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

In the Matter of the Accusation Against: Neil Michael Richman, M.D. Physician's & Surgeon's Certificate No G 84884 Respondent.	Case No.: 800-2019-056645

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed on August 8, 2025, and the time for action having expired at 5:00 p.m. on August 18, 2025, the petition is deemed denied by operation of law.

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

In the Matter of the Accusation Against: **Neil Michael Richman, M.D.** **Physician's & Surgeon's Certificate No. G 84884** **Respondent.**	**Case No. 800-2019-056645** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Ian Scharg, Esq. on behalf of Respondent, Neil Michael Richman, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of August 8, 2025, at 5:00 p.m.

Execution is stayed until August 18, 2025, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: August 8, 2025

Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the Accusation Against: Neil Michael Richman, M.D. Physician's & Surgeon's Certificate No. G 84884 Respondent.	Case No. 800-2019-056645

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 8, 2025.

IT IS SO ORDERED: July 10, 2025.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

NEIL MICHAEL RICHMAN, M.D.,

Physician's and Surgeon's Certificate No. G 84884

Respondent.

Agency Case No. 800-2019-056645

OAH No. 2024110528

PROPOSED DECISION

Administrative Law Judge Michael C. Starkey, State of California, Office of Administrative Hearings, heard this matter on May 19 through 22, 2025, via videoconference.

Deputy Attorneys General Thomas Ostly and D. Mark Jackson represented complainant Reji Varghese, Executive Director, Medical Board of California, Department of Consumer Affairs.

Attorney Ian Scharg represented respondent Neil Michael Richman, M.D., who was present.

The matter was submitted on May 22, 2025.

FACTUAL FINDINGS

Jurisdictional Matters

1. On October 8, 1998, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 84884 to respondent Neil Michael Richman, M.D. This certificate was in full force and effect at all relevant times and is scheduled to expire on March 31, 2026, unless renewed.

2. On April 14, 2022, acting in his official capacity as Executive Director of the Board, complainant William Prasifka issued and served an accusation against respondent. On June 23, 2023, Reji Varghese succeeded Prasifka as the Executive Director of the Board and assumed the role of complainant in this proceeding. Complainant requests discipline of respondent's certificate based on allegations that he committed a negligent act during an orthopedic surgery in 2017 and a second negligent act during an orthopedic surgery in 2018. Complainant also seeks costs.

3. Respondent timely filed a notice of defense and this proceeding followed.

Background

4. The facts of this matter are largely undisputed. Respondent is an experienced, board-certified orthopedic surgeon. The disputed issue is whether respondent breached the standard of care while performing two surgical procedures in 2017 and 2018.

Respondent's Treatment of Patient 1

5. On February 9, 2018, Patient 1 suffered a right ankle injury. He was transported to and admitted into Watsonville Community Hospital. Respondent evaluated Patient 1's ankle injury and learned that he was 44 years old; he was homeless; and he had a history of alcohol abuse and was suffering from withdrawal. Patient 1 reported that he was struck by a car in a parking lot while intoxicated. After an examination, respondent diagnosed Patient 1 with a right ankle fracture, likely with ligament damage, more specifically:

> bimalleolar equivalent [fracture] with displaced lateral malleolus [fracture], likely deltoid ligament disruption, lateral talar subluxation in mortise with increased medial clear space. This is an unstable [fracture] for which operative treatment (ORIF) [open reduction internal fixation] [is] strongly recommended.

6. On February 10, 2018, respondent performed an ORIF procedure to repair the lateral malleolus fracture and respondent performed a primary repair of the deltoid ligament on Patient 1's right ankle. As is standard, respondent used intra-operative fluoroscopy (an imaging technique that uses lower radiation x-rays to produce a video image) during the surgical procedure.

7. In his operative report respondent noted that, after the fracture was fixed definitively with non-locking screws,

> the ankle was stressed with both valgus which showed significant widening in the medial clear space with talar tilt and then with external rotation stress which appeared to tilt

> the talus [a bone in the foot just below, and bearing weight from, the tibia and fibula] did not appear to widen the interval between the distal fibula and the tibia at the syndesmosis [fibrous joint between the tibia and fibula].

8. After respondent performed the deltoid ligament repair, he reported that:

> the ankle was stressed again. This seemed to significantly improve the stability for the medial side. There was much less medial clear space widening with valgus, though there still was a little bit. That was felt to be acceptable.

