

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

| | | |
|--|---|---------------------------------|
| In the Matter of the Accusation |) | |
| Against: |) | |
| |) | |
| |) | |
| LESLIE HOWARD EDRICH, M.D. |) | Case No. 800-2016-024606 |
| |) | |
| Physician's and Surgeon's |) | |
| Certificate No. G48000 |) | |
| |) | |
| Respondent |) | |
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DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 16, 2020.

IT IS SO ORDERED December 17, 2019.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
Deputy Attorney General
4 State Bar No. 179733
California Department of Justice
5 300 South Spring Street, Suite 1702
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7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

13 LESLIE HOWARD EDRICH, M.D.
14 701 East 28th Street, Suite 400
Long Beach California 90806

15 Physician's and Surgeon's Certificate
16 No. G 48000,

17 Respondent.

Case No. 800-2016-024606

OAH No. 2019080026

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical
23 Board of California ("Board"). She brought this action solely in her official capacity and is
24 represented in this matter by Xavier Becerra, Attorney General of the State of California, by
25 Rebecca L. Smith, Deputy Attorney General.

26 2. Respondent Leslie Howard Edrich, M.D. ("Respondent") is represented in this
27 proceeding by attorneys Dennis Ames and Pogey Henderson, 2677 North Main Street, Suite 901
28 Santa Ana, California 92705-6632.

1 You committed acts constituting negligence in violation of Business and
2 Professions Code section 2234, subdivision (c), with respect to your
3 intraoperative and post-operative care and treatment of Patient 1 in 2013, as
4 set forth in Accusation No. 800-2016-024606.

5 **B. EDUCATION COURSE.** Within sixty (60) calendar days of the effective date of
6 this Decision, Respondent shall submit to the Board or its designee for its prior approval
7 educational program(s) or course(s) which shall not be less than twenty (20) hours. The
8 educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or
9 knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at
10 Respondent's expense and shall be in addition to the Continuing Medical Education ("CME")
11 requirements for renewal of licensure. Following the completion of each course, the Board or its
12 designee may administer an examination to test Respondent's knowledge of the course.
13 Respondent shall provide proof of attendance for twenty (20) hours of CME in satisfaction of this
14 condition.

15 Respondent shall submit a certification of successful completion to the Board or its
16 designee not later than fifteen (15) calendar days after successfully completing the educational
17 program(s) or course(s), or not later than fifteen (15) calendar days after the effective date of the
18 Decision, whichever is later.

19 If Respondent fails to enroll, participate in, or successfully complete the educational
20 program(s) or course(s) within the designated time period, Respondent shall receive a notification
21 from the Board or its designee to cease the practice of medicine within three (3) calendar days
22 after being so notified. Respondent shall not resume the practice of medicine until enrollment or
23 participation in the educational program(s) or course(s) has been completed. Failure to
24 successfully complete the educational program(s) or course(s) outlined above shall constitute
25 unprofessional conduct and is grounds for further disciplinary action.

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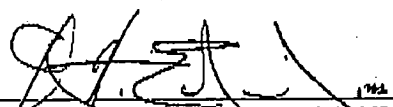
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1 ACCEPTANCE

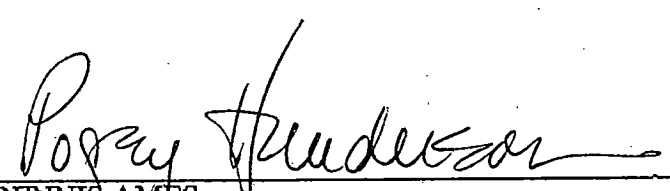
2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorneys, Dennis Ames and Pogeey Henderson. I understand the stipulation
4 and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
5 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
6 bound by the Decision and Order of the Medical Board of California.

7
8 DATED: 10/15/19


9 LESLIE HOWARD EDRICH, M.D.
Respondent

10 I have read and fully discussed with Respondent Leslie Howard Edrich, M.D. the terms and
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
12 I approve its form and content.

