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8 **BEFORE THE**
PODIATRIC MEDICAL BOARD OF CALIFORNIA
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation
12 Against:

Case No. 500-2016-000338

13 **PETER REDKO, DPM**

FIRST AMENDED ACCUSATION

14 North Bay Foot and Ankle Center
1400 Professional Drive #102
Petaluma, CA 94954

15 Doctor of Podiatric Medicine
16 License No. E-4517

17 Respondent.

18
19
20 Complainant alleges:

21 **PARTIES**

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

25 2. On or about September 22, 2003, the Board issued Doctor of Podiatric Medicine
26 License E4517 to Peter Redko, DPM (Respondent). The Doctor of Podiatric Medicine license
27 was in full force and effect at all times relevant to the allegations brought herein and will expire
28 on July 31, 2023, unless renewed.

JURISDICTION

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

4. Section 2222 of the Code states:

"The California Board of Podiatric Medicine shall enforce and administer this article as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by this chapter are applicable to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing Panel established under Section 11371 of the Government Code is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.

The Board may order the denial of an application or issue a certificate subject to conditions as set forth in Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 11373, and 11529 of the Government Code. For these purposes, the California Board of Podiatric Medicine shall exercise the powers granted and be governed by the procedures set forth in this chapter.'

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

6. Section 2497 of the Code states:

"(a) The board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222.

"(b) The board may hear all matters, including but not limited to, any contested case or may assign any such matters to an administrative law judge. The proceedings shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the administrative

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

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

5 "(b) Gross negligence.

6 (c) Repeated negligent acts.

7 "..."

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

10 9. Section 802.1 of the Code requires that a doctor of podiatric medicine who is
11 convicted of any felony or misdemeanor report that conviction in writing to the Board within 30
12 days of that conviction.

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

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

19 COST RECOVERY

20 12. Section 2497.5 of the Code states:

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

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

1 “(c) When the payment directed in the board's order for payment of costs is not made by the
2 licensee, the board may enforce the order for payment by bringing an action in any appropriate
3 court. This right of enforcement shall be in addition to any other rights the board may have as to
4 any licensee directed to pay costs.

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

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

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

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

16 **FIRST CAUSE FOR DISCIPLINE**

17 (Gross Negligence and/or Repeated Negligent Acts)

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

21 14. Patient One, a 51 year-old female, was first seen in Respondent's Petaluma office² on
22 December 9, 2014. Patient One reported that she hurt her left foot approximately five to six
23 months previously while running and it hurts constantly. A previous physician ordered an MRI
24 and diagnosed the patient with two torn tendons (a split tear of the peroneus brevis at the ankle
25 level and a complete tear of the lateral hemi-tendon at the distal fibular tip, between the ankle and

26
27 ¹ The subject patients are referred to herein as Patient One and Patient Two to preserve
patient confidentiality. The patients' full names will be produced to Respondent upon request.

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

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

4 15. Respondent noted on the progress note⁴ that the patient was allergic to aspirin and
5 sensitive to sulfa and ceftin medications. He also noted that she was on methadone for restless
6 leg syndrome and another medication for migraines. Respondent did not conduct or document
7 any further information about the patient's methadone use or substance abuse history.
8 Respondent did not review the MRI itself, but only the report, and did not review any medical
9 records from other physicians, including the prior physician to determine what other conservative
10 treatment methods had been tried. Additionally, Respondent's physical examination is cursory
11 and does not document the patient's range of motion or that he considered the possibility of
12 anterior cavus.⁵

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

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

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

⁵ Cavus means a high arched foot.

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

4 17. On December 16, 2014, Respondent performed out-patient surgery on Patient One at
5 Petaluma Valley Hospital. Before the surgery, Patient One completed a general two-page consent
6 form that filled in the blanks with the type of surgery (“left peroneal tendon repair”) and the name
7 of the surgeon (“Redko”). There was no explanation on the hospital consent detailing the
8 specifics about the surgery or the risks and benefits of the specific surgery being performed by
9 Respondent, including the risk of sural nerve⁶ entrapment or alternative treatment options.

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

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

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

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28 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.

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

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

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

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

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26 ⁸ Xartemis XR is the trade name also known as Percocet, containing both oxycodone and
27 acetaminophen. Oxycodone is an opioid pain reliever. It is a Schedule II controlled substance as
28 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.

1 with continued edema the patient also had peroneal tendinitis.¹⁰ Under the “Plan” section of the
2 note, Respondent documented that he suggested the patient obtain custom molded orthotics and
3 he taped the patient’s left foot and ankle using the low-Dye strapping technique.¹¹

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

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

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

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

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

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

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

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

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

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

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

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

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

20 **SECOND CAUSE FOR DISCIPLINE**

21 (Inadequate Medical Record Keeping)

22 31. Respondent is subject to disciplinary action under section 2266 of the Code in that
23 Respondent failed to keep adequate and accurate medical records related to the care and treatment
24 of Patient One as alleged in paragraphs 13 through 30, which are herein incorporated by
25 reference, as if fully set forth below.