Fluoroscopy images taken during the surgery support respondent's report of these procedures. While reviewing these images in the operating room during the surgery, respondent did not note an asymmetry of the mortise, which indicates widening of the syndesmosis that might require further fixation.

9. After surgery, Patient 1 was taken to a recovery room, in stable condition.

10. The following day, February 11, 2018, respondent re-reviewed the intra-operative fluoroscopy images and determined that the images showed a widening of the syndesmosis. He reported:

> I reviewed yesterday's C-arm images from the surgery. comparing the stress mortise views of the normal ankle with the injured one following fixation and ligament repair, there seems to be about 2 mm residual difference at the medial clear as well as at the syndesmosis.

¶ . . . ¶

As noted above, review of yesterday's C-arm images suggest that the syndesmosis may not be stable under stress.

¶ . . . ¶

I recommended to patient [right] ankle syndesmosis fixation w/ Tightrope fixation; minimally invasive surgery. I discussed surgery details, reasons for recommendation (w/ photos & pictures), risks, benefits and expected outcome. Patient agreed to proceed.

11. At hearing, respondent testified that he made a "very subtle finding" when he observed separation of "about two millimeters" between the lower ends of tibia and fibula, and a "slight increased space on the right side of talus." Respondent described this finding as a "slight degree of instability."

12. On February 12, 2018, respondent performed a second surgery—syndesmosis fixation with a double tightrope device—upon Patient 1, under general anesthesia. In his operative report, under the heading "INDICATIONS FOR SURGERY," respondent reported:

The patient is a 44-year-old male who on February 9 suffered the above-noted injury which was closed. He underwent operative repair on February 10. Scrutinization of the intraoperative C-arm views from the surgery yesterday revealed slight widening of the syndesmosis

> suggesting injury to the syndesmosis with residual laxity. I discussed this with the patient yesterday showing him photos of his x-rays and using diagrams and pictures, recommended syndesmosis fixation to prevent widening of the syndesmosis and increased risk for posttraumatic arthritis. The procedure was described in detail including potential risks, which are quite small and complications as well as expected outcomes. Please refer to the clinic notes for details of that discussion. The patient presents for right ankle syndesmosis fixation following that discussion.

Respondent did not mention any concern about Patient 1's ability to comply with post-operative instructions.

13. There is no evidence or allegation that respondent acted unprofessionally in connection with the second surgery.

Respondent's Treatment of Patient 2

14. Patient 2 was 80 years old and obese. On November 18, 2017, he fell and fractured his right intertrochanteric femur.

15. On November 20, 2017, respondent performed an open reduction internal fixation surgery upon Patient 2's right hip femur fracture with a cephalomedullary nail. As is standard, respondent used intraoperative fluoroscopy for the surgical procedure and used a lag screw to hold the nail in place. Respondent believed that he placed the lag screw correctly, but actually placed the lag screw too deeply into the femoral head, such that the tip of the screw was nearly (or perhaps actually) protruding from the femoral head into the joint space.

16. Shortly after the surgery, while Patient 2 was in the recovery room, respondent rereviewed the fluoroscopy images taken during surgery and determined the lag screw was placed too close to the edge of the femoral head. In his operative report, respondent explained:

> While the patient was still in recovery room, I was reviewing the patient's intraoperative C-arm [fluoroscopy] films on the PACS System in the Recovery Room at the nursing station on a computer monitor with much higher resolution than the C-arm monitor in the OR. With the higher resolution monitor, it appeared that the tip of the lag screw on the AP [anterior posterior] view was very close to the edge of the subchondral bone in the femoral head. I felt that this was very close to the articular surface and did not leave much margin for error. I discussed this finding with the patient and his wife and showed the wife the C-arm image. I recommended that the lag screw be backed off several millimeters, which would allow for margin for error and better to avoid articular penetration of the lag screw.

17. After obtaining informed consent, respondent returned Patient 2 to the operating room for a second surgery to adjust the lag screw placement. An anesthesiologist was present, but this surgery was performed under local anesthetic, with sedation. At hearing, respondent explained that he first inserted a screwdriver into the existing sutured incision at the end of the nail and loosened a set screw that holds the lag screw in place. Then respondent removed "one or two" sutures and reopened another incision; inserted a screwdriver, and "backed off" the lag screw 2.25

turns (approximately 8 to 10 millimeters), such that the tip of the lag screw was further away from the surface of the femoral head and joint space. Respondent then retightened the set screw; irrigated the wounds, and re-sutured the second incision. Patient 2 was taken to a recovery room in stable condition.

