

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

In the Matter of the First Amended)	
Accusation and Petition to Revoke)	
Probation Against:)	
)	
MARY CHARLENE MURPHY, M.D.)	Case No. 800-2014-007772
)	
Physician's and Surgeon's)	OAH No. 2016050898
Certificate No. G 74754)	
)	
Respondent)	
_____)	

DECISION

The attached Proposed Decision 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 3, 2017.

IT IS SO ORDERED January 4, 2017.

MEDICAL BOARD OF CALIFORNIA

By: Michelle Anne Bholat M.D.
**Michelle Anne Bholat, M.D., Chair
Panel B**

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DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the First Amended
Accusation and Petition to Revoke
Probation Against:

MARY CHARLENE MURPHY, M.D.,

Physician's and Surgeon's Certificate No.
G74754,

Respondent.

Case No. 8002014007772

OAH No. 2016050898

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on October 31, and November 1, 2016, in San Diego, California.

Lori Jean Forcucci, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

David Rosenberg, Attorney at Law, Rosenberg, Shpall, and Zeigen, APLC, represented respondent, Mary Charlene Murphy, M.D., who was present.

A week before the hearing respondent asked for a continuance because she had just retained counsel and counsel wanted time to prepare on her behalf. Complainant opposed this motion and the motion was denied. The matter was submitted on November 1, 2016.

SUMMARY

Complainant asserted that respondent's license should be revoked because while she was on disciplinary probation, she committed gross negligence, repeated negligent acts, failed to accurately and adequately chart medical records, and committed dishonest and corrupt acts relating to her care of patients A.C. and C.H. For the reasons stated in this decision it is determined that respondent is presently not amenable to remain on probation and the public

interest requires that the stay of revocation previously imposed on respondent be vacated and her license to practice medicine be revoked.

FACTUAL FINDINGS

Jurisdiction

1. On August 25, 2016, Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), filed the First Amended Accusation and Petition to Revoke Probation. The initial accusation was filed on March 16, 2016. Respondent timely filed a Notice of Defense.

The First Amended Accusation and Petition to Revoke Probation alleged that respondent committed gross negligence and repeated negligent acts, was incompetent, was dishonest, failed to maintain adequate or accurate records, and committed general unprofessional conduct in her care and treatment of patients A.C. and C.H. The First Amended Accusation and Petition to Revoke Probation further alleged as a cause to revoke probation that respondent violated sections of the Business and Professions Code regarding her care of both patients and she failed to comply with the term of her probation that required she obey all laws.

License History and July 27, 2011, Discipline

2. On July 23, 1992, the Board issued Physician's and Surgeon's Certificate Number G74754 to respondent. The certificate is current and will expire on December 31, 2017, unless renewed.

3. On June 27, 2011, effective July 27, 2011, in the action entitled *In the Matter of the Accusation Against Mary Charlene Murphy, M.D.*, Case No. 10-2008-193683, the Board adopted the Stipulated Settlement and Disciplinary Order respondent signed on May 6, 2011. The accusation, which was filed on June 22, 2010, alleged that respondent committed gross negligence and repeated negligent acts with regards to five patients and falsified a medical record of one of those patients. Respondent admitted the truth of the allegations detailed in the accusation

By the terms of the stipulated agreement and disciplinary order, respondent was placed on probation for five years, suspended from practice for 30 days, required to take education, ethics and medical records keeping courses and enroll in and successfully complete a clinical training program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California-San Diego School of Medicine. Respondent was also required to have a practice monitor. Respondent was required to enroll in the medical record keeping class and PACE program within 60 calendar days of the effective date of the decision.

Among the terms and conditions, Condition 9 required that respondent "obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders."

4. The specific allegations in the accusation involved surgical procedures respondent performed on patients L.M., C.R., S.V., N.M. and K.G. In her stipulated agreement, respondent admitted that she committed gross negligence when she decided to have L.M., a medically fragile elderly patient, undergo a "contraindicated" gastric surgical procedure on April 24, 2006, that contributed to his death three days after the surgery and when she utilized the wrong limb to form C.R.'s colostomy on March 5, 2007.

Respondent, further, admitted that on January 5, 2008, she committed repeated negligent acts with regards to her care of patient S.V. when she performed a contraindicated abdominal surgery on S.V.; on April 25, 2008 she caused devascularization of N.M.'s transverse colon during the laparoscopic procedure she performed on S.V.; and on re-exploration of N.M. the day after the laparoscopic procedure, she failed to convert to an open procedure in a timely manner. In addition, respondent admitted she was negligent when she performed an overly aggressive surgical procedure on patient K.G. on June 27, 2007.

Respondent, also, as detailed in the accusation, admitted that she falsified patient C.R.'s medical records when she omitted in her operative report that she had utilized the wrong limb to form C.R.'s colostomy.

5. Although her probation was set to terminate in July 2016, respondent is still on probation because she has not paid her probation monitoring costs and, further, the accusation in this matter was filed on March 25, 2016, before her probation was set to expire. Under Condition 16 of the Board's decision, respondent's probation is automatically extended until this present matter is final. She otherwise has complied with the terms of her probation, including taking and successfully completing medical records keeping course and PACE, although no evidence was offered regarding when she completed these programs.

Patient A.C.

6. The Sherman Heights Family Health Care Clinic (SHFHC) referred A.C., a 35-year-old woman with possible cancer in her left breast, to respondent on October 24, 2013. On November 6, 2013, respondent first saw A.C., conducted a history and physical of her, and scheduled her for an excisional biopsy on November 8, 2013, at her office.

On November 8, 2013, respondent performed the excisional biopsy of A.C.'s left breast. As a local anesthetic, according to her operative report, she administered a 50 ml dose of 1% Lidocaine with epinephrine (Lidocaine). During the procedure, respondent's friend, B.L., accompanied A.C. and helped translate for her. On October 15, 2015, a Health Quality Investigation Unit investigator interviewed respondent about the procedure (interview).

Respondent confirmed that B.L, who was not medically trained, may have opened a sealed sterile package, a scalpel and gauze, and “dropped” them in the sterile field.¹

In respondent’s Operative Report dated November 8, 2013, documenting the procedure, respondent wrote that she obtained a specimen from the excisional biopsy, “immediately” placed the specimen in formalin, and sent it to the laboratory, San Diego Pathology. In fact, respondent failed to send the biopsy to the laboratory until May 17, 2014.

Postoperatively, respondent saw A.C. on November 18, 2013. She documented that there was bruising in the left breast and A.C. had pain. Respondent noted that the pathology report was pending.

On December 3, 2013, respondent again saw patient A.C. for her second postoperative visit. Respondent noted that patient A.C.’s left breast wound appeared “well-healed” and that the pathology result was still pending. She wrote “Path?” and she circled the letter “P.” She recorded that she would follow up “on path.”

On March 14, 2014, patient A.C. went to SHFHC with complaints of increasing left breast discomfort. SHFHC asked that respondent see patient A.C. for follow-up regarding the “[left] breast cyst removal from 10/25/13.”

On March 25, 2014, respondent saw patient A.C. She performed a physical and history documenting that approximately one month earlier, A.C. had noticed an egg-sized lump in the left breast in the area of the previously-healed biopsy. At her interview respondent admitted that she mistook A.C.’s pathology report for another patient’s pathology report and erroneously thought that A.C. had a tissue diagnosis of Granulomatous Mastitis (G.M.).²

Respondent further documented that the area on A.C.’s left breast was tender and appeared red. She noted a 2-3 cm left axillary lymphadenopathy, and wrote “given a diagnosis of [G.M.],” a course of steroids “is indicated” because G.M. is “responsive to” steroids. Respondent further recorded that if there was no improvement with the steroids, then the patient would need another left breast biopsy.

¹ Respondent did not have a specific recollection that B.L. opened the sterile package at her Health Quality Investigation interview. She stated at the October 15, 2015, interview that she has had family members or translators open items and drop them in the field. B.L. had, apparently, told the Health Quality Unit Investigator that she handed items to respondent during the procedure. B.L. did not testify in this proceeding. However, during her testimony in this proceeding respondent admitted that B.L. opened a package or packages and dropped the items in the field. Respondent denied that the surgical field’s sterility was compromised.

² Granulomatous Mastitis is condition that manifests like cancer but is benign.

On May 15, 2014, respondent had her last appointment with A.C. Respondent again documented that A.C. had a history of G.M., and noted the absence of patient A.C.'s pathology report with the notation "Path?" Respondent found that the left breast pain was improved, but patient A.C. still had a mass with some pain, and respondent felt that she would need another excisional biopsy. A.C. became upset and asked for a referral to another physician. As she stated in her interview, at this time respondent made an effort to find the pathology report. She checked her filing system and called all four laboratories she used, but she was unable to trace the biopsy during the patient's visit, and reported this to A.C.

Later that day on May 15, 2014, respondent found A.C.'s untested biopsy specimen from the excisional biopsy she performed on November 8, 2013, which she recorded on November 8, 2013, that she had sent to San Diego Pathology. She found the specimen in the cupboard of her examination room. At her October 15, 2015 Health Quality Investigation Unit interview, respondent explained that at the time her office "arrangements were in kind of uproar" and she "lost [her] usual procedures for handling [specimens]." She added that during that time she did not have anyone at her office to whom she could give the specimen.

On May 17, 2014, two days after she found A.C.'s specimen in her office cupboard, respondent sent the specimen to Quest Diagnostic Laboratories for histological evaluation. Quest Diagnostic Laboratories received this specimen on May 20, 2014, showing patient A.C.'s name, and the procurement date of November 8, 2013. In the pathology report, Bruce Shirer, M.D., the pathologist, wrote that the specimen revealed mostly fibrocystic disease with a small focus of markedly atypical cells suspicious for malignancy.

Subsequent testing on June 3, 2014, revealed that A.C. had a Grade III cancer. She underwent preoperative chemotherapy from June 17, 2014, to October 7, 2014, with a good response; had scheduled surgery on November 2, 2014, and underwent postoperative radiation.

A.C.'s "October 25, 2013," and "November 6, 2013," History and Physical Notes

7. Relating to her November 6, 2013, evaluation of A.C., respondent prepared two different handwritten History and Physical notes. She sent one to SHFHC on December 20, 2013, and the other, with multiple entries that were not in the note she sent SHFHC, were in the medical record she provided the Health Quality Investigation Unit. For some reason, the note she sent SHFHC was dated "10/25/13." SHFHC gave this copy to the Health Quality Investigation Unit.³ A fax time stamp on this note was dated December 20, 2013, and contained the name "Dr. Murphy." The SHFHC note respondent gave the Health Quality Investigation Unit had the "10/25/13" date on it, but that date was crossed-out and the date "11/08/13" was interlineated with the "06" further interlineated over the "08" in order to identify a date of "11/06/13."

³ A.C. was originally scheduled to see respondent on October 25, 2013, and the date was included in the form respondent completed.

Further, respondent prepared a typewritten note dated November 8, 2013, that also documented the examination she performed on A.C. on November 6, 2013. This typewritten note referenced physical findings listed on the "11/06/13" handwritten note respondent gave the Healthy Quality Investigation Unit.

Patient C.H.

8. On or about August 2011, Carrie Costantini, M.D., a medical oncologist, referred C.H.,⁴ a 41-year-old female, to respondent, after C.H. had been diagnosed with right breast cancer in 2010, with no metastatic disease in 2010. C.H. had undergone chemotherapy but delayed having further surgery. Respondent and C.H. discussed the need for a right modified radical mastectomy and, at C.H.'s request, a prophylactic left simple mastectomy.

On February 23, 2012, C.H. returned to see respondent for a planned right modified radical mastectomy and left simple mastectomy scheduled for April 13, 2012.

On April 13, 2012, respondent performed a right modified radical mastectomy and left simple mastectomy on C.H. and placed three drains into C.H. On the dictated preoperative history, respondent recorded C.H.'s vital signs as follows: blood pressure: 120/84; heart rate: 90s; temperature: 98.1; O2 saturation: 97 percent on room air. At her May 4, 2016, interview, respondent admitted she "used" the vital signs Dr. Costantini recorded in her February 8, 2012, notes as C.H.'s vital signs on April 13, 2012.⁵ Respondent did not document the source of those vital signs in C.H.'s medical record.

In the operative report she prepared, respondent noted that she obtained a specimen of "axillary tissue" that she sent to the pathology lab. In a report dated April 18, 2012, pathologist Doug J Ellison, M.D., found no lymph nodes present in the specimen respondent obtained. Due to Dr. Ellison's failure to find lymph nodes in the tissue sample, respondent communicated with Dr. Costantini and other oncologists in order to see how C.H.'s treatment would proceed and, specifically, whether they would be willing to extend the radiation field. She expressed reluctance to Dr. Costantini to re-explore the area to obtain lymph nodes due to the possibility of damage to an artery or nerve.

Investigator Duncan Fraser interviewed C.H. by phone on November 5, 2015, who told him that on April 16, 2012, she presented for her first postoperative visit with respondent. C.H. had a large band of black skin that went across her chest to her back. Respondent removed the dead skin. This visit was not documented in patient C.H.'s medical record.

⁴ Dr. Costantini is spelled "Constantini" throughout C.H.'s chart, but in her own notes Dr. Costantini spelled her name "Costantini."

⁵ The vital signs were the same with the exception of C.H.'s heart rate which Dr. Costantini recorded as 104. Respondent recorded it in the 90s.

