ROB BONTA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
WENDY WIDLUS
Deputy Attorney General
State Bar No. 82958
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6457
Facsimile: (916) 731-2117
E-mail: Wendy.Widlus@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **JAMES CHUN WANG, D.P.M.** **9827 Vicar Street** **Los Angeles, CA 90034** **Doctor of Podiatric Medicine License No. E 3910,** Respondent.	Case No. 500-2018-000679 OAH No. 2020100804 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On or about August 24, 1993, the Podiatric Medical Board issued Doctor of Podiatric Medicine License Number E 3910 to James Chun Wang, D.P.M. (Respondent). The Doctor of Podiatric Medicine License was in full force and effect at all times relevant to the charges brought

herein and will expire on February 28, 2023, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Podiatric Medical Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2229 of the Code states:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
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> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.
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> (c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

5. 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.
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> 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.

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 2227 of the Code states:

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

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

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

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

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

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

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

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

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

. . .

(b) Gross negligence.

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

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

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

. . .

COST RECOVERY

9. 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 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.

DEFINITIONS

10. A bunion [also known as hallux valgus] is defined as an inflamed swelling of the small fluid-filled sac on the first joint of the big toe accompanied by enlargement and protrusion of the joint and is comprised of bone and soft tissue.

11. A hallux is defined as the great toe and hallux abductus is a fixed angulation of the great toe directed away from the body midline.

12. Neurovascular is defined as pertaining to both nervous and vascular elements, or to nerves controlling the caliber of blood vessels.

13. The first metatarsocuneiform joint is located around the middle foot. It is on the inner side of the foot, behind the first metatarsal (which leads to the bones of the big toe) and in front of the navicular bone. It is shaped similarly to a wedge.

14. A Lapidus bunionectomy is a surgical procedure to remove a bunion. The Lapidus procedure is a surgical procedure used to treat a bunion which involves fusing the joint between the first metatarsal bone and the medial cuneiform, one of the small bones in the midfoot. The surgery includes removing the cartilage surfaces from both bones, correcting the angular deformity, then placing hardware (screws and often a small plate) to allow the two bones to grow together, or fuse. When the bones are fused, the first metatarsal will not move abnormally and will allow the first toe to stay straight and decrease the risk of the bunion coming back.

15. Medially applied is defined as situated in or pertaining to the middle.

16. External fixation is defined as a surgical method of immobilizing bones to allow a fracture to heal properly. An external fixator is a rod which is screwed into the bone and exits the body to be attached to a stabilizing structure on the outside of the body. The external fixator is used to provide stability to bone and soft tissue and can also be applied as a procedure to correct bone misalignment, restore limb length, or protect soft tissue after a serious burn or injury.

17. Internal fixation is defined as an orthopedic operation that involves the surgical implementation of implants for the purpose of repairing a bone. An internal fixator may be made of stainless steel, titanium alloy, or cobalt-chrome alloy.

18. Open reduction is defined as a surgical procedure where bone fracture fragments are exposed surgically by dissecting the tissues.

19. Closed reduction is defined as the manipulation of bone fragments without surgical exposure of the fragments.

20. The term lucencies is defined as a pale area revealed in radiography, computed

tomography, or similar examination technique.

21. Erythema is defined as abnormal redness of the skin or mucous membranes due to capillary congestion.

22. Edema is defined as the swelling of soft tissues as a result of excess fluid accumulation.

23. Cellulitis is a spreading bacterial infection just below the skin surface. It is most commonly caused by Streptococcus pyogenes or Staphylococcus aureus. In humans, the skin and the tissues under the skin are the most common locations for microbial infection. Skin is the first defense against invading bacteria and other microbes. An infection can occur when this normally strong barrier is damaged due to surgery, injury, or a burn. Usually, the immune system kills any invading bacteria, but sometimes the bacteria are able to grow and cause an infection. Disease-causing bacteria release proteins called enzymes which cause tissue damage. The body's reaction to damage is inflammation which is characterized by pain, redness, heat, and swelling. This red, painful region grows bigger as the infection and resulting tissue damage spread.

