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

In the Matter of the Accusation Against: CONNIE MELANIE CHOY, D.P.M. Specialty MOB-1st floor Podiatry 3600 Broadway Oakland, CA 94611-5730 Doctor of Podiatric Medicine License No. E-5005, Respondent.	Case No. 500-2022-001257 **ACCUSATION**

PARTIES

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

2. On June 1, 2012, the Board issued Podiatrist License No. E-5005 to Connie Melanie Choy, D.P.M. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2025, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board 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.

(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.

(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 [The Medical Practice Act] 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.

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. . .

9. Section 801 of the Code states in pertinent part:

(a) Except as provided in Section 801.01 and subdivisions (b), (c), (d), and (e) of this section, every insurer providing professional liability insurance to a person who holds a license, certificate, or similar authority from or under any agency specified in subdivision (a) of Section 800 shall send a complete report to that agency as to any settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

COST RECOVERY

10. 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

11. "Hallux valgus," commonly referred to as a bunion, is an inflamed swelling of the small fluid-filled sac on the outside of the first joint of the big toe accompanied by enlargement and protrusion of the joint and is comprised of bone and soft tissue. This foot deformity occurs from years of pressure on the big toe joint (the metatarsophalangeal, or MTP, joint). Eventually, the great toe joint gets out of alignment, and a bony bump forms. The medical term for bunions is hallux abducto valgus.

12. "Hallux varus" is defined as a big toe joint deformity. As opposed to a bunion which causes the big toe to point toward the other toes, hallux varus causes the big toe to point towards the opposite foot away from the other toes. Hallux varus is a condition characterized by the medial deviation of the hallux relative to the 1st metatarsal bone, most often the result of overcorrection from prior bunion surgery. Hallux varus may be recognized immediately after bunion surgery or may gradually occur in the first few months after surgery.

13. A "bunionette" is described as a prominence of the fifth metatarsal bone where it meets the bone of the little toe; it is often associated with the little toe tuning inward. Bunionettes are similar to bunions, the protrusions that occur on the inside of the foot below the big toe.

14. Hallux varus revision surgery generally involves releasing the tight soft tissues on the inside portion of the joint and possibly re-cutting the metatarsal bone to reposition it back into its normal position.

15. The "hallux abductus angle," also known as the first metatarsophalangeal angle, is a preoperative measurement used to assess the presence and severity of the alignment of the first metatarsophalangeal joint on a weight-bearing dorsoplantar radiograph of the foot.

16. "Metatarsus adductus" ["metatarsus varus"] is a measurement to describe the degree of metatarsal deviation towards the midline of the body. A measurement greater than 15 degrees is abnormal. This is a common foot deformity noted at birth that causes the front half of the foot, or forefoot, to turn inward. The metatarsus refers to the long bones group of bones in the middle section of the foot. Each foot has five metatarsal bones, each connected to the phalanges of the toes.

17. An "angulated fragment" is defined as a specific type of fracture displacement where the normal axis of the bone has been altered such that the distal portion of the bone points off in a different direction.

18. Sesamoid bones exist in the feet and bear the additional stress of shock absorption from walking. The tibial sesamoid position is assessed by its relation to the mid-axis of the first metatarsal.

19. A "capitol fragment" is defined as a fragment of bone avulsed [forcibly torn] from the head of a bone - e.g., of the metatarsus. The capital fragment, when described in an operative report, refers to the distal position, [i.e., further away from the heel bone] portion of bone which is resected from the proximal metatarsal using a power saw so that the capital fragment can be repositioned in a more favorable position.

20. An "osteotomy" is defined as a surgical procedure that involves cutting bone and sometimes adding bone tissue, used for changing the angular position of a joint, and is a treatment for problems at the joints, i.e., the area where two bones meet. The procedure is used to correct the angle, bowing or rotation of bones; shorten or lengthen bones; to correct the alignment of a deformed joint; repair a damaged joint or to shift the patient's weight from a damaged area of a joint to an area where there is more normal or healthy cartilage. There are many surgical techniques and variations of osteotomy techniques.

