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

In the Matter of the Accusation Against:	)	
Eric Changchien, M.D.	)	**Case No. 800-2017-031781**
Physician's and Surgeon's Certificate No. A 108490	)	
Respondent	)	

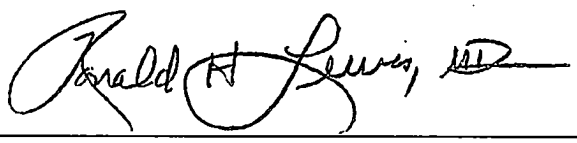
DECISION

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 March 6, 2020.

IT IS SO ORDERED: February 6, 2020.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the Accusation Against: ERIC CHANGCHIEN, M.D. Department of General Surgery, MOB 2 3430 East La Palma Avenue Anaheim, California 92806-2020 Physician's and Surgeon's Certificate No. A 108490, Respondent.	Case No. 800-2017-031781 OAH No. 2019021107 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

2. Respondent Eric Changchien, M.D. ("Respondent") is represented in this proceeding by attorney Raymond J. McMahon, whose address is 5440 Trabuco Road, Irvine, California 92620.

3. On or about June 24, 2009, the Board issued Physician's and Surgeon's Certificate No. A 108490 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-031781, and will expire on November 30, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-031781 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 6, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031781 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-031781. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2017-031781 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2017-031781 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format ("PDF") and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 108490 issued to Respondent Eric Changchien, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

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

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

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

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation

Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice

where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (60) calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (60) calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within fifteen (15) calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (15) calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds eighteen (18) calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws;

General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than one-hundred twenty (120) calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10/31/2019

ERIC CHANGCHIEN, M.D.
Respondent

I have read and fully discussed with Respondent Eric Changchien, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: Nov 1, 2019

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

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

DATED: November 1, 2019

Respectfully submitted,

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

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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

In the Matter of the Accusation Against: Eric M. Changchien, M.D. 3660 Park Sierra Drive, Suite 105 Riverside, California 92505 Physician's and Surgeon's Certificate No. A 108490, Respondent.	Case No. 800-2017-031781 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On June 24, 2009, the Medical Board issued Physician's and Surgeon's Certificate Number A 108490 to Eric M. Changchien, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2020, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

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

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

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

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

"..."

5. 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.

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"(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."

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 practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated 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."

FACTUAL ALLEGATIONS

8. In 2014, Patient 1[1] complained of ongoing right shoulder pain to his primary care physician, Dr. C.W. Prior x-rays were negative and the pain did not respond to nonsteroidal anti-inflammatory drugs. An MRI of the shoulder, performed on November 21, 2014, revealed acromioclavicular disease and an incidental finding of a 5.1 cm axillary mass beneath the right shoulder highly suspicious for malignancy. On ultrasound, the mass was estimated to be 5.7 cm in its greatest dimension. An ultrasound guided core needle biopsy was performed on December 12, 2014. The patient experienced right upper extremity spasm and numbness following biopsy which subsequently resolved. Initial pathology from the biopsy revealed a spindle cell lesion of low cellularity, positive for S-100, and consistent with a neural lesion, possibly a neurofibroma.[2] Two addenda were subsequently issued. The first addendum suggested that the tumor may be a schwannoma[3] or other neural tumor, and the second excluded a melanocytic lesion. There is no

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[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1, with the identity of the patient disclosed to Respondent in discovery.

[2] A neurofibroma is a tumor formed on a nerve cell sheath, frequently symptomless but occasionally malignant.

[3] A schwannoma is a benign peripheral nerve sheath tumor that only rarely becomes malignant.

notation as to when the addenda were made available. Dr. C.W. referred Patient 1 to Mission Surgical Clinic.