C.H. told Investigator Fraser that she presented for her second postoperative visit with respondent on April 18, 2012, and was experiencing excessive wound leakage. C.H. further reported that respondent placed absorbable sutures to try to close the skin and stop the leakage. C.H. continued to leak from the sutures. This reported visit was also not documented in patient C.H.'s medical record.

C.H. said she presented to respondent on April 19, 2012, for her third postoperative visit and respondent added more sutures to the wound. Respondent noted a record of this visit in C.H.'s medical chart but did not record that she added sutures. C.H. reported pain which was being managed by pain medication. As her plan respondent prescribed pain medication for C.H., indicated that she would follow-up with C.H. in one week, and would send C.H.'s records to Dr. Costantini and the oncology group. Respondent identified three drains and the fluid output from the drains over a two day period. Respondent noted that C.H. had epidermolysis⁶ on both mastectomy incisions, without acute wound infection.

C.H. told the investigator that she returned to see respondent due to problems with fluid from the drainage on April 23 or 24, 2012, and that respondent applied more gauze to the wound. Such a visit was also not documented in C.H.'s chart.

C.H. said she returned to see respondent on May 8, 2012, which respondent documented. Respondent noted that C.H. was having "clear drainage" when she stood up or bent over. However, respondent did not document either the existence or removal of patient C.H.'s drains. Respondent and patient C.H. discussed a debridement surgery to clean up the wound and try to close it. C.H. was scheduled for an operative breast wound debridement and wound closure on May 9, 2012. C.H. cancelled the procedure and transferred her care to another physician. Patient C.H. continued her medical and cancer care with the new health care provider.

Doctor Dabadghav's Testimony

9. Ninad Dabadghav, M.D. graduated from Rush Medical College in 1985 and has worked as Staff Surgeon in the Department of Surgery at Kaiser Hospital in Santa Clara since 1991. Dr. Dabadghav also serves as Clinical Associate Professor of Surgery at Stanford University and has been an Expert Reviewer for the Medical Board since 2014. He is certified by the American Board of Surgery.

Dr. Dabadghav reviewed A.C.'s and C.H.'s medical records and the transcription of respondent's interviews with the Division of Health Quality Investigation, among other materials. Dr. Dabadghav prepared detailed reports of his findings relating to respondent's care of patients A.C. and C.H. Dr. Dabadghav testified consistent with his reports. Dr. Dabadghav addressed respondent's conduct, the applicable standards of care and departures from the standards of care.

⁶ Epidermolysis is "the state of loosening or detachment of the epidermis" according to www.merriam-webster.com.

RESPONDENT'S FAILURE TO TIMELY SEND PATIENT A.C.'S BREAST BIOPSY SPECIMEN FOR TESTING

10. Dr. Dabadghav first addressed respondent's failure to timely send A.C.'s biopsy specimen to the lab for testing. The standard of care required respondent to make every effort to ensure that the biopsy specimen was sent to a lab for analysis and be able to explain any delay. It is the physician's duty to follow up and make sure that this is done. The timeline to obtain a biopsy from a lab is five to seven days.

Respondent violated the standard of care and committed an extreme departure from this standard when she "flagrant[ly]" mishandled A.C.'s breast biopsy specimen causing a five month delay in the diagnosis of Stage IIIB breast cancer. Dr. Dabadghav commented that respondent's explanation that her "office environment were [sic] in a kind of uproar" and she "lost our usual procedures for handling: the specimen," as she stated at her interview, did not relieve her of her duty to comply with the standard of care.

RESPONDENT'S MISDIAGNOSIS AND TREATMENT OF A.C.

11. Dr. Dabadghav next discussed the standard of care applicable to respondent's mistaken diagnosis of Granulomatous Mastitis (G.M.). He identified the applicable standard of care as follows: Prior to seeing a patient, a doctor has the responsibility to review the reasons, especially for a returning patient, the patient is seeing the doctor, the patient's medical history, and future work up and/or plans for follow up. If data is missing it is the doctor's duty to follow up on the deficiency and update the chart in a timely manner.

Dr. Dabadghav concluded that respondent violated this standard of care when she mistakenly diagnosed A.C. with G.M. Respondent admitted at her interview she mistook A.C.'s pathology report with another patient's pathology report and erroneously thought that A.C. had a tissue diagnosis of G.M. Her conduct represented an extreme departure from the standard of care because she didn't adequately review A.C.'s medical chart and failed to follow up with the status of A.C.'s specimen. Due to her failure to adequately review A.C.'s chart, she treated A.C. with a steroid which was not appropriate for a patient like A.C. with cancer. Respondent continued to fail to adequately review A.C.'s chart until she found A.C.'s biopsy specimen in her office on May 15, 2014. Respondent committed this error despite seeing A.C. on November 18, 2013, and December 3, 2013, documenting that A.C.'s pathology report was pending and there was not a hard copy of the pathology report in A.C.'s records.

RESPONDENT'S FAILURE TO MAINTAIN ADEQUATE AND ACCURATE MEDICAL RECORDS.

12. Regarding respondent's failure to adequately and accurately maintain A.C.'s medical records, Dr. Dabadghav stated that the standard of care requires that for each patient encounter, the doctor must accurately document the patient's history and physical condition, relevant medical and/or treatment options and future work up or plans for follow up. The

doctor must do this in a timely manner and sign the record. Further, the doctor must write amendments or corrections to the record in a separate document with a clear date and time stamp of the changes he or she made.

Dr. Dabadghav found that respondent committed an extreme departure from the applicable standard of care with respect to a handwritten note dated November 6, 2013, respondent wrote documenting A.C.'s first visit. Respondent had sent this note to SHFHC, who referred A.C. to her, with a fax stamp of December 20, 2013. In contrast, the note in the medical chart contained additional findings that were not contained in the note respondent sent to SHFHC, although this note in the chart corresponded to the findings contained in the typed History and Physical (H&P) report dated November 8, 2013. Dr. Dabadghav concluded that respondent made changes to the November 6, 2013, note found in her medical chart on or after December 20, 2013, at least six weeks after she saw A.C. He testified that respondent should have signed and dated any changes she made and the disparity in the notes indicated that respondent manipulated or tampered with A.C.'s medical record.

RESPONDENT'S ADMINISTRATION OF LIDOCAINE WITH EPINEPHRINE TO A.C.

13. With respect to that claim that respondent administered an excessive dosage of 1% Lidocaine with epinephrine to A.C. on November 8, 2013, Dr. Dabadghav testified that the standard of care required a physician to be familiar with the medication and the physician must know the recommended age- and/or weight-related dosages, as well as the toxicity dosage levels of the drug. It is crucial, he noted, that if a toxic drug dose is given to the patient that the doctor examine and check the patient's vitals after the procedure. For 1% Lidocaine with epinephrine, the maximum dose should not exceed 7.5 mg/kg. If the patient has received near the maximum limit the patient should be examined for Lidocaine toxicity and monitored for 10 to 15 minutes.

Dr. Dabadghav found that respondent committed an extreme departure from the standard of care because she administered 500 mg of Lidocaine to A.C. when the maximum dose for A.C. was 495 mg, considering A.C.'s weight, and respondent did not document that she monitored A.C. postoperatively. Respondent appeared to not know the correct calculation and dosing of 1% Lidocaine with epinephrine when she stated at her October 15, 2015, interview that she believed that the dosage she administered to A.C. was "a lot below what I would use and a lot less than anything approaching toxicity level."

RESPONDENT OBTAINED ASSISTANCE FROM A.C.'S FRIEND TO ASSIST IN THE PROCEDURE

14. With respect to the allegation that respondent obtained assistance from A.C.'s friend to open sterile packaging during A.C.'s procedure, Dr. Dabadghav described the standard of care as follows: A physician must follow strict aseptic and sterility protocols to create a uniform standard of asepsis, sterility and cleanliness in any operating suite environment. Each physician should incorporate and adhere to locally standardized aseptic and sterility protocols tailored to the physician's specific practice; have medically trained staff

in the operating area at all times; and each physician needs to develop and follow a standardized workflow for how specimens are labeled, processed, stored and transported to a pathology laboratory.

Respondent stated at her October 15, 2015, interview that she did not recall B.L. handing her implements but she might have asked a patient, translator or family member to open the package and "drop[] it" in the surgical field. However, at this hearing, respondent admitted that she asked B.L. to open a package or packages containing a scalpel or gauze, although she said she couldn't remember specifics. B.L. told the investigator that respondent asked her to hand her a scalpel and then a piece of gauze.

Dr. Dabadghav found two departures from the standard of care with respect to this issue. He concluded that respondent committed an extreme departure from the standard of care when she used an unqualified and non-medically trained person to handle and open sealed packages containing sterile medical supplies. He also found that respondent committed a simple departure because she did not have a qualified medical assistant at the time she performed the procedure. He further found that respondent committed a simple departure because she did not follow a standardized workflow for handling A.C.'s procured biopsy specimen.

FAILURE TO ADEQUATELY CHART PATIENT C.H.'S POSTOPERATIVE CARE AND
RESPONDENT FAILED TO ADEQUATELY CHART C.H.'S MINOR POSTOPERATIVE
PROCEDURES

15. As Dr. Dabadghav detailed in his report, the applicable standard of care requires that a physician give a patient who has undergone a major surgical procedure a clear description and parameters of basic home wound care and management. The operating physician is also required to give the patient documented and appropriately timed postoperative appointments with a brief description of these appointments. These appointments must be documented in the patient's chart. If drains are involved for a radical mastectomy the patient should be given clear instructions on drain care and output. If at any of the postoperative visits there needs to be minor procedures performed, such as drain removal or removal of sutures or wound debridement or opening under local anesthetic, these procedures must be performed in a clean, well-lit environment where a patient can lay supine.

In his evaluation of respondent's compliance with these standards, Dr. Dabadghav reviewed C.H.'s statements to the Division of Health Quality Investigation investigator regarding her post-operative care, respondent's statements at her interview, and C.H.'s medical records.⁷

⁷ C.H.'s statements to Investigator Fraser were considered as administrative hearsay under Government Code section 11513.

C.H. told Investigator Fraser that she saw respondent after her April 13, 2012, radical mastectomy on April 16, 18, and 19, 2012, and May 8, 2012. But only the April 19, 2012, and May 8, 2012, visits were documented in C.H.'s chart. C.H. said she was scheduled to see respondent on May 9, 2012, but she cancelled that appointment. At the first two postoperative visits she told the investigator that respondent removed the dressings and performed an in-office debridement of the wound. As a result, C.H. had clear leakage from the wound and returned to respondent's office on April 18, 2012. C.H. said respondent placed absorbable sutures to try to close the skin and stop the leakage. This was not successful and she still had leakage from the wound. C.H. said that she saw respondent on April 23, or 24, 2012, and again on May 8, 2012, after she left messages for respondent that fluid was "pouring out" of the wound. At the May 8, 2012, visit respondent removed the drains and discussed with C.H. having surgery to "clean the wound and try to close it."

Respondent documented on May 9, 2012, that she evaluated C.H. on May 8, 2012, but did not mention C.H.'s drains. Dr. Dabadghav noted that respondent said at her interview that as C.H.'s surgeon, it was her practice to remove the drains herself and she believed that she removed the drains sometime between April 19, and May 8, 2012. Dr. Dabadghav concluded that respondent removed the drains on or before May 8, 2012, but that she did not document the visit or procedure.

Regarding the issue of C.H.'s documentation of other surgical procedures she performed on C.H., Dr. Dabadghav noted that respondent said at her interview that she may have seen C.H. before April 19, 2012, and performed some minor postoperative wound care like a limited wound debridement of C.H.'s mastectomy incisions and re-suturing one of C.H.'s drains.⁸ These procedures were not documented in C.H.'s medical record.

Dr. Dabadghav concluded that respondent committed two extreme departures with respect to her documentation of the postoperative care she provided C.H. He found that respondent committed an extreme departure because there was inadequate and a lack of proper documentation of C.H.'s multiple postoperative visits, and she also committed an extreme departure for not documenting multiple minor postoperative procedures done on C.H.

IMPROPER DOCUMENTATION IN THE MEDICAL RECORD

16. Dr. Dabadghav testified that any physician who performs a preoperative history and physical on a patient must have done so within 30 days of the procedure. The vital signs taken and documented in the History and Physical (H&P) need to be as current as possible

⁸ At respondent's May 4, 2016, interview, Dr. Murray recited C.H.'s statements to Investigator Fraser that between April 19, and April 23, 2012, respondent did "some stitching" and "some debriding," as she termed it, and that these procedures happened in her office. Dr. Murray asked respondent detailed questions about the performance of these procedures. Throughout her responses, respondent acknowledged that she performed the procedures and at the hearing she did not seek to clarify her statements or deny that she made them.

and cannot be greater than 24 hours old. If the vital signs are from another medical care provider's H&P, this needs to be clearly documented.

In respondent's dictated April 13, 2012, preoperative history, respondent admitted at her interview that she had taken C.H.'s vital signs from Dr. Costantini's February 8, 2012, H&P. These vital signs were outdated and unusable. Dr. Dabadghav concluded that this was a simple departure from the standard of care.

RESPONDENT REPORTED DOING AN ANATOMICALLY CORRECT LYMPH NODE DISSECTION THAT FAILED TO YIELD ANY LYMPH NODES.

17. In addition, Dr. Dabadghav found that respondent committed a simple departure from the standard of care when she performed right axillary node dissection that did not yield any lymph nodes. He described this result as "very unusual" and "unexpected" and that as a result "this situation is somewhat a deviation from the norm." He commented in his report that respondent should have been able to obtain some "lymphoid aggregates." He further commented that respondent described in her operative report that she did an anatomically correct lymph node dissection, when, in fact, she may not have, but he conceded that he cannot "prove or disprove this theory."