24. Prophylactic medication is defined as a drug or a treatment designed and used to prevent a disease from occurring.

25. Bactrim DS is a combination antibiotic used to treat ear infections, urinary tract infections, bronchitis, traveler's diarrhea, shigellosis, and Pneumocystis jiroveci pneumonia.

26. Osteomyelitis is defined as a bone infection, almost always caused by a bacteria and which over time can result in destruction of the bone.

27. Super soaks are defined as the complete immersion of a foot that has an external fixation device in water with Epson salt for a prolonged period of time on a daily basis.

28. Clindamycin is a semisynthetic antibiotic used to treat gram-positive penicillin-resistant infections.

29. Vancomycin is an antibiotic which is highly effective against gram-positive bacteria and which is administered intravenously in the treatment of severe staphylococcal infections resistant to other antibiotics.

30. A radiographic examination is defined as a procedure in which a radiopaque and a

radiolucent contrast medium are used simultaneously to visualize internal anatomy.

31. Lucency is defined in radiology as a region in an image caused by an absorber of lower x-ray attenuation than its surrounding tissues; in general, the opposite of opacity. The term is used in reports of a radiographic examination in which a radiopaque [referring to a material or tissue that blocks passage of x-rays, and has a bone or near bone density and which radiopaque structures are white or near white on conventional x-rays] and a radiolucent [radiolucent is defined as almost entirely transparent to radiation and almost entirely invisible in x-ray photographs and under fluoroscopy] contrast medium are used simultaneously to visualize internal anatomy.

32. Heel spur syndrome is defined as a calcium deposit causing a bony protrusion on the underside of the heel bone.

33. Plantar fasciitis is defined as a painful inflammation of the fibrous band of connective tissue [plantar fascia] that runs along the bottom of the foot and connects the heel bone to the ball of the foot.

34. Tendo-Achilles equinus also referred to as Achilles equinus or tight Achilles tendon is defined as a condition in which the upward bending of the ankle joint is limited. An ankle equinus deformity is not a medical condition as such but is more reflective of a condition where the foot is unable to dorsiflex, or bend upwards at the level of the ankle joint. As a result of this condition, there are many foot and ankle problems that can occur.

35. The tibial nerve is responsible for feeling and sensation in the ankle and foot. The tibial nerve passes through a narrow passage, called the tarsal tunnel, made of tarsal ligaments and surrounding bone and tissue in the ankle. The tibial nerve may get compressed in the event of an injury to the ankle due to swelling of the ligaments, or for any other reason, which leads to pain and numbness in the ankle. This is known as tarsal tunnel syndrome.

36. Percussion of the tarsal tunnel [also referred to as tarsal tunnel syndrome] occurs when the tarsal tunnel, located on the inside of the ankle, and formed by the ankle bones and the band of ligaments that stretches across the foot, has compression of the posterior tibial nerve as it travels through the tarsal tunnel. Many of the blood vessels, nerves and tendons that provide

movement and flexibility to the foot travel through the tarsal tunnel. Compression of the posterior tibial nerve can cause pain, tingling or numbness in the foot. Tarsal tunnel syndrome is similar to the better-known carpal tunnel syndrome.

37. Tarsal Tunnel Syndrome Release is a surgical procedure which cuts the laciniate ligament [a strong fibrous band in the foot] and tarsal muscles which has compressed the tibial nerve. The symptoms usually get better after the surgery

38. Wound dehiscence is defined as the separation of the layers of a surgical wound. The separation may be partial or only superficial, or complete with separation of all layers and total disruption.

39. Flexor retinaculum is a fibrous band of fascia on the medial side of the ankle that extends downward from the medial malleolus of the tibia to the calcaneus and that covers over the bony grooves containing the tendons of the flexor muscles, the posterior tibial artery and vein, and the tibial nerve as they pass into the sole of the foot.

