

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

In the Matter of the Accusation
Against:

MAHLON DOUGLAS CANNON, M.D.
Certificate No. C-36460

Respondent.

No. D-4228
L-50192

DECISION

The attached Proposed Decision of the Administrative Law Judge
is hereby adopted by the Division of Medical Quality of the Medical
Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on July 10, 1991.

IT IS SO ORDERED June 10, 1991.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA



THERESA CLAASSEN
Secretary/Treasurer

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

In the Matter of the Accusation)	
Against:)	No. D-4228
)	
MAHLON DOUGLAS CANNON, M.D.)	OAH No. L-50192
5727 Ravenspur, No. 304)	
Rancho Palos Verdes, CA 90274)	
)	
Physician and Surgeon)	
Certificate No. C036460)	
)	
Respondent.)	
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PROPOSED DECISION

This matter came on for hearing before Richard J. Lopez, Administrative Law Judge of the Office of Administrative Hearings on 19 February 1991, and thereafter on the following days in 1991: February 20, 21, 25, 26, 27, 28; March 4, 5, 6, 7, 11, 12, 13, 14, 18 and 19.

Calvin W. Torrance and Linda J. Vogel, Deputies Attorney General represented the complainant.

Henry Levin and Mark Levin, Attorneys at Law, represented respondent.

At the request of complainant the record was held open to allow complainant to file and serve written summation. Said summation was received on 27 March 1991. Thereafter, respondent's oral summation was heard on 2 April 1991, followed by complainant's oral rebuttal thereto. The matter was then submitted for decision.

The Administrative Law Judge now finds, determines and orders as follows:

PARTIES AND JURISDICTION

1

Complainant, Kenneth J. Wagstaff, Director of the Medical Board of the State of California (MBC) brought subject accusation and first supplemental accusation (pleadings) in said official capacity.

2

On 30 April 1975, Mahlon Douglas Cannon, M.D., respondent herein, was issued physician and surgeon certificate number C036460 by the Board of Medical Quality Assurance, predecessor to MBC. That license is in current status at the present time, and was in full force and effect at all times mentioned in this decision.

3

(A) On complainant's motion the allegations set forth in paragraph 10(C) of the accusation were stricken and, therefore, dismissed:

(B) All motions and arguments not affirmed or denied herein, or on the record, are found not to be established by the facts or the law and are, accordingly, denied.

4

All pre-hearing jurisdictional requirements have been met. Jurisdiction for that proceeding does exist.

FINDINGS OF FACT

RE

PLEADINGS

Findings re: Patient Donna H.

5

On 12 August 1986, Donna H., a 20 year old, female, gravida 1 (number of pregnancies) para 0 (number of live births), 21 weeks pregnant, sought an elective abortion from Her Medical Clinic (HMC), a physician's office located at 2700 South Figueroa, Los Angeles, California. Laminaria had been inserted the previous day, 11 August 1986, by another physician at HMC. Donna H.'s first visit to the HMC had been 28 July 1986, at which time she was evaluated as having a pregnancy of approximately 19 weeks,

2

(A) On 12 August 1986, Donna H., who was a known asthmatic, had a dilation and evacuation, performed by respondent, while under general anesthetic of Brevital and nitrous oxide. The anaesthesia was administered by a Certified Registered Nurse Anaesthetist (CRNA) under respondent's supervision. Donna H. was not intubated at the start of the surgery.

(B) The surgery was performed and the anaesthesia was administered without a proper pre-operative examination.

(C) Donna H.'s history was two weeks old, and was - in light of Donna H.'s asthmatic condition - inadequate at the time that it was taken, and was not updated at the time of surgery and induction of anaesthesia.

(D) Anaesthesia was induced with Brevital, followed by nitrous oxide.

(E) Shortly after induction, the CRNA experienced difficulty in ventilating Donna H. by mask, due to bronchospasm and/or laryngospasm.

(F) Respondent continued with the abortion for a period of no less than 4 to 5 minutes while the CRNA attempted to restore Donna H.'s respiration.

(G) Neither the CRNA nor respondent administered to Donna H. any sufficient medication to reverse bronchospasm.

(H) Respondent then attempted the "Heimlich maneuver" on Donna H. Following that, he returned her to a supine position and tried to clear her airway with his fingers.

(I) Respondent attempted to ventilate said patient for approximately two more minutes; a tracheotomy or a cricothyrotomy was attempted, but said attempt failed to establish an airway.

(J) Paramedics were then called, did appear and they left with Donna H. in full arrest. Donna H. died on 13 August 1986, as a result of the failure to establish an airway or ventilate her.

With regard to respondent's treatment and care of patient Donna H. respondent committed or omitted the following particular acts:

(A) Respondent allowed Donna H., a known asthmatic, to be administered general anaesthesia of a barbiturate type, without a physical examination.