On cross examination, Dr. Dabadghav admitted that the pathologist who reviewed the specimen may have missed the diagnosis of the tissue or done an inadequate analysis. He also admitted that C.H. may have had an aberrant anatomy that made it difficult to obtain lymph nodes.

RESPONDENT LEFT DRAINS IN C.H. FOR LONGER THAN WOULD BE EXPECTED

18. Dr. Dabadghav also found that respondent left the drains in C.H. for longer than would be expected, considering that the drains were not functioning, painful to C.H., and were left in C.H. beyond the standard timeframe for a postoperative drain from a modified radical mastectomy wound. In his report, Dr. Dabadghav acknowledged that it was "unclear exactly when the drains were removed" and he concluded that the drains must have been removed on May 8, 2012, because this was C.H.'s last visit with respondent.⁹ He found a simple departure for this conduct. With respect to his conclusion, Dr. Dabadghav did not explain what he meant by the "standard timeframe" for the drains to be removed and, further, the factual basis for his conclusion that respondent removed the drains on May 8, 2012, appeared based on C.H.'s statements to Investigator Fraser. However, respondent said in her interview that she believed she removed the drains between April 19, and May 8, 2012.

⁹ Dr. Dabadghav wrote in his report that C.H. told Investigator Fraser that respondent removed the drains but C.H. did not state this in her interview. C.H. died on March 24, 2016.

Respondent's Testimony

19. Respondent graduated from Thomas Jefferson Medical College in Philadelphia in 1991. She was on active duty in the Navy from 1991 until 2000, when she was honorably discharged. In the Navy, she did an internship at the Naval Hospital and was assigned to a repair ship as the ship's medical doctor. After two years she was "given a spot" in general surgery and was a resident in general surgery from 1994 to 1998. She was then assigned as the surgeon for the John Stennis carrier group and later rotated to the Naval Hospital where she was a staff surgeon.

After discharge from the Navy, she joined a medical group of general surgeons and had privileges at Scripps and in Chula Vista. She was board certified in 2000 and recertified in 2010. She has been in solo practice since 2004. She no longer holds privileges at any hospital.

Regarding patient A.C., respondent said she had an independent recollection of her. She denied that she falsified A.C.'s medical record and stressed that she accurately described in detail the examination she conducted on November 6, 2013, as documented in the record she sent to the Division of Health Quality Investigations. As proof of this, respondent stressed that the November 8, 2013, report accurately documented the November 6, 2013, examination she performed. Respondent explained that sometime after December 20, 2013, she corrected the handwritten note to accurately reflect the November 6, 2013, examination she performed on A.C. and relied upon the November 8, 2013, typewritten report she prepared. Respondent did not explain why she decided to make these corrections after December 20, 2013.

With respect to her failure to send A.C.'s biopsy to the pathology lab until May 17, 2014, respondent explained that it was her custom and practice to give the specimen to her secretary. If she did not get the lab report within two weeks she would call the lab. In this case, respondent said she understood, albeit mistakenly, that the lab report indicated that A.C. had G.M, explaining that she "lost [her] normal procedures for handling specimens," and she did not have a secretary to whom she could give the specimen. It was her intention to handle the specimen herself and she could not explain what went wrong although she has tried to understand what happened and was clearly very upset about it. Respondent did not blame anyone but herself for the mistake.

It was not until May 15, 2014, that respondent discovered that she did not have a hard copy of the lab report and found A.C.'s specimen on that date. She said that she has sent over 200 specimens to labs and it never occurred to her before this incident that this mistake had happened. When she learned that she made this mistake, she became very upset, made sure that the specimen was sent to the lab, and she followed up with the lab.

Concerning her dosage of 1% Lidocaine with epinephrine to A.C., she explained that, contrary to what she said at her October 15, 2015, interview, she knew the safe dosage of Lidocaine she needed to administer. Respondent said that she panicked when she told the board's medical consultant Brian Murray, M.D., that she did not calculate "the maximum

dosage of the lidocaine with epinephrine that [A.C.] should have given her weight” because the amount she gave A.C. was “quite a lot less than anything approaching toxicity level.” Respondent testified that, in fact, she knew the toxicity level for Lidocaine with epinephrine.

Respondent added that she monitored A.C. after she administered the Lidocaine and A.C. did not have a toxic reaction to the medication.

Concerning whether B.L., A.C.’s friend and interpreter, contaminated the sterile surgical field when she opened a sterile package containing surgical items and handed them to respondent, respondent testified that B.L. handed her items though she did not recall the specifics. Respondent, however, denied that the sterile surgical field was compromised. She explained that B.L. opened a “couple of packages” for her and never touched the contents. Respondent added that if B.L. did touch the instruments she would have thrown the item or items away.

Concerning C.H., respondent said she saw C.H. on April 19, 2012, after the radical mastectomy performed on April 13, 2012, and again on April 19, 2012, and would have asked C.H. about the output from the drains. Respondent said that the drains were painful to C.H. Respondent acknowledged that she said at her interview that she believed she removed the drains at some time after April 19, 2012, and before May 8, 2012.

Respondent denied that she left the drains in too long. She said she needed to tailor C.H.’s use of the drains to the possibility of infection versus the amount of fluid that was draining. She did not believe the amount of C.H.’s fluid drainage indicated a contrary conclusion. As a factor for leaving the drains in as long as she did, respondent said C.H.’s wound area was being kept dry.

With respect to her inability to obtain lymph nodes from the dissection she performed, respondent said she felt she conducted a good lymph node dissection and obtained a good size specimen but was unable to obtain lymph nodes due to C.H.’s “very fibrotic” breast tissue. Respondent documented the difficulty she had obtaining a specimen with lymph nodes in a communication to the pathologist, Dr. Ellison. As a result of her inability to obtain lymph nodes, respondent consulted with oncologists to see if they would be able to “extend the radiation field.” She expressed that she did not want to re-explore the area due to the possibility that she may damage a nerve or artery.

Respondent added in her testimony that in C.H.’s case, the presence of lymph nodes would not have changed the course of her treatment.

Respondent addressed C.H.’s report to Investigator Fraser that she had multiple post-operative visits, aside from the visits that respondent documented on April 19, 2012, and May 8, 2012. Respondent said that “it is hard to imagine [C.H.] would remember the visits three years after respondent saw her.” She also admitted that it was possible a progress note may have been misfiled, but did not elaborate.

During the time she treated A.C. and C.H., respondent's husband developed Alzheimer's and by 2012 this disease fully manifested itself. He rapidly declined and passed away in 2015. Respondent did not address how his condition affected her ability to practice medicine and whether his illness played a role in the conduct at issue in this proceeding. It is certainly understandable that it would have had an impact.¹⁰

Respondent wants to keep her license so that she can take care of her family. She accepted responsibility for her failure to get A.C.'s specimen to the lab timely and emphasized that she never made such a mistake before. She stated that she has been in compliance with the terms of her probation, except for the payment of probation monitoring costs. Respondent has been unable to pay these costs due to the financial hardship she was under since she was placed on probation. Respondent noted that she recently sold her home in order to place her in a better position financially. She does not believe that she is a risk to patients.

Overall, respondent's testimony was credible. She answered questions about her conduct in a candid and direct manner to the extent her recollection allowed with the exception of her failure to offer or attempt to offer an explanation regarding why she made changes to the record of her November 6, 2013, evaluation of A.C. after December 20, 2013. Her lack of any explanation suggested she was being less than candid or forthcoming on this issue. But, the record with the additions she made to this note appeared to accurately reflect the exam she performed, based on her typewritten report dated November 8, 2013. It cannot be concluded, thus, that she altered this record for an improper, dishonest or fraudulent purpose.

Character Evidence

20. Two individuals testified on respondent's behalf as character witnesses. A. Grant Kingsbury, M.D. is a licensed physician who is board certified in internal medicine and has known respondent professionally since 1997. Dr. Kingsbury and respondent have shared hundreds of patients and he has referred many surgical patients to her. He said that he cannot recall any negative outcomes from any of those patients or that respondent performed below the applicable standard of care and he has no concerns about her as a general surgeon. Dr. Kingsbury said that he has not known respondent to be forgetful or unorganized. He added that respondent has an excellent bedside manner. He said that her colleagues had a good opinion of her and she had a very good reputation for honesty and integrity. Dr. Kingsbury acknowledged that he has not talked to anyone about respondent since she was placed on probation in July 2011.

Carla Jean Desjardins, R.N., has worked with respondent and other surgeons and they became friends. Respondent performed surgery on her in 2001. During the time she worked for respondent, she saw respondent interact with patients numerous times. She treated

¹⁰ In her May 4, 2016 interview, respondent stated that she is under the care of a psychiatrist and is taking two medications for depression and anxiety: Effexor and Prozac. She denied the medications affect her ability to practice medicine.

patients very well; she was never inappropriate or forgetful. Ms. Desjardins said that respondent's office was very well organized. She added that respondent has an excellent reputation for honesty and integrity. Ms. Desjardins was not aware of the details of respondent's probation.

Dr. Kingsbury's and Ms. Desjardins's testimony was credible. But they did not testify that they were aware of the allegations contained in the first amended accusation and petition to revoke probation. Thus, their opinions regarding respondent's abilities as a surgeon are not fully credited.

Evaluation

21. In evaluating Dr. Dabadghav's expert testimony, consideration has been given to his qualifications and the reasons and factual bases for his opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

Dr. Dabadghav's testimony was, for the most part, credible. He credibly testified, with support in the record, that respondent committed the following extreme departures from the applicable standards of care: She failed to timely send A.C.'s biopsy specimen to the lab; she failed to adequately review A.C.'s medical record between November 13, 2013, and May 15, 2014, with the result that she mistakenly diagnosed A.C. with a condition she did not have; she failed to adequately and accurately record the examination of A.C. she conducted on November 6, 2013, when she failed to record when she made changes to the November 6, 2013, record at some time after December 20, 2013; she administered 1% Lidocaine with epinephrine to A.C. in excess of the dosage for A.C.'s weight; she allowed an unqualified and non-medically trained person to handle and open sealed packages containing sterile medical supplies during the procedure she performed on A.C. on November 8, 2013; she failed to maintain adequate and proper documentation of C.H.'s postoperative visits and also did not document that she performed a limited wound debridement of C.H.'s mastectomy incisions, re-sutured one of C.H.'s drains prior to April 19, 2012, and removed C.H.'s drains between April 19, 2012, and May 8, 2012.

Dr. Dabadghav, further, credibly testified that respondent committed the following negligent acts: On November 8, 2013, she failed to have a qualified medical assistant present for patient A.C.'s surgical procedure; on November 8, 2013, she failed to follow her standardized office workflow methods and, as a result, misplaced the biological specimen she procured from A.C. on November 8, 2013; and on April 13, 2012, respondent documented in C.H.'s record outdated and expired medical information with respect to C.H.'s vital signs without an acknowledgement that she obtained this information from a report written on February 8, 2012, by another doctor.

However, Dr. Dabadghav's testimony that respondent committed an extreme departure when, as alleged, she failed to perform a postoperative assessment of A.C. for Lidocaine

toxicity is not accepted over respondent's credible testimony that she observed A.C. for possible Lidocaine toxicity after she performed the procedure on November 8, 2013.

In addition, Dr. Dabadghav's testimony that respondent allowed patient C.H.'s drains to remain in place for a period of time beyond that expected for such drains was not credible and not supported in the record and is also not accepted. Dr. Dabadghav did not define what the applicable timeframe was to leave the drains in C.H. and the record only showed that respondent left the drains in C.H. between April 19, 2012, and May 8, 2012. Thus, his assumption that respondent removed the drains in C.H. on May 8, 2012, was not supported by the record.

Moreover, Dr. Dabadghav's testimony that respondent committed a negligent act when she failed to obtain any lymph nodes from the procedure she performed on C.H. was not supported by the evidence. Dr. Dabadghav acknowledged that it was possible that due to C.H.'s fibrotic breast tissue that it may have been difficult to obtain lymph nodes. He also stated the pathologist may have missed the lymph nodes in his analysis. His opinion in this regard is, accordingly, not accepted.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standards of Proof

2. The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. Complainant also bears the burden of proof to establish that cause exists to revoke probation in this administrative proceeding. The standard of proof in a proceeding to revoke probation is a preponderance of the evidence. (*Sandarg v. Dental Board of California* (2010) 184 Cal.App.4th 1434, 1441-1442.)

The phrase “preponderance of evidence” is usually defined in terms of probability of truth, e.g., “such evidence as, when weighed with that opposed to it, has more convincing force and the greater probability of truth.” (BAJI (8th ed.), No. 2.60; 1 Witkin, Evidence, Burden of Proof and Presumptions § 35 (4th ed. 2000).)

Applicable Statutes Regarding Causes to Impose Discipline

4. Business and Professions Code section 2227, subdivision (a), states:

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) 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 the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

5. Business and Professions Code section 2234 provides in part:

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:

[¶] . . . [¶]

- (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.

(d) Incompetence.

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

6. Business and Professions Code section 2266 provides:

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.

Decisional Authority Regarding Standards of Care

7. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App. 4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.)