18. There is no evidence or allegation that respondent acted unprofessionally in connection with the second surgery.

19. Patient 2 remained hospitalized and was treated for urinary retention and anemia until his discharge to a skilled nursing facility on November 27, 2020.

The Hospital Investigation and Complaint to the Board

20. On June 7, 2019, the Chief of Medical Staff of Watsonville Community Hospital filed a report with the Board, as follows:

> Upon receiving reports of concerns regarding [respondent's] quality of surgical care, the Watsonville Community Hospital medical staff initiated an Ad Hoc Committee investigation under its Medical Staff Bylaws on or about February 28, 2019, As the investigation proceeded, further concerns were uncovered, resulting in imposition of a summary suspension of all [respondent's] clinical privileges on May 23, 2019. [Respondent] resigned from the medical staff on June 6, 2019 while under investigation. Because [respondent] resigned from the medical staff, the medical staff did not draw any final conclusions regarding his quality of care in this matter.

The Investigative Interview of Respondent

21. The Board investigated the June 7, 2019, complaint, and respondent's care of at least four patients.

22. On April 28, 2021, respondent was interviewed by two Department of Consumer Affairs, Health Quality Investigation Unit investigators and District Medical Consultant Harry Khasigian, M.D. Regarding his review of the fluoroscopic images during the first surgery on Patient 1, respondent was asked if he felt the resolution was so poor that he could not assess the syndesmosis. He denied this. He later explained that his "initial interpretation of stress view was that it was okay," but when reviewing the images the next day he was "being a little more critical" and "decided that maybe it wasn't okay."

Respondent's Additional Evidence

23. Respondent testified at hearing. He is 66 years old.

24. Respondent earned a bachelor's degree in chemistry in 1982, a master's degree in medical anthropology in 1989, and a medical degree in 1990. He completed a surgical internship in 1991, a surgical residency in 1995, and an orthopedic fellowship in 1996. Respondent then received two additional years of post-graduate training in orthopedics in New Zealand. Since 1998, he has worked as an orthopedic specialist, mostly in California.

25. Respondent is also certified to operate and supervise the operation of fluoroscopy and x-ray imaging devices. He explained that he maintains this certification because his clinics have such devices and it is required that there be a physician certified to supervise their operation.

26. Respondent has been certified as a diplomate of the American Board of Orthopaedic Surgery (ABOS) since 2002. He has been a fellow of the American Academy of Orthopaedic Surgeons (AAOS) since 2005. From 2001 through 2014, respondent worked as an orthopedic surgeon at the Natividad Medical Center (Natividad) in Monterey.

27. Respondent currently provides outpatient orthopedic clinic services for Santa Cruz County Health Services Agency. He performs closed reductions of fractures, administers injections, and applies casts and splints, but does not perform surgical procedures. Respondent also occasionally works as an assistant surgeon to Kartheek Reddy, M.D., who serves as the primary surgeon in orthopedic procedures.

28. From January 2017 through July 2018, respondent worked as an orthopedic surgeon for a multispecialty group based at Watsonville Community Hospital. This work ended after he resigned during the investigation referenced in Factual Finding 20.

29. Respondent reports attributes at least some of this investigation to a personal dispute with another orthopedic surgeon, who was the chair of the investigating committee. Respondent reports that he resigned his position while the investigation was pending on the advice of legal counsel.

30. As of August 1, 2023, respondent's surgical privileges at Natividad Medical Center were restored, but only to assist surgeries, not to perform them as a primary surgeon. Respondent reports that the process of re-obtaining full surgical privileges would be burdensome and require a period of supervision. He enjoys his current work. Respondent reports that the last time he performed an orthopedic

surgery as the primary surgeon was in 2022, and he has no intention of acting in the capacity of a primary surgeon again.

31. Regarding his treatment of Patient 1, respondent denies departing from the standard of care. He reports that he had performed more than 75 ankle surgeries previously, including at least one bimalleolar-equivalent fracture repair surgery. However, he had not previously repaired both a lateral malleolus and performed a deltoid ligament repair in the same surgery. Respondent reports that he learned the ORIF and deltoid ligament repair surgical techniques he employed at an orthopedic trauma conference.

