ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
MICHAEL C. BRUMMEL
Deputy Attorney General
State Bar No. 236116
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2307
Facsimile: (559) 445-5106
E-mail: Michael.Brummel@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **CYRUS WINSTON SIRCAR, D.P.M.** **4151 Foothill Rd.** **Santa Barbara, CA 93110** **Podiatrist License No. E-5304** Respondent.	Case No. 500-2021-001175 **ACCUSATION**

PARTIES

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

2. On or about July 22, 2016, the Podiatric Medical Board issued Podiatrist License No. E-5304 to Cyrus Winston Sircar, D.P.M. (Respondent). The Podiatrist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2023, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Podiatric Medical Board (Board), under the authority of the following laws. All section references are to the Business and Professions Code (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 of the Code, states:

> 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:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(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.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients 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 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.

FACTUAL ALLEGATIONS

2018

9. On or about January 4, 2018, Patient A presented to Respondent complaining of bunion pain lasting six months. Respondent documented a discussion about conservative management including the use of appropriate shoes, inserts, and activity modification. Respondent told Patient A that surgery remains a treatment option if conservative measures fail. Patient A stated that she would like to have surgery at Respondent's surgery center.

10. On or about July 11, 2018, Patient A telephoned Respondent's office and stated that treatments were ineffective, and she was interested in surgery. The records do not state what types of conservative care were tried and were unsuccessful. The records state that Respondent discussed the need for surgical correction with Patient A.

11. On or about August 13, 2018, Patient A signed and dated a consent form that included alternative treatments and possible complications. The form included a diagram and the right first metatarsal area is circled. It is not clear who reviewed this form with Patient A.

12. On or about August 17, 2018, Respondent performed a right foot bunionectomy and an Akin procedure on Patient A's right foot. Patient A's records include documentation that the recent history and physical were reviewed, and that the risks benefits, and alternatives of the procedure were reviewed with Patient A. The operative report indicates a closing base procedure was performed. Respondent attempted to place a plate, but it was unsuccessful resulting in the

need for staples. The operative report does not indicate that a second Akin procedure was performed. The operative report notes some gapping and that it was filled with DBM[1] bone.

13. On or about August 18, 2018, Respondent documented text messages in which Patient A complained of increasing pain. Respondent directed her to take pain medication, rest, and elevate her foot. Respondent noted that pain medicine seemed to be working, and she should continue with the medication and hydrate to avoid problems. The next series of messages indicates that Patient A is experiencing itching from the steri-strips and that she changed her outer gauze and applied antibiotic cream possibly due to leakage from the wounds. Patient A included some pictures indicating that she is doing limited activities. Respondent advised her to leave the steri-strips on since there was drainage. Patient A told him that there is an ACE bandage on as well, and thanked Respondent for his care.

14. On or about August 21, 2018, Patient A presented to Respondent walking on one foot and no longer using a knee scooter. Patient A's x-ray revealed dorsiflexion of the first metatarsal. Respondent did not document any compliance issues related to weight bearing.

15. On or about August 21, 2018, Patient A was advised to continue with the cam walker and there is a mention of noted dorsiflexion of the bone.

16. On or about August 21, 2018, the records indicate swelling at the osteotomy and subluxation of the toe.

17. On or about September 1, 2018, Patient A sent Respondent additional pictures of her wounds, and Respondent replied that they looked better.

18. On or about September 4, 2018, Patient A presented with slight dorsal flexion of her first metatarsal.

19. On or about September 7, 2018, Patient A texted Respondent that the redness and swelling are improving, allowing her to put some extra weight on her foot.

20. On or about September 11, 2018, Patient A texted Respondent explaining that she was walking in the boot and applying more pressure. Patient A added that the wound seems to be

[1] Demineralized Bone Matrix is an osteo-conductive scaffold that is manufactured by acid extraction of allograft bone.

healing and inquired about hyperbaric treatment. Respondent told her that hyperbaric treatment would probably not help at this point, but she might consider a bone stimulator. Respondent told her that fractures take four to six weeks to heal and that it is a slow process. Patient A sent additional pictures to Respondent, and Respondent placed an order for hyperbaric oxygen.

21. On or about September 18, 2018, Patient A's x-ray revealed no interval healing of the osteotomy site and great toe valgus alignment with medial shifting of the metatarsal phalangeal joint. Patient A signed consent forms for surgical treatment that was nearly identical to the prior surgical consent forms.