8. The courts have defined gross negligence as “the want of even scant care or an extreme departure from the ordinary standard of care.” (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. Incompetence has been defined as “an absence of qualification, ability or fitness to perform a prescribed duty or function.” (*Id.* at 1054)

Cause Exists, in Part, Under the First Cause for Discipline to Impose Discipline Against Respondent’s License for Conduct Constituting Gross Negligence

9. Cause exists to impose discipline on respondent’s medical license pursuant to Business and Professions Code section 2234, subdivision (b), gross negligence, relating to her care and treatment of patients A.C. and C.H.

Clear and convincing evidence established that respondent committed gross negligence when she failed to timely send A.C.’s specimen to a laboratory for analysis. She sent patient A.C.’s breast biopsy specimen to a laboratory on May 17, 2014, although she obtained the specimen from A.C. on November 8, 2013.

Clear and convincing evidence established that respondent committed gross negligence when she did not adequately review patient A.C.’s medical records and, as a result, she

mistakenly diagnosed A.C. with Granulomatous Mastitis, and also failed to timely follow up on A.C.'s specimen, which she mistakenly thought she had sent to the lab.

Clear and convincing evidence established that respondent committed gross negligence when she failed to maintain accurate and adequate medical records for patient A.C. Respondent did not record that she made additions to the record of her November 6, 2013 examination of A.C., as found in her medical chart, documenting physical findings she made of A.C., although she made these additions to the record on or after December 20, 2013.

Clear and convincing evidence established that respondent committed gross negligence when she administered an excessive dose of 1% Lidocaine with epinephrine to A.C. At the same time, complainant did not establish by clear and convincing evidence that respondent failed to perform a postoperative assessment of A.C. for Lidocaine toxicity given respondent's credible testimony that she did.

Clear and convincing evidence established that respondent committed gross negligence when she allowed a non-medically trained, unsterile person to assist her in handling and opening sealed packages containing sterile medical supplies during A.C.'s November 8, 2013, procedure.

Clear and convincing evidence established that respondent committed gross negligence when she failed to adequately and completely document C.H.'s postoperative visits and that she had performed a limited wound debridement of C.H.'s mastectomy incisions, re-sutured one of C.H.'s drains, and removed C.H.'s drains between April 19, 2012, and May 8, 2012.

Cause Exists, in Part, to Impose Discipline Under the Second Cause for Discipline Against Respondent's License for Repeated Negligent Acts

10. Cause exists to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (c), repeated negligent acts, relating to her care and treatment of A.C. and C.H.

Clear and convincing evidence established that respondent on November 8, 2013, committed a negligent act when she failed to have a qualified medical assistant present for patient A.C.'s surgical procedure.

Clear and convincing evidence established that on November 8, 2013, respondent committed a negligent act when she failed to follow her standardized office workflow methods and, as a result, misplaced the biological specimen she procured from A.C.

Clear and convincing evidence established that on April 13, 2012, respondent committed a negligent act when she documented in C.H.'s record outdated and expired medical information with respect to C.H.'s vital signs without stating that she obtained this information from a report written on February 8, 2012, by another doctor.

Complainant did not establish by clear and convincing evidence that respondent committed a negligent act when she allowed patient C.H.'s drains, when they were non-functional and painful to C.H., to remain in place for a period of time beyond that expected for such drains.

Complainant did not establish by clear and convincing evidence that respondent committed a negligent act for her failure to obtain any lymph nodes from the dissection she performed on C.H.

Cause Does Not Exist to Impose Discipline Under the Third Cause for Discipline Against Respondent's License For Incompetence

11. Cause does not exist to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2234, subdivision (d), incompetence, and to revoke respondent's probation for failure to obey all laws, relating to her care and treatment of A.C. and C.H.

Dr. Dabdaghav did not testify that respondent's conduct was incompetent. As a result, it was not established that respondent failed to display the skill and training expected of a doctor.¹¹

Cause Exists Under the Fourth Cause for Discipline to Impose Discipline Against Respondent's License for Failure to Maintain Accurate and Adequate Medical Records

12. Cause exists to impose discipline on respondent's medical license pursuant to Business and Professions Code section 2226, failure to maintain accurate and adequate medical records, and to revoke respondent's probation for failure to obey all laws, relating to her care and treatment of A.C. and C.H.

Clear and convincing evidence established that respondent failed to document accurately that she made changes on or after December 20, 2013, to her note documenting the physical examination of A.C. she conducted on November 6, 2013. Respondent also failed to document that she had performed minor surgical procedures on C.H. prior to April 19, 2012, as she admitted in her interview, or that she removed C.H.'s drains between April 19, 2012, and May 8, 2012.

¹¹ In his report, Dr. Dabadghav suggested that respondent displayed incompetence when she said at her interview that she did not know the dosage to weight ratio for the administration of 1% Lidocaine with epinephrine, but he did not conclude this in his report. Even if Dr. Dabadghav concluded she displayed incompetence in this regard, respondent credibly testified that she knew the ratios but was scared and panicked during the interview and offered an incorrect response.

Cause Does Not Exist Under the Fifth Cause for Discipline to Impose Discipline Against Respondent's License for Committing a Dishonest or Corrupt Act Substantially Related to the Qualifications, Functions or Duties of a Physician

13. Cause does not exist to impose discipline on respondent's license pursuant to Business and Professions Code sections 2234, subdivisions (e), commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

California courts have considered the term "dishonesty" within various statutory schemes and have relied on the common understanding involving fraud, deception, betrayal, faithlessness; absence of integrity; or a disposition to cheat, deceive, or defraud. (*Chodur v. Edmonds* (1985) 174 Cal.App.3d 565.) By this definition, respondent did not alter or fabricate A.C.'s and C.H.'s medical records for an improper or fraudulent purpose. Respondent made changes to A.C.'s November 6, 2013, note on or after December 20, 2013, but these changes were consistent with the record she prepared on November 8, 2013, of the examination she conducted on November 6, 2013. Similarly, her incorporation of vital signs on April 13, 2012, that another doctor recorded of C.H. on February 8, 2012 was an act of negligence, as found, but it was not a dishonest or fraudulent act. Both acts were more due to disarray and disorganization than any deceptive design on respondent's part.

Cause Does Not Exist Under the Sixth Cause for Discipline to Impose Discipline Against Respondent's License for Unprofessional Conduct

14. Cause does not exist to impose discipline on respondent's license for unprofessional conduct because she engaged in conduct that breached the rules or ethical code of the medical profession or conduct unbecoming to a member in good standing of the medical profession because she failed to comply with the terms of her probation. No evidence was offered at the hearing concerning whether respondent breached the ethical rules governing the practice of medicine by her failure to comply with the terms of her disciplinary probation.

Cause Exists to Revoke Respondent's Probation for Her Failure to Obey All Laws

15. Cause exists to revoke respondent's probation because she failed to comply with Condition 9 of the terms of her disciplinary probation in Case No. 10-2008-193683. As found above, respondent violated Business and Professions Code sections (b) and (c), gross negligence and repeated negligent acts, and Business and Professions Code section 2266, failure to accurately and adequately maintain medical records. She engaged in this conduct and violated these sections while she was on probation and was required to obey all laws. As a result, she violated Condition 9 of her probation.

The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

16. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (11th Edition 2011) states:

The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

For each of the violations established relating to respondent's record keeping of misconduct regarding the treatment of A.C. and C.H., the Board's disciplinary guidelines provide for a minimum penalty of a stayed revocation with a probationary period of five years and a maximum penalty of revocation. For a violation of probation the minimum recommended penalty is a 30 day suspension and the maximum penalty is revocation. As recommended, the maximum penalty should be given for repeated similar offenses.

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

17. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Ettinger* 135 Cal.App.3d at 856.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) The determination whether respondent's license should be revoked or suspended includes an evaluation of the rehabilitation and mitigation factors.

After considering the Board's guidelines, the evidence of rehabilitation and mitigation and the evidence of record as a whole, it is determined that it is not in the public interest to allow respondent to remain licensed and on probation at this time. This determination is made for the following reasons.

During the period at issue in this proceeding, April 13, 2012, to May 17, 2014, respondent was on probation relating to her care and treatment of five surgical patients. Respondent's probation started on July 27, 2011, and except for the payment of costs related to her probation, she has complied with the terms of probation. Notably, she successfully completed the PACE program and a medical records keeping course.

During this period, respondent's office was in disarray, as she stated in her interview. Respondent also appeared to be in disarray. She misplaced A.C.'s biopsy specimen in her office cupboard for five months, during which time she mistakenly diagnosed A.C. with a condition A.C. did not have and provided A.C. a treatment that was contraindicated for a patient with cancer. This oversight was particularly egregious considering that had respondent done a cursory review of A.C.'s chart she would have seen both that A.C. did not have the condition and, further, A.C.'s pathology report was pending. Due to her mistake, A.C. suffered a five month delay in the diagnosis and treatment of her cancer. Respondent also allowed an untrained friend of A.C. to assist her during A.C.'s procedure; and she departed from standards of care in charting and maintaining A.C.'s records when she changed A.C.'s record at least six weeks after she examined her on November 6, 2013, without documenting when she made these changes. Respondent similarly failed to follow the standard of care for charting her medical records when she failed to document multiple surgical procedures she performed on C.H., a patient who had a radical mastectomy and when she used outdated information about vital signs taken of C.H. from another doctor's report. At the hearing respondent did not explain why, for both A.C. and C.H., from April 19, 2012, to March 25, 2014, she had such difficulty keeping adequate and accurate medical records. Considering that respondent had likely completed a course in medical record keeping related to her probation when this misconduct occurred, these errors were inexcusable.

As a mitigating factor, in 2012, respondent's husband's Alzheimer's disease manifested itself and he rapidly deteriorated. This situation understandably would have greatly affected respondent. But she did not offer any insight concerning how her ability to practice medicine was affected, if at all, by her husband's illness. Respondent, moreover, did not state whether she received any treatment or therapy, or has received any therapy or treatment since 2012 that would address the concerns raised by her conduct. As noted, at her May 4, 2016 interview, respondent was taking two medications for depression at the time. The information by itself, however, does not allow any conclusions to be drawn concerning whether depression contributed to the conduct at issue in this proceeding or whether she has obtained meaningful treatment to address such a condition.

Respondent presented minimal evidence of rehabilitation. As her character witnesses attested, she appeared to be a caring and conscientious doctor and, as her hearing testimony showed, she was genuinely mortified by the error she made losing A.C.'s specimen for five months. She was also attentive to both A.C. and C.H. and their care. Further, respondent's conduct occurred over three years ago and no similar allegations against her have been made. Thus, a significant period of time has passed since the conduct at issue here occurred and it has not been repeated.

However, considering the serious nature of the misconduct at issue and that the misconduct occurred over a two year period of time, it is determined that these considerations do not warrant a disposition less than revocation. The evidence as a whole shows that respondent is presently not amenable to remain on probation, the public interest requires that her stay of the revocation be rescinded and her license revoked. This conclusion is made

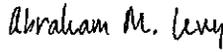
without prejudice to her ability to apply for reinstatement when she can provide evidence of adequate rehabilitation.

ORDER

The order staying the revocation that was previously imposed in *In the Matter of the Accusation Against Mary Charlene Murphy, M.D.*, Case No. 10-2008-193683, is vacated and the revocation issued in that matter is imposed.

Physician's and Surgeon's Certificate No. G74754 issued to respondent Mary Charlene Murphy, M.D., is revoked.

DATED: December 1, 2016

DocuSigned by:

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ABRAHAM M. LEVY
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 25, 2016
BY: *[Signature]* ANALYST

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

12
13 **In the Matter of the First Amended**
Accusation and Petition to Revoke
14 **Probation Against:**
15 **MARY CHARLENE MURPHY, M.D.**
4060 4th Avenue, Suite 610
16 San Diego, CA 92103
17 **Physician's and Surgeon's Certificate**
18 **No. G74754,**
19 **Respondent.**

Case No. 8002014007772
FIRST AMENDED ACCUSATION AND
PETITION TO REVOKE PROBATION

20 Complainant alleges:

21 **PARTIES**

- 22 1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation and
23 Petition to Revoke Probation solely in her official capacity as the Executive Director of the
24 Medical Board of California.
25 2. On or about July 23, 1992, the Medical Board of California issued Physician's and
26 Surgeon's Certificate No. G74754 to Mary Charlene Murphy, M.D. (Respondent). Physician's
27 and Surgeon's Certificate No. G74754 was in effect at all times relevant to the charges brought
28 herein and will expire on December 31, 2017, unless renewed.

1 LICENSE HISTORY

2 3. In a disciplinary action entitled, "*In the Matter of Accusation Against Mary Charlene*
3 *Murphy, M.D.*," Case No. 10-2008-193683, the Medical Board of California issued a decision,
4 effective July 27, 2011, in which Respondent's Physician's and Surgeon's Certificate was
5 revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's
6 Certificate was placed on probation for a period of five (5) years with certain terms and
7 conditions. A true and correct copy of that decision is attached as Exhibit A and is incorporated
8 by reference.

9 JURISDICTION

10 4. This First Amended Accusation and Petition to Revoke Probation is brought before
11 the Medical Board of California (Board), Department of Consumer Affairs, under the authority of
12 the following laws and the Board's Decision in the Case entitled *In the Matter of Accusation*
13 *Against Mary Charlene Murphy, M.D.*," Case No. 10-2008-193683. All section references are to
14 the Business and Professions Code (Code) unless otherwise indicated.

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

19 6. Section 2234 of the Code states:

20 "The board shall take action against any licensee who is charged with
21 unprofessional conduct. In addition to other provisions of this article, unprofessional
22 conduct includes, but is not limited to, the following:

23 "(a) Violating or attempting to violate, directly or indirectly, assisting in or
24 abetting the violation of, or conspiring to violate any provision of this chapter.