32. Respondent contends that his fixation of the syndesmosis injury to Patient 1 during the initial surgery was satisfactory. However, he reports that, after the initial surgery, he became concerned about Patient 1's ability to comply with post-surgery instructions to remain non-weightbearing for 10 weeks, based on Patient 1's history of homelessness and alcohol abuse. Respondent explained that many of his patients at the Santa Cruz County clinics are homeless and he understands that this population faces additional challenges complying with such instructions. However, respondent did admit that there was a "subtle instability" in Patient 1's ankle joint that he did not appreciate during the first surgery, and only discovered when reviewing intra-surgery images the next day. Respondent described this slight increased space on the right side of the talus as "one millimeter." Respondent admits that his decision to recommend a second surgery for additional fixation was not based on any new information, but respondent reports that he does not believe he made any mistake in his treatment of Patient 1.

33. Regarding his treatment of Patient 2, respondent reports that he had performed 50 to 75 intertrochanteric fracture repair surgeries previously and assisted

more than 25 others. During the initial surgery, respondent believed he had placed the lag screw correctly. However, he admits that he placed it deeper into the femoral head than he intended or was appropriate. He admits that if he had questions about this placement, he could have "gotten additional imaging" in the operating room, before concluding the surgery. Regarding Patient 2's recovery, respondent reported that Patient 2 had post-polio syndrome, walked with crutches, and had an enlarged prostate. Respondent credibly attributed Patient 2's post-surgery water retention to his enlarged prostrate and his minor post-surgery difficulties with physical therapy to his post-polio syndrome, not the second surgical procedure to adjust the lag screw.

34. Dr. Reddy testified at hearing and wrote a letter in support of respondent. Dr. Reddy is an experienced, board-certified, orthopedic surgeon. Dr. Reddy reports that he has known respondent since 2018 and respondent has assisted him in 75 to 150 surgeries, mostly knee or hip replacements. In 2019, Dr. Reddy also proctored several of respondent's surgeries, in connection with respondent's reappointment of privileges as an assistant surgeon at Natividad. Dr. Reddy holds respondent in high regard and reports that respondent is very competent, and "seems up to date." Dr. Reddy also confirmed that a "high majority" of respondent's clinic patients present special treatment challenges, because of substance abuse disorder and social living situations.

35. David Godley, M.D., also testified at hearing and wrote a letter in support of respondent. Dr. Godley practiced orthopedic surgery for 40 years. He retired from full-time practice, but for the last seven years has worked part-time with respondent at the Santa Cruz County orthopedic clinics. He is familiar with respondent's outpatient work, but has never performed surgery with respondent. Dr. Godley regards respondent as a "knowledgeable, compassionate, and experienced physician who

cares greatly about all his patients." Dr. Godley specifically reports that respondent is knowledgeable on current orthopedic practices and that they usually agree on the treatment for patients.

36. Respondent submitted four other letters of support from former colleagues, and his accountant and personal friend. The authors hold respondent in high regard and report that he is caring, compassionate, competent, and dedicated to the care of his patients.

37. Respondent reports that he currently earns a total of approximately $7,200 per month. He reports that, in addition to typical personal expenses, he also bears numerous professional expenses, such as his malpractice insurance, and various licensing and certification fees. Respondent reports that complainant's request for approximately $25,000 in costs, if granted, would be significant financial hardship for him. This testimony appeared sincere, but respondent did not offer any documentary support for these claims.

Expert Opinions

DR. DEZFULI

38. Complainant engaged Bobby Dezfuli, M.D., as an expert witness for this matter. Dr. Dezfuli has been licensed as a physician in Arizona since 2011 and in California since 2012. After receiving a medical degree, he completed a four-year residency in orthopedic surgery, and then a one-year fellowship in hands and upper extremities. Dr. Dezfuli has been certified as a diplomate in orthopedic surgery, with a sub-specialty in orthopedic surgery of the hand, by the ABOS since 2017 and 2018, respectively. He performs one to 10 orthopedic surgeries per day at a Kaiser Permanente hospital in Woodland Hills. Dr. Dezfuli also serves as the administrative

head of its department of orthopedic surgery. Approximately two-thirds of his surgeries involve an upper extremity, and one-third a lower extremity. He is affiliated with an orthopedic residency program at a facility in Ventura, supervising, assisting, and critiquing dozens of orthopedic surgeries performed by residents each year. He has authored or co-authored more than a dozen publications about orthopedics. Dr. Dezfuli has also served as an expert for the Board for five to six years. He has reviewed more than 30 cases in this capacity and found a departure from the standard of care in only three.

