

**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

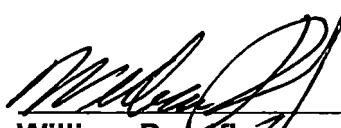
DECISION

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**

1 ROB BONTA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LAWRENCE MERCER
Deputy Attorney General
4 State Bar No. 111898
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 510-3488
6 Facsimile: (415) 703-5480
Attorneys for Complainant
7

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

12 In the Matter of the Accusation Against:

Case No. 800-2019-055062

13 **CHUC VAN DANG, M.D.**
15035 East 14th Street
San Leandro CA 94578-1901

14 **STIPULATED SURRENDER OF**
LICENSE AND ORDER

15 **Physician's and Surgeon's Certificate No. G**
42462

16 Respondent.
17

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

20 **PARTIES**

21 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
22 California (Board). He brought this action solely in his official capacity and is represented in this
23 matter by Rob Bonta, Attorney General of the State of California, by Lawrence Mercer, Deputy
24 Attorney General.

25 2. Chuc Van Dang, M.D. (Respondent) is represented in this proceeding by his attorneys
26 Geoffrey Mires and Kevin Mintz and Rankin, Shuey, Ranucci, Mintz, Lampasona & Reynolds,
27 2030 Franklin Street, Sixth Floor, Oakland, CA 94612.
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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, 2012

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

1 MATTHEW RODRIQUEZ
Acting Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LAWRENCE MERCER
Deputy Attorney General
4 State Bar No. 111898
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5 San Francisco, CA 94102-7004
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8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
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10 **STATE OF CALIFORNIA**

11
12 In the Matter of the Accusation Against:
13 **Chuc Van Dang, M.D.**
14 **15035 East 14th Street**
San Leandro, CA 94578-1901
15
16 **Physician's and Surgeon's Certificate No.**
G 42462,
17
18 Respondent.

Case No. 800-2019-055062
ACCUSATION

19 **PARTIES**

- 20 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
21 as the Executive Director of the Medical Board of California, Department of Consumer Affairs
22 (Board).
23 2. On or about July 9, 1980, the Medical Board issued Physician's and Surgeon's
24 Certificate Number G 42462 to Chuc Van Dang, M.D. (Respondent). The Physician's and
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
26 herein and will expire on February 28, 2022, unless renewed.

27 //

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

4 (2) When the standard of care requires a change in the diagnosis, act, or
5 omission that constitutes the negligent act described in paragraph (1), including, but
6 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
7 licensee's conduct departs from the applicable standard of care, each departure
8 constitutes a separate and distinct breach of the standard of care.

9 (d) Incompetence.

10 (e) The commission of any act involving dishonesty or corruption that is
11 substantially related to the qualifications, functions, or duties of a physician and
12 surgeon.

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

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

17 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
18 adequate and accurate records relating to the provision of services to their patients constitutes
19 unprofessional conduct.

20 FIRST CAUSE FOR DISCIPLINE

21 (Gross Negligence/Repeated Acts of Negligence)

22 7. Respondent Chuc Van Dang, M.D. is subject to disciplinary action under sections
23 2234 and/or 2234(b) and/or 2234(c) in that Respondent engaged in unprofessional conduct and
24 was grossly negligent and/or committed repeated acts of negligence in his patient care and
25 treatment. The circumstances are as follows:

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

28 PATIENT 1

9. On July 5, 2018, Patient 1¹, 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.

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

3 10. On July 6, 2018, Respondent took Patient 1 to the operating room. At that time,
4 Respondent determined that the patient had a large direct hernia, which is the type of hernia that
5 may recur. Respondent elected to use 40 mm Freedom ProFlor Inshitra (40 FPF1) mesh for the
6 repair; however, the available mesh of that type had an expiration date of July 1, 2018. Nursing
7 staff advised Respondent that the mesh was expired and that hospital policy prohibited use of
8 expired prostheses. Respondent was offered alternative synthetic non-absorbable mesh prostheses
9 to secure the hernia repair, but he declined other options. Respondent documented this fact and
10 stated that he would accept full responsibility for his use of the expired mesh. Respondent
11 proceeded to perform the hernia repair and the patient had an uneventful recovery; however,
12 Respondent's election to use the expired mesh violated hospital policy and constituted
13 unprofessional conduct and negligence in exercising his medical judgement.

14 **PATIENT 2**

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

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

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27 ² Obtaining the "critical view of safety" by skeletonizing the cystic duct and artery, and
28 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.

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

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

17 PATIENT 3

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

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

8 15. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject
9 to discipline pursuant to Business and Professions Code sections 2234 and/or 2234(b) and/or
10 2234(c), based on his gross negligence and/or repeated negligent acts, including but not limited
11 to:

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

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

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

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

22 **SECOND CAUSE FOR DISCIPLINE**

23 **(Failure to Keep Adequate and Accurate Records)**

24 16. Respondent Chuc Van Dang, M.D. is subject to disciplinary action under sections
25 2234 and/or 2266, in that Respondent failed to maintain adequate and accurate records.

26 17. Paragraphs 9 through 14 above are incorporated as though fully set out herein. As to
27 each negligent act or omission set forth therein, Respondent failed to adequately and accurately
28

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

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

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

7 **PRAYER**

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


10 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 42462,
11 issued to Chuc Van Dang, M.D.;

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

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

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

17
18 DATED: APR 30 2021


19 WILLIAM PRASIFKA
20 Executive Director
21 Medical Board of California
22 Department of Consumer Affairs
23 State of California
24 Complainant

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