21. A "chevron osteotomy," also called an Austin bunionectomy, is a common technique for correcting mild to moderate bunion deformities. The procedure is done on the bone, and the bunion is corrected by relocating or sliding across the top of the first metatarsal bone. The procedure is generally used to correct the bunion by placing the metatarsal head behind the great toe, aligned with lesser toes, and to release a tight tendon that tends the great toe towards the second toe.

The osteotomy is performed near the great toe joint and is useful when the distal end of the metatarsal needs to be realigned. There are many different variations of osteotomies. Some osteotomies require immobilization or non-weight-bearing status for four to six weeks and therefore are not popular. The choice of procedure will depend on how much of each of the

different bones and soft tissue are involved, as well as the individual surgeon's preferences.

Minimally invasive surgery allows the performance of a chevron osteotomy through small percutaneous [needle puncture] incisions. Following the osteotomy, the capital fragment is shifted laterally and fixated with either compression FT screws for the minimally invasive surgery approach or compression PT screws for the traditional open approach.

22. A "K wire" [Kirschner wire] is a stainless-steel wire sharpened on one or both sides, used to hold bone fragments together or to provide an anchor for skeletal traction. These wires can be drilled through the bone to hold the fragments in place. The wires can be placed through or be buried beneath the skin. K-wires are often used to stabilize a broken bone and can be removed in the office once the fracture has healed. Some K-wires are threaded, which helps prevent movement or backing out of the wire, although that can also make the wires more difficult to remove. K wires are available in various types, lengths and diameters and are widely used in orthopedics and other types of medical and veterinary surgery.

23. Fluoroscopy is a real-time study of moving body structures--similar to an X-ray movie. A continuous X-ray beam is passed through the body part being examined. The beam is transmitted to a TV-like monitor so that the body part and its motion can be seen in detail. As an imaging tool, fluoroscopy enables physicians to look at many body systems, including the skeletal, digestive, urinary, respiratory, and reproductive systems. Fluoroscopy may be performed to evaluate specific areas of the body, including the bones, muscles, and joints. Fluoroscopy is useful in surgery to confirm the alignment of osteotomies, bones, or placement of fixation devices during a surgical procedure.

24. "Tightrope" is a device made by an orthopedic implant company used to stabilize the syndesmosis [a joint in which the bones are united by fibrous connective tissue forming an interosseous membrane or ligament] after an injury. This device allows flexible fixation, an improvement over the previously rigid forms of fixation.

25. A "surgical curette" is an instrument used for surgical scraping or debridement of human tissue. They come in a range of sizes, forms, and blade types to fit a variety of medical procedures, such as the removal of diseased bone.

26. A "salvage procedure" for failed toe joint replacement is revision surgery for patients who experience a failed first metatarsophalangeal joint replacement. The salvage procedure involves reconstruction of the great toe to restore function and relieve pain.

FACTUAL ALLEGATIONS

27. The Board opened an investigation into Respondent's care of Patient 1[1] based on a report pursuant to Business and Professions Code Section 801 that stated Patient 1 was paid $160,000 as a result of Respondent's failure to correctly operate on Patient 1's foot which ultimately led to additional surgery to fuse Patient 1's joint.

28. On or about June 30, 2022, the Department of Consumer Affairs Division of Investigation Health Quality Investigations Unit assigned an Investigator to investigate this matter for the Board.

29. On or about September 9, 2022, the Investigator telephonically interviewed Patient 1 regarding her complaint.

30. Respondent performed the second surgery three days after the first surgery in an attempt to repair Patient 1's foot. Following the second surgery, Patient 1 experienced continued problems with her foot. The respondent scheduled a third surgery for August 2019.

31. During the August 21, 2019, third surgery Respondent added additional screws to Patient 1's foot in an attempt to have the bones heal correctly.

32. Following the third surgery, Patient 1 experienced additional complications and requested that a different doctor examine her foot. Ultimately, the bones in Patient 1's foot had to be fused.

33. Patient 1 experiences limited mobility and walks with a limp. Patient 1 filed the lawsuit against Respondent in September 2021.

34. The Investigator contacted Patient 1's and Respondent's attorneys and obtained Patient 1's medical records, documents from the civil lawsuit, including various depositions, X-rays, and Respondent's curriculum vitae. Respondent's redacted curriculum vitae states she is an

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

American College of Foot and Ankle Surgeons Fellow, certified in Foot and Rearfoot/Reconstructive Surgery by the *American Board of Foot and Ankle Surgery*, and has a California Radiology and Fluoroscopy Operator permit.

