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

In the Matter of the Accusation Against: Chuc Van Dang, M.D. Physician's and Surgeon's Certificate No. G 42462 Respondent.	Case No. 800-2019-055062

DECISION

The attached Stipulated Surrender 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 February 2, 2022.

IT IS SO ORDERED January 26, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LAWRENCE MERCER
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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: **CHUC VAN DANG, M.D.** **15035 East 14th Street** **San Leandro CA 94578-1901** **Physician's and Surgeon's Certificate No. G 42462** Respondent.	Case No. 800-2019-055062 **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. William Prasifka (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 Lawrence Mercer, Deputy Attorney General.

2. Chuc Van Dang, M.D. (Respondent) is represented in this proceeding by his attorneys Geoffrey Mires and Kevin Mintz and Rankin, Shuey, Ranucci, Mintz, Lampasona & Reynolds, 2030 Franklin Street, Sixth Floor, Oakland, CA 94612.

3. On or about July 9, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42462 to Chuc Van Dang, M.D. (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. 800-2019-055062 and will expire on February 28, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-055062 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 April 30, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2019-055062 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. 800-2019-055062. 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 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.

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. 800-2019-055062, if proven at a hearing, constitute cause for imposing discipline upon his 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 his right to contest that cause for discipline exists based on those charges.

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

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

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

13. 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 Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 42462, issued to Respondent Chuc Van Dang, M.D., is surrendered and accepted by the Board.

1. Respondent shall lose all rights and privileges as a physician and surgeon in California as of January 28, 2022.

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

3. 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. 800-2019-055062 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

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 and that, as of January 28, 2022, I will lose all rights and privileges as a California physician and surgeon. 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: 03 JAN 2022

CHUC VAN DANG, M.D.
Respondent

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

RANKIN, SHUEY, MINTZ, et al.

DATED: January 6, 2022

GEOFFREY A. MIRES
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: January 7, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-055062

MATTHEW RODRIQUEZ
Acting Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LAWRENCE MERCER
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Chuc Van Dang, M.D.** **15035 East 14th Street** **San Leandro, CA 94578-1901** **Physician's and Surgeon's Certificate No. G 42462,** Respondent.	Case No. 800-2019-055062 **A C C U S A T I O N**

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 July 9, 1980, the Medical Board issued Physician's and Surgeon's Certificate Number G 42462 to Chuc Van Dang, 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 February 28, 2022, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. 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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

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

6. 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Acts of Negligence)

7. Respondent Chuc Van Dang, M.D. is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent engaged in unprofessional conduct and was grossly negligent and/or committed repeated acts of negligence in his patient care and treatment. The circumstances are as follows:

8. At all relevant times, Respondent was a non-board certified physician and surgeon with a general surgical practice in Alameda County, California.

PATIENT 1

9. On July 5, 2018, Patient 1[1], a 74-year old male, came under Respondent's care and treatment for a left inguinal hernia. At the pre-operative visit, Respondent obtained the patient's informed consent to an open inguinal hernia repair with mesh. The purpose of the mesh was to reduce the risk of recurrence of the hernia compared to suture repair alone. Use of mesh does

[1] Patient names are redacted to protect privacy.

have risks, including infection and erosion. Per FDA regulations, manufacturers designate an expiration date to assure package integrity and sterility.

10. On July 6, 2018, Respondent took Patient 1 to the operating room. At that time, Respondent determined that the patient had a large direct hernia, which is the type of hernia that may recur. Respondent elected to use 40 mm Freedom ProFlor Insightra (40 FPFI) mesh for the repair; however, the available mesh of that type had an expiration date of July 1, 2018. Nursing staff advised Respondent that the mesh was expired and that hospital policy prohibited use of expired prostheses. Respondent was offered alternative synthetic non-absorbable mesh prostheses to secure the hernia repair, but he declined other options. Respondent documented this fact and stated that he would accept full responsibility for his use of the expired mesh. Respondent proceeded to perform the hernia repair and the patient had an uneventful recovery; however, Respondent's election to use the expired mesh violated hospital policy and constituted unprofessional conduct and negligence in exercising his medical judgement.

PATIENT 2

11. On October 13, 2017, Patient 2, a 49-year old male, presented to the ED with epigastric and abdominal pain. A CT scan disclosed cholelithiasis, gallbladder wall thickening and pericholecystic fluid and acute cholecystitis was diagnosed. Respondent was contacted and came to see the patient on the morning of October 13, 2017. He consented the patient to a cholecystectomy and the patient was taken to the OR that evening.