22. On or about September 24, 2018, Respondent texted Patient A asking for permission to post the photos of her foot on his website and Patient A agreed.

23. On or about October 2, 2018, Patient A signed a patient consent form for surgery that was nearly identical to the prior surgical consent forms. Patient A's x-ray revealed incomplete healing of the osteotomy on the right, and erosive changes at the first metatarsal, a cause for concern of a possible bone infection. Respondent's postoperative report indicates that Patient A is doing well and has transitioned to walking barefoot in regular shoes. The records indicate that Patient A's osteotomy on the right foot surgery site is healing and the left foot will be addressed later. The Respondent noted that there is a decrease in range of motion at the big toe joint. Patient A was advised to discontinue using a cam walker.

24. On or about October 18, 2018, Respondent signed a preoperative surgical clearance for Patient A.

25. On or about October 19, 2018, Respondent performed a double osteotomy on Patient A's first metatarsal, a Tailor's bunion correction on her fifth metatarsal, and a Scarf procedure on the first metatarsal at the phalangeal joint. Respondent performed an exostosis on the fifth metatarsal head and the base of the proximal phalanx was resected. Respondent listed the surgery as a double osteotomy in the records, but there is no documentation of an actual osteotomy.

26. On or about October 22, 2018, Patient A reported that she was experiencing severe excruciating pain, and there was dried blood on the bandaging. Respondent told her to take her medication, rest, and elevate. Respondent provided an order for a muscle relaxant, and ordered

supplies for her to change dressings at the office. Patient A sent additional pictures, which showed good progress; however, the right foot incision appeared to be slightly open. Respondent told her to continue using the ace bandage.

27. On or about November 6, 2018, Patient A presented to Respondent reporting that she was healing well on the left side. Patient A was ambulating on the left side, and there was some slight rotation of the fifth digit. Patient A's x-ray report revealed that the bone union is not present; and there is still healing occurring at the osteotomy sites. The postoperative x-ray showed two staples in place. Respondent directed her to use a toe spacer to try and keep the digits apart.

28. On or about November 7, 2018, Respondent removed the right foot hardware and performed a base wedge procedure using an A plate to fixate the osteotomy.

29. On or about November 27, 2018, Patient A presented to Respondent six weeks post bunionectomy complaining of continued pain and swelling in her right foot. Patient A underwent x-rays, which revealed a bunionectomy had been performed on the left side as well, and two screws were placed in the mid-shaft area. Respondent documented that Patient A was doing well and was pleased with her progress. Respondent documented a limited range of motion and scheduled a revision surgery on Patient A's right foot.

30. On or about December 7, 2018, Respondent documented an annual history and physical noting that the history and physical were reviewed with Patient A and that the risks benefits, and alternatives of the procedure were discussed.

31. On or about December 8, 2018, Patient A told Respondent that her pain level is high but tolerable.

32. On or about December 18, 2018, Patient A presented two weeks postoperatively with noted improvement in the alignment and a stable surgical site.

33. On or about December 18, 2018, Patient A presented to Respondent stating that she was doing well, using her splint, and weight bearing. Patient A's x-ray revealed that the hardware is intact, and the alignment was good. Respondent placed a cast below the knee.

///

2019

34. On or about January 2, 2019, Patient A's x-rays show improvement. Respondent instructed Patient A to discontinue use of the cam walker and discussed an insurance concern with Patient A.

35. On or about January 15, 2019, Patient A reported that she had improved and was weight-bearing using a cam walker. Patient A was working on range of motion exercises and discussed custom inserts with Respondent. Respondent told Patient A to discontinue the use of the cam walker chart with weight bearing to tolerance and recommended orthotic therapy.

36. On or about March 8, 2019, Patient A continued to report significant swelling on her right foot. Respondent attributes the swelling to the need to revise the surgery. The records note that one of the offices will be closing and Respondent will be joining a different clinic.

37. On or about September 18, 2019, Respondent noted that Patient A is doing well, and applying weight on the right forefoot even standing on one foot. Respondent directed Patient A to continue with the current treatment plan and schedule surgery for the opposite side.

38. On or about August 31, 2019, Patient A sent Respondent text messages and pictures indicating that she was experiencing a reaction to the steri-strips. Respondent advised her to remove the steri-strips and let the wound get some air.