25 [Chapter 5, the Medical Practices Act.]

26 "(b) Gross negligence.

27 "(c) Repeated negligent acts. To be repeated, there must be two or more
28 negligent acts or omissions. An initial negligent act or omission followed by a

1 separate and distinct departure from the applicable standard of care shall constitute
2 repeated negligent acts.

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

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

11 “(d) Incompetence.

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

15 “...”

16 7. Section 2266 of the Code states:

17 “The failure of a physician and surgeon to maintain adequate and accurate
18 records relating to the provision of services to their patients constitutes unprofessional
19 conduct.”

20 8. Unprofessional conduct under section 2234 is conduct which breaches the rules or
21 ethical code of the medical profession, or conduct which is unbecoming to a member in good
22 standing of the medical profession, which demonstrates an unfitness to practice medicine. (*Shea*
23 *v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 9. Respondent has subjected her Physician's and Surgeon's Certificate No. G74754 to
4 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of
5 the Code, in that she was grossly negligent in her care and treatment of patient A.C., as more
6 particularly alleged hereinafter:

7 **Patient A.C.**

8 10. Patient A.C., a 35 year-old female, was referred to Respondent on or about October
9 24, 2013, by Sherman Heights Family Health Center (SHFHC), after she was evaluated for a two-
10 week old left breast lump. Patient A.C. was first seen by Respondent on or about November 6,
11 2013.

12 11. On or about November 6, 2013, Respondent evaluated patient A.C.'s left breast lump
13 and scheduled patient A.C. for an excisional biopsy to take place on November 8, 2013, at
14 Respondent's office, under local anesthetic.

15 12. On or about November 8, 2013, patient A.C. presented to Respondent's office with
16 her friend, B.L.,¹ who was present during the procedure.

17 (a) Respondent performed an excisional biopsy on patient A.C. Respondent had no
18 medical assistant present, and asked B.L., a person who was not medically trained,
19 gloved or sterile, to assist her with patient A.C.'s procedure. B.L. assisted Respondent
20 by performing acts, included but not limited to, opening sealed sterile packages
21 containing a scalpel and gauze, and dropping them in a sterile field.

22 (b) Patient A.C. weighed 146 pounds (approximately 66 kg). Respondent administered a
23 50 cc (500 mg) dose of 1% Lidocaine with epinephrine (Lidocaine) to patient A.C. The
24 maximum dose of 1% Lidocaine for a single event procedure is not to exceed 7.5
25 mg/kg, to avoid toxicity. The maximum dose of 1% Lidocaine for a single event, for a
26 person weighing 66 kg is 495 mg. Respondent was unaware that correct dosage of

27
28 ¹ B.L. was present both as a friend, and as a translator for patient A.C.

1 Lidocaine should have been calculated based upon the weight of the patient, but rather
2 believed that the correct dose was calculated by the size of the lesion or area to be
3 anesthetized. Postoperatively, Respondent did not examine patient A.C. for Lidocaine
4 toxicity and/or monitor her.

5 (c) During patient A.C.'s November 8, 2013 procedure, Respondent failed to follow her
6 standardized workflow methods.

7 (d) Respondent's operative note stated that Respondent procured one specimen from the
8 biopsy, placed it in formalin and sent it to San Diego Pathology. However, Respondent
9 failed to send the biopsy out to a laboratory until on or about May 17, 2014.

10 Respondent handled the biopsy herself.

11 13. On or about November 18, 2013, Respondent saw patient A.C. for her first
12 postoperative visit. Respondent noted that other than some mild left breast bruising and pain, the
13 patient was doing well and that pathology results were pending.

14 14. On or about December 3, 2013, Respondent saw patient A.C. for her second
15 postoperative visit. Respondent noted that patient A.C.'s left breast wound appeared to be well
16 healed and that the pathology result was still pending, but she would follow up.

17 15. On or about March 14, 2014, patient A.C. was seen at SHFHC with complaints of
18 increasing left breast discomfort. SHFHC requested that Respondent see patient A.C.

19 16. On or about March 25, 2014, Respondent saw patient A.C. Respondent performed a
20 physical and history documenting that approximately one month earlier, the patient had noticed
21 an egg sized lump in the left breast in the area of the previously-healed biopsy. In the history,
22 Respondent noted that patient A.C. had a history of Granulomatous Mastitis (GM); however,
23 Respondent had mistaken patient A.C. for another patient who had that tissue diagnosis. The area
24 on patient A.C.'s left breast was tender and appeared red. Respondent noted a 2-3 cm left axillary
25 lymphadenopathy, and noted her belief that GM was the cause of patient A.C.'s presenting
26 symptoms and findings. Respondent treated patient A.C. with a week of quick tapering
27 Prednisone, noting that if there was no improvement with the steroids, then the patient would
28 need another left breast biopsy.

1 17. On or about May 15, 2014, Respondent had her last patient visit with patient A.C.
2 Respondent again documented the history of GM, and noted the absence of patient A.C.'s
3 pathology report. Respondent found that the left breast pain was significantly improved, but
4 patient A.C. still had a palpable mass, and would need another excisional biopsy. Respondent
5 made an effort to find the pathology report, calling the four laboratories she used, but was unable
6 to trace the biopsy during the patient's visit, and reported this to patient A.C. Patient A.C.
7 requested a referral to another physician. Later that day, Respondent did find patient A.C.'s
8 biopsy specimen from November 8, 2013, untested in the cupboard of her examination room.
9 Two days later, Respondent sent the specimen to Quest Diagnostic Laboratories for histological
10 evaluation.

11 18. On or about May 16, 2014, Patient A.C. presented to the Sharp Coronado Emergency
12 room, with complaints of a painful, tender left breast mass with erythematous skin changes, where
13 she was treated with antibiotics. That provider scheduled a mammogram and an ultrasound (U/S)
14 guided biopsy of the left breast mass.

15 19. On or about May 20, 2014, Quest Diagnostic Laboratories received a left breast
16 biopsy specimen from Respondent, showing patient A.C.'s name, and the procurement date of
17 November 8, 2013. The pathology report revealed mostly fibrocystic disease with a small focus
18 of markedly atypical cells suspicious for malignancy.

19 20. The U/S guided biopsy done at Sharp Coronado Hospital on or about June 3, 2014,
20 revealed a poorly differentiated invasive ductal carcinoma, Grade 3. A left axillary U/S guided
21 lymph node biopsy was performed, which resulted in findings consistent with metastatic poorly
22 differentiated breast ductal carcinoma. Patient A.C.'s subsequent physician diagnosed Stage III B
23 inflammatory left breast cancer, and recommended neoadjuvant chemotherapy with eventual
24 modified radical mastectomy and right simple mastectomy and postoperative radiation therapy.²

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² Patient A.C. subsequently had preoperative chemotherapy from June 17, 2014 to October 7, 2014, with a very good response; had planned surgery on November 2, 2014, and underwent postoperative radiation and bilateral oophorectomies.

1 21. On or about December 29, 2015, a manager at SHFHC signed a Declaration of
2 Custodian of Records, certifying that a true copy of the complete records of patient A.C. from
3 SHFHC was provided. On or about January 21, 2015, Respondent signed a Declaration of
4 Custodian of Records, certifying a true copy of the complete records of patient A.C. from
5 Respondent's office was provided.

6 22. The notes for patient A.C. dated on or about November 6, 2013, provided that
7 Respondent provided contained multiple entries that did not appear on November 6, 2013, notes
8 that SHFHC provided. Further, the notes dated on or about November 8, 2013, that Respondent
9 provided showed that Respondent performed a history and physical assessment; however, the
10 November 8, 2013, notes that SHFHC provided contained no history and physical assessment.
11 The added entries on Respondent's copies were not written as new entries with clear date and
12 time stamps.

13 **Patient C.H.**

14 23. Patient C.H., a 41 year-old female, was referred to Respondent on or about August
15 2011, by Dr. C., a medical oncologist, after patient C.H. had been diagnosed with right breast
16 cancer in 2010, with no metastatic disease in 2010. Patient C.H. had undergone chemotherapy
17 after a surgical placement of an Ifusaport³ from December 2010, to April 2011. Patient C.H. had
18 delayed surgery, but had been taking Tamoxifen⁴ since April 2011. Respondent and patient C.H.
19 discussed the need for a right modified radical mastectomy⁵ and, at the request of patient C.H., a
20 prophylactic left simple mastectomy.⁶

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22 ³ Ifusaports are devices used for long-term access to the patient's blood stream.

23 ⁴ Tamoxifen blocks the actions of estrogen and is used to treat and prevent some types of
24 breast cancer.

25 ⁵ A modified radical mastectomy is a procedure in which the entire breast is removed,
26 including the skin, breast tissue, areola, and nipple, and most of the lymph nodes under the arm.
The lining over the large muscle in the chest is also removed, but the muscle itself is left in place.

27 ⁶ During simple mastectomy, the nipple, areola, and all of the breast tissue are removed.
28 Removal of the underarm lymph nodes is not performed, and no muscles are removed.

1 24. On or about February 23, 2012, patient C.H. returned to see Respondent. Patient
2 C.H.'s surgery, a planned right modified radical mastectomy and left simple mastectomy, was
3 scheduled to proceed on April 13, 2012.

4 25. On or about April 13, 2012, Respondent performed a right modified radical
5 mastectomy and left simple mastectomy on patient C.H. On the dictated preoperative history for
6 April 13, 2012, Respondent recorded the patient's vital signs as blood pressure: 120/84; heart
7 rate: 90s; temperature: 98.1; O2 saturation: 97% on room air. However, Respondent recorded the
8 vital signs taken more than 60 days previously by another doctor, and did not document the
9 source of the vital signs in patient C.H.'s medical record. In the operative report, Respondent
10 described the correct anatomical landmarks for an adequate lymph node sampling, and noted in
11 the specimen section that she had axillary contents sent as part of the specimen. However, the
12 final pathology report stated that there were no lymph nodes present in the axillary

13 26. On or about April 16, 2012, patient C.H. reported that she presented for her first
14 postoperative visit with Respondent. Patient C.H. had developed bilateral seroma⁷ leakage from
15 the incisions, making movement difficult for patient C.H. Respondent removed dressings, and
16 diagnosed that both mastectomy incisions had some "dead" skin, and performed an in-office
17 debridement of the wounds. This visit was reported by patient C.H., but not documented in
18 patient C.H.'s medical record.

19 27. On or about April 18, 2012, late in the day, patient C.H. reported that she presented
20 for her second postoperative visit with Respondent, due to worrisome wound leakage patient C.H.
21 was experiencing. Patient C.H. further reported that Respondent placed absorbable sutures to try
22 to close the skin and stop the leakage. This procedure was not successful and patient C.H.
23 continued to leak from the sutures. This visit was reported by patient C.H., but not documented
24 in patient C.H.'s medical record.

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27 ⁷ A seroma is a pocket of clear serous fluid that sometimes develops in the body after
28 surgery.

1 28. On or about April 19, 2012, patient C.H. presented to Respondent for her third
2 postoperative visit. Patient C.H. had three drains present, and was found to have epidermolysis⁸
3 on both mastectomy incisions, without acute wound infection. Respondent documented the April
4 19, 2012 visit, and performed minor postoperative procedures, but did not document any surgical
5 postoperative procedures performed that day⁹.

6 29. On or about April 23 or 24, 2012, patient C.H. spoke with Respondent telephonically.
7 Respondent did not document a telephone call on either date in patient C.H.'s medical record.

8 30. On or about May 8, 2012, patient C.H. presented to Respondent for her fourth
9 postoperative visit, which Respondent documented. However, Respondent did not document any
10 information concerning either the existence or removal of patient C.H.'s three drains on this date.
11 Patient C.H. reported that the drains were removed at the May 8, 2016, appointment. Respondent
12 and patient C.H. discussed a surgery to clean up the wound and try to close it.

13 31. Patient C.H. was scheduled for an operative breast wound debridement and wound
14 closure on May 9, 2012. However, patient C.H. cancelled the procedure and transferred her care
15 to another physician, where she was seen on May 31, 2012. Patient C.H. continued her medical
16 and cancer care with the new health care provider from that time forward.

17 32. Respondent committed gross negligence in her care and treatment of patients A.C.
18 and C.H., which included, but was not limited to the following:

- 19 (a) Respondent failed to timely send patient A.C.'s breast biopsy specimen, taken on or
20 about November 8, 2013, to a laboratory for evaluation, resulting in an approximate
21 five-month delay in the evaluation of patient A.C.'s specimen;
- 22 (b) Respondent failed to adequately review patient A.C.'s medical records and/or
23 documentation, resulting in a mistaken diagnosis and treatment of patient A.C. for
24

25
26 ⁸ Epidermolysis is the loosening of the epidermis, with extensive blistering of the skin
and mucous membranes.

27 ⁹ In her medical board interview, Respondent stated that she may have performed minor
28 postoperative procedures like a limited wound debridement and a re-suture of one of the drains.