39. Dr. Dezfuli was asked to review respondent's care for four patients, including Patients 1 and 2. He reviewed documents including: investigation reports, a statement from respondent, a transcript of the investigative interview of respondent, and relevant medical records of the four patients. Dr. Dezfuli issued a report dated January 15, 2022, and also testified at hearing. In his report, Dr. Dezfuli opined that respondent departed from the standard of care in his treatment of three of the four patients, including Patients 1 and 2.

40. In his report, Dr. Dezfuli expressly mentioned reviewing radiographs from respondent's surgery upon Patient 2, but not radiographs from respondent's surgery upon Patient 1. However, at hearing, Dr. Dezfuli credibly reported that he reviewed the intra-operative fluoroscopy images from the surgeries of both patients.

DR. MARMOR

41. Respondent engaged Meir Tibrin Marmor, M.D., as an expert witness. Dr. Marmor earned a medical degree in Haifa, Israel, in 1996, and completed an eight-year residency in orthopedic surgery as a military surgeon. He then completed two years of fellowship in orthopedic trauma surgery. He has worked as an orthopedic surgeon at

the University of California San Francisco General Trauma Center since 2008 as an assistant, associate, and now full professor. He conducts surgeries and teaches residents. Dr. Marmor has been licensed as a physician in California since 2009 and he holds several certifications, including a certification in orthopedic surgery by the ABOS. He has authored or co-authored more than 80 peer-reviewed publications about orthopedics, including on syndesmosis injuries, intertrochanteric fractures, and the specific hardware used to repair Patient 2's hip fracture.

42. Dr. Marmor was first asked to review respondent's treatment of four patients, including Patients 1 and 2, in connection with the 2019 Watsonville Community Hospital investigation. More recently, he was asked to render an opinion on this care for this proceeding. Dr. Marmor reviewed the medical records and imaging, as well as the report of Dr. Dezfuli.

43. Dr. Marmor credibly reports that he was not asked to be an advocate for respondent or given guidance other than to state whether respondent met the standard of care in his treatment of the relevant patients. At hearing, Dr. Marmor defined the standard of care as the treatment that an average or reasonable surgeon would administer for a particular injury or diagnosis. When asked to define an extreme or simple departure, he stated that he was not sure of the definitions for those terms but opined that a mistake must rise to a certain level to constitute a breach of the standard of care and that an extreme departure is one that causes bodily harm.

PATIENT 1

44. Dr. Dezfuli offered no criticism of respondent's diagnosis of Patient 1's injury or respondent's ORIF repair of the lateral malleolus fracture. Dr. Dezfuli reports that he and most orthopedic surgeons would not perform a deltoid ligament repair

procedure to address this type of syndesmosis injury, but Dr. Dezfuli opines that respondent's technique was within the standard of care. Dr. Dezfuli opines that respondent's deltoid ligament repair procedure reduced and improved the syndesmotic instability in Patient 2's ankle.

45. However, Dr. Dezfuli opines that, based primarily on respondent's own surgical report, as well as the radiographs, a significant asymmetry of the ankle mortise persisted after respondent performed these procedures, and the standard of care required respondent to fix that. Dr. Dezfuli disagrees with respondent's characterization of the remaining syndesmotic disruption as "subtle," and opines that "it was obvious." Dr. Dezfuli opines that respondent "absolutely" did not interpret the radiographs correctly and that even junior residents are supposed to understand the need to repair such asymmetry surgically. Dr. Dezfuli opines that conservative (non-surgical treatment) was not adequate to address the remaining asymmetry. Dr. Dezfuli explained that a surgeon is not supposed to bring a patient back for a second surgery to address a problem that was apparent and could have been addressed during the initial surgery. He opined that if a resident performed this way, he would consider it unacceptable and "very concerning." Dr. Dezfuli reports that this is such a basic concept that he considered calling it an extreme departure from the standard of care. However, based on the fact that respondent identified the remaining instability and discussed it with Patient 1 shortly after surgery, Dr. Dezfuli opines that it was a simple departure from the standard of care.

