

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **DAVID C. CHANG, M.D.**

4 Holder of License No. 59452
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-20-0679A

**ORDER FOR LETTER OF
REPRIMAND; AND CONSENT TO THE
SAME**

7 David C. Chang, M.D. ("Respondent") elects to permanently waive any right to a
8 hearing and appeal with respect to this Order for a Letter of Reprimand; admits the
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order
10 by the Board.

11 **FINDINGS OF FACT**

12 1. The Board is the duly constituted authority for the regulation and control of
13 the practice of allopathic medicine in the State of Arizona.

14 2. Respondent is the holder of license number 59452 for the practice of
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-20-0679A after receiving notification
17 that Respondent's Hospital privileges had been summarily suspended.

18 4. Based on the complaint, Board staff requested Medical Consultant ("MC")
19 review of Respondent's care and treatment of five patients. The MC identified deviations
20 from the standard of care with regard to Respondent's care and treatment of four of them
21 (KO, MA, LN, and HM).

22 5. KO was a 73 year-old female who underwent a right thoracotomy for
23 resection of a right upper lobe lung mass. The intraoperative anesthetic course was
24 uneventful. Upon arrival to PACU, KO developed respiratory failure. Respondent was not
25 with KO during transport and could not be found. Interventions were performed by the

1 other personnel present in PACU. The remainder of the hospital course was
2 unremarkable.

3 6. MA was a 73 year-old female who underwent surgical repair of an ascending
4 aortic aneurysm with aortic valve replacement ("AVR"). The intraoperative anesthetic
5 course was uneventful. At the time of the pump run and circulatory arrest, Respondent
6 was not present in the surgical suite. Staff contacted Respondent to return for separation
7 from the cardiopulmonary bypass.

8 7. LN was a 78 year-old male who underwent CABG with Maze procedure and
9 left atrial appendage exclusion. The intraoperative anesthetic course was uneventful. It
10 was reported by staff that Dr. Chang left the OR several times and was not available
11 during the patient's care. The postoperative hospital course was uneventful, and LN was
12 discharged in satisfactory condition.

13 8. HM was an 88 year-old male with AI/CAD who underwent an AVR/CABG. It
14 was reported that HM was sedated by Dr. Chang during placement of invasive monitors,
15 and he became apneic requiring respiratory support. The intervention was performed by
16 OR personnel as Dr. Chang had left the OR after administering IV Propofol to the patient.
17 The remainder of the intraoperative anesthetic course was unremarkable. The remainder
18 of the hospital course was also unremarkable, and HM was discharged home in
19 satisfactory condition.

20 9. The standard of care requires a physician to give report regarding a patient
21 and transfer care to the treating personnel. Respondent deviated from this standard of
22 care for Patient KO by failing to give report regarding the patient and transfer care to the
23 treating nursing personnel upon arrival in the PACU.

24 10. The standard of care requires an anesthesiologist to remain present at the
25 bedside to attend to anesthetized patients. Respondent deviated from the standard of

1 care for Patients MA, LN and HM by failing to remain present at the bedside while
2 administering anesthesia to a patient.

3 11. There was the potential for patient harm in that all four patients were at risk
4 of improperly addressed adverse events during periods when Respondent was
5 unavailable.

6 12. Respondent has relocated to California and is not currently practicing
7 medicine in Arizona.

8 13. Effective January 9, 2023, Respondent's Arizona medical license expired
9 due to non-renewal and the expiration is stayed pending the outcome of this matter.

10 **CONCLUSIONS OF LAW**

11 a. The Board possesses jurisdiction over the subject matter hereof and over
12 Respondent.

13 b. The conduct and circumstances described above constitute unprofessional
14 conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or
15 might be harmful or dangerous to the health of the patient or the public.").

16 **ORDER**

17 IT IS HEREBY ORDERED THAT:

18 1. Respondent is issued a Letter of Reprimand.

19
20 DATED AND EFFECTIVE this 4th 31st day of August, 2023.

21 ARIZONA MEDICAL BOARD

22
23 By Patricia E. McSorley
24 Patricia E. McSorley
25 Executive Director

CONSENT TO ENTRY OF ORDER

1
2 1. Respondent has read and understands this Consent Agreement and the
3 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent
4 acknowledges he has the right to consult with legal counsel regarding this matter.

5 2. Respondent acknowledges and agrees that this Order is entered into freely
6 and voluntarily and that no promise was made or coercion used to induce such entry.

7 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to
8 a hearing or judicial review in state or federal court on the matters alleged, or to challenge
9 this Order in its entirety as issued by the Board, and waives any other cause of action
10 related thereto or arising from said Order.

11 4. The Order is not effective until approved by the Board and signed by its
12 Executive Director.

13 5. All admissions made by Respondent in this Order are solely for final
14 disposition of this matter and any subsequent related administrative proceedings or civil
15 litigation involving the Board and Respondent. Therefore, said admissions by Respondent
16 are not intended or made for any other use, such as in the context of another state or
17 federal government regulatory agency proceeding, civil or criminal court proceeding, in the
18 State of Arizona or any other state or federal court.

19 6. Notwithstanding any language in this Order, this Order does not preclude in
20 any way any other State agency or officer or political subdivision of this state from
21 instituting proceedings, investigating claims, or taking legal action as may be appropriate
22 now or in the future relating to this matter or other matters concerning Respondent,
23 including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent
24 acknowledges that, other than with respect to the Board, this Order makes no
25 representations, implied or otherwise, about the views or intended actions of any other

1 state agency or officer or political subdivisions of the State relating to this matter or other
2 matters concerning Respondent


3 7. Upon signing this agreement, and returning this document (or a copy thereof)
4 to the Board's Executive Director, Respondent may not revoke the consent to the entry of
5 the Order. Respondent may not make any modifications to the document. Any
6 modifications to this original document are ineffective and void unless mutually approved
7 by the parties.

8 8. This Order is a public record that will be publicly disseminated as a formal
9 disciplinary action of the Board and will be reported to the National Practitioner's Data
10 Bank and on the Board's web site as a disciplinary action.

11 9. If the Board does not adopt this Order, Respondent will not assert as a
12 defense that the Board's consideration of the Order constitutes bias, prejudice,
13 prejudgment or other similar defense.

14 10. *Respondent has read and understands the terms of this agreement.*

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DAVID C. CHANG, M.D.

DATED: 5/17/23

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EXECUTED COPY of the foregoing mailed
this 3rd day of August, 2023 to:

David C. Chang, M.D.
Address of Record

Gary Fadell, Esq.
Fadell, Cheney & Burt
1601 North 7th Street Suite 400
Phoenix, Arizona 85006-2296
Attorney for Respondent

ORIGINAL of the foregoing filed
this 3rd day of August, 2023 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Proby
Board staff