1 Granulomatous Mastitis, and failure to timely, definitively, follow up on the result of
2 patient A.C.'s biopsy specimen;

3 (c) Respondent failed to maintain accurate and adequate medical records for patient A.C.;

4 (d) Respondent administered an excessive dose of 1% Lidocaine with epinephrine to patient
5 A.C., and failed to provide patient A.C. with a postoperative assessment for Lidocaine
6 toxicity;

7 (e) Respondent obtained assistance from a non-medically trained, unsterile person in
8 handling and opening sealed packages containing sterile medical supplies during patient
9 A.C.'s procedure;

10 (f) Respondent failed to adequately and completely document patient C.H.'s postoperative
11 visits; and

12 (g) Respondent failed to adequately and completely document patient C.H.'s minor
13 postoperative procedures;

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Repeated Negligent Acts)**

16 33. Respondent has further subjected her Physician's and Surgeon's Certificate No.
17 G74754 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
18 subdivision (c), of the Code, in that she committed repeated negligent acts in her care and
19 treatment of patient A.C., as more particularly alleged hereinafter:

20 (a) Paragraphs 9 through 32, above, are incorporated by reference and realleged, as if fully
21 set forth herein;

22 (b) On or about November 8, 2013, Respondent failed to obtain a qualified medical
23 assistant to be present for patient A.C.'s surgical procedure;

24 (c) On or about November 8, 2013, Respondent failed to follow her standardized workflow
25 methods for patient A.C.;

26 (d) Respondent allowed patient C.H.'s operatively placed drains, which were non-
27 functional and painful, to remain in place for too long a period of time;

28 ///

1 (e) Respondent reported that she had performed an anatomically correct right axillary
2 lymph node dissection, but failed to yield any lymph nodes; and

3 (f) On or about April 13, 2012, Respondent documented outdated and expired medical
4 information without proper documented acknowledgement.

5 **THIRD CAUSE FOR DISCIPLINE**

6 **(Incompetence)**

7 34. Respondent has further subjected her Physician's and Surgeon's Certificate No.
8 G74754 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
9 subdivision (d), of the Code, in that she committed acts of incompetence in her care and treatment
10 of patient A.C., as more particularly alleged hereinafter:

11 35. Paragraphs 9 through 24, above, are incorporated by reference and realleged, as if
12 fully set forth herein.

13 **FOURTH CAUSE FOR DISCIPLINE**

14 **(Failure to Maintain Accurate and Adequate Medical Records)**

15 36. Respondent has further subjected her Physician's and Surgeon's Certificate No.
16 G74754 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the
17 Code, in that she failed to maintain accurate and adequate medical records in her care and
18 treatment of patients A.C. and C.H., as more particularly alleged hereinafter:

19 37. Paragraphs 9 through 35, above, are incorporated by reference and realleged, as if
20 fully set forth herein.

21 **FIFTH CAUSE FOR DISCIPLINE**

22 **(The Commission of any Act Involving Dishonesty or Corruption That Is Substantially
23 Related to the Qualifications, Functions, or Duties of a Physician and Surgeon)**

24 38. Respondent has further subjected her Physician's and Surgeon's Certificate No.
25 G74754 to disciplinary action under sections 2227 and 2234, as defined by section 2234,
26 subdivision (e), of the Code, in that she caused changes to be made to patient A.C.'s and C.H.'s
27 medical records without dating and/or time-stamping the changes to show that the changes were
28 added later, as more particularly alleged hereinafter:

1 39. Paragraphs 9 through 37, above, are incorporated by reference and relleged, as if fully
2 set forth herein.

3 **SIXTH CAUSE FOR DISCIPLINE**

4 **(Unprofessional Conduct)**

5 40. Respondent has subjected her Physician's and Surgeon's Certificate No. G74754 to
6 disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that
7 she has engaged in conduct which breaches the rules or ethical code of the medical profession, or
8 conduct which is unbecoming a member in good standing of the medical profession, and which
9 demonstrates an unfitness to practice medicine, by failing to comply with the terms of her
10 probation, as more particularly alleged hereinafter:

11 41. Paragraphs 9 through 39, above, are incorporated by reference and realleged, as if
12 fully set forth herein; and

13 42. Paragraphs 43 through 45, below, are incorporated by reference and realleged, as if
14 fully set forth herein.

15 **CAUSE TO REVOKE PROBATION**

16 **(Failure to Obey All Laws)**

17 43. At all times after the effective date of the Board's Decision and Order in Case No. 10-
18 2008-193683, Condition 9 stated:

19 "Respondent shall obey all federal, state and local laws, all rules governing the
20 practice of medicine in California, and remain in full compliance with any court
21 ordered criminal probation, payments and other orders."

22 44. Respondent's probation is subject to revocation because she failed to comply with
23 Probation Condition No. 9, referenced above, in that she failed to obey all laws, specifically
24 sections 2334, subdivisions (b), (c), and (d), and section 2266 of the Code, as more particularly
25 alleged in paragraphs 9 through 42, above, which are incorporated by reference and realleged as if
26 fully set forth herein.

27 ///

28 ///

1 **DISCIPLINARY CONSIDERATIONS**

2 45. To determine the degree of discipline, if any, to be imposed on Respondent,
3 Complainant alleges that on or about July 27, 2011, in the disciplinary action entitled, "*In the*
4 *Matter of Accusation Against Mary Charlene Murphy, M.D.*," Case No. 10-2008-193683, before
5 the Medical Board of California, Respondent's Physician's and Surgeon's Certificate No. G74754
6 was revoked and was placed on probation for a period of five (5) years with various certain terms
7 and conditions. That decision is now final, and incorporated by reference and realleged as if fully
8 set forth herein.

9 **PRAYER**

10 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
11 and that following the hearing, the Board issue a decision:

12 1. Revoking the probation that was granted to Respondent by the Medical Board of
13 California in Case No. 10-2008-193683, and imposing the disciplinary order that was stayed,
14 thereby revoking Physician's and Surgeon's Certificate No. G74754 issued to Respondent Mary
15 Charlene Murphy, M.D.;

16 2. Revoking or suspending Physician's and Surgeon's Certificate No. G74754, issued to
17 Mary Charlene Murphy, M.D.;

18 3. Revoking, suspending or denying approval of Respondent Mary Charlene Murphy,
19 M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

20 4. Ordering Respondent Mary Charlene Murphy, M.D., to pay to the Board, if placed on
21 probation, the costs of probation monitoring;

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

23
24 DATED: August 25, 2016



25 KIMBERLY KIRCHMEYER
26 Executive Director
27 Medical Board of California
28 State of California
Complainant

SD2016800195

Exhibit A

Decision and Order

Medical Board of California Case No. 10-2008-193683

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

In the Matter of the Accusation Against:)
)
MARY CHARLENE MURPHY, M.D.) Case No. 10-2008-193683
)
Physician's and Surgeon's)
Certificate No. G-74754)
)
Respondent.)
_____)

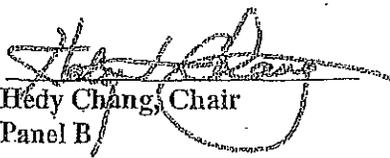
DECISION

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 July 27, 2011.

IT IS SO ORDERED June 27, 2011.

MEDICAL BOARD OF CALIFORNIA

By: 
Hedy Chang, Chair
Panel B

1 KAMALA D. HARRIS
Attorney General of California
2 GAIL M. HEPPBELL
Supervising Deputy Attorney General
3 MARA FAUST
Deputy Attorney General
4 State Bar No. 111729
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 324-5358
Facsimile: (916) 327-2247
7 *Attorneys for Complainant*

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

11 In the Matter of the Accusation Against:
12 **MARY CHARLENE MURPHY, M.D.**
4060 4th Avenue, Suite 115
13 San Diego, CA 92103
Physician's and Surgeon's Certificate No. G
14 74754

Case No. 10-2008-193683

OAH No. 2010080176
**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

15 Respondent.

16
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. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of
22 California. She brought this action solely in her official capacity and is represented in this matter
23 by Kamala D. Harris, Attorney General of the State of California, by Mara Faust, Deputy
24 Attorney General.
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1 respondent's expense, approved in advance by the Division or its designee. Failure to
2 successfully complete the course during the first 6 months of probation is a violation of probation.

3 A medical record keeping course taken after the acts that gave rise to the charges in the
4 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the
5 Division or its designee, be accepted towards the fulfillment of this condition if the course would
6 have been approved by the Division or its designee had the course been taken after the effective
7 date of this Decision.

8 Respondent shall submit a certification of successful completion to the Division or its
9 designee not later than 15 calendar days after successfully completing the course, or not later than
10 15 calendar days after the effective date of the Decision, whichever is later.

11 4. ETHICS COURSE Within 60 calendar days of the effective date of this Decision,
12 respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the
13 Division or its designee. Failure to successfully complete the course during the first year of
14 probation is a violation of probation.

15 An ethics course taken after the acts that gave rise to the charges in the Accusation, but
16 prior to the effective date of the Decision may, in the sole discretion of the Division or its
17 designee, be accepted towards the fulfillment of this condition if the course would have been
18 approved by the Division or its designee had the course been taken after the effective date of this
19 Decision.

20 Respondent shall submit a certification of successful completion to the Division or its
21 designee not later than 15 calendar days after successfully completing the course, or not later than
22 15 calendar days after the effective date of the Decision, whichever is later.

23 5. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date
24 of this Decision, respondent shall enroll in a clinical training or educational program equivalent to
25 the Physician Assessment and Clinical Education Program (PACE) offered at the University of
26 California - San Diego School of Medicine ("Program").

27 The Program shall consist of a Comprehensive Assessment program comprised of a two-
28 day assessment of respondent's physical and mental health; basic clinical and communication

1 skills common to all clinicians; and medical knowledge, skill and judgment pertaining to
2 respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education
3 in the area of practice in which respondent was alleged to be deficient and which takes into
4 account data obtained from the assessment, Decision(s), Accusation(s), and any other information
5 that the Division or its designee deems relevant. Respondent shall pay all expenses associated
6 with the clinical training program.

7 Based on respondent's performance and test results in the assessment and clinical
8 education, the Program will advise the Division or its designee of its recommendation(s) for the
9 scope and length of any additional educational or clinical training, treatment for any medical
10 condition, treatment for any psychological condition, or anything else affecting respondent's
11 practice of medicine. Respondent shall comply with Program recommendations.

12 At the completion of any additional educational or clinical training, respondent shall submit
13 to and pass an examination. The Program's determination whether or not respondent passed the
14 examination or successfully completed the Program shall be binding.

15 Respondent shall complete the Program not later than six months after respondent's initial
16 enrollment unless the Division or its designee agrees in writing to a later time for completion.

17 Failure to participate in and complete successfully all phases of the clinical training
18 program outlined above is a violation of probation.

19 Respondent shall not practice medicine in the area of intra-abdominal surgery until
20 respondent has successfully completed the Program and has been so notified by the Division or its
21 designee in writing, except that respondent may practice in a clinical training program approved
22 by the Division or its designee. Respondent's practice of medicine shall be restricted only to that
23 which is required by the approved training program.

24 6. MONITORING - PRACTICE Within 30 calendar days of the effective date of
25 this Decision, respondent shall submit to the Division or its designee for prior approval as a
26 practice monitor(s); the name and qualifications of one or more licensed physicians and surgeons
27 whose licenses are valid and in good standing, and who are preferably American Board of
28 Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or

1 personal relationship with respondent, or other relationship that could reasonably be expected to
2 compromise the ability of the monitor to render fair and unbiased reports to the Division,
3 including, but not limited to, any form of bartering, shall be in respondent's field of practice, and
4 must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

5 The Division or its designee shall provide the approved monitor with copies of the
6 Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of
7 receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit
8 a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands
9 the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor
10 disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan
11 with the signed statement.

12 Within 60 calendar days of the effective date of this Decision, and continuing throughout
13 probation, respondent's practice shall be monitored by the approved monitor. Respondent shall
14 make all records available for immediate inspection and copying on the premises by the monitor
15 at all times during business hours, and shall retain the records for the entire term of probation.

16 The monitor(s) shall submit a quarterly written report to the Division or its designee which
17 includes an evaluation of respondent's performance, indicating whether respondent's practices are
18 within the standards of practice of medicine, and whether respondent is practicing medicine
19 safely.

20 It shall be the sole responsibility of respondent to ensure that the monitor submits the
21 quarterly written reports to the Division or its designee within 10 calendar days after the end of
22 the preceding quarter.

23 However, upon recommendation by the approved monitor that respondent's practice
24 no longer needs to be monitored, and upon a written report stating that fact, then this condition
25 will cease.

26 ///

27 ///

28

1 If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of
2 such resignation or unavailability, submit to the Division or its designee, for prior approval, the
3 name and qualifications of a replacement monitor who will be assuming that responsibility within
4 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days
5 of the resignation or unavailability of the monitor, respondent shall be suspended from the
6 practice of medicine until a replacement monitor is approved and prepared to assume immediate
7 monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar
8 days after being so notified by the Division or designee.

9 In lieu of a monitor, respondent may participate in a professional enhancement program
10 equivalent to the one offered by the Physician Assessment and Clinical Education Program at the
11 University of California, San Diego School of Medicine, that includes, at minimum, quarterly
12 chart review, semi-annual practice assessment, and semi-annual review of professional growth
13 and education. Respondent shall participate in the professional enhancement program at
14 respondent's expense during the term of probation.

15 Failure to maintain all records, or to make all appropriate records available for immediate
16 inspection and copying on the premises, or to comply with this condition as outlined above is a
17 violation of probation.

18 7. NOTIFICATION Prior to engaging in the practice of medicine, the respondent shall
19 provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief
20 Executive Officer at every hospital where privileges or membership are extended to respondent,
21 at any other facility where respondent engages in the practice of medicine, including all physician
22 and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every
23 insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall
24 submit proof of compliance to the Division or its designee within 15 calendar days.

25 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

26 8. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is
27 prohibited from supervising physician assistants.

