing injury (Vehicle Code section 23152(a) and with the criminal enhancement of driving while having a blood alcohol concentration of .20% (Vehicle Code section 23538(b)(2). Respondent pleaded not guilty to the misdemeanor charges.

34. After a multiday trial, on May 7, 2021, Respondent was found guilty by jury verdict on both the charged misdemeanor counts. He was sentenced on May 13, 2021, to three years of court probation, 20 days' incarceration, and conditions including installation of a driver interlock device.

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FOURTH CAUSE FOR DISCIPLINE

(Conviction of Substantially Related Offense)

35. The allegations of paragraphs 32-34 above are incorporated by reference as if set out in full. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2236 of the Code, in that Respondent was convicted of an offense substantially related to the qualifications, functions, or duties of a licensee; to wit: causing injury to another while driving under the influence of alcohol.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

36. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) of the Code, in that his care and treatment of Patient Two included a departure from the standard of care constituting gross negligence and/or a departure that, in conjunction with the other negligent acts alleged herein, constituted repeated negligent acts. The circumstances are as follows:

37. Seventy-two-year-old Patient Two first saw Respondent on January 14, 2020, upon referral by her primary care physician. Patient Two had been recently treated with corticosteriod injections by consulting orthopedists for her severe right ankle pain At this first visit, Respondent gave Patient Two another corticosteroid injection, and discussed with her the possibility of surgery. After no improvement in the condition, Patient Two agreed to undergo a total ankle joint implant by Respondent.

38. After pre-surgical work-up cleared her for surgery, Respondent performed the total ankle joint implant on February 2, 2020, at a local hospital. Patient Two was discharged as non-ambulatory to her home the following day. Respondent saw Patient Two for the first post-operative visit one week later; he told her the surgery site "looks good."

39. On February 18, at the second post-operative office visit, Respondent removed the bandage and splint from the surgical site. Respondent again told Patient Two the surgical site

"looks good." At the following week's office visit, Respondent removed all but three of the staples in Patient Two's right ankle. Respondent informed Patient Two that she would begin physical therapy in two weeks. Respondent assured Patient Two that the incision site "looks good."

39. On March 3, four weeks post-surgery, Respondent removed the remaining staples and sutures from Patient Two's anterior right ankle. Respondent's chart entries for that visit note a wound dehiscence.[12] As planned, Patient Two was referred for physical therapy. At the first physical therapy appointment on March 9, 2020, the physical therapist unwrapped her dressing and expressed concern that the surgical incision did not appear to be healing well.

40. Patient Two saw Respondent for the next scheduled office visit the following day. After being informed of the physical therapist's concern about the surgical wound's appearance, Respondent assured her that it "looks good" and told her to return in two weeks.

41. At her second physical therapy appointment on March 16, 2020, the therapist again unwrapped and examined her right ankle, noting significant drainage from what appeared to be an infected incision presenting necrotic tissue. The therapist declined to treat Patient Two at this visit, and called Respondent's office with her observations and concerns.

42. At the scheduled office visit on March 17, 2020, Patient Two's surgical incision was blackened necrotic tissue with redness and swelling. Respondent noted the wound measured 90 mm x 58 mm. Respondent applied a topical antiseptic, bandaged the site, and gave Patient Two a prescription for Amoxicillin, an antibiotic. When Patient Two's companion at this visit suggested the infection could be treated by a wound specialist at a local hospital, Respondent assured them he could better manage the wound care.

43. Patient Two returned to Respondent's office on March 20, 2020, telling him she was suffering increasing pain and could barely walk. Respondent swabbed the wound for a laboratory culture sample, debrided the area, and applied an Epifix amniotic graft Respondent notes that he contacted an infectious disease specialist on this same date, who reportedly recommended he

[12] Dehiscence is a partial or total separation of previously approximated wound edges, due to a failure of proper wound healing.

switch the prescribed oral Amoxicillin to Augmentin, which Respondent did. In his interview with Board investigators on June 15, 2021, Respondent stated that he had discussed possible IV antibiotics with the infectious disease specialist but the decision was made to continue with oral antibiotics. There is nothing in Respondent's chart entries referring to that discussion of IV antibiotics. At the March 27, 2020, office visit, Respondent noted that the ankle swelling was decreased and told Patient Two the oral antibiotic was working.