46. In his report, Dr. Marmor opined that he agrees with Dr. Dezfuli that performing fixation to further reduce the syndesmosis during the initial surgery "certainly would have been the optimal treatment," but disagrees that further fixation was required by the standard of care. He reported that many times surgeons forget to

stress the syndesmosis after fixation of ankle fractures when intraoperative imaging "looks normal" and it "is controversial if fixation is even necessary in those situations." Dr. Marmor uses a checklist to remind him to stress the syndesmosis, but is not aware of other surgeons doing that and does not regard it to be the standard of care. He opined:

> In my opinion, [respondent] met the standard of care. He did not settle for the intraoperative images. He examined the images postoperatively, suspecting syndesmosis injury and came to a shared decision with the patient to go back to the operating room to improve fixation and the potential outcome. [Respondent] showed that he took responsibility for his actions when he could have treated the patient in a cast or CAM [Controlled Ankle Motion] boot without discussion. Instead, he chose to admit that there was a syndesmotic disruption and recommended better management.

47. When asked at hearing if it would have been appropriate for respondent to not tell Patient 1 about the remaining syndesmotic disruption, Dr. Marmor opined that it was "at the discretion of the surgeon" and that sharing "all your concerns" might influence rehabilitation and the outcome, so one does "not share everything." Dr. Marmor opined that most reasonable surgeons would have "said good enough and see how the patient does," but respondent concluded the syndesmosis was not sufficiently stable, shared that with the patient, and went back to correct it. Dr. Marmor characterized this as "the epitome of the standard of care."

48. At hearing, Dr. Marmor opined that, based on the intraoperative images after respondent's surgical repairs, it was a "judgment call" as to whether further fixation was required; his opinion was "no"; but "there's more to decision-making." He explained that with a "compliant patient," instructions not to stress the ankle would be sufficient. Dr. Marmor typically places such patient in a CAM boot for six weeks. Dr. Marmor reported that the homeless status of Patient 1 was not a factor in his opinions and he tries not to make assumptions about patients, but a patient's ability to comply with post-operative instructions might guide a treatment decision. Dr. Marmor opined that "ideally" a surgeon would document the reasons for such a treatment decision. Dr. Marmor admits that respondent did not receive new information after the initial surgery. He opined that it appears that respondent "just changed his mind" about the need for further surgical fixation.

PATIENT 2

49. It is undisputed that respondent placed the lag screw too deeply into the head of Patient 2's femur and that, if left that way, it would pose a serious and unacceptable risk of complications. Dr. Dezfuli opines that Patient 2's injury was a common fracture and the surgical treatment respondent administered was routine. He reports that this surgical procedure is taught to junior residents. Dr. Dezfuli acknowledges that Patient 2's obesity made interpreting the intraoperative images more difficult and surgeons occasionally place such a screw too deeply. However, he opines that the intraoperative images show that the lag screw penetrated the joint space. Regardless, he opines that if such images are blurry or hard to read, there are "always remedies," such as using another imaging device, or bringing in a colleague to help troubleshoot the problem. Dr. Dezfuli opines that the standard of care is to ensure the screw is placed appropriately before concluding the surgery. Dr. Dezfuli

opines that respondent breached this standard of care by concluding the initial surgery with the lag screw placed too deeply in Patient 2's femoral head.

50. Dr. Dezfuli reports that again he considered calling this an extreme departure from the standard of care. However, as with Patient 1, based on the fact that respondent identified the mistake, discussed it with Patient 2, and remedied it shortly after surgery, Dr. Dezfuli opines that respondent's misplacement of the lag screw was a simple departure from the standard of care.

51. Dr. Dezfuli notes that Patient 2 was in the hospital for more than a week after the surgeries and he "wonders" whether the second surgery exacerbated his anemia, but does not know whether the second surgery led to the longer stay.

52. In his report, Dr. Marmor admitted that it "obviously would have been optimal treatment" if respondent had properly placed the lag screw during the first surgery. However, Dr. Marmor opined that respondent met the standard of care. He cited Patient 2's obesity and opined that in his "experience, poor fluoroscopic imaging that results in suboptimal screw length is not uncommon" and that this "is not necessarily below the standard of care." Dr. Marmor opined:

> [Respondent's] subsequent actions by taking the patient back showed he was capable of evaluating intraoperative imaging. He admitted to the patient that the hardware was not in optimal position and was able to correct the problem with local anesthesia. The decision to correct the problem under local anesthesia was appropriate and showed excellent surgical technique. In my opinion, Dr. Richman

met the standard of care in his care and treatment of the patient.