28 9. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules

1 governing the practice of medicine in California, and remain in full compliance with any court
2 ordered criminal probation, payments and other orders.

3 10. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations
4 under penalty of perjury on forms provided by the Division, stating whether there has been
5 compliance with all the conditions of probation. Respondent shall submit quarterly declarations
6 not later than 10 calendar days after the end of the preceding quarter.

7 11. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's
8 probation unit. Respondent shall, at all times, keep the Division informed of respondent's
9 business and residence addresses. Changes of such addresses shall be immediately
10 communicated in writing to the Division or its designee. Under no circumstances shall a post
11 office box serve as an address of record, except as allowed by Business and Professions Code
12 section 2021(b).

13 Respondent shall not engage in the practice of medicine in respondent's place of residence.
14 Respondent shall maintain a current and renewed California physician's and surgeon's license.

15 Respondent shall immediately inform the Division, or its designee, in writing, of travel to
16 any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than
17 30 calendar days.

18 12. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be
19 available in person for interviews either at respondent's place of business or at the probation unit
20 office, with the Division or its designee, upon request at various intervals, and either with or
21 without prior notice throughout the term of probation.

22 13. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should
23 leave the State of California to reside or to practice, respondent shall notify the Division or its
24 designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is
25 defined as any period of time exceeding 30 calendar days in which respondent is not engaging in
26 any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

27 All time spent in an intensive training program outside the State of California which has
28 been approved by the Division or its designee shall be considered as time spent in the practice of

1 medicine within the State. A Board-ordered suspension of practice shall not be considered as a
2 period of non-practice. Periods of temporary or permanent residence or practice outside
3 California will not apply to the reduction of the probationary term. Periods of temporary or
4 permanent residence or practice outside California will relieve respondent of the responsibility to
5 comply with the probationary terms and conditions with the exception of this condition and the
6 following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and
7 Cost Recovery.

8 Respondent's license shall be automatically cancelled if respondent's periods of temporary
9 or permanent residence or practice outside California total two years. However, respondent's
10 license shall not be cancelled as long as respondent is residing and practicing medicine in another
11 state of the United States and is on active probation with the medical licensing authority of that
12 state, in which case the two year period shall begin on the date probation is completed or
13 terminated in that state.

14 14. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

15 In the event respondent resides in the State of California and for any reason respondent
16 stops practicing medicine in California, respondent shall notify the Division or its designee in
17 writing within 30 calendar days prior to the dates of non-practice and return to practice. Any
18 period of non-practice within California, as defined in this condition, will not apply to the
19 reduction of the probationary term and does not relieve respondent of the responsibility to comply
20 with the terms and conditions of probation. Non-practice is defined as any period of time
21 exceeding 30 calendar days in which respondent is not engaging in any activities defined in
22 sections 2051 and 2052 of the Business and Professions Code.

23 All time spent in an intensive training program which has been approved by the Division or
24 its designee shall be considered time spent in the practice of medicine. For purposes of this
25 condition, non-practice due to a Board-ordered suspension or in compliance with any other
26 condition of probation, shall not be considered a period of non-practice.

27 Respondent's license shall be automatically cancelled if respondent resides in California
28 and for a total of two years, fails to engage in California in any of the activities described in

1 Business and Professions Code sections 2051 and 2052.

2 15. COMPLETION OF PROBATION Respondent shall comply with all financial
3 obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior
4 to the completion of probation. Upon successful completion of probation, respondent's certificate
5 shall be fully restored.

6 16. VIOLATION OF PROBATION Failure to fully comply with any term or condition
7 of probation is a violation of probation. If respondent violates probation in any respect, the
8 Division, after giving respondent notice and the opportunity to be heard, may revoke probation
9 and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke
10 Probation, or an Interim Suspension Order is filed against respondent during probation, the
11 Division shall have continuing jurisdiction until the matter is final, and the period of probation
12 shall be extended until the matter is final.

13 17. LICENSE SURRENDER Following the effective date of this Decision, if
14 respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the
15 terms and conditions of probation, respondent may request the voluntary surrender of
16 respondent's license. The Division reserves the right to evaluate respondent's request and to
17 exercise its discretion whether or not to grant the request, or to take any other action deemed
18 appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender,
19 respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the
20 Division or its designee and respondent shall no longer practice medicine. Respondent will no
21 longer be subject to the terms and conditions of probation and the surrender of respondent's
22 license shall be deemed disciplinary action. If respondent re-applies for a medical license, the
23 application shall be treated as a petition for reinstatement of a revoked certificate.

24 18. PROBATION MONITORING COSTS Respondent shall pay the costs associated
25 with probation monitoring each and every year of probation, as designated by the Division, which
26 are currently set at \$3,999, but may be adjusted on an annual basis. Such costs shall be payable to
27 the Medical Board of California and delivered to the Division or its designee no later than
28 January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a

1 violation of probation.

2
3 ACCEPTANCE

4 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
5 discussed it with my attorney, Cary W. Miller. I understand the stipulation and the effect it will
6 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
7 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
8 Decision and Order of the Medical Board of California.

9 DATED: 06 May 2011 Mary C. Murphy M.D.
10 MARY CHARLENE MURPHY, M.D.
11 Respondent

12 I have read and fully discussed with Respondent MARY CHARLENE MURPHY, M.D. the
13 terms and conditions and other matters contained in the above Stipulated Settlement and
14 Disciplinary Order. I approve its form and content.

15 DATED: 5/6/11 Cary W. Miller
16 Cary W. Miller
17 Attorney for Respondent

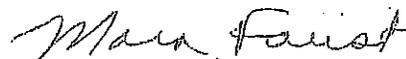
18 ENDORSEMENT

19 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
20 submitted for consideration by the Medical Board of California of the Department of Consumer
21 Affairs.

Dated: May 9, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General



MARA FAUST
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 10-2008-193683

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 22 2010
BY: [Signature] ANALYST

1 EDMUND G. BROWN JR.
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7 *Attorneys for Complainant*

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

11 In the Matter of the Accusation Against:

Case No. 10-2008-193683

12 MARY CHARLENE MURPHY, M.D.
4060 4th Avenue, Suite 115
13 San Diego, CA 92103

ACCUSATION

14 Physician's and Surgeon's Certificate Number
15 G 74754

16 Respondent.

17 Complainant alleges:

18 PARTIES

19 1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity
20 as the Executive Director of the Medical Board of California, Department of Consumer Affairs,
21 State of California ("Board").

22 2. On or about July 23, 1992, the Board issued physician's and surgeon's certificate
23 number G 74754 ("license") to Mary Charlene Murphy, M.D., ("Respondent"). The license was
24 in full force and effect at all times relevant to the charges brought hereon, and will expire on
25 December 31, 2011, unless renewed.

26 JURISDICTION

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

1 4. The Medical Practice Act ("MPA") is codified at sections 2000-2521 of the Business
2 and Professions Code.

3 5. Pursuant to section 2001.1, the Board's highest priority is public protection.

4 6. Section 2227(a) of the Code provides as follows:

5 A licensee whose matter has been heard by an administrative
6 law judge of the Medical Quality Hearing Panel as designated in
7 Section 11371 of the Government Code, or whose default has
8 been entered, and who is found guilty, or who has entered into a
stipulation for disciplinary action with the [B]oard¹, may, in
accordance with the provisions of this chapter:

9 (1) Have his or her license revoked upon order of the division.

10 (2) Have his or her right to practice suspended for a period not
11 to exceed one year upon order of the division.

12 (3) Be placed on probation and be required to pay the costs of
13 probation monitoring upon order of the division.

14 (4) Be publicly reprimanded by the division.

15 (5) Have any other action taken in relation to discipline as part of
16 an order of probation, as the division or an administrative law judge
may deem proper.

17 7. Section 2234 reads, in relevant part, as follows:

18 The Division of Medical Quality shall take action against
19 any licensee who is charged with unprofessional conduct.
20 In addition to other provisions of this article, unprofessional
conduct includes, but is not limited to, the following:

21 (b) Gross negligence.

22 (c) Repeated negligent acts. To be repeated, there must be two
23 or more negligent acts or omissions. An initial negligent act or
24 omission followed by a separate and distinct departure from the
applicable standard of care shall constitute repeated negligent acts.

25
26 ¹ California Business and Professions Code section 2002, as amended and effective January 1, 2008,
27 provides that, unless otherwise expressly provided, the term "[B]oard" as used in the Medical Practice Act refers to
28 the Medical Board of California. References to the "Division of Medical Quality" and "Division of Licensing" set
forth in the Medical Practice Act are also referable to the Medical Board of California.

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

3 (2) When the standard of care requires a change in the diagnosis,
4 act, or omission that constitutes the negligent act described in paragraph
5 (1), including, but not limited to, a reevaluation of the diagnosis or
6 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.

7 8. Section 2261 provides, in relevant part, as follows:

8 Knowingly making or signing any certificate or other document directly
9 or indirectly related to the practice of medicine... which falsely represents
10 the existence or nonexistence of a state of facts, constitutes unprofessional
conduct.

11 9. Section 2266 provides as follows:

12 The failure of a physician and surgeon to maintain adequate and
13 accurate records relating to the provision of services to their patients
constitutes unprofessional conduct.

14 **FIRST CAUSE FOR DISCIPLINE**

15 (Gross Negligence)

16 [B&P Code Section 2234(b)]

17 10. Respondent is a physician and surgeon, and is certified by the American Board of
18 Surgery. At the time the events giving rise to the instant Accusation occurred, Respondent was a
19 general surgeon on staff at Scripps Mercy Hospital in San Diego, California.

20 11. Respondent committed acts of gross negligence relative to her care and treatment of
21 two separate patients, in violation of section 2234(b). The facts constituting gross negligence are
set forth, *infra*.

22 Patient L.M.²

23 12. Patient L.M. was an 85 year-old man with a distant history of gastric resection with a
24 side-to-side gastrojejunostomy reconstruction secondary to stomach cancer when he presented to
25 Respondent on or about April 15, 2006, with a large bowel obstruction. Respondent performed
26 emergent exploratory surgery and discovered obstructing transverse colon cancer, liver

27 _____
28 ² Patient initials are used throughout this pleading to protect patient privacy.

1 metastases, and peritoneal carcinomatosis. After lysing adhesions and decompressing the dilated
2 proximal colon utilizing a colotomy procedure, Respondent performed a segmental colectomy
3 and primary anastomosis³, with biopsy of the metastatic lesions. Although she failed to document
4 it in the patient's chart, Respondent contends L.M. was adamant in forbidding her to perform a
5 colostomy, and that L.M.'s wishes governed Respondent's operative choices throughout the time
6 she cared for him.

7 13. Two days post-op, on or about April 17, 2006, L.M. developed nausea, emesis, and
8 increased abdominal pain. Amid concerns of a colocolic anastomotic leak, Respondent ordered
9 an abdominal CT-scan. The scan revealed expected post-operative changes, which neither
10 confirmed, nor ruled-out a leak. The reading radiologist noted a dilated stomach with possible
11 pneumatosis of the stomach wall. Respondent believed the scan indicated a re-exploration
12 procedure was appropriate. Her pre-operative diagnosis was gastric dilatation/pneumatosis.

13 14. Respondent performed the re-exploration later that day. L.M.'s stomach looked
14 healthy, but Respondent felt the right colon appeared "dusky". Concerned that the dusky
15 appearance may have been due to colonic ischemia, Respondent performed a right-sided
16 hemicolectomy, attaching the terminal ileum to the distal transverse colon. She also performed a
17 gastrostomy to decompress the stomach. The pathology report analyzing the resected colon did
18 not confirm critical ischemia, though there were scattered ulcerations that were possibly ischemic
19 in nature.

20 15. On or about April 23, 2006, Respondent documented concerns about a gastric outlet
21 obstruction, noting that, "we need to know whether there is an abscess, adhesions, or tumor
22 obstructing the efferent limb." The next day, April 24, 2006, Respondent conducted another re-
23 exploration, with a pre-operative diagnosis of gastric dilatation secondary to possible rupture.
24 The pre-operative diagnosis proved to be incorrect, but Respondent did find peritoneal
25 contamination with small bowel contents and leakage from the ileal stump adjacent to the
26 ileocolic anastomosis she had fashioned two days earlier. Respondent proceeded to revise and re-

27
28 ³ An anastomosis is the connection of normally separate parts or spaces so they intercommunicate.

1 create the ileocolic anastomosis. She also revised the gastrojejunostomy that had been performed
2 years earlier, utilizing a total of two anastomoses to re-establish intestinal continuity. L.M. did
3 not do well postoperatively, and he passed away about three days after the surgery.

4 16. Respondent's decision to perform a re-exploration procedure on L.M. two days after
5 he had undergone emergency intra-abdominal surgery constitutes gross negligence. The
6 symptoms L.M. was displaying on post-operative day two should have been recognized as
7 secondary to a routine postoperative ileus. A reasonably prudent surgeon would have simply
8 placed a nasogastric tube, and waited a few days for the ileus to resolve. Further, Respondent
9 took the unusual step of obtaining a CT-scan on post-operative day two. A reasonably prudent
10 surgeon would consider it a mistake to be guided by CT-scan findings sooner than post-operative
11 day five or six following a laparotomy. Intraoperatively, L.M.'s stomach was normal, and it was
12 unnecessary for Respondent to perform a gastrostomy when a nasogastric tube would have
13 sufficed, without the risk of leak from creating another hole in L.M.'s gastrointestinal tract.
14 Finally, despite the alleged "dusky" appearance of the right colon, Respondent should not have
15 performed a hemicolectomy at that time given all the circumstances. Indeed, the pathology
16 findings demonstrated the absence of any full thickness necrosis in the colon at that time, and the
17 hemicolectomy exposed L.M. to an unreasonable risk for post-surgical complications.