44. At the next office visit on April 1, 2020, Respondent's chart notes state the wound was then 90% granulated and measured 89 mm x 34 mm. Respondent again debrided the site and applied the Epifix. Respondent informed Patient Two that he needed to see her in the office three times a week for wound care. There is nothing in Respondent's chart notes at this visit reflecting consideration of a deep space infection or the need for a deep culture around the ankle prosthesis and possible bone biopsy.

45. Respondent saw Patient Two approximately three times per week through early May, 2020. During this period Patient Two had begun to walk more comfortably, reportedly up to a mile, but began experience increased pain in her right ankle. Respondent continued to dress the wound and assure Patient Two that the surgical incision was healing. At the June 5, 2020, office visit, Patient Two reported feeling ill for the preceding few days. Respondent lanced and drained what he termed a "blood blister" at the wound site and continued his regimen of wound care and oral antibiotics.

46. At the office visit on June 19, 2020, Respondent treated the wound, took another culture sample, and prescribed pain medication to address Patient Two's complaint of increasing pain in her ankle. After leaving Respondent's office, Patient Two contacted her primary care physician, who referred her to an infectious disease specialist. That specialist ordered x-rays of her ankle and told her that there could be an infection deeper in the wound around the ankle implant. The specialist referred Patient Two to a local plastic surgeon for additional consultation. Patient Two continued to see Respondent for wound care as well.

47. Patient Two saw the plastic surgeon on July 13, 2020, who referred her to the orthopedic department at UCSF, where she was seen on July 24, 2020. Diagnostic laboratory

tests and imaging confirmed initial physician concerns that the infection was affecting the prosthesis and surrounding bone. Patient Two underwent surgery to remove the ankle implant on August 5, 2020, and remained in the hospital until August 13, 2020.

48. Respondent has subjected his license to disciplinary action for unprofessional conduct by his failure to provide appropriate post-operative care to Patient Two by recognizing and appropriately responding to the clinical indications of a significant infection. This departure from the standard of care constituted gross negligence in violation of section 2234(b) of the Code and/or, in conjunction with the other departures alleged herein, repeated negligent acts in violation of section 2234(c) of the Code.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

49. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) of the Code, in that his care and treatment of Patient Three included a departure from the standard of care constituting gross negligence and/or a departure that, in conjunction with the other negligent acts alleged herein, constituted repeated negligent acts. The circumstances are as follows:

50. Fifty-one-year-old Patient Three was seen by Respondent on July 20, 2018.

51. A July 27, 2018, hospital progress note documents Patient Three had a toe infection since May 2018. Patient Three was complaining of increasing erythema and pain and the appearance of dry gangrene was documented. The progress note also states that Patient Three had a skin graft performed by Respondent that failed.

52. A subsequent MRI showed osteomyelitis on Patient Three's right fifth toe. The progress note reflects multiple attempts from other care providers to contact Respondent without success. Multiple attempts to receive results of the bone biopsy and culture also failed.

53. The operative report on July 28, 2018, authored by a different surgeon than Respondent documented that a partial amputation was performed, diagnosed right diabetic foot infection, and osteomyelitis of the right fifth toe. Findings of that surgeon also included purulent drainage at the base of the toe with erythema and edema and a full thickness ulceration to bone.

54. The operative report on August 4, 2018, authored by a different surgeon than Respondent references excisional debridement and wound vacuum assisted closure applied. The operative report on August 14, 2018, authored by a different surgeon than Respondent references excisional debridement right foot wound and revision of partial fifth ray amputation.

55. There is evidence that peripheral arterial disease was present based on Respondent statements made in a recorded interview with the Board. There is no evidence that the wound was free of infection based on the patient's history, medical records, and subsequent treatment records. The record references multiple unsuccessful attempts by other care providers to contact Respondent without response.

56. The standard of care in doctor communication is to respond to calls from a hospital or physician within a reasonable amount of time. The standard of care in the application of skin grafting substitutes is to ensure a clean viable or granular wound bed without evidence of peripheral arterial disease or infection prior to application of the graft.