13
14 DATED: 10/21/19


15 DENNIS AMES
16 POGEY HENDERSON
Attorneys for Respondent

17
18 ENDORSEMENT

19 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
20 submitted for consideration by the Medical Board of California.

21 DATED: 10/22/19

Respectfully submitted,

22
23 XAVIER BECERRA
Attorney General of California
24 JUDITH T. ALVARADO
Supervising Deputy Attorney General

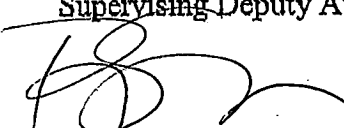

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26 REBECCA L. SMITH
27 Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2016-024606

1 JURISDICTION

2 This Accusation is brought before the Board under the authority of the following provisions
3 of the California Business and Professions Code ("Code") unless otherwise indicated.

4 3. Section 2004 of the Code states:

5 "The board shall have the responsibility for the following:

6 "(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice
7 Act.

8 "(b) The administration and hearing of disciplinary actions.

9 "(c) Carrying out disciplinary actions appropriate to findings made by a panel or an
10 administrative law judge.

11 "(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of
12 disciplinary actions.

13 "(e) Reviewing the quality of medical practice carried out by physician and surgeon
14 certificate holders under the jurisdiction of the board.

15 "..."

16 4. Section 2227 of the Code states:

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

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

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

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

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

28 ///

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

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

9 5. Section 2234 of the Code, states:

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

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

15 “(b) Gross negligence.

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

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

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

26 “...”

27 ///

28 ///

1 April 7, 2013. It revealed early tracer accumulation proximal to common bile duct with eventual
2 drainage to bowel, and tracer accumulation in gallbladder fossa with drainage through the drain.

3 12. In evaluating a possible post-cholecystectomy bile leak, an ERCP⁴ was performed on
4 April 9, 2013. The ERCP revealed a leak near the cystic duct remnant. The remainder of the
5 biliary system appeared normal. A sphincterotomy with stent placement was performed, with
6 proximal end of the stent noted to be in the left hepatic duct. Radiology reported that the
7 retrograde injection demonstrated a normal caliber common bile duct, left hepatic duct and ductal
8 branches. In addition, radiology reported that a portion of the right hepatic duct was noted to be
9 opacified with extravasation of contrast agent around it.

10 13. On April 13, 2013, the patient underwent an abdominal and pelvic CT scan which
11 showed multiple fluid collections post-ERCP with a "majority of the fluid collections located
12 about pancreas and right upper quadrant. Largest collection exerting mass effect on the left lobe
13 of liver, may be subcapsular in location 4.1 x 12.9 x 7.0 cm, intrahepatic biliary dilatation."

14 14. On April 15, 2013, the patient underwent CT guided drainage and drain placement in
15 the lesser sac biloma and subcapsular biloma.⁵

16 15. A further HIDA scan performed on April 16, 2013 demonstrated drainage of tracer
17 through the JP drain with no extravasation into the abdominal cavity. It was further noted that
18 tracer stasis proximal to stent had eventual drainage to bowel, thereby excluding complete
19 obstruction.

20 16. On the following day, April 17, 2013, a repeat ERCP with stenting was performed
21 secondary to a persistent biliary leak. The gastroenterology service noted a concern for a stent
22 malfunction. A cholangiogram⁶ demonstrated a leak near the cystic duct and opacification of the
23 left hepatic duct system but there was no visualization of right hepatic duct system. After the
24

25 ⁴ An ERCP, which stands for endoscopic retrograde cholangiopancreatography, is a procedure that
uses endoscopy, x-ray and contrast to view the bile ducts, pancreatic duct and gallbladder.

26 ⁵ A biloma is an intra-abdominal bile collection secondary to a bile duct disruption.

27 ⁶ A cholangiogram is an x-ray procedure performed with contrast to visualize the bile ducts after a
28 cholecystectomy.

1 stent was removed, a repeat cholangiogram was performed with balloon occlusion distal and
2 proximal to the leak near cystic duct. The right hepatic duct system was still not visualized. A
3 new stent was placed and previous sphincterotomy extended from 5 mm to 10 mm.