9. On January 5, 2015, Respondent, a general surgeon, saw Patient 1 at Mission Surgical Clinic in consultation for the right axillary mass. Respondent noted that the patient was asymptomatic and could not feel the mass. Respondent further noted that two days after the biopsy, the patient experienced bilateral upper extremity numbness. Respondent documented a normal upper extremity motor examination and a possible non-mobile 2 to 3 cm right axillary mass. Respondent noted that he discussed at length the incidental finding of a right axillary mass, biopsy suspicious for neurofibroma, setting forth in his consultation report:

> "We discussed potential management options, including watchful waiting with serial ultrasounds, versus surgical excision. We discussed risks with waiting, including the possibility of this progressing, or the rare possibility that this represented malignancy, as well as risk of excision, including bleeding, infection, worsening neuropathy, and injury to the surrounding structures. [The patient] is concerned about his mass and would prefer it to be removed."

10. That same day, Respondent instructed his office to schedule the patient for surgery and schedule an assistant surgeon for the surgery.

11. On February 5, 2015, Respondent performed the scheduled right axillary mass surgery at Parkview Community Hospital. The patient underwent pre-operative needle localization of the mass by radiologist Dr. J.R. and again experienced numbness and spasm during the localization procedure. Dr. R.S., another surgeon at Mission Surgical Clinic, initially assisted Respondent with the surgery at which time the patient's right axilla was explored.

12. One hour and five minutes into the three hour and eleven-minute surgery and prior to the removal of the tumor, Dr. R.S., who had a 12:00 p.m. meeting at Mission Surgical Clinic, scrubbed out and Dr. M.A., another surgeon at Mission Surgical Clinic, scrubbed in to assist Respondent.

13. After Dr. M.A. joined in the surgery as Respondent's assistant surgeon, the large mass was identified. There was a vein running along the mass which was isolated with vessel

loops. Dissection was initially carried out with monopolar electrocautery, but elicited a vigorous flexion response from the right upper extremity. Dissection then proceeded with bipolar electrocautery. A nerve exiting the mass was ligated and tagged with a silk tie prior to transection and further dissection of the mass. A second nerve entering the mass was identified after further dissection and similarly ligated and tagged prior to division. The tumor was removed and an intra-operative frozen section of the completely excised mass identified the tumor as likely a schwannoma. The wound was closed and the operation completed. Dr. M.A. was present during the dissection of the mass as well as the ligation and division of the nerves and removal of the tumor.

14. A nerve stimulator was not used during surgery. While Respondent has indicated that a nerve stimulator was not available, the hospital risk management confirmed that a nerve stimulator was available at the time of the patient's surgery.[4]

15. In the recovery room, the patient immediately complained of right upper extremity weakness. Respondent suspected a neurologic injury and ordered an urgent neurology consult. Brachial plexopathy was the initial working diagnosis. High dose steroids were given and multiple imaging studies were obtained to rule out a hematoma and multifocal schwannomas. Physical therapy was also involved. Respondent noted that there were no neurosurgeons on staff at Parkview Community Hospital and that he contacted neurosurgeons at other medical centers for advice. It was recommended that the patient undergo aggressive physical therapy prior to any consideration of operative repair.

16. Deep vein thrombosis ("DVT") prophylaxis is not mentioned in the patient's medical records from the hospital, including the operative report, progress notes, post operative orders and medication administration logs. The records do not have any orders for mandatory ambulation, sequential compression devices, or use of heparin or low molecular weight heparin. Respondent

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[4] At the time of Respondent's interview with the Board on October 4, 2018, Respondent represented that Parkview Hospital did not have a nerve stimulator at the time of the patient's surgery. On October 25, 2018, risk management at Parkview Community Hospital confirmed that the hospital had a nerve stimulator available at the time of the patient's surgery.

does, however, set forth in his post operative progress notes that the patient was ambulating without difficulty, which may be interpreted as DVT prophylaxis.

17. The patient was eventually discharged from the hospital on February 10, 2015. He was ordered to follow up with Respondent in his office as well as undergo outpatient physical and occupational therapy.

18. On February 11, 2015, the patient called Respondent's office complaining of left lower extremity swelling and pain. He underwent a lower extremity duplex ultrasound on February 13th, which was positive for a deep vein thrombosis. On February 14th, anticoagulation was initiated.