40. Staphylococcus aureus is defined as a common species found especially on nasal mucous membrane and skin. It is a bacterial species that produces exotoxins including those that cause toxic shock syndrome, with resulting skin rash, and renal, hepatic, and central nervous system disease. Staphylococcus aureus causes cellulitis, pneumonia, osteomyelitis, endocarditis, suppuration of wounds and other infections. Staphylococcus aureus is also a cause of infection in burn patients and humans are the chief reservoir.

41. Methicillin is a semisynthetic penicillin antibiotic used principally in the treatment of severe, penicillin-resistant staphylococci infections.

42. Intravenous antibiotics are used instead of oral antibiotics for very severe infections, because intravenous antibiotics reach tissues faster and at higher concentrations than do oral antibiotics. Intravenous antibiotics are used for infections in parts of the body where penetration of oral antibiotics is less effective, such as in bone as well as for infections that are resistant to oral antibiotics.

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FACTUAL ALLEGATIONS

Patient 1[1]

43. The Board opened an investigation into Respondent's care of Patient 1 which disclosed that on January 18, 2017, Respondent saw Patient 1 for complaints regarding a painful bunion on his right foot and a painful fourth toe on his left foot.

44. Respondent's records of Patient 1's first visit to Respondent on January 18, 2017, disclose Patient 1 stated he had a problem with the bunion for several years. Patient 1 stated he had treated the bunion problem with orthotics and knew he needed to have surgery on it in the near future. Patient 1 reported pain of 5 on a 0 to 10 scale.

45. Respondent documented a review of Patient 1's systems and family history and performed a physical examination which revealed, among other issues, that Patient 1 had hyperkeratotic tissue and severe bilateral hallux valgus deformities. Respondent found Patient 1's neurovascular status to be intact with no sign of infection. Respondent's assessment revealed that Patient 1 suffered from bilateral painful bunion deformity and a hammertoe on his left foot.

46. Respondent fully discussed his findings with Patient 1, including the diagnoses and cause of Patient 1's various foot issues and treatment options for each of the problems. The patient was to try a pumice for the hyperkeratotic tissue with Vaseline while skiing.

47. At Patient 1's request Respondent discussed surgical correction of the deformity at the first metatarsocuneiform joint which would include a Lapidus bunionectomy. The initial examination reports that internal versus external fixation was discussed and that Patient 1 chose the external fixation. Patient 1 was instructed to think about the options and to return to see Respondent as necessary.

48. Respondent's records did not have any documentation of X-rays being taken or reviewed during this appointment.

49. On September 8, 2017, Respondent performed a Lapidus bunionectomy with bone graft with the application of an external fixator on Patient 1's right foot for Respondent's

[1] The names of the patients and/or witnesses are anonymized to protect their privacy rights. The names will be provided to Respondent upon written request for discovery.

preoperative diagnosis of a severe and painful hallux valgus deformity.

50. On September 13, 2017, five days after the surgery, Respondent saw Patient 1, who said he had minimal pain. Respondent's examination of Patient 1 showed minimal to no edema, there was no sign of any soft tissue infection, and his neurovascular status was intact. Diagnostic Radiology X-rays taken showed the patient to be status post Lapidus procedure with an external fixation device in place, with no abnormal lucencies. Patient 1's external fixation was tightened, the patient was told he could bathe, and to return to see Respondent in one week

51. On September 21, 2017, thirteen days after his surgery, Patient 1 returned for a follow-up examination. Patient 1 told Respondent he had been on his foot more and recently noticed more redness, swelling and pain. Patient 1 was not having fever, chills or night sweats.

52. Respondent examined Patient 1 and found slight erythema and diffuse edema on the midfoot and forefoot area. There were signs of clear drainage at the proximal pin site with no sign of cellulitis. The screws and fixation were intact and the fixator was tightened. Respondent's assessment indicated Patient 1 was 1.6 weeks postop with some superficial, slight, possible infection.

53. Respondent instructed Patient 1 to transition to super soaks of his right foot and prescribed prophylactic Clindamycin 300 mg, one by mouth twice a day.