4 17. Given the inability to opacify the right hepatic duct on ERCP, an MRCP⁷ was
5 performed the following day. It revealed low confluences of right and left hepatic ducts, which
6 were of normal variant, located approximately 1.7 cm proximal to the ampulla. There was no
7 evidence of intrahepatic or extrahepatic biliary dilation. A stent was identified in the left hepatic
8 duct and common bile duct. There was decreased abdominal fluid collections post-drainage and
9 drain placement as well as small to moderate left pleural effusion.

10 18. On April 20, 2013, the retroperitoneal drain output was 10 mL and removed. The
11 subcapsular drain output was 420 mL and JP drain output was 60 mL.

12 19. The patient had persistent fever and pain. A CT scan of the abdomen and pelvis was
13 performed on April 20, 2013 and identified a new fluid collection in the pelvis. Persistent left
14 pleural effusion with left lower lobe lung consolidation, worrisome for pneumonia, was also
15 noted.

16 20. On April 23, 2013, a CT guided drain and drain placement for pelvic bilious fluid
17 collection was performed and on April 26, 2013, the pelvic drain was removed.

18 21. On May 1, 2013, a HIDA scan revealed tracer passage through subcapsular drain with
19 no extravasation into the abdominal cavity.

20 22. On May 2, 2013, an intracapsular drain clamp was placed. The patient's alkaline
21 phosphate ("ALP") level⁸ was noted to be elevated at 544 u/l (reference range 45-129 u/l).

22 23. On May 3, 2013, a HIDA scan revealed tracer passage to the bowel with no evidence
23 of intra-abdominal spillage or bile leak, but a new focus of loculated bile collection was noted

24 ///

25 ⁷ A MRCP, which stands for magnetic resonance cholangiopancreatography, is a specialized MRI
26 exam that evaluates the hepatobiliary and pancreatic systems, including the liver, gallbladder, bile ducts,
pancreas and pancreatic duct.

27 ⁸ ALP is an enzyme found in several tissues throughout the body. The highest concentrations of
28 ALP are present in the cells that comprise bone and the liver. Elevated levels of ALP in the blood are
most commonly caused by liver disease or bone disorders.

1 superior to dome of liver. The intracapsular drain was removed on May 3, 2013 and the patient's
2 ALP was noted to be 667 u/l.

3 24. On May 4, 2013, the patient's ALP was further elevated at 846 u/l. Nursing
4 documented moderate yellow colored drainage in the abdominal dressings, requiring three
5 dressing changes with pressure dressing. There was no further mention of continued drainage in
6 subsequent nursing notes.

7 25. On May 5, 2013, the patient was noted to have continued nausea and emesis. Her
8 ALP was 914 u/l.

9 26. On May 6, 2013, the patient's ALP increased to 1158 u/l. A gastroenterology
10 consultant attributed the ALP elevation to "cholestasis from medications and/or TPN use."

11 27. On May 7, 2013, the patient was noted to have continued nausea and a small amount
12 of emesis. Her ALP level was 1254 u/l.

13 28. On May 8, 2013, the patient was noted to have had two episodes of emesis and an
14 ALP of 1565 u/l.

15 29. The patient was discharged on May 9, 2013. She was noted to have minimal
16 abdominal pain and was ambulating. She tolerated her diet but did have an episode of nausea and
17 three episodes of vomiting on the morning of discharge. She had elevated liver function tests, a
18 temperature of 99.9 and blood pressure of 126/78.

19 30. On May 11, 2013, the patient presented to the emergency department at Kaiser-
20 Harbor City with complaints of abdominal pain, fever, nausea and vomiting since discharge. A
21 CT scan demonstrated intrahepatic duct dilation, scattered hypodensities in abdomen including
22 the region of the porta hepatis/central liver, pancreas, hepatorenal fossa central mesentery and left
23 pelvis, also in left hepatic lobe, measuring 9.5 x 4 cm, occlusion of portal vein.

24 31. On May 12, 2013, the patient was transferred to the hospital at which time she was
25 noted to have hemepositive emesis and bowel movement.