26 a. Respondent failed to document a thorough evaluation of Patient One's peroneal
27 tendon tears, including documenting an adequate history, substance abuse history (including
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1 evaluation of Patient One's use of methadone), and documenting the patient's ankle range of
2 motion and status of the patient's anterior cavus.

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

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

8 THIRD CAUSE FOR DISCIPLINE

9 (Excessive and Injurious Use of Alcohol)

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

14 33. On June 16, 2019, Respondent was arrested by Sonoma County law enforcement
15 officers after he crashed his car into another, causing injuries to the other driver. Blood alcohol
16 testing established that Respondent's blood alcohol percentage some hours after the accident was
17 .20%.

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

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

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1 **FOURTH CAUSE FOR DISCIPLINE**

2 (Failure to Report Misdemeanor Conviction)

3 36. Respondent has subjected his license to disciplinary action for unprofessional conduct
4 for his failure to report his conviction by jury verdict of the misdemeanors described in the Third
5 Cause for Discipline herein within 30 days of that conviction, as required by section 802.1 of the
6 Code.

7 **FIFTH CAUSE FOR DISCIPLINE**

8 (Conviction of Substantially Related Offense)

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

14 **SIXTH CAUSE FOR DISCIPLINE**

15 (Gross Negligence and/or Repeated Negligent Acts)

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

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

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

3 39. On February 18, at the second post-operative office visit, Respondent removed the
4 bandage and splint from the surgical site. Respondent again told Patient Two the surgical site
5 “looks good.” At the following week’s office visit, Respondent removed all but three of the
6 staples in Patient Two’s right ankle. Respondent informed Patient Two that she would begin
7 physical therapy in two weeks. Respondent assured Patient Two that the incision site “looks
8 good.”

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

14 42. Patient Two saw Respondent for the next scheduled office visit the following day.
15 After being informed of the physical therapist’s concern about the surgical wound’s appearance,
16 Respondent assured her that it “looks good” and told her to return in two weeks.

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

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

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

1 45. Patient Two returned to Respondent's office on March 20, 2020, telling him she was
2 suffering increasing pain and could barely walk. Respondent swabbed the wound for a laboratory
3 culture sample, debrided the area, and applied an Epifix amniotic graft. Respondent notes that he
4 contacted an infectious disease specialist on this same date, who reportedly recommended he
5 switch the prescribed oral Amoxicillin to Augmentin, which Respondent did. In his interview
6 with Board investigators on June 15, 2021, Respondent stated that he had discussed possible IV
7 antibiotics with the infectious disease specialist but the decision was made to continue with oral
8 antibiotics. There is nothing in Respondent's chart entries referring to that discussion of IV
9 antibiotics. At the March 27, 2020, office visit, Respondent noted that the ankle swelling was
10 decreased and told Patient Two the oral antibiotic was working.

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

17 47. Respondent saw Patient Two approximately three times per week through early May,
18 2020. During this period Patient Two had begun to walk more comfortably, reportedly up to a
19 mile, but began experience increased pain in her right ankle. Respondent continued to dress the
20 wound and assure Patient Two that the surgical incision was healing. At the June 5, 2020, office
21 visit, Patient Two reported feeling ill for the preceding few days. Respondent lanced and drained
22 what he termed a "blood blister" at the wound site and continued his regimen of wound care and
23 oral antibiotics.

24 48. At the office visit on June 19, 2020, Respondent treated the wound, took another
25 culture sample, and prescribed pain medication to address Patient Two's complaint of increasing
26 pain in her ankle. After leaving Respondent's office, Patient Two contacted her primary care
27 physician, who referred her to an infectious disease specialist. That specialist ordered x-rays of
28 her ankle and told her that there could be an infection deeper in the wound around the ankle

1 implant. The specialist referred Patient Two to a local plastic surgeon for additional consultation.
2 Patient Two continued to see Respondent for wound care as well.

3 49. Patient Two saw the plastic surgeon on July 13, 2020, who referred her to the
4 orthopedic department at UCSF, where she was seen on July 24, 2020. Diagnostic laboratory
5 tests and imaging confirmed initial physician concerns that the infection was affecting the
6 prosthesis and surrounding bone. Patient Two underwent surgery to remove the ankle implant on
7 August 5, 2020, and remained in the hospital until August 13, 2020.

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

14 **DISCIPLINE CONSIDERATIONS**

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

25 52. Respondent's probation in Case Number 1B-2009-200359 terminated on November
26 27, 2013, following his Petition for Early Termination of Probation.

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1 PRAYER

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

4 1. Revoking or suspending Doctor of Podiatric Medicine License No. E-4517, issued to
5 Peter Redko, DPM.;

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

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

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11
12 DATED: JUN 28 2022


13 BRIAN NASLUND
14 Executive Officer
15 Board of Podiatric Medicine
16 Department of Consumer Affairs
17 State of California
18 Complainant
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