57. Respondent's failure to respond after multiple attempts and application of a skin graft without ensuring there was adequate circulation to the area for healing, and without ensuring that the wound was free of infection, was a departure from the standard of care.

58. These departures from the standard of care constitute gross negligence in violation of section 2234(b) of the Code and/or, in conjunction with the other departures alleged herein, repeated negligent acts in violation of section 2234(c) of the Code.

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

59. Respondent is subject to disciplinary action under section 2234(b) and/or 2234(c) of the Code, in that his care and treatment of Patient Four included a departure from the stand of care constituting gross negligence and/or a departure that, in conjunction with the other negligent acts alleged herein, constituted repeated negligent acts. The circumstances are as follows:

60. Fifty-one-year-old Patient Four saw Respondent on June 22, 2018.

61. During a hospital stay from June 22, 2018, through August 7, 2018, Patient Four was treated for osteomyelitis.[13] On June 25, 2018, Respondent performed left foot incision and drainage, left second ray amputation, left third toe amputation, and left foot ulcer debridements.

62. The June 25, 2018, operative report documented included incision and drainage, left second ray, amputation, left third toe amputation, left foot, skin rearrangement with primary closure, and left foot ulcer debridement. The operative report reflects that there was purulence present during the procedure in multiple planes.

63. June 22, 2018, podiatry consultation notes reflect patient was seen in the ICU with a nurse relating a one-month history of plantar foot ulcer and one week history of a left third toe ulcer treated in a different clinic was also documented.

64. The Hospitalist progress note from June 26, 2018, references Respondent performed surgery on June 25, 2018, including incision and drainage, partial second ray, amputation, and left third toe amputation with ulcer debridement.

65. Podiatry progress notes from June 26, 2018, document awaiting the bone biopsy and culture report, postop day one incision and drainage, and second ray and third toe amputation. The notes also document that dressings were clean and dry and capillary filling time were within normal limits.

66. The standard of care in the treatment of deep abscess is to perform a prompt incision and drainage, cultures, debridement of necrotic tissue, pulse lavage and to leave the wound open with packing to assess the abscess site and allow for proper healing.

67. The June 25, 2018, operative report reflects the surgery was not performed for three days after admission and following extensive incision and drainage of multiple planes, the wounds were primary closed.

68. The failure to promptly treat the abscess and the performance of primary closure following deep incision and drainage of multiple planes represent a departure from the standard of care.

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[13] Osteomyelitis is a bone infection that can be caused by bacteria, fungi, or other germs. It can affect any bone in the body, but it's most common in the long bones of the arms and legs.

69. This departure from the standard of care constituted gross negligence in violation of section 2234(b) of the Code and/or, in conjunction with the other departures alleged herein, repeated negligent acts in violation of section 2234(c) of the Code.

DISCIPLINE CONSIDERATIONS

70. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about September 14, 2011, in a prior disciplinary action entitled In the Matter of the Accusation Against Peter M. Redko, DPM, before the Board of Podiatric Medicine, in Case Number 1B-2009-200359, Respondent's license was revoked, revocation stayed and he was placed on probation for 35 months based on allegations of unprofessional conduct (gross negligence, repeated negligent acts) and inadequate medical records in the care and treatment of two patients. One patient was a fifteen-year-old girl whose left great toe had to be partially amputated when it developed gangrene after Respondent performed a bunionectomy and hallux osteotomy on the toe. The second patient was a 65-year-old male who developed deep vein thrombosis after Respondent performed right foot surgery.

71. Respondent's probation in Case Number 1B-2009-200359 terminated on November 27, 2013, following his Petition for Early Termination of Probation.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Podiatric Medicine issue a decision:

1. Revoking or suspending Doctor of Podiatric Medicine License E4517, issued to Peter Redko, DPM.;

2. Ordering Peter Redko, DPM to pay the Board of Podiatric Medicine the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2497.5, and, if placed on probation, the annual costs of probation monitoring; and

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3. Taking such other and further action as deemed necessary and proper.

DATED: FEB 06 2025

BRIAN NASLUND
Executive Officer
Board of Podiatric Medicine
Department of Consumer Affairs
State of California
Complainant