54. On September 27, 2017, nineteen days after his surgery, Patient 1 returned for a follow-up examination. Respondent's assessment indicated significant decrease in erythema, edema, and negative drainage on physical examination with negative cellulitis, with the fixator screws intact and the fixator was tightened. The radiographs showed increased consolidation of the fusion site. Respondent's records stated the report from Diagnostic Radiology showed stable degenerative changes of the first metatarsal phalangeal joint with postsurgical changes related to Lapidus procedure and bunionectomy with medially applied external fixation and postoperative soft tissue swelling and no significant change from prior examination.

55. Respondent instructed Patient 1 to continue with the super soaks and to follow up with Respondent.

56. On October 4, 2017, three and a half weeks after surgery, Patient 1 followed up with

Respondent and reported he was not experiencing fever, chills or night sweats. Patient 1 said he had been doing his super soaks and that he was doing quite well.

57. Respondent's physical examination showed the screws and fixator to be intact with no reported sign of infection, pin tract problems, cellulitis, edema or erythema. Patient 1's fixator was tightened and Respondent instructed Patient 1 to return in two weeks for an x-ray of his foot.

58. On October 5, 2017, Patient 1 began feeling "bad" and he decided to go to a hospital emergency department on October 8, 2017, where he was given a prescription for Bactrim DS.

59. On October 10, 2017, Patient 1 returned to the hospital emergency department and was admitted with minimal fever and a normal white count. Patient 1's culture and sensitivity test was negative at that time and was attributed to the patient being on Bactrim and Clindamycin. Patient 1's radiographs and bone scan were both consistent with possible osteomyelitis and he was placed on an IV antibiotic regimen. Patient 1 was placed on a six-week course of IV antibiotics and discharged from the hospital on October 12, 2017.

60. On October 18, 2017, Patient 1 returned to Respondent's office and told Respondent that he had been admitted to the hospital where he was seen by an infectious disease physician who placed him on Vancomycin for what the infectious disease physician believed to be an active bone infection.

61. Patient 1 was referred to another infectious disease physician at a different medical institution. That infectious disease physician's physical examination showed no sign of infection, no edema, or negative erythema. The fixator screws were intact and functional with no loosening of the screws. Diagnostic radiology on October 18, 2017, displayed a prior right foot Lapidus procedure with healing bunionectomy, and unchanged attempted instrumented first 1MT joint arthrodesis and placement of an external fixator with some soft tissue swelling of the right foot. The radiographs displayed no reported lucency or any sign of bone infection. The assessment and plan was to tighten the fixator, continue with super soaks and removal of the fixator the following week.

62. On October 27, 2017, Patient 1's external fixation device was removed. Patient 1 had no further visits with Respondent following the removal of the external fixation device.

63. On February 1, 2018, Patient 1 went to see another physician due to the continued pain he was suffering in his right great toe. That physician ordered additional tests which revealed residual hallux valgus deformity and external fixator pinning the tarsometatarsal joint. On March 27, 2018, after reviewing the new test results, that physician's assessment was right hallux valgus with recurrence and osteomyelitis and the physician recommended a hallux MP joint fusion.

64. On April 27, 2018, Patient 1 underwent a fusion of the right first metatarsophalangeal joint with a new fixation device, open approach. Subsequent to his surgical fusion of the right first metatarsophalangeal joint, Patient 1 submitted a complaint to the Board.

65. On June 27, 2019, the Department of Consumer Affairs Division of Investigation Health Quality Investigations Unit Investigator [Investigator] assigned to investigate this matter for the Board interviewed Respondent with Respondent's attorney and the Board's medical consultant present throughout the interview.

66. During the interview Respondent stated Patient 1 came to see him for surgery due to a bunion deformity. Respondent stated Patient 1 provided him with x-rays of the area that was being evaluated for surgery. The Board's medical consultant asked Respondent why he decided on a procedure that involved an external fixator. Respondent stated that he told Patient 1 that he could surgically install either an external or internal fixator to treat his foot and Patient 1 agreed to the external fixator. When asked about the results of the procedure, Respondent said that Patient 1 healed despite the complications that occurred during the surgery.

