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

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

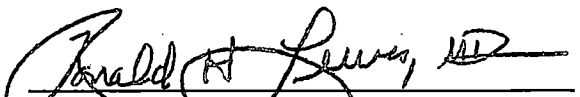
DECISION

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

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

IT IS SO ORDERED December 17, 2019.

MEDICAL BOARD OF CALIFORNIA



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

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: LESLIE HOWARD EDRICH, M.D. 701 East 28th Street, Suite 400 Long Beach California 90806 Physician's and Surgeon's Certificate No. G 48000, Respondent.	Case No. 800-2016-024606 OAH No. 2019080026 **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 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 Leslie Howard Edrich, M.D. ("Respondent") is represented in this proceeding by attorneys Dennis Ames and Pogey Henderson, 2677 North Main Street, Suite 901 Santa Ana, California 92705-6632.

3. On or about July 2, 1982, the Board issued Physician's and Surgeon's Certificate No. G 48000 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-024606, and will expire on December 31, 2019, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-024606 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 July 2, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2016-024606 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. 800-2016-024606. 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. 800-2016-024606 and that he has thereby subjected his license to disciplinary action.

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

CONTINGENCY

11. 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.

12. 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.

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 Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND.

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate G 48000 issued to Respondent Leslie Howard Edrich, M.D. is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient 1 as set forth in Accusation No. 800-2016-024606, is as follows:

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

B. <u>EDUCATION COURSE</u>. Within sixty (60) calendar days of the effective date of this Decision, 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 twenty (20) hours. 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 twenty (20) hours of CME in satisfaction of this condition.

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 educational program(s) or course(s), or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the educational program(s) or course(s) 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 educational program(s) or course(s) has been completed. Failure to successfully complete the educational program(s) or course(s) outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Dennis Ames and Pogey Henderson. 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: 10/21/2019

LESLIE HOWARD EDRICH, M.D.
Respondent

I have read and fully discussed with Respondent Leslie Howard Edrich, 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: 10/21/19

DENNIS AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

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

DATED: 10/22/19

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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Exhibit A

Accusation No. 800-2016-024606

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 2 20 19
BY _____ ANALYST

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

In the Matter of the Accusation Against: LESLIE HOWARD EDRICH, M.D. 701 East 28th Street, Suite 400 Long Beach, California 90806 Physician's and Surgeon's Certificate No. G 48000, Respondent.	Case No. 800-2016-024606 **ACCUSATION**

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 or about July 2, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number G 48000 to Leslie Howard Edrich, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2019, unless renewed.

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JURISDICTION

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.

3. 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.

"..."

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.

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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."

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.

"..."

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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."

FACTUAL ALLEGATIONS

7. Patient 1,[1] a then 28-year-old female patient, was admitted to MemorialCare Long Beach Memorial Hospital ("hospital") on April 1, 2013 with a diagnosis of acute cholecystitis.[2] An abdominal ultrasound performed that same day showed multiple gallstones, normal gallbladder wall thickness and no pericholecystic fluid. The common bile duct was noted to be 0.3 mm. The patient's laboratory studies showed abnormally elevated liver function tests.

8. On April 3, 2013, Respondent performed a laparoscopic cholecystectomy which was converted to an open cholecystectomy with a common bile duct repair of an iatrogenic 2 mm to 3 mm laceration of the common bile duct at the junction to the cystic duct. The repair was made with three interrupted 4-0 chromic sutures and a Jackson-Pratt drain ("JP drain") was placed near the common duct repair site. Respondent noted that following the procedure, the patient was taken to the recovery room in satisfactory condition.

9. Pathology revealed that the gallbladder measured 9 x 3 x 3 cm with wall thickness ranging from 0.1 cm to 0.2 cm. Scattered lymphocytes were noted in submucosa and multiple yellow lobulated stones, ranging from 0.1 cm to 1 cm in diameter, were present with some of the stones tightly lodged at the neck of the gallbladder and cystic duct.

10. The plan was to discharge the patient on April 6, 2013 if stable; however, the discharge was held as a result of nausea, emesis and tachycardia of 100 to 110 beats per minute.

11. On April 7, 2013, the patient had elevated liver function tests and bilious fluid observed in her drain. To evaluate for a possible biliary leak, a HIDA scan[3] was performed on

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[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1.

[2] Cholecystitis is inflammation of the gallbladder.

[3] A HIDA scan, which stands for hepatobiliary iminodiacetic acid scan or cholescintigraphy, is an imaging test used to view the liver, gallbladder, bile ducts, and small intestines and involves injecting a radioactive tracer into the patient's vein.

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

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

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

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

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

16. On the following day, April 17, 2013, a repeat ERCP with stenting was performed secondary to a persistent biliary leak. The gastroenterology service noted a concern for a stent malfunction. A cholangiogram[6] demonstrated a leak near the cystic duct and opacification of the left hepatic duct system but there was no visualization of right hepatic duct system. After the

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

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

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

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

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

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

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

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

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

22. On May 2, 2013, an intracapsular drain clamp was placed. The patient's alkaline phosphate ("ALP") level[8] was noted to be elevated at 544 u/l (reference range 45-129 u/l).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35. On May 13, 2013, an EGD[9] and an ERCP were performed. It was noted that a pre-pyloric peptic ulcer was identified without bleeding and the biliary stent was removed. A cholangiogram demonstrated a leak that was not in vicinity of cystic duct stump. A stent was placed. An MRCP was recommended because the right hepatic duct was not visualized.

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

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

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

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

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

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

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

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

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

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

STANDARD OF CARE

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

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

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

CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

46. 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 7 through 45, above, as though fully set forth herein. The circumstances are as follows:

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

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

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

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

50. Respondent's acts and/or omissions as set forth in 8 through 49, 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.

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 48000, issued to Leslie Howard Edrich, M.D.;

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

3. Ordering Leslie Howard Edrich, 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: July 2, 2019

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

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