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

In the Matter of the Accusation Against:	
Peilin Chang, M.D.	Case No. 800-2019-054023
Physician's and Surgeon's Certificate No. A 61036	
Respondent.	

DECISION

The attached Stipulated Surrender of License and 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 May 06, 2024.

IT IS SO ORDERED April 29, 2024.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
GREG W. CHAMBERS
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **PEILIN CHANG, M.D.** **P O Box 3379** **Freedom, CA 95019-3379** **Physician's and Surgeon's Certificate No. A 61036** Respondent.	Case No. 800-2019-054023 OAH No. 2024010261 **STIPULATED SURRENDER OF LICENSE AND 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. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Thomas Ostly, Deputy Attorney General .

2. PEILIN CHANG, M.D. (Respondent) is represented in this proceeding by attorney Julie Pulliam, 2151 Pine Flat Road, Santa Cruz, CA 95060.

3. On or about October 11, 1996, the Board issued Physician's and Surgeon's Certificate No. A 61036 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-054023 and will expire on May 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-054023 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 March 18, 2022. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2019-054023 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-054023. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her 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.

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2019-054023, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up her right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of her Physician's and Surgeon's Certificate No. A 61036 without further notice to, or opportunity to be heard by, Respondent

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to

approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

17. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 61036, issued to Respondent PEILIN CHANG, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2019-054023 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $33,041.25 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2019-054023 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 4/12/24

PEILIN CHANG, M.D.
Respondent

I have read and fully discussed with Respondent Peilin Chang, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: April 12, 2024

JULIE PULLIAM
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 4/17/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
GREG W. CHAMBERS
Supervising Deputy Attorney General

Thomas Ostly

THOMAS OSTLY
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-054023

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

In the Matter of the Accusation Against: **PEILIN CHANG M.D.** **PO Box 3379** **Freedom, CA 95019** **Physician's and Surgeon's Certificate No. A 61036,** Respondent.	Case No. 800-2019-054023 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 11, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 61036 to Peilin Chang M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

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JURISDICTION

3. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

4. Section 2234 of the Code, in pertinent part, 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."

5. 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."

6. Section 2228.1 of the Code provides, in pertinent part, that the Board shall require a licensee who is disciplined based on inappropriate prescribing resulting in harm to patients, to disclose to his or her patients information regarding his or her probation status. The license is

required to disclose: Probation status, the lengthy of the probation, the probation end date, all practice restrictions placed on the license by the Board, the Board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the Board's Internet Web site.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

8. At the time of the events alleged in this Accusation, Respondent practiced as a pain management specialist in Freedom, California.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence/Repeated Negligent Acts)
Patient 1[1]

9. Respondent began documenting treatment of Patient 1 in January 2016 for neck pain, cervical radiculopathy, and lower back pain from multiple bicycle accidents and a 2001 motor vehicle accident. The patient was taking buprenorphine[2], which Respondent continued to prescribe the amount of 8 mg every 8 hours, 90 pills a month. The last documented treatment of Patient 1 by Respondent was in January 2018. During this period, Respondent saw Patient 1 monthly.

[1] Patients are referred to by number to protect privacy.

[2] Buprenorphine is a medication approved by the Food and Drug Administration (FDA) to treat Opioid Use Disorder. It produces effects such as euphoria or respiratory depression at low to moderate doses.

10. Respondent's medical record for Patient 1 consists of documentation of vital signs, and an assessment of the patient's general appearance and gait. Over the course of treatment, no musculoskeletal examination was documented, and only one cervical spine and neurologic examination was documented, on January 11, 2017. During an interview with the Board's investigators, Respondent acknowledged failing to document physical examinations of Patient 1, and explained that she conducted physical examinations, but did not feel it necessary to document the entire examination during each visit, since the patient presented with chronic pain issues.

11. Respondent prescribed buprenorphine consistently over a period of two years, and stated in her interview that she did not consider lowering Patient 1's dosage of medication because he had a lot of pain that was not improving. However, Patient 1 was averaging over 30mg a day of buprenorphine when recommended dosage was 16mg daily, with a max of 24mg daily.

12. There is no indication in the record that Respondent assessed and monitored the patient's risk of opiate abuse using an (Opioid Risk Tool) ORT[3] or similar method. An ORT can be used to determine which patients are at risk for opioid-related, aberrant behaviors. Similarly, there is no indication that Respondent considered or discussed with Patient 1 the use of non-pharmacologic treatment options, or considered discontinuation of buprenorphine when the patient did not show improvement. There is little indication in the record that Respondent took steps to monitor Patient 1's use of medication over the course of treatment. Respondent failed to obtain UDS, and at no time during her treatment of Patient 1 were toxicology screens ordered. There is no documentation or presentation of any laboratory findings in Patient 1's medical record.

13. Respondent noted in July 2017, that Patient 1 had a family history of addition, and that she discussed with the patient that he needed to be aware of the risk of addiction. However, there is no documentation that Respondent discussed the risk of buprenorphine misuse. There was no documentation in any of the clinic notes that CURES[4] was accessed to determine if Patient 1 was

[3] The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior.

