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BY Ruby's Fitzwater ANALYST

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
EMILY L. BRINKMAN
Deputy Attorney General
State Bar No. 219400
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5742
Facsimile: (415) 703-5843
E-mail: Emily.Brinkman@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **PETER REDKO, DPM** North Bay Foot and Ankle Center 1400 Professional Drive #102 Petaluma, CA 94954 **Doctor of Podiatric Medicine No. E4517** Respondent.	Case No. 500-2016-000338 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about September 22, 2003, the Board of Podiatric Medicine issued Doctor of Podiatric Medicine Number E4517 to Peter Redko, DPM (Respondent). The Doctor of Podiatric Medicine was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2017, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Podiatric Medicine (Board), Department of Consumer Affairs, 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 California Board of Podiatric Medicine 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 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."

6. 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.

". . . ."

7. 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

8. 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

(Unprofessional Conduct: gross negligence and/or repeated negligent acts based on the care provided to Patient MS)[1]

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

10. Patient MS, a then 51 year old female, was first seen in Respondent's Petaluma office[2] on December 9, 2014. Patient MS reported that she hurt her foot approximately five to six months previously while running and her left foot 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 the fifth metatarsal base.)[3] According to Patient MS, Respondent reviewed only the

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[1] Patient initials are used to protect the patient's privacy. Respondent may learn the name of the patient during discovery.

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

[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

MRI report and advised her that surgery was her only option. Respondent also informed the patient that she would be able to run again within six months after surgery.

11. 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]

12. 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 MS. 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 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.

13. On or about December 16, 2014, Respondent performed out-patient surgery on Patient MS at Petaluma Valley Hospital. Before the surgery, Patient MS completed a general two page consent form that filled in the blanks with the type of surgery ("left peroneal tendon repair")

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[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.

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.

14. 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 MS 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]

15. Patient MS 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.

16. 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 MS. Rather he made a handwritten 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]

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[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.

[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 (continued...)

17. On or about January 5, 2015, Patient MS contacted Respondent's office for an earlier appointment than previously scheduled because she was in so much pain from the 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).

18. Patient MS went to 11 physical therapy sessions, two of which were documented in Respondent's records. Patient MS 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."

19. On or about February 17, 2015, Patient MS returned to Respondent's office for another follow-up appointment. According to Patient MS, 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 MS 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 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]

(...continued)
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.

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

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

20. Patient MS' last appointment with Respondent occurred on or about March 13, 2015. Patient MS 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.

21. 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.

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

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

24. Continued email and telephone contact between Respondent and Patient MS 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 MS undergo more physical therapy and continue wearing a brace. Respondent did not document or maintain any copies of his patient communications.

25. Patient MS 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, 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 MS' hamstring to replace the tendon in the ankle and to reconstruct the peroneal brevis tendon. She has now been diagnosed with chronic regional pain syndrome to her left foot and ankle.

26. 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 adequate informed consent prior to surgery.

b. 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 a 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.

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

d. Respondent failed to properly manage Patient MS' post-surgical issues, including ordering imaging studies to reassess and reassure the patient on the effectiveness of his surgery. Additionally, Respondent ordered conservative care post-surgically when he should have started with those treatment methods before performing surgery.

SECOND CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping)

27. 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 MS as alleged in paragraphs 9 through 26, which are herein incorporated by reference, as if fully set forth below.

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

DISCIPLINE CONSIDERATIONS

28. 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.

29. 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 Number 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,

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

DATED: April 12, 2017

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

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