26 32. That same day, Respondent performed a general surgery consultation. He noted that
27 the patient had been discharged following two normal HIDA scans that confirmed no evidence of
28 ongoing biliary extravasation and that all of her issues appeared to be in resolution, although she

1 was discharged with a known significantly elevated ALP of unknown etiology. With respect to
2 his physical examination, Respondent noted the absence of acute findings and that the abdomen
3 was benign but diffusely subjectively tendered. He noted that the patient had significant retching
4 of unknown etiology during his evaluation. His impression was that the very complicated 28-
5 year-old patient with postoperative course following repair of a small bile leak was "almost
6 unexplainable without any acute evidence of pathology although clinically failing to thrive."
7 Respondent recommended a gastroenterology evaluation and stent removal as it was possibly
8 aggravating the problem. He declined to have a HIDA scan done to evaluate for bile leak and
9 repeated his reasoning that it was not necessary since no persistent leak was demonstrated on the
10 prior two HIDA scans performed.

11 33. On May 12, 2013, a CT scan revealed a biliary stent without pneumobilia, mild
12 dilatation of right hepatic duct, the reappearance of a subcapsular heterogenous fluid collection
13 measuring 5.3 x 7.1 cm (previously measuring 3.6 x 4.9 cm) and a heterogenous fluid collection
14 in the transverse mesocolon.

15 34. On May 13, 2013, an infectious disease consultation was performed for possible
16 ascending cholangitis. Broad-spectrum antibiotics and anti-fungal treatment were provided. It
17 was noted that during the patient's previous admission, the patient was treated empirically with
18 broad spectrum antibiotics and no organisms were identified on previous cultures except for
19 candida albicans from the subcapsular abdominal and pelvic drains.

20 35. On May 13, 2013, an EGD⁹ and an ERCP were performed. It was noted that a pre-
21 pyloric peptic ulcer was identified without bleeding and the biliary stent was removed. A
22 cholangiogram demonstrated a leak that was not in vicinity of cystic duct stump. A stent was
23 placed. An MRCP was recommended because the right hepatic duct was not visualized.

24 36. On May 14, 2013, Respondent noted multiple conversations with the physicians
25 involved in the patient's care. He noted that the "[a]berrant right hepatic duct is complicating and
26 confusing ERCP readings." He further noted that while there was a questionable small leak on
27

28 ⁹ An EGD, which stands for esophagogastroduodenoscopy, is an endoscopic procedure for
examining the esophagus, stomach and duodenum.

1 ERCP injection, there was no extravasation on the two HIDA scans performed the previous week.
2 Respondent noted that he appreciated gastroenterology consult, Dr. S.G.'s concern that the side of
3 the stent may be partially occluding the right hepatic duct orifice, but that it was not demonstrated
4 on HIDA. Respondent concluded that there was no need to perform another HIDA scan at this
5 time and that the common bile duct issues could be re-evaluated in 7 to 14 days.

6 37. That same day, an ultrasound of abdomen demonstrated pseudo aneurysm at the
7 porta-hepatis region measuring 4 x 1.9 cm and a complete left subhepatic collection measuring
8 6.5 x 8 x 5 cm probably due to a hematoma.

9 38. On May 15, 2013, laboratory studies revealed persistent elevated liver function
10 studies and family medicine consult, Dr. A.F. requested an urgent consult with hepatobiliary
11 surgeon, Dr. S.C. Respondent's progress note dated that same day reflects that he discussed the
12 case with Drs. A.F. and S.G. and agreed to consult with hepatobiliary surgeon, Dr. S.C.

13 39. On May 15, 2013, the patient underwent a coil embolization of right hepatic artery for
14 treatment of pseudo aneurysm. A transection of right hepatic artery 6 cm distal to the origin was
15 noted. No active bleeding was identified.