[4] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to

obtaining controlled narcotics from any other provider. If a CURES report had been generated, it would have shown Patient 1 received occasional opiate prescriptions such as oxycodone from other providers.

14. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 1, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) of the Code in that Respondent committed gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent prescribed a controlled substance, without an appropriate evaluation and history and without regular, consistent assessment of the indication for the medications, and without conducting appropriate examination of the patient's cervical spine.

B. Respondent prescribed controlled substances in high amounts without documentation of any physical examination to support the care provided, or rationale for the doses prescribed.

C. Respondent prescribed buprenorphine without documenting any assessment or concern for misuse of the medication.

D. Respondent prescribed a controlled substance, over a long period of time and in high doses, without documenting a treatment plan with specific treatment goals.

E. Respondent prescribed and treated Patient 1 without documenting need to deviate from current standards for prescribing opioids.

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence/Repeated Negligent Acts)
Patient 2

15. Respondent had been seeing Patient 2 since 2003 for severe systemic lupus erythematosus (SLE), chronic pain in multiple areas of her body and anxiety. Patient 2's pain scale was reported as 9/10 at each visit from 2016-2018. Respondent regularly prescribed opiates,

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ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances.

including Oxycontin[5], Dilaudid[6], Fentora[7] and Actiq[8]. She also prescribed diazepam[9]. These medications were often prescribed in combination with each other. The Morphine milligram Equivalent (MME)[10] was in excess of 2000 mg per day. Respondent's record contains no assessment of the rationale for prescribing multiple immediate release opiates, or the reason for the prescribing in a high dosage. There was documentation of UDS done in April 2018, but none was performed in 2016 or 2017. The single UDS showed a very high concentration of hydromorphone and oxycodone. When interviewed by the Board, Respondent stated UDS was recommended for 2016 and 2017, but it was hard for Patient 2 due to her being wheelchair bound. Respondent was asked at her Board interview about Patient 2's MME level over 1000/day when normal level is 90 mme/day. Respondent stated Patient 2 was already on a high MME when she started seeing her. There is no indication Respondent consulted CURES, although her record indicates she was aware the patient received prescriptions from other prescribers.

16. Patient 2's last visit with Respondent was on July 16, 2018, and her usual pain medications as above were refilled. Patient 2 passed away ten days later on July 26, 2018 as a result of acute fentanyl[11], hydromorphone, oxycodone, and diazepam intoxication.

17. Respondent did not perform a physical examination of the body parts that were the source of Patient 2's complaints of pain. During what appeared to be telephonic visits during the

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[5] Oxycodone, sold under the brand names Roxicodone and OxyContin, among others, is an opioid medication used for treatment of moderate to severe pain. It is highly addictive and a common drug of abuse.

[6] Hydromorphone, also known as dihydromorphinone, and sold under the brand name Dilaudid, among others, is an opioid used to treat moderate to severe pain.

[7] Fentora is used to help relieve sudden (breakthrough) cancer pain in people who are regularly taking moderate to large amounts of opioid pain medication.

[8] Actiq is used to help relieve sudden (breakthrough) cancer pain in people who are regularly taking moderate to large amounts of opioid pain medication.

[9] Diazepam, first marketed as Valium, is a medicine of the benzodiazepine family that acts as an anxiolytic. It is commonly used to treat a range of conditions, including anxiety, seizures, alcohol withdrawal syndrome, benzodiazepine withdrawal syndrome, muscle spasms, and insomnia.

[10] Opioid dosage is often discussed in terms of "morphine milligram equivalents," or MME. MME per day, MME/d, is a standard measure of the daily dose of any opioid. The MME of morphine is one, meaning that morphine is exactly as potent as morphine. MMEs greater than one signify greater potency, while MMEs less than one signify lesser potency. At the time of the events alleged in this Accusation, the standard of care has been to limit opioid dose to less than 50 MME/d in almost all patients, and to exceed 90 MME/d in only the most unusual circumstances and with only the most careful documentation.

[11] Fentanyl is a synthetic opioid that is 80-100 times stronger than morphine.

pandemic, documentation of physical examinations appeared to have been copied from previous in-person visits.

18. There was a lack of documentation in the medical record of the benefits that the opiates provided this patient. Respondent failed to discuss and document the risks of concurrent opiate and benzodiazepine treatment with Patient 2.

19. Respondent prescribed opiates to a Patient 2 when she presented with clear psychiatric comorbidities. Patient 2 was unable to complete the most basic aspects of grooming, indicating a patient at high risk of abuse.

20. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 2, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) of the Code in that Respondent committed gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent prescribed controlled substances, without an appropriate evaluation and history and without assessment of the indication for the medications at the level they were being furnished.

B. Respondent prescribed controlled substances in extremely high doses without documentation of sufficient physical examination or medical indication to support the care provided, or rationale for the large doses prescribed, and continued to prescribe over a long period of time without noting any measurable improvement in the patient's pain or function.

C. Respondent prescribed, without explanation or rationale, high dose opiates, three of which where immediate release products, without implementing opioid risk tools or assessment.