18 17. The decision to order a CT-scan on post-operative day two, which led to the the
19 decision to put L.M. through an abdominal re-exploration that day resulting in the performance of
20 a gastrostomy and right-sided hemicolectomy secondary to the re-exploration, all constitute
21 extreme departures from the standard of care relative to Respondent's care and treatment of
22 patient L.M.

23 18. The gastrojejunostomy revision performed by Respondent on L.M. on or about April
24 24, 2006, constitutes gross negligence. By the time Respondent took L.M. back to surgery on or
25 about April 24, 2006, he was a very medically fragile elderly gentleman who had recently
26 undergone two major operative procedures. He should not have been subjected to any surgical
27 procedure for a condition that was not directly life-threatening. The gastrojejunostomy in place
28 prior to the surgery had worked well for many years, and there was no reason to suspect it would

1 not continue to keep working. Thus, the revision procedure was completely unnecessary, and
2 subjected L.M. to unreasonable risk for post-surgical complications. The contraindicated revision
3 procedure contributed to L.M.'s death three days later. Performance of the procedure under the
4 circumstances constitutes an extreme departure from the ordinary standard of conduct relative to
5 Respondent's care and treatment of patient L.M.

6 Patient C.R.

7 19. C.R. was a chronically debilitated, bedbound 68 year-old female patient when she
8 underwent a blind-ended distal colostomy. The surgical procedure was performed by Respondent
9 on or about March 5, 2007, utilizing a minimally invasive trephine incision. Prior to the surgery,
10 Respondent made no formal identification of the proximal limb. Rather, she assumed from the
11 orientation of the bowel that the superior bowel was proximal, and the inferior bowel was distal.
12 Consequently, Respondent mistakenly formed the colostomy from the defunctionalized (distal)
13 limb, and stapled off the end of the functional (proximal) limb.

14 20. On or about March 16, 2007, Respondent re-explored C.R.'s abdomen because the
15 colostomy was not working, and C.R. had become critically ill with respiratory failure and
16 hypotension. Respondent utilized a midline incision to re-explore C.R.'s abdomen. In her
17 operative note, she documented the presence of a volvulus (abnormally twisted) descending
18 colon, but did not document the fact that she had fashioned the colostomy from the wrong limb
19 eleven days earlier. Respondent appropriately revised the colostomy to a correct and functional
20 formation, and the post-operative pathology report documented removal of the original
21 colostomy. Postoperatively, C.R. developed abdominal wall necrosis requiring debridement, and
22 a bowel fistula. She died from complications related to her underlying vascular disease thirteen
23 months later.

24 21. Forming the colostomy from the wrong limb constitutes gross negligence by
25 Respondent relative to her care and treatment of C.R. All reasonably prudent surgeons
26 understand the potential of mistakenly utilizing the wrong limb when performing a colostomy,
27 particularly when using a minimally invasive technique such as a trephine incision. There are a
28 number of different means available to a surgeon to assure that the proper limb is utilized in

1 forming a colostomy, and the surgeon must avail himself or herself of one of those means to
2 ensure the appropriate limb is used. Respondent's failure to take proper steps to satisfy herself
3 that she was utilizing the correct limb when she performed the March 9, 2006, colostomy on C.R.
4 constitutes an extreme departure from the ordinary standard of conduct relative to Respondent's
5 care and treatment of patient L.M.

6 SECOND CAUSE FOR DISCIPLINE
7 (Repeated Negligent Acts)
8 [B&P Code Section 2234(c)]

9 22. Respondent's license is subject to disciplinary action under section 2234(c) in that she
10 is guilty of repeated negligent acts relative to her care and treatment of three separate patients.
11 The facts constituting the negligence are set forth, *infra*.

12 Patient S.V.

13 23. Patient S.V. was 63 years-old when she was admitted to the hospital on or about
14 December 20, 2007. S.V. was an obese, diabetic female with a chief complaint of abdominal pain.
15 Laboratory testing revealed an elevated white blood cell ("WBC") count, and an abdominal CT-
16 scan was positive for inflammation in the area of the terminal ileum, cecum, appendix, and
17 sigmoid colon. S.V. was treated conservatively with antibiotic therapy for three days.

18 24. However, by December 23, 2007, she was experiencing more abdominal pain, her
19 WBC had risen, and a repeat abdominal CT-scan showed increased inflammatory changes. At
20 that point, with conservative therapy having failed, Respondent decided to perform abdominal
21 exploratory surgery. Respondent's preoperative diagnosis was cecal diverticulitis. However,
22 intraoperatively, she discovered two areas of perforation in S.V.'s terminal ileum, which
23 Respondent thought may have been secondary to Crohn's disease, a bacterial infection, or a
24 mycobacterial infection. The sigmoid colon was observed to be positive for diverticulosis, but
25 negative for inflammation. During the surgical procedure, Respondent placed a drain in the right
26 paracolic gutter.

27 25. On or about January 4, 2008, post-op day 12, the drain produced material that
28 appeared to be fecal in nature. Although S.V.'s WBC was elevated, an abdominal CT-scan
performed that day was negative for any signs of abscess or colitis. The next day, January 5,

1 2008, Respondent performed a second abdominal exploratory procedure. At that time, she found
2 a small sigmoid colon diverticular perforation. She proceeded to resect 5 mm. of sigmoid colon,
3 and completed a Hartmann's operation with an end colostomy and blind rectosigmoid stump.
4 During the exploratory surgery, Respondent disrupted the ileocolic anastomosis from the prior
5 exploratory surgery, which required resection and creation of a new anastomosis.

6 26. Respondent's decision to perform a re-exploration of S.V.'s abdomen on or about
7 January 5, 2008, is a departure from the standard of care. The fecal fistula was being controlled
8 by the right paracolic gutter drain, and the abdominal CT-scan performed that day did not
9 demonstrate a drainable collection, and did not suggest the presence of colonic ischemia. Even if
10 S.V. was experiencing either an anastomotic leak and/or a perforated sigmoid diverticulitis, both
11 conditions could be treated by drainage alone, and a drain was already in place. Further, the re-
12 exploration surgery was difficult and unreasonably dangerous under the circumstances. S.V. was
13 in stable condition, and as she was only on post-op day 13, it was quite possible that S.V.'s fecal
14 fistula would have spontaneously resolved with bowel rest and additional time. Re-exploring the
15 abdomen subjected S.V. to unreasonable complications due to the inflammation and adhesions of
16 all bowel segments at that post-operative stage. In short, the surgical risks of the January 5, 2008,
17 abdominal re-exploration clearly outweighed the potential benefits, and exposing S.V. to those
18 risks constitutes a departure from the applicable standard of care relative to Respondent's care and
19 treatment of patient S.V.

20 Patient N.M.

21 27. Patient N.M. was a 70 year-old morbidly obese female with a history of diabetes,
22 revision gastric bypass surgery, and a chronically incarcerated ventral incisional hernia when she
23 presented to Tri-City Hospital with acute cholecystitis on or about April 19, 2008. She was
24 admitted for IV antibiotic therapy. The admitting internist noted that N.M. was likely to
25 ultimately need an open (as opposed to laparoscopic) cholecystectomy given her history of gastric
26 bypass and her underlying obesity, as the procedure would be more challenging given those
27 factors.

28

1 28. On or about April 25, 2008, Respondent took N.M. to the operating room for a
2 laparoscopic procedure consisting of gall bladder removal, lysis of adhesions, and a ventral hernia
3 suture repair. The operation lasted 3 hours and 20 minutes. By the evening of April 26, 2008,
4 N.M. was hypotensive, and had experienced a significant drop in hemoglobin and hematocrit
5 levels, which was suggestive of an intra-abdominal hemorrhage. Respondent took N.M. back to
6 surgery and commenced a laparoscopic exploratory procedure. After approximately 2 hours and
7 30 minutes, Respondent converted to an open procedure because she was unable to evacuate all
8 clot material and adequately evaluate the abdomen for the source of the bleed. When Respondent
9 opened N.M.'s abdomen, she discovered a segment of transverse colon that had been
10 devascularized during the prior day's operative procedure, which required resection. Respondent
11 removed 31 cm. of colon, and made a primary anastomosis. The surgery lasted a total of 4 hours
12 and 30 minutes.

13 29. Respondent's decision to begin and complete the April 25, 2008, surgery
14 laparoscopically constitutes a departure from the applicable standard of care given N.M.'s risk
15 factors, which included two prior open upper abdominal operations and a symptomatic,
16 chronically incarcerated ventral hernia. Further, Respondent's devascularization of N.M.'s
17 transverse colon constitutes a departure from the applicable standard of care. Finally,
18 Respondent's performance of the April 26, 2008, exploratory procedure on N.M. constitutes a
19 departure from the applicable standard of care in that Respondent began the procedure
20 laparoscopically, and it took her over two hours to make the decision to convert to an open
21 procedure. That was an unacceptably long period of time given N.M.'s comorbidities and the life-
22 threatening nature of her intra-abdominal bleed.

23 Patient K.G.

24 30. Patient K.G. was an 82 year-old man suffering from a partially obstructing right-
25 sided colon cancer when, on or about June 24, 2007, Respondent performed an exploratory
26 surgical procedure on K.G. utilizing a right upper quadrant oblique transverse incision.
27 Intraoperatively, Respondent discovered a large hepatic flexure mass that invaded the mesentery,
28 including large lymph nodes within the mesentery. Respondent attempted a radical resection of

1 the cancerous tissue, and as the surgery progressed, Respondent encountered massive
2 hemorrhaging from the root of the mesentery. Respondent called for, and received, assistance
3 from an on-call trauma surgeon, and the two surgeons were able to get control of the bleeding,
4 which proved to be a venous bleed from a superior mesenteric vein branch. Seven units of blood
5 were required to restore adequate blood volume. Due to concerns about the viability of the small
6 bowel, Respondent did not make an anastomosis, but rather performed a "damage control"
7 abdominal closure utilizing an IV bag and surgical towels to avoid an abdominal compartment
8 syndrome.

9 31. Postoperatively, K.G.'s condition deteriorated. He developed signs and symptoms
10 of sepsis such as disseminated intravascular coagulation and anuria. On or about the morning of
11 June 25, 2007, Respondent took K.G. back to surgery and removed 42 cm. of nonviable small
12 bowel. That afternoon, Respondent again took K.G. back to surgery and removed another 251
13 cm. of ischemic small intestine. At that time, she also made a jejunocolic anastomosis, which
14 remained leak-free through K.G.'s July 17, 2007, hospital discharge.

15 32. Respondent's care and treatment of K.G. constitutes a departure from the
16 applicable standard of care relative to the initial cancer surgery. While surgical intervention was
17 indicated, given the fact that K.G. was an elderly and sick gentleman, Respondent's surgical
18 technique was overly aggressive, and demonstrated an unacceptable disregard for potential
19 surgical risks.

20 33. In sum, Respondent's actions as described, *supra*, constitute repeated negligent
21 acts within the meaning of section 2234(c) relative to her care and treatment of S.V., N.M., and
22 K.G., respectively as follows:

- 23 1. On or about January 5, 2008, Respondent performed a contra-indicated
24 abdominal exploratory surgery on patient S.V.
- 25 2. On or about April 25, 2008, Respondent performed a laparoscopic
26 abdominal procedure on patient N.M., when the circumstances warranted
27 an open procedure.
- 28 3. Respondent caused devascularization of N.M.'s transverse colon during

the laparoscopic procedure she performed on or about April 25, 2008.

4. When Respondent re-explored N.M.'s abdomen the day after the initial laparoscopic procedure, she began the re-exploration laparoscopically, and failed to convert to an open procedure in a timely manner.

5. The operative procedure Respondent performed on K.G. on or about June 24, 2007, was overly aggressive under the circumstances that existed at the time.

THIRD CAUSE FOR DISCIPLINE

(False Documentation)

[B&P Code Section 2261]

Patient C.R.

34. Complainant hereby incorporates paragraphs 19-20 of the instant Accusation as though fully set forth herein.

35. Respondent is guilty of unprofessional conduct pursuant to section 2261 in that she drafted and signed an operative report relative to the March 16, 2007, surgical procedure she performed on patient C.R., and knowingly failed to state in the report that she had utilized the wrong limb to form C.R.'s colostomy on or about March 5, 2007. Respondent omitted her error from the report intentionally and purposefully, despite the fact that her error was a significant and material factor in C.R.'s medical care and treatment. The unprofessional conduct committed by Respondent in falsifying C.R.'s medical record subjects her license to discipline.

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PRAYER

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

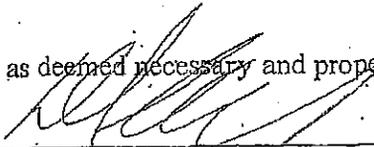
4 1. Revoking or suspending physician's and surgeon's certificate number G 74754, issued
5 to Mary Charlene Murphy, M.D.,

6 2. Revoking, suspending or denying approval of Mary Charlene Murphy, M.D.'s
7 authority to supervise physician's assistants, pursuant to section 3527 of the Code;

8 3. Ordering Mary Charlene Murphy, M.D., to pay the costs of probation monitoring, if
9 placed on probation; and,

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

11 DATED: June 22, 2010


LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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