39. On or about October 2, 2019, Patient A's x-rays that revealed two staples in the base of the right foot from a past surgery. The position of the first metatarsal indicated probable overcorrection. The left foot x-ray showed a bunion deformity.

40. On or about November 7, 2019, Patient A's x-ray indicated that her right fifth toe is leaning, and Respondent recommended placing a piece of gauze in between to help with the alignment.

2020

41. On or about January 22, 2020, Patient A's primary physician referred Patient A to another podiatrist, Dr. M.H., for a second opinion. On or about January 22, 2020, Patient A's primary physician referred her to another podiatrist, Dr. M.H., for a second opinion. Dr. M.H. obtained x-rays of Patient A's foot, which revealed some bone non-union and possible loosening

of the hardware. The first metatarsal appeared shortened, with reasonable alignment, with changes in the fifth metatarsal and fifth digit. Over time, Patient A repeated complained to Dr. M.H. of continued pain in her foot. During following visits, Dr. M.H. and Patient A discussed the possibility of a fusion or the use of a Cartiva implant.

42. On or about March 18, 2020, Dr. M.H. performed a repair of Patient A's first metatarsal nonunion right, first metatarsal joint cheilectomy and implant, hardware removal and application of a short leg splint.

43. On or about May 5, 2020, Dr. M.H. performed a revision fusion of the first metatarsal base wedge osteotomy, hardware removal, joint cheilectomy, and implantation of a Cartiva implant on Patient A. Dr. M.H. directed her to continue with the boot, but to transition to fully weight bearing and gentle range of motion exercises. During following visits, Patient A weaned from walking in the boot and transitioned into light activities. Patient A improved, but showed signs of first metatarsal arthritis. Patient A continued to complaint of foot pain and elected to proceed with a joint fusion.

44. On or about August 19, 2020, Patient A underwent a fusion of the joint along with a bone graft. Following the fusion, Patient A improved, and transitioned to full weight-bearing. Patient A was instructed by Dr. M.H. to use a metatarsal pad to offload the second and third metatarsal heads, use a tennis shoe, and consider a fifth metatarsal resection if her symptoms continued.

2021

45. On or about July 27, 2021, Patient A presented to Dr. M.H. with a possible third interspace neuroma. Patient A subsequently underwent several imaging studies and failed conservative care before surgery.

46. On or about September 23, 2021, Dr. M.H. performed a second and third metatarsal osteotomies and repair of the joint regarding the digits and excision of a third interspace neuroma. Following surgery, Patient A presented complaining of continued pain. Dr. M.H. discussed neuroma excision as well as shortening the second toe.

47. On or about October 13, 2021, Patient A presented to Respondent for a preoperative visit for a right foot third interspace neuroma, and second and third metatarsal osteotomies. Patient A signed a surgical consent form for the upcoming surgery with Dr. M.H. Patient A's x-rays revealed that she was stable postoperatively. Dr. M.H. recommended that she continue with the cam walker, but transition to full weight bearing and repeat x-rays in four weeks.

STANDARD OF CARE

48. The standard of care is to take appropriate preoperative x-rays to make a proper decision as to subsequent medical care. These findings need to be reviewed with a patient so that they understand the problem. A surgical decision is to be based in part upon these x-rays. Postoperatively x-rays are obtained and even intraoperative images are taken to make sure that the surgery outcome was satisfactory. The x-rays need to be reviewed by the surgeon. Any complications need to be reviewed immediately with a patient and steps taken to address any problem.

49. The standard of care is to keep the patient advised of the postoperative progression of the surgery. If there are complications, a patient needs to be made aware of them. The treatment protocol needs to be reviewed with a patient if the plan is to take no action, or if it requires repeated surgery.

50. The standard of care is that a patient needs to be told the benefits, risks, complications, and alternatives to the surgery being performed. This allows the patient to determine if surgery is the best course of action.

51. The standard of care is to provide a patient with an explanation for the cause of any complication resulting from surgery. Complications do occur during surgery for a variety of reasons. It is the surgeons' duty to explain the complication to the patient, how to fix it, and any potential long-term complications that can result.