67. On August 5, 2019, the Investigator interviewed Patient 1 who explained he went to see Respondent due to issues with his right big toe crossing over his long toe and wanted to have a bunionectomy performed to help fix this issue. After Patient 1 met with Respondent for a consultation regarding his right foot, Respondent suggested that he undergo a procedure that involves an external fixator instead of a bunionectomy. Respondent told Patient 1 that an external fixator would not only treat the issue involving his overlapping big toe but would allow Patient 1 to put more weight on his foot after surgery, and his recovery time would be less than a traditional bunionectomy. Patient 1 decided to go through with the procedure, but regretted having the

procedure, after realizing the results of the external fixator did not match those promised by Respondent. After the procedure Patient 1 developed hammer toes and an infection in his foot as detailed in his complaint to the Board. Patient 1 has now lost range of motion in his right foot.

Patient 2

68. Patient 2 presented for an initial visit to Respondent on July 13, 2017, with a chief complaint of pain in his left heel. Respondent diagnosed Patient 2 with heel spur syndrome/plantar fasciitis of the left foot secondary to tendo-Achilles equinus. Per Respondent's records, Respondent gave Patient 2 a regimen of home physical therapy and discussed other treatment options with Patient 2.

69. On or about July 25, 2017, Patient 2 returned to Respondent complaining of continued heel pain. Per Respondent's records, he diagnosed Patient 2 with severe plantar fasciitis, left heel. Respondent prescribed continued stretching exercises and Patient 2 was scheduled for a return visit with Respondent two weeks later.

70. Per Respondent's records, Patient 2 returned to Respondent August 29, 2017, and stated the pain in his heel was severe. Patient 2 told Respondent that the prescribed physical therapy, night splints, immobilization, cortisone shots and inserts had not relieved his pain.

71. Per Respondent's records, Patient 2 was suffering pain with percussion of the tarsal tunnel. Respondent's diagnosis was that Patient 2 was suffering distal tarsal tunnel syndrome with a possible calcaneal nerve branch neuroma. Respondent suggested Patient 2 undergo surgery for a distal tarsal tunnel release and Patient 2 stated that he would consider the surgery.

72. Per Respondent's records, on or about September 7, 2017, after obtaining informed consent from Patient 2, Respondent performed a distal tarsal tunnel release on Patient 2.

73. Per Respondent's records, on or about September 12, 2017, Patient 2 saw Respondent for a post-operative visit. According to Respondent's records, Patient 2 was healing without evidence of dehiscence, drainage or infection. Respondent instructed Patient 2 to continue his post-operative care regimen and return in one week.

74. Per Respondent's records, Patient 2 returned on September 19, 2017, for a post-surgical evaluation by Respondent. Respondent noted a slight dehiscence without drainage or

signs of infection. Respondent placed Patient 2 on *Epsom Salt* soaks to treat the dehiscence. Respondent requested that Patient 2 send him a picture of his foot in 24 hours and the patient agreed to do so.

75. Per Respondent's records, after Patient 2's September 19, 2017, office visit, a significant number of text messages between Patient 2 and Respondent were sent on an almost daily basis. Within the text message are a number of photographs of Patient 2's foot that appeared to demonstrate signs of a post-operative infection.

76. On September 21, 2017, Patient 2 was admitted to a local hospital for treatment of an infected surgical wound. On September 23, 2017, a hospital surgeon performed an incision and drainage of the surgical wound.

77. The surgeon's operative note for the September 23, 2017, surgery states the flexor retinaculum was intact without evidence of a surgical incision.

78. Patient 2 was discharged September 27, 2017, after undergoing the September 23, 2017, surgery. Thereafter on November 15, 2017, Patient 2 had to be readmitted to the hospital for a second surgery and drainage of the surgical wound. Methicillian sensitive Staphylococcus aureus was isolated from Patient 2's surgical wound which resulted in Patient 2 being placed on long term intravenous antibiotics.