35. On or about December 9, 2022, Respondent and her attorney participated in a telephonic, digitally recorded Subject interview with the Investigator and the Board's Medical Consultant.

36. On or about March 3, 2023, the Department of Consumer Affairs Division of Investigation Health Quality Investigations Unit Analyst contacted Expert Dr. 1, an approved expert for the Board and confirmed the expert's qualifications to perform an expert review of the case. The Analyst uploaded the electronic case binder with all of the case materials to Expert Dr. 1 for his expert review.

37. On or about March 13, 2023, the Analyst uploaded additional imaging records of Patient 1 for Expert Dr. 1's expert review.

38. On or about March 17, 2023, Expert Dr. 1 provided the Board with his expert report that he prepared on or about March 16, 2023, based on his review of all of the materials the Board provided to him.

39. Expert Dr. 1's March 16, 2023, report delineated simple departures from the standard of care for lack of adequate preoperative and postoperative X-ray documentation, lack of adequate preparation in handling a postoperative complication, an inadequate plan for a third surgery without referral to another provider, placing the patient in a splint instead of a short leg cast to limit weight bearing, failure to properly prepare the bone surfaces to insure fusion of the osteotomy site during second and third surgeries, failure to document measurements for the management of hallux valgus based on evaluation of pre and postoperative imaging, and overall treatment.

40. Expert Dr. 1's March 16, 2023, report discussed the chronology of Patient 1's various surgeries and outcomes. Per Respondent's records, on June 6, 2019, Patient 1 initially saw Respondent for evaluation of bilateral bunions and a bump on the lateral aspect of her left foot which visit included x-rays and a discussion about surgery. According to Respondent's records

the patient had previously undergone unsuccessful non-surgical treatment for her painful feet with other providers.

41. Respondent scheduled a preoperative evaluation on June 19, 2019, followed by surgery on June 28, 2019, to correct hallux abducto valgus and a bunionette on Patient 1's left foot.

42. Non-weight bearing postoperative x rays taken June 28, 2019, in the hospital's postoperative care unit, revealed an angulated capital fragment. In her deposition, Respondent stated she performed intraoperative fluoroscopic confirmation during the surgery, which revealed satisfactory alignment of the surgery site. However, the X-rays also revealed that the capital fragment was in a varus position. The Respondent did not comment on whether the tibial sesamoid was peeking, a common finding in patients with hallux varus. Unfortunately, Respondent stated she did not save the images.

43. Respondent was unable to read the X-rays before Patient 1 was discharged so Respondent contacted the patient at her home after the surgery to explain her concerns and gave her the opportunity to immediately return to the operating room to correct the malalignment but Patient 1 declined to do so. Instead, Patient 1 and her husband did return to Respondent's office on July 2, 2019, to review the X-rays and discuss her treatment options.

44. On July 3, 2019, Patient 1 underwent a second surgery to allow Respondent to remove the screw, realign the metatarsal head, and re-fixate the metatarsal head osteotomy. Respondent used intraoperative fluoroscopy to confirm the patient's fixation was secure and the metatarsal head was in good alignment. According to Respondent, these intraoperative fluoroscopy images were saved.

45. Respondent's July 3, 2019, operative report describes that she removed the screw, which was not loose, and replaced it with a new screw. Respondent's operative report did not describe the status of Patient 1's capsule, tendon, tissue planes, or bone. Nor did Respondent's operative report or deposition testimony describe performing any other procedures, such as capsule and tendon balancing, remodeling the osteotomy site, drilling the bone, or any other measures to stimulate bleeding across the osteotomy site and bone healing. Respondent did not

give an explanation why this was not done.

46. Significantly, Respondent stated in her deposition that she had no recall of the details of any of the procedures she performed on Patient 1.