16 40. On May 15, 2013, hepatobiliary surgeon, Dr. S.C., performed a consultation. He
17 recommended observation of subcapsular biloma with serial ultrasound imaging, possible
18 percutaneous evacuation if the patient is symptomatic for pain. Dr. S.C. noted that possible
19 surgical intervention would be necessary if the biloma is not contained. Family practice consult,
20 Dr. A.F. noted her discussion with Dr. S.C. wherein Dr. S.C. indicated that the right hepatic artery
21 injury resulted in ischemia and necrosis of the right hepatic lobe and duct and that he expected
22 that the right hepatic lobe would necrose and eventually scar over the course of months resulting
23 in a decrease in the subcapsular collection over time.

24 41. On May 16, 2013, a repeat EGD for biliary stent removal was performed. The
25 endoscope was unable to advance past the first portion of the duodenum due to extrinsic
26 compression from a large round lesion, probable hematoma or biloma.

27 42. On May 17, 2013, the patient was transferred to Cedars-Sinai Medical Center for a
28 higher level of care where she was diagnosed with a gastric outlet obstruction secondary to an

1 extrinsic compression from a hematoma extending from the porta-hepatis, requiring an open
2 surgical evacuation with an unplanned small bowel resection due to an enterotomy. A subsequent
3 ERCP one week after surgery identified a transection of the right hepatic duct and she underwent
4 successful stenting across the division with establishment of confluence of the right hepatic duct
5 with the common duct.

6 STANDARD OF CARE

7 43. The standard of care for a general surgeon performing a cholecystectomy requires an
8 intraoperative cholangiogram when pre-operative liver function tests suggest a possible common
9 duct obstruction, abnormal anatomy is encountered during surgery and a bile duct injury is
10 encountered during surgery.

11 44. The standard of care for a general surgeon providing post-operative care and
12 treatment to a patient who suffered a bile duct injury during a cholecystectomy, requires
13 evaluation of anatomy above and below the point of injury, including the use of various
14 diagnostic studies (i.e., ERCP, PTC,¹⁰ MRCP) to properly define the entire anatomy.

15 45. The standard of care for a general surgeon providing post-operative care and
16 treatment to a patient suffering from a persistent bile leak following a cholecystectomy, requires
17 consideration and evaluation of possible causes of the leak.

18 CAUSE FOR DISCIPLINE

19 (Repeated Negligent Acts)

20 46. Respondent is subject to disciplinary action under section 2234, subdivision (c), of
21 the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patient 1.
22 Complainant refers to and, by this reference, incorporates herein, paragraphs 7 through 45, above,
23 as though fully set forth herein. The circumstances are as follows:

24 47. Respondent failed to perform an intraoperative cholangiogram despite the indications
25 of pre-operative abnormal liver function tests, abnormal anatomy encountered during surgery and
26 iatrogenic bile duct injury identified intraoperatively.

27 ¹⁰ PTC, which stands for percutaneous transhepatic cholangiography, is a radiological technique
28 used to visualize the anatomy of the biliary tract wherein contrast medium is injected into a bile duct in the
liver and x-rays are taken.

1 48. Post-operatively, Respondent failed to appropriately manage the patient's bile duct
2 leak by evaluating the anatomy above and below the point of injury to properly define the entire
3 anatomy.

4 49. Post-operatively, Respondent failed to identify or appreciate the injury to the right
5 hepatic duct despite clinical evidence suggesting a greater injury to the biliary system rather than
6 the 2-3 mm repaired tear that Respondent believed was the source.

7 50. Respondent's acts and/or omissions as set forth in 8 through 49, above, whether
8 proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence
9 pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

10 **PRAYER**

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


13 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 48000,
14 issued to Leslie Howard Edrich, M.D.;

15 2. Revoking, suspending or denying approval of Leslie Howard Edrich, M.D.'s authority
16 to supervise physician assistants and advanced practice nurses;

17 3. Ordering Leslie Howard Edrich, M.D., if placed on probation, to pay the Board the
18 costs of probation monitoring; and

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

20
21 DATED: July 2, 2019

22 
23 KIMBERLY KIRCHMEYER
24 Executive Director
25 Medical Board of California
26 Department of Consumer Affairs
27 State of California
28 Complainant

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