12. At the surgery, Respondent decompressed the gallbladder with a needle to begin. The process of finding the cystic duct was by dissecting the fundus of the gallbladder to the infundibulum, an atypical approach, rather than the "critical view of safety" (CVS)[2] standardly utilized in laparoscopic gallbladder surgeries. He did not order an intraoperative cholangiogram to better delineate the biliary anatomy during the laparoscopic cholecystectomy. The procedure of dissecting the gallbladder was stated to be difficult as the upper half of the gallbladder was noted

[2] Obtaining the "critical view of safety" by skeletonizing the cystic duct and artery, and dissecting the gallbladder from the liver bed before clipping and dividing any structures in the Triangle of Calot is a common method to confirm the anatomy (and avoid injury to the common bile duct) and minimize the need for cholangiography.

to be intrahepatic and did not peel easily off the liver. Because of the amount of inflammation and edema fluid encountered during the procedure, Respondent placed a Jackson-Pratt (JP) drain. By reason of Respondent's failure to obtain the CVS and/or to use intraoperative cholangiography, the patient sustained a Type II Bismuth common bile duct injury. This type of injury occurs when the common bile duct is mistaken for the cystic duct. Respondent did not discover the injury intraoperatively, nor did he have a high index of suspicion for a bile duct injury post-operatively.

13. The patient remained in the hospital three days post-operatively. The nursing staff noted greenish-yellow bilious output from the JP drain on the patient's day of discharge. Respondent himself noted reddish-brown output. Respondent should have had a high index of suspicion for a possible bile leak and started a workup while the patient was still in the hospital. In a subsequent interview, Respondent stated that the output at the first postoperative visit was more than expected and bilious in nature, but he did not order a drain fluid assay, blood tests or imaging that would elucidate the source and possible cause of the greenish fluid. Consequently, there was a substantial and medically unacceptable delay in the discovery that the patient had suffered a common bile duct injury, with resulting transfer to a higher level of care, re-hospitalization, additional surgery and debility for the patient.

PATIENT 3

14. Patient 3, a 26-year old female, was seen, examined and evaluated by Respondent on March 14, 2019, for severe upper abdominal pain. Respondent concluded that the patient had signs and symptoms consistent with symptomatic chronic cholecystitis and he obtained the patient's consent to a laparoscopic cholecystectomy. On March 15, 2019, Respondent took the patient to the OR for the planned procedure. In his approach to the procedure, Respondent failed to get the CVS required during the performance of a laparoscopic cholecystectomy to minimize the risk of a common bile duct injury. In the course of the procedure, Respondent encountered an unknown tubular structure, which had the appearance of a biliary duct and, more specifically the cystic duct that Respondent believed he had already transected. Respondent concluded that the first structure he had thought was the cystic duct (and which he had already clipped and transected) was actually the common bile duct. Respondent did not do a laparoscopic

cholangiogram or convert the procedure to an open procedure, which were available options for him to better visualize and evaluate the unclear vascular and biliary anatomy of his patient's gallbladder and biliary structures. Instead, he scrubbed out of the OR to talk to the patient's family and with their consent had the patient transferred to another hospital for a higher level of care. At the subsequent open gallbladder procedure at another hospital, the surgeon found no common bile duct injury and felt that the tubular structure that Respondent encountered was an aberrant or second cystic artery.

15. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Business and Professions Code sections 2234 and/or 2234(b) and/or 2234(c), based on his gross negligence and/or repeated negligent acts, including but not limited to:

A. Respondent elected to use expired synthetic non-absorbable mesh prostheses to secure the hernia repair despite the hospital policy against such use and the availability of alternative, unexpired mesh;

B. Respondent failed to get the CVS required during the performance of a laparoscopic cholecystectomy;

C. Respondent failed to employ available options for him to better visualize and evaluate the unclear vascular and biliary anatomy of his patient's gallbladder and biliary structures, such as a cholangiogram or an open procedure;

D. Respondent failed to timely investigate the possibility of intraoperative common bile duct injury.

SECOND CAUSE FOR DISCIPLINE

(Failure to Keep Adequate and Accurate Records)

16. Respondent Chuc Van Dang, M.D. is subject to disciplinary action under sections 2234 and/or 2266, in that Respondent failed to maintain adequate and accurate records.

17. Paragraphs 9 through 14 above are incorporated as though fully set out herein. As to each negligent act or omission set forth therein, Respondent failed to adequately and accurately

set forth sufficient facts to demonstrate compliance or attempted compliance with the standard of care, including but not limited to the following:

A. Respondent failed to document that he obtained the necessary CVS for the performance of a laparoscopic cholecystectomy;

B. Respondent failed to document his consideration of alternative options to visualize the patient's gallbladder and biliary anatomy.

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 G 42462, issued to Chuc Van Dang, M.D.;

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

3. Ordering Chuc Van Dang, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: APR 30 2021

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

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