19. The patient underwent outpatient occupational therapy following his February 10th discharge from the hospital with only marginal improvement in his right upper extremity extensor function. Dr. C.W. then referred the patient to the neurosurgery department at UCLA where his brachial plexus injury was evaluated and a nerve grafting procedure was attempted but the amount of scarring in the brachial plexus region due to the initial surgery prevented the identification of the proximal stump of the transected radial nerve. Thereafter, the patient was seen by neurosurgeon Dr. J.B. at UC San Diego. On September 18, 2015, Dr. J.B. performed a nerve transfer surgery which failed to provide meaningful improvement in the motor function of Patient 1's right upper extremity. On December 3, 2015, in another attempt to restore function in the patient's right upper extremity, Dr. J.B. performed a tendon transfer surgery. While the patient has had significant improvement in the use of his right upper extremity, as of July 7, 2017, he continues to have significant deficits.

STANDARD OF CARE

20. The standard of care for a surgeon performing an axillary mass removal requires that the surgeon discuss with the patient the risks of surgical intervention and the likelihood of a complication or unfavorable outcome. When a patient elects to proceed with surgery but surgery may not be in that patient's best interest, the surgeon should explain this to the patient and avoid surgery.

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21. When a surgeon considers performing a surgical intervention, such as an axillary mass removal procedure, the standard of care requires that the surgeon recognize his surgical limitations and avoid performing a procedure that is outside of his scope of practice or beyond his expertise.

22. When a surgeon considers performing a surgical intervention, such as an axillary mass removal procedure, the standard of care requires that pre-operatively the surgeon review all of the available imaging and diagnostic studies and pathology reports in order to appreciate the anatomic relationships between critical structures and the target pathology. The surgeon should recognize the possibility that normal anatomic relationships may be displaced and distorted by the mass.

23. Tumors of neurologic origin in cutaneous locations all over the body, such as neurofibromas are occasionally within the scope of a general surgeon's practice; however, surgery of deep neurologic tumors are not within a general surgeon's scope of practice.

24. General surgeons frequently operate in the axilla, in the region below the level of the axillary vein; however, the risk of major neurologic or vascular injury above the level of the axillary vein when performing surgical dissection is generally outside the scope of practice of general surgeons. The brachial plexus, a complex cluster of major motor and sensory nerves to the upper extremity, is located above the level of the axillary vein. Surgery in the region of the brachial plexus has the potential to be disabling to the patient and should only be undertaken by surgeons with expertise in the treatment of the brachial plexus.

25. Through normal dissection in the axilla below the level of the axillary vein, surgeons should actively attempt to identify the thoracodorsal and long thoracic nerves, which are descending branches off of the brachial plexus descending below the axillary vein. The thoracodorsal nerve innervates the lattisimus dorsi muscle and can be confirmed with a twitch of the lattisimus muscle with stimulation by a forceps or nerve stimulator. The long thoracic nerve innervates the serratus anterior muscle and can be confirmed with a twitch of the serratus muscle with similar stimulation. Division of these nerves significantly impairs shoulder function and great effort should be made to preserve them. The radial nerve in the axilla is a major branch of

the brachial plexus that lies above the axillary vein and provides motor function to numerous muscles of the upper extremity. The radial nerve is an essential nerve for any meaningful upper extremity function and preservation of this nerve is absolutely vital to maintain meaningful upper extremity function. A nerve stimulator can be used to locate and identify nerves intra-operatively.

26. When a patient undergoes a procedure requiring several hours of anesthesia and then inpatient hospitalization, the standard of care requires prophylaxis against a deep vein thrombosis. A DVT is a blood clot that most often forms in the veins of the calf. General anesthesia and hospitalization are risk factors for DVT. A DVT can cause symptoms such as swelling and pain in the leg. The danger with a DVT is that a portion of the blood clot can dislodge and travel through the venous circulation causing a pulmonary embolism, which can lead to shortness of breath, hypoxia and even death. Often DVTs are recognized during hospitalization but they occasionally become noticeable after discharge. The three methods of prophylaxis against a DVT are (1) encouraging early and frequent ambulation, (2) placing sequential compression devices on the patient's legs, and (3) using low dose or low molecular weight heparin. DVT prophylaxis should be addressed in admission and postoperative orders as well as in progress notes.