53. At hearing, Dr. Marmor opined that the standard of care did not require a surgeon to identify misplacement of a lag screw during the surgery, but rather as soon as the surgeon recognizes the problem, ideally during the surgery but "often times afterwards," which he characterized as "very common." He reports that "we all make these mistakes." When asked if it would be acceptable to him if a resident did this, Dr. Marmor stated that the difference between a mistake and a breach of the standard of care is "confusing," but while a physician can make a mistake, he cannot let a patient leave the hospital with a lag screw in that position.

Ultimate Factual Findings

54. During the February 10, 2018, surgery upon Patient 1's ankle, respondent committed a simple departure from the standard of care when he failed to determine that the syndesmosis required further fixation. Dr. Dezfuli's opinion to this effect is more persuasive than Dr. Marmor's opinion to the contrary. Dr. Marmor has more specific experience and expertise with the two surgical procedures at issue, but Dr. Dezfuli is also a board-certified orthopedic surgeon who has performed and supervised residents in performing the same hip surgery and similar ankle surgeries. Dr. Marmor appeared to misunderstand the definition of an extreme departure and admitted that he found the distinction between a mistake and a breach of the standard of care "confusing." He also seemed to view respondent's fulfillment of his ethical duty to disclose his mistakes to the patient as a factor in determining whether the standard of care for the surgery itself was breached. Further, Dr. Marmor's suggestion that respondent had the discretion to conceal his opinion that further fixation was needed was troubling. Dr. Marmor opined that it was a "judgment call" as

to whether further fixation was required and that, for a "compliant patient," instructions not to stress the ankle would have been sufficient. However, at hearing respondent reported that a primary reason he performed the second surgery was his concern that Patient 1 would not be able to follow postoperative instructions. Also, nothing in respondent's charting suggests that he believed the second surgery was elective. The day after the initial surgery, respondent stated that "review of yesterday's C-arm images suggest that the syndesmosis may not be stable under stress." Dr. Marmor's report and testimony that respondent complied with the standard of care were unpersuasive, in light of the opinions of Dr. Dezfuli and the undisputed fact that, based solely upon information available to respondent prior to and during the first surgery, respondent recommended and performed a second surgery under general anesthesia, for further fixation that could have been performed during the first surgery.

55. During the November 20, 2017, surgery upon Patient 2's hip, respondent committed a simple departure from the standard of care when he finished the surgery with the lag screw placed too deeply in Patient 2's femoral head, resulting in a second procedure under sedation. It is undisputed that the placement of the screw was a mistake and, if left alone, posed a high risk of serious negative consequences. The only dispute is when this mistake, if uncorrected, constitutes a departure from standard of care. Dr. Dezfuli's opinion that the standard of care requires a surgeon to correct this mistake before the surgery is concluded is more persuasive than Dr. Marmor's opinion that the standard of care allows a surgeon to correct the mistake any time before the patient leaves the hospital. Respondent discovered his mistake shortly after the initial surgery and corrected it without the need to subject the 80-year-old patient to the risks of general anesthesia a second time. Again, respondent discovered the mistake solely via information that was available to him during the initial surgery. Dr. Marmor

again appears to believe that respondent's candor and remediation of the error negate the breach. These are mitigating factors important for the determination of discipline, but the evidence shows that respondent committed a simple departure from the standard of care.

56. No harm to Patient 1 or Patient 2 was alleged or proven.

Costs

57. In connection with the investigation and enforcement of this accusation, complainant requests an award of costs in the total amount of $27,131, comprising $5,800 in expert witness fees, and $21,331 in attorney and paralegal services provided by the Department of Justice and billed to the Board. That request is supported by declarations that comply with the requirements of California Code of Regulations, title 1, section 1042. Respondent argues that the legal bills include vague and duplicative billing, and the expert witness fees should be reduced because the expert was asked to review respondent's treatment of four patients, but only his care of two patients was at issue in this proceeding. These arguments are not persuasive. Complainant proved $27,131 in reasonable costs.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant is required to prove cause for discipline of a professional license by "clear and convincing proof to a reasonable certainty." (Cf. *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) To the extent

respondent contends mitigation or rehabilitation, it is his burden to prove those contentions by a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