47. On July 5, 2019, Dr. 2 saw Patient 1 for a postoperative inspection and dressing change.

48. On July 18, 2019, Dr. 3, an associate podiatrist in the practice, saw Patient 1 in Respondent's absence. Dr. 3 splinted Patient 1's toe with tape to maintain rectus alignment while the soft tissue and bone healed and placed the patient on non-weight bearing status. In the medical records, Dr. 3 noted Patient 1's complaints of painful weight bearing, hallux in slight varus rotation to hallux.

49. On July 25, 2019, Dr. 3 saw Patient 1 and reported that the patient said she felt less pulling in her toe. Patient 1 reported burning and tingling on the bottom of her foot, and Dr. 3's examination revealed hallux rectus or "straight toe." Dr. 3's records state the patient was instructed to continue to wear a postoperative, non-weight bearing shoe and splint the toe.

50. According to Patient 1 she also visited a non-Kaiser podiatrist for a second opinion and fusion of the joint as well as other procedures that were discussed during that visit.

51. On August 2, 2019, Respondent evaluated Patient 1 for a preoperative visit in which her records stated she found Patient 1 had an angular rotation of hallux. Respondent's note stated she planned to remove and replace Patient 1's hardware and have the patient continue her non-weight bearing status.

52. During her deposition, Respondent stated Patient 1 was not fully compliant with regard to her non-weight bearing status. During this visit, the patient's great toe appeared straight, but an X-ray confirmed that Patient 1's capital fragment had rotated and become angled. During this visit, Respondent recommended a third surgery to stabilize the fragment and prevent it from moving. Respondent explained to Patient 1 this problem, if untreated, would result in early arthritis in the great toe joint. Respondent did not comment on any other X-ray findings including a common finding in patients with hallux varus, the tibial sesamoid position after surgery.

53. Patient 1 agreed to another surgery if Dr. 3 assisted, and Respondent agreed to this request. Respondent ordered Patient 1 to undergo blood tests for calcium and Vitamin D to determine if inadequate levels of those nutrients were preventing Patient 1's bone from consolidating. Before the surgery date, when Respondent determined Patient 1's Vitamin D levels were below normal, Respondent placed Patient 1 on vitamin D and ordered a bone stimulator to enhance healing. After that, Patient 1 became ill, which resulted in her surgery being postponed for two weeks.

54. On August 21, 2019, Patient 1 underwent her third surgery during which Respondent removed the previous screw. Respondent encountered difficulty stabilizing the metatarsal head on the metatarsal. Respondent used a K-wire and two screws to fixate Patient 1's metatarsal head. Respondent considered using Tightrope to secure the hallux on the lateral aspect of the joint but decided it was not necessary.

55. Respondent's August 21, 2019, operative report did not describe the procedure performed in sufficient detail to enable another person to understand her thought process, the problems Respondent encountered and Respondent's treatment plan. Respondent failed to include any description of Patient 1's soft tissue, capsule, tendon and bone. Respondent did not describe resurfacing the osteotomy surfaces to stimulate bleeding, nor did she indicate she drilled Patient 1's bone to stimulate bleeding.

56. Respondent's August 21, 2019, operative report for this third repeat surgery did not contain an extensive description of the surgery plan, the quality of the patient's tissue Respondent encountered during the performed procedure, or whether Respondent's original treatment plan was carried out or needed modification.

57. During her September 4, 2019, visit with Respondent two weeks after the August 21, 2019, surgery, Patient 1 explained to Respondent she felt her great toe pulling into a varus position. X-rays confirmed the capital fragment was unchanged but Patient 1's toe was drifting in a medial direction. Respondent review of the X-ray did not comment on whether the tibial sesamoid was peeking, although this is a common finding in patients with hallux varus. The radiologist's report provided very little useful information. Respondent simply reassured Patient

1 and splinted her toe.

58. Respondent saw Patient 1 on September 11, 2019, and Patient 1 reported mild nerve pain and that she was elevating her legs. Patient 1 had finished her pain and antibiotic medications. Patient 1 stated she was feeling a pulling and experienced pain at K-wire pin site. The X-rays showed that the surgical correction was maintained without displacement.

59. At her five weeks postoperative visit on September 30th, the osteotomy on X-ray appeared fused, but Patient 1 was having pain which Respondent determined was from the screws. Respondent did not comment on any other X-ray findings, including the presence or absence of tibial sesamoid peeking.