79. The standard of care with regard to a preoperative evaluation for bunionectomy should include complete weight bearing radiographic exam and interpretation of the involved foot.

80. The standard of care with regard to repeated, prolonged immersion of a portion of the body which has undergone surgery with screws, wires, or pins that penetrate bone and exit the skin requires that the body part is not immersed in water for any prolonged period of time so as to prevent a postoperative infection.

81. The standard of care is to have a high index of suspicion of a post-operative infection when the cardinal signs of infection are present.

82. The standard of care is to immediately and aggressively treat any suspected post-operative infection.

83. The standard of care is to incise the flexor retinaculum during the performance of a tarsal tunnel release procedure.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

84. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent when he engaged in the conduct described above in paragraphs 43 through 62, and paragraphs 68 through 76, including but not limited to, the following:

A. Respondent's September 21, 2017, direction to Patient 1 to use super soaks for Patient 1's foot subsequent to Respondent's performance of the September 8, 2017, Lapidus bunionectomy, which utilized an external fixation device, was an extreme departure from the standard of care, regardless of whether there were clinical signs of infection at that time.

B. Respondent's September 21, 2017, direction to Patient 1 to use super soaks for Patient 1's foot which already showed clinical signs of infection subsequent to Respondent's performance of the September 8, 2017, Lapidus bunionectomy which utilized an external fixation device was an extreme departure from the standard of care.

C. Respondent's September 19, 2017, failure to diagnose Patient 2's post-operative infection was an extreme departure from the standard of care.

D. Respondent's failure to immediately and aggressively treat any suspected post-operative infection subsequent to Patient 2's September 19, 2017, office visit when Patient 2 thereafter sent Respondent significant numbers of text messages and photographs of the operative site which appeared to demonstrate signs of a post-operative infection.

E. Since the flexor retinaculum was not incised during the September 7, 2017, initial procedure as documented in the subsequent surgery by the hospital surgeon, the procedure was not properly performed and this constitutes negligence.

85. Respondent's acts and/or omissions as set forth in paragraphs 43 through 62, and paragraphs 68 through 76, and paragraph 84, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of

the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

86. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he was negligent in his care and treatment of Patient 1 and Patient 2. The circumstances are as follows:

A. Respondent failed to conduct a complete pre-operative examination when he did not order and evaluate an initial radiographic evaluation for Patient 1 in or around the initial January, 2017, office visit.

B. Respondent failed to conduct a complete pre-operative examination when he did not order and subsequently evaluate a preoperative radiographic evaluation for Patient 1 prior to the September 8, 2017, Lapidus bunionectomy.

C. Respondent failed to diagnose Patient 2's post-operative infection during Patient 2's September 19, 2017, post-operative office visit.

D. Respondent failed to immediately and aggressively treat any suspected post-operative infection subsequent to Patient 2's September 19, 2017, office visit when Patient 2 thereafter sent Respondent significant numbers of text messages and photographs of the operative site which appeared to demonstrate signs of a post-operative infection.

E. Respondent failed to incise Patient 2's flexor retinaculum during the September 7, 2017, initial procedure as documented in the subsequent surgery by the hospital surgeon and therefore, the procedure was not properly performed.

87. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

88. Respondent's acts and/or omissions as set forth in in paragraphs 43 through 62, and paragraphs 68 through 76 and 86 above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts, pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

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

90. The allegations of the First and Second Causes for Discipline are incorporated herein by reference as if fully set forth.

91. Respondent's acts and/or omissions as set forth in in paragraphs 43 through 62, and paragraphs 68 through 76, and paragraphs 84 through 88 above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct.

PRAYER

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

1. Revoking or suspending Doctor of Podiatric Medicine License Number E 3910, issued to James Chun Wang, D.P.M.;

2. Ordering James Chun Wang, D.P.M. to pay the Podiatric Medical Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2497.5;

3. Ordering James Chun Wang, D.P.M., if placed on probation, to pay the costs of probation monitoring; and,

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

DATED: JUN 09 2021

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

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