27. Once a physician suspects that a patient has a DVT, the standard of care requires the immediate same day initiation of a workup, including a lower extremity duplex ultrasound to identify the presence of clot in the lower extremity veins. If a DVT is indeed identified, anticoagulation should begin immediately to minimize the risk of a pulmonary embolism. The longer the interval between formation of the DVT and anticoagulation, the higher the risk is to the patient of having a pulmonary embolism.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Pre-Operative Care and Treatment)

28. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in his pre-operative care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 24, above, as though fully set forth herein. The circumstances are as follows:

29. Prior to commencing surgery, Respondent failed to recognize that the tumor was above the level of the axillary vessels and likely involved the brachial plexus. The pre-operative work up suggested that the patient had a tumor of the brachial plexus. The tumor was very large at 5 cm in size but not palpable on physical examination; the tumor was in the axilla of neurologic origin on biopsy; biopsy of the tumor itself caused upper extremity numbness and spasm; and, MRI demonstrated the tumor to be above the level of the axillary vessels.

30. Respondent's acts and/or omissions as set forth in paragraphs 8 through 24 and 29, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence – Intra-Operative Care and Treatment)

31. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in his intraoperative care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 25, above, as though fully set forth herein. The circumstances are as follows:

32. Intraoperatively, Respondent failed to recognize that he was working inside the brachial plexus rather than below the axillary vein. He failed to identify the general anatomic landmarks, including the axillary vein, to be sure of the anatomic space he was dissecting within; he failed to recognize that the patient's right axillary anatomy was significantly distorted as normal anatomic relations were displaced by the tumor; he failed to utilize formal intraoperative nerve monitoring; he acknowledged that nerve reconstruction may be necessary in the future by placing silk tagging sutures on the two ends of the nerves and then intentionally transecting the nerve in two places to remove the tumor; and though he failed to identify the exact nerve intraoperatively, stimulation clearly elicited upper extremity motion, thus indicating that the nerve was a functional motor nerve to the upper extremity and he still sacrificed it to remove the tumor.

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33. Respondent's acts and/or omissions as set forth in paragraphs 8 through 25 and 32, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

34. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 33, above, as though fully set forth herein. The circumstances are as follows:

35. Prior to commencing surgery, Respondent failed to recognize that the tumor was above the level of the axillary vessels and likely involved the brachial plexus. The pre-operative work up suggested that the patient had a tumor of the brachial plexus. The tumor was very large at 5 cm in size but not palpable on physical examination; the tumor was in the axilla of neurologic origin on biopsy; biopsy of the tumor itself caused upper extremity numbness and spasm; and, MRI demonstrated the tumor to be above the level of the axillary vessels.

36. Intraoperatively, Respondent failed to recognize that he was working inside the brachial plexus rather than below the axillary vein. He failed to identify the general anatomic landmarks, including the axillary vein, to be sure of the anatomic space he was dissecting within; he failed to recognize that the patient's right axillary anatomy was significantly distorted as normal anatomic relations were displaced by the tumor; he failed to utilize formal intraoperative nerve monitoring; he acknowledged that nerve reconstruction may be necessary in the future by placing silk tagging sutures on the two ends of the nerves and then intentionally transecting the nerve in two places to remove the tumor; and though he failed to identify the exact nerve intraoperatively, stimulation clearly elicited upper extremity motion, thus indicating that the nerve was a functional motor nerve to the upper extremity and he still sacrificed it to remove the tumor.

37. Respondent failed to immediately initiate a DVT workup the same day the patient called Respondent to complain about swelling and pain in his left leg.

38. Respondent's acts and/or omissions as set forth in paragraphs 8 through 37, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Dishonesty)

39. Respondent is subject to disciplinary action under 2234, subdivision (e), in that he committed unprofessional conduct when he was dishonest at his Board interview by affirmatively representing that a nerve stimulator was not available at the hospital on February 5, 2015 at the time he performed surgery on Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraph 14, above, as though fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

40. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 19, above, as though fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 108490, issued to Eric M. Changchien, M.D.;

2. Revoking, suspending or denying approval of Eric M. Changchien, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering Eric M. Changchien, M.D. to pay the Board the costs of probation monitoring; and

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

DATED: February 6, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2018503075