A fourth surgery was discussed to remove the screw and place the tight rope fixation to prevent the toe from tilting into hallux varus. Patient 1 was hesitant to undergo another surgery and was instead sent to physical therapy which resulted the patient experiencing increased pain due to the range of motion exercises.

60. On Patient 1's follow-up exam on October 15, 2019, following a course of physical therapy, Respondent noted crepitus in the joint and rotation or angulation of the capital fragment on X-ray. Respondent stressed the importance of bringing Patient 1 back to the operating room to fix the deformity with Tightrope to prevent progression of the deformity and eventual arthritis requiring joint fusion.

61. Patient 1's last visit with Respondent was on October 15, 2019. Thereafter Patient 1 was seen by Dr. 4 and underwent two more surgeries including a metatarsal joint fusion by Dr. 4.

DEPARTURES FROM THE STANDARD OF CARE

62. With regard to surgical procedures to correct hallux varus, the standard of care is to fixate the capital fragment securely to allow for "bony healing" to take place.

63. Expert Dr. 1's analysis states that a chevron osteotomy is one of the most common surgical procedures utilized to correct a hallux valgus deformity. A radiologist read and interpreted Patient 1's preoperative and postoperative X-rays and described normal findings. A surgeon is expected to review the X-rays and provide the surgeon's impression of the images.

64. The most common causes of hallux varus after performing a bunionectomy include

excessive bone resection (aka staking the metatarsal head) of the metatarsal head, over-aggressive medial capsulorrhaphy (aka tightening the medial capsule too much) or lateral capsulotomy (aka aggressive release of the lateral structures). The cause can also be an aggressive plantar lateral release, an adductor tendon transfer, a fibular sesamoidectomy or any procedure such as moving a capital fragment too much that can lead to a negative intermetatarsal angle. A chevron osteotomy performed on a metatarsus adductus foot type can more easily lead to hallux varus. "Acquired (i.e., as a result of a surgical complication) hallux varus occurrence" varies but it occurs one to two percent of the time.

65. It is very important for the foot surgeon to demonstrate an understanding of both preoperative and postoperative issues. Expert Dr. 1's review found that the Respondent did not possess this understanding. Expert Dr. 1's review found no evidence in Respondent's medical records indicating Respondent's recognition that a complication had occurred that would result in hallux varus deformity. Respondent's preoperative and postoperative lack of adequate X-ray documentation represents a simple departure from the standard of care for a podiatric surgeon.

66. Regarding Patient 1's postoperative complication following Respondent's July 3, 2019, second surgery, the standard of care requires the surgeon to understand why and how a surgical complication occurred. Information on the probable causes of a hallux varus complications following surgery is part of a foot surgeon's training and is readily available. A foot surgeon can also consult with colleagues and/or obtain second opinions to prepare for a patient's second surgery adequately.

67. Expert Dr. 1's review found Respondent failed to seek an explanation for why the hallux varus complication occurred. Respondent's documentation of the second surgery is minimal. There was no indication Respondent had any plans for the second surgery other than to remove and replace a single screw. Respondent's documentation did not contain an analysis of Patient 1's X-rays, any comment on Patient 1's tibial sesamoid position, nor a detailed operative report explaining Respondent's findings of the soft tissue and bone. Expert Dr. 1 stated that the causes of post-surgical hallux varus are well known but Respondent's documentation did not discuss these causes nor Respondent's plans to address those causes. The depositions of the

Respondent's and t Patient 1, seen in light of the actual procedure Respondent performed, demonstrate that Respondent was not adequately prepared for the first surgery's complication nor how she planned to proceed in the second surgery. Respondent's failure to understand why and how the surgical complication occurred and her failure to plan how she would remedy the complication represents a simple departure from the standard of care for a podiatric surgeon.

68. Expert Dr. 1 analyzed the standard of care regarding Respondent's decision to perform a third surgery on August 21, 2019, for a repair of the hallux varus complication which resulted from her first surgery on Patient 1. The standard of care requires that a surgeon who performed a second surgery with a suboptimal outcome that required a third surgery would either bring in or refer the case to a more experienced surgeon. Respondent never acknowledged the almost immediate failure of the first two procedures. Moreover, neither Respondent's documentation nor deposition reflected a surgical plan to ensure that the third surgery would resolve the complications from the previous surgeries. Under these facts, Respondent's failure to obtain a second opinion and/or a possible referral to a more experienced provider represents a simple departure from the standard of care for a podiatric surgeon.