Cause for Discipline (Repeated Negligent Acts)

2. The Board may discipline the physician's and surgeon's certificate of a licensee who commits unprofessional conduct. (Bus. & Prof. Code, § 2234 [all further statutory references are to the Business and Professions Code unless stated otherwise].) Unprofessional conduct includes repeated negligent acts by a physician, which are two or more separate and distinct acts involving simple departures from the standard of care. (§ 2234, subd. (c).) Respondent committed two departures from the standard of care, which constitute repeated acts of negligence. (Factual Findings 54 and 55.) Cause exists to discipline respondent's physician's and surgeon's certificate under section 2234, subdivision (c).

Determination of Discipline

3. Cause for discipline having been established, the next issue is what discipline is appropriate. The Board's highest priority is protection of the public. (§ 2229.) However, "to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees." (Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines ("Guidelines") (12th ed. 2016), at p. 2; see Cal. Code Regs., tit. 16, § 1361.) The Board may consider a respondent's attitude toward his offense and his character, as evidenced by his behavior and demeanor at hearing. (*Yellen v. Board of Medical Quality Assurance* (1985) 174 Cal.App.3d 1040, 1059–1060.) The Guidelines expressly provide for disciplinary orders that deviate from the recommended discipline, in appropriate circumstances where the departures and supporting facts are identified.

4. For the violations found in this case, the Guidelines recommend a maximum discipline of outright revocation and a minimum disciplinary order of revocation, stayed, with a five-year period of probation with standard and optional conditions. Notably, the Guidelines provide that in "cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered." Complainant argues for the minimum discipline. Respondent maintains that there is no cause for discipline, but if cause were found, the appropriate discipline would be no more than a public letter of reproval.

5. Respondent committed two simple departures from the standard of care. These departures related to two different patients. However, cause exists to deviate from the Guidelines and impose a lesser level of discipline. Respondent has been practicing for more than 26 years with no previous license discipline. He presents as a thoughtful surgeon who genuinely cares about his patients. He appears to be diligent in keeping abreast of new developments in his practice areas. Respondent's two surgical errors were relatively minor. After the surgeries, he diligently reviewed the intraoperative images and then promptly acted with candor and in the best interests of his patients. No patient harm was alleged or proven. The public will be adequately protected by imposition of a public reprimand and an education requirement. (See § 2227, subd. (a)(4).)

Costs

6. A licensee who is found to have committed a violation of the licensing act may be ordered to pay a sum not to exceed the reasonable costs of investigation and enforcement. (§ 125.3.) Cause exists to order respondent to pay the Board's costs. (Legal Conclusion 2.) As set forth in Factual Finding 57, the reasonable costs in this matter are $27,131.

7. Cost awards must not deter licensees with potentially meritorious claims from exercising their right to an administrative hearing. (*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Cost awards must be reduced where a licensee has been successful at hearing in getting the charges dismissed or reduced; a licensee is unable to pay; or where the scope of the investigation was disproportionate to the alleged misconduct. (*Ibid.*) The agency must also consider whether the licensee has raised a colorable challenge to the proposed discipline, and a licensee's good faith belief in the merits of his or her position. (*Ibid.*). Respondent had a good faith belief in the merits of his defense, was successful in reducing the requested discipline, and proved a limited ability to pay a significant cost award. The cost award will be reduced from $27,131 to $5,000. Respondent may pay this award pursuant to a reasonable payment plan, as approved by the Board.

ORDER

1. Physician's and Surgeon's Certificate No. G 84884, issued to respondent Neil Michael Richman, M.D., is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4).

2. Respondent is hereby ordered to complete an educational course and failure to do in accordance with this order may be cause for further disciplinary action. This course will be approved by the Board to remediate the deficiencies identified in this matter.

3. Respondent is hereby ordered to reimburse the Medical Board of California the amount of $5,000 for its investigation and enforcement costs, pursuant to Business and Professions Code section 125.3. Respondent shall complete this reimbursement within 90 days from the effective date of this decision, or pursuant to a payment plan authorized by the Board.

DATE: 06/19/2025

MICHAEL C. STARKEY
Administrative Law Judge
Office of Administrative Hearings