52. The standard of care for billing for surgical and non-surgical procedures is that the billing should accurately reflect the services consented to and rendered. At times, a physician must utilize prudent judgment when there is no perfect code for the service provided and rely on similar procedure coding.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

53. Respondent's Podiatrist License No. E-5304 is subject to disciplinary action under section 2227, as defined by section 2234, subdivision (b), in that he committed act(s) and/or omission(s) constituting gross negligence as more particularly alleged in paragraphs 9 through 51, which are hereby incorporated by reference and realleged as if fully set forth herein.

54. Respondent obtained x-rays, but did not document if he personally reviewed them. It is unclear if Patient A walked on her foot and created a problem during her recovery. Patient A's intraoperative x-rays show the plate, which Respondent believed to be placed improperly and replaced with staples. Respondent only documented a single intraoperative view, which is insufficient to determine whether the bone position was proper during surgery. Additional imaging would reveal if the position was improper, or if the position was proper, but the Patient A's later noncompliance led to complications. Respondent's failure to obtain adequate x-rays intraoperatively and immediately postoperatively represents and extreme departure from the standard of care.

55. Patient A's postoperative x-rays clearly showed a dorsiflexion of the distal part of the metatarsal. This is a surgical complication. There was a significant amount of movement of Patient A's bone that should have been addressed promptly no matter the cause. Patient A's subsequent pain and deformity in the joint were related to the malposition of the bone. Patient A should have been given the option to make a decision about proceeding with surgery or not. Respondent did not discuss the complication with Patient A until after he operated on her opposite foot. The complication should have been addressed first, prior to proceeding with any surgical procedure on the opposite foot. Respondent's surgery on the opposite foot prior to resolving the complications in the primary foot resulted in delay in treatment, which constitutes an extreme departure from the standard of care.

56. Patient A's consent forms for all three surgeries are template. Each surgery, especially the surgery that resulted in complications, have their own unique inherent risk and potential complications. The consent form includes a diagram, but it only includes a circle

around the toes/bones that are being addressed. The procedure may need to be modified on the table depending on the intra-operative findings. Patient A needs to be aware that changes could occur intraoperatively and that she may end up having a different procedure performed. Respondent was unsure if Patient A signed the consent form for the first surgery in the office or elsewhere. It is imperative that the consent form be reviewed with the patient by the surgeon so that if the patient has any questions, they can ask for a more clear or detailed explanation. It is not clear from the records who obtained consent from Patient A or if she was provided an appropriate opportunity to ask questions. Respondent's failure to utilize a unique consent form for each procedure including a clear explanation of risks and benefits that can be understood by Patient A, constitutes an extreme departure from the standard of care.

57. Respondent believed that the osteotomy site had completely healed and that the actual site of Patient A's complaint was further away from the surgical site. Respondent concluded that this mean that the surgery was not the cause of the complication. Respondent was incorrect. The bone was not in the proper position, which created jamming of Patient A's joint, which led to accelerated arthritis to the point. Patient A required two surgeries, one, which aimed to save the integrity of her joint, and the other to fuse the joint. Following the original surgery, the bone had completely healed. Furthermore, if the source of the complication was improper intraoperative bone position or patient noncompliance, the source is immaterial. The complication needed to be identified and promptly corrected. Respondent failed to identify and/or take responsibility for the root cause of the complication and take timely appropriate action, which constitutes an extreme departure from the standard of care.

58. Patient A's consent form indicated that an Akin procedure was performed in the right foot. The operative report contains no indication that an Akin procedure was performed. A Scarf procedure was performed on Patient A's left foot, but it was listed on the operative report as a double osteotomy. Respondent performed a fifth metatarsal osteotomy, but it was listed on the operative report as an ostectomy. Respondent improperly listed procedures performed on the operative report and potentially the subsequent billing, which constitutes an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

59. Respondent's Podiatrist License No. DPM 5304 is subject to disciplinary action under section 2227, as defined by section 2234, subdivision (c), in that he committed act(s) and/or omission(s) constituting negligence in connection with his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 57, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

60. Respondent's Podiatrist License No. E-5304 is subject to disciplinary action under section 2266, in that he failed to maintain adequate and accurate medical records in connection with his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 57, which are hereby incorporated by reference and realleged as if fully set forth herein.

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 No. E-5304, issued to Cyrus Winston Sircar, D.P.M.;

2. Ordering Cyrus Winston Sircar, 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; and,

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

DATED: MAY 0 2 2023

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

LA2022503317