69. Although Respondent claimed during her deposition that Patient 1's lack of postoperative compliance may have contributed to her poor outcome, expert Dr. 1's analysis of Patient 1's surgeries found Respondent failed to provide appropriate postoperative treatment. Expert Dr. 1's reports states Patient 1's unstable fracture required non-weight-bearing status and cast immobilization. A short leg cast limits the patient from weight bearing instead of a splint, that is less protective than a short leg cast. Neither Respondent nor her associate Dr. 3 placed Patient 1 in a short leg cast and chose to merely splint Patient 1's toe with tape. Respondent's failure to treat Patient 1 by requiring a short leg cast for Patient 1 is a simple departure from the standard of care.

70. Expert Dr. 1 analyzed the standard of care regarding proper preparation of the bone surfaces to ensure fusion of the osteotomy site necessary during the second and third surgeries. When a repeat osteotomy is performed it is important to "freshen" the bone edges, i.e., to create bone bleeding by perforating the bone at the osteotomy site. Without bleeding bone, the bones'

failure to fuse is much more likely to occur. The standard of care when perforating the bony fusion sites requires the surgeon to use a saw, curette, or drill to "freshen" the bone edges. Respondent's failure to use a saw, curette or drill to perforate the bony fusion sites to properly prepare the bone surfaces to ensure fusion of the osteotomy site during second and third surgeries were simple departures from the standard of care.

71. Expert Dr. 1 analyzed the standard of care regarding Respondent's performance of Patient 1's July 3, 2019, second surgery when Respondent replaced the screw in the capital fragment. The standard of care for preparation for a repeat surgery to remove a screw found to be "not loose" and "tightly" replace the screw required the surgeon to have a preoperative plan and seek consultations, literature review or consider alternative surgical procedures which are different than the original procedure. As a result of Respondent's lack of recall and her limited operative report detail Expert 1 found no evidence Respondent competently performed the procedure within the standard of care for a foot surgeon performing a repeat surgery for a complication. Respondent's failure to perform the second surgery competently resulted in a simple departure from the standard of care.

72. Expert Dr. 1 analyzed the standard of care regarding Respondent's performance of Patient 1's third surgery on August 21, 2019, to remove a screw and replace the screw with two larger screws and a K-wire in an attempt to have the bones heal correctly. This surgery was essentially the same as the previous surgery except for adding oral vitamin D to Patient 1's diet and using a bone stimulator prior to the surgery, and it ultimately failed. Multiple surgeries can result in chronic inflammation and nerve pain and in this case led to Patient 1's eventual joint fusion. For that reason, Expert Dr. 1 found Respondent's performance of Patient 1's third surgery to be a simple departure from the standard of care.

73. Expert Dr. 1 analyzed the standard of care for a surgeon's documentation of the treatment plan, record keeping, lack of peer review, and memory regarding the treatment of complications that arise from surgical procedures to correct hallux valgus deformity. Expert Dr. 1 determined that Respondent's records did not explain her treatment plan adequately. Respondent's inability to recall any details about this case combined with the fill-in-the-blanks

pre- populated charting system Respondent used, poor record keeping, and lack of peer review demonstrated that Respondent failed to fully understand the complexity of the complications resulting in Respondent's simple departures from the standard of care in her documentation of her performance of each of Patient 1's second and third surgeries.

74. Expert Dr. 1 analyzed the standard of care for surgical management of hallux valgus which requires the surgeon to evaluate the X-ray films preoperatively and postoperatively and document the findings. The preoperative evaluation should include the findings regarding the measurement of hallux abductus angle, metatarsus adductus angle, tibial sesamoid position, and metatarsal protrusion. The postoperative evaluation of the X-ray measurements should include the tibial sesamoid position, hallux abductus angle, and capital fragment alignment. Patient 1's medical records did not reflect that Respondent performed either preoperative or postoperative evaluations of Patient 1's X-rays and Respondent's failure to do so represents a simple departure from the standard of care.