D. Respondent prescribed narcotics in high doses without documenting any substance abuse history, and without close monitoring of the patient's risk of opioid misuse.

E. Respondent prescribed controlled substances, over a long period of time and in high doses, without obtaining/and/or documenting informed consent.

F. Respondent prescribed controlled substances, over a long period of time and in high doses, without documenting a treatment plan with specific treatment goals.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts)
Patient 3

21. Patient 3 was seen by Respondent on November 6, 2016 for pain in his neck, arm, lower back, and leg on an ongoing basis. Respondent's record for the November 6, 2016 visit does not document a physical examination of the cervical spine, lumbar spine or any of the extremities, and consists only of vital signs, assessment of the patient's general appearance, orientation and gait. Respondent prescribed 90 mg of oxycodone per day.

22. Respondent saw Patient 3 monthly. Patient 3 reported the same pain scale of 8/10 from 2016-2021. Respondent's record documented no meaningful examination of the patient over the duration of treatment. Respondent explained during her interview that she wanted to "minimize the ink and the paper." There is no indication that Respondent monitored the patient with UDS or took any other measures to monitor the patient's compliance between November 2016 and April 2018. The only other mention of UDS was in February 2021, when Respondent noted the patient was due for screening, but due to the pandemic, facilities were limited.

23. At an April 2018 treatment visit, Respondent documented for the first time that she considered UDS for Patient 3. At that time, she instructed Patient 3 to go to a local facility to get a "urine toxicity test" done. At his May 2018 visit, Patient 3 informed Respondent he was unable to obtain a UDS test. During the June 2018 follow-up visit, Patient 3 presented UDS results for another patient, which he claimed was given to him in error by the facility. Respondent told Patient 3 to get correct UDS results, and continued to prescribe Oxycodone. On August 6, 2018 Patient 3 brought in his own urine drug test kit. Respondent reported the test done by Patient 3 test showed no evidence of drug abuse and is consistent with his current medication use. There is no documentation of any laboratory findings of UDS, and no documentation that any other urine screening was conducted over the course of treatment. There is no record of tools such as ORT being used in the treatment of Patient 3. An ORT can be used to determine which patient are at risk for opioid-related, aberrant behaviors.

24. At no time during her treatment of Patient 3 did Respondent access the CURES database. There was no documentation in any of the clinic notes that CURES was accessed in any other way to determine if Patient 3 was obtaining controlled narcotics from any other provider.

25. Respondent did not perform a physical examination of the body parts that were the source of Patient 3's complaints of pain. The medical records for each visit were essentially the same. During what appeared to be telephonic visits during the pandemic, the notes from previous in-person physical examinations were copied into the telephonic visit record.

26. As of January 2019, it is required by law that prescribers offer a prescription of naloxone or another drug approved by the FDA for the complete or partial reversal of opioid depression to a patient when certain conditions are met. There is no known evidence that Patient 3 was offered naloxone.

27. Respondent is guilty of unprofessional conduct in her care and treatment of Patient 3, and is subject to disciplinary action under section 2234 and/or 2234(b) and/or 2234(c) of the Code in that Respondent committed gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent prescribed controlled substances, without an appropriate evaluation and history, without assessment of the indication for the medications, and without ongoing assessment of the risk of opiate misuse.

B. Respondent issued monthly prescriptions for controlled substances, without ever consulting the CURES system.

C. Respondent prescribed a controlled substance for more than five years, without conducting regular UDS, and, after 2019, without offering the patient a prescription for naloxone.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

28. Respondent is guilty of unprofessional conduct and is subject to discipline for violation of sections 2234 and/or 2266 of the Code for failure to maintain adequate and accurate medical records for each of the three patients alleged above.

29. In each case, Respondent's medical records fail to include a complete or even partial assessment of the patient's presenting condition, an assessment of the patient, the rationale for prescribing, or response to treatment. Respondent's records regularly stated that a medication had been prescribed for the patient, but did not state the medical indication or rational for the prescription. Respondent failed to document whether appropriate physical examinations of the patients, and failed to document any effort to monitor the patients' compliance with the medications prescribed. Respondent failed to document an appropriate or adequate informed consent was provided to any of the three patients, at any time over the course of treatment, or for the types, amounts and combinations of drugs prescribed.

PRESCRIBING RESULTING IN HARM TO PATIENTS

30. Respondent's patterns of prescribing controlled substances to the three patients described in this Accusation subjected the patients to unnecessary polypharmacy. Her indiscriminate and incautious prescribing of controlled medications increased the chance of many adverse outcomes, including adverse drug reactions, adverse drug interactions, falls, cognitive impairment and mortality. In particular, Respondent's prescribing to Patient 2, without appropriate monitoring or informed consent, may have contributed to the patient's death.

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 61036, issued to Peilin Chang, M.D.;

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

3. Ordering Peilin Chang, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Peilin Chang, M.D. to provide a separate disclosure pursuant to Business and Professions Code section 2228.1; and

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

DATED: MAR 18 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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