75. Expert Dr. 1 analyzed Respondent's entire treatment of Patient 1. That analysis found Respondent demonstrated she possessed the training, certification, and expertise to meet the standard of care for a podiatric surgeon performing chevron osteotomy for correction of hallux valgus.

76. Expert Dr. 1's review of Patient 1's X-rays demonstrated Respondent's issues with preoperative patient evaluation of X-rays as well as a lack of X-ray measurements which could have predicted the problems Respondent experienced during the repeated surgeries. The second and third surgeries demonstrated Respondent's overall lack of understanding of treating a surgical complication such as hallux varus.

77. Expert Dr. 1's review identified Respondent's ample opportunities to seek consultations, literature review, and second opinions which Patient 1 urged her to do.

78. Expert Dr. 1's review identified Respondent's documentation was poor, particularly when Respondent faced complications resulting from her first surgery. Expert Dr. 1 found that the "populate the blank space template driven" operative report Respondent utilized works poorly when used by a surgeon facing a non-standard procedure such as dealing with a surgical

complication from the initial surgery. Respondent's lack of recall compounded this problem. The standard of care for surgeons regarding documentation of surgery complications requires that the surgeon dictate notes with details that explain the surgeon's thoughts, concerns, and alternative procedures for adequate preparation for all possibilities. Respondent's operative reports lacked this significant information.

79. Patient 1 underwent five surgeries, including a salvage procedure to fuse her great toe joint. Patient 1 has continued pain in her left foot and can no longer wear shoes with a heel greater than one inch. Expert Dr. 1's review identified Respondent's care as contributing to Patient 1's outcome.

80. Expert Dr. 1's review found that despite Respondent's knowledge and training, Respondent demonstrated multiple simple departures from the standard of care during her treatment of Patient 1. The accumulation of Respondent's multiple simple departures from the standard of care represents a simple departure from the standard of care.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

A. Respondent's June 28, 2019, lack of adequate X-ray documentation preoperatively and postoperatively represents a simple departure from the standard of care for a podiatric surgeon.

B. Respondent's failure to understand why and how the June 28, 2019, surgical complication occurred and her failure to plan to remedy the complication during the July 3, 2019, second surgery represents a simple departure from the standard of care for a podiatric surgeon.

C. Respondent's failure to associate with or to refer the case to another, more experienced surgeon for the third surgery on August 21, 2019, after the July 3, 2019, second surgery's sub-optimal outcome represents a simple departure from the standard of care for a podiatric surgeon.

D. Respondent's failure to treat Patient 1 by requiring her to be in a short leg cast represents a simple departure from the standard of care for a podiatric surgeon.

E. Respondent's failure to use a saw, curette or drill to perforate the boney fusion sites to properly prepare the bone surfaces to ensure fusion of the osteotomy site during second and third surgeries represents a simple departure from the standard of care for a podiatric surgeon.

F. Respondent's failure to perform the second surgery competently represents a simple departure from the standard of care for a podiatric surgeon.

G. Respondent's failure to perform the third surgery competently represents a simple departure from the standard of care for a podiatric surgeon.

H. Respondent's lack of documentation of her performance of each of Patient 1's second and third surgeries represents a simple departure from the standard of care for a podiatric surgeon.

I. Respondent's failure to perform either preoperative or postoperative evaluations of the patient's X-rays represent a simple departure from the standard of care for a podiatric surgeon.

J. The accumulation of Respondent's multiple simple departures from the standard of care represents a simple departure from the standard of care for a podiatric surgeon.

82. Respondent's acts and/or omissions as set forth in paragraphs 27 through 61 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.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

83. Respondent is subject to disciplinary action under Code section 2266, in that She failed to maintain adequate and accurate records relating to the services she provided to Patient 1. The circumstances are as follows:

84. Complainant refers to and, by this reference, incorporates paragraphs 27 through 61, above, as though set forth fully herein.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

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

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

87. Respondent's acts and/or omissions as outlined in paragraphs 27 through 61, 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 Podiatrist License No. E-5005, issued to Connie Melanie Choy, D.P.M.;

2. Ordering her 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 Connie Melanie Choy, 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: AUG 0 1 2023

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

Complainant

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