(B) Respondent allowed Donna H., a known asthmatic, to be administered a general anaesthesia of a barbiturate type, without an adequate and current medical history.

(C) Donna H. was given an insufficient dosage of medication to dry up secretions.

(D) Following the report of the CRNA that she was having difficulty ventilating Donna H., respondent continued to perform Donna H.'s abortion to completion, rather than assisting the CRNA with Donna H.'s ventilation.

(E) Respondent failed to administer or have administered to Donna H. any sufficient medication to reverse laryngospasm.

(F) Respondent's said acts and omissions caused Donna H.'s preventable death.

7

Respondent's conduct set forth in Finding 6 constitutes gross negligence and is, accordingly, unprofessional conduct.

8

Additionally, with regard to respondent's treatment of patient Donna H. respondent committed the following particular acts:

(A) Respondent performed an abortion on Donna H. without an adequate and current medical history.

(B) Respondent performed an abortion on Donna H. without an adequate physical examination.

9

Respondent's conduct set forth in Finding 6(A) is a negligent act. Respondent's conduct set forth in Findings 6(B), 6(C), 6(D), 6(E), 6(F), 8(A), and 8(B), considered separately, does constitute negligence. Accordingly, said negligent acts subsequent to Finding 6(A) are repeated negligent acts and said conduct is, therefore, unprofessional conduct.

Respondent's conduct set forth in Findings 6(C), 6(D), 6(E) does constitute incompetence, and is accordingly unprofessional conduct. Said conduct did cause Donna H.'s preventive death.

Findings re: Patient Liliana C.

On 20 September 1986, Liliana C., a 22 year old female, gravida 1, para 0, approximately 17-19 weeks pregnant, a known asthmatic, sought at elective abortion at Her Medical Clinic.

(A) On 20 September 1986, at 9:15 a.m., laminaria were inserted. At 2:30 p.m., Liliana C. received a preoperative medication of Librium, with Atropine. Following that, respondent removed Liliana C.'s laminaria and administered a paracervical block of 10cc of 2% Xylocaine with epinephrine.

(B) The care of Liliana C. was then assumed by an HMC physician (M.D.) other than respondent who began the surgery. Liliana C. seized, had slowed respirations, and then developed cardiac arrest.

(C) Certain of the staff of HMC became involved in the attempts at Liliana C.'s resuscitation while the M.D. completed the abortion.

(D) Liliana C. developed a full respiratory arrest and cardiac arrest.

(E) Ultimately, Liliana C. was transported by paramedics to California Hospital Medical Center, where she was brain dead upon arrival. She was pronounced dead a week later.

The whole of the evidence and reasonable inferences therefrom did establish that Liliana C., with proper care and treatment at HMC, would not have died. However, it was not established clearly and convincingly, other than as set forth in Finding 11(A), to what extent, if any, respondent provided care and treatment of Liliana C. Accordingly, it was not established that respondent was one of those at HMC who caused or contributed to Liliana C.'s preventable death.

Findings Re: Patient Isabel M.

13

On 1 November 1985, respondent performed an elective abortion on Isabel M., a 27 year old female, gravida 6, para 4, tab 2 (number of previous therapeutic abortions), who was approximately 9 weeks pregnant. With regard to the treatment and care of said patient respondent performed an abortion on Isabel M. without conducting a physical examination.

14

Respondent's conduct set forth in Finding 13 is a negligent act and is, in light of Finding 9 a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Cordelia M.

15

On 7 January 1986, Cordelia M., a 34 year old female, gravida 3, para 1, approximately 6 weeks pregnant, Rh negative, received an elective abortion from respondent. On 17 January 1986, Cordelia M. returned to respondent with complaints of pelvic pain and bleeding without fever. The procedure was repeated at HMC.

16

As part of respondent's treatment and care, Cordelia M., who was Rh negative, did not receive Rhogam after the 7 January 1986 abortion, nor was her Rh negativity noted at the time of the repeat procedure at HMC.

17

Respondent's conduct set forth in Finding 16 does constitute negligence and is, in light of Findings 9 and 14, a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Reina E.

18

On 2 May 1986, Reina E., a 33 year old female, gravida 8, para 5, tab 2, 11 weeks pregnant by dates and 14 weeks pregnant by size, had an abortion by respondent.

(A) Preoperatively, Reina E. complained of an approximate one week history of chills, fever and pain all over her body.

(B) No pre-operative physical examination was conducted.

(C) Respondent recognized Reina E.'s septic incomplete abortion only post-operatively. Respondent then arranged for Reina E.'s transfer to Martin Luther King Hospital, where she was treated with antibiotics and her uterus was repaired. She was discharged on 7 May 1986.

19

With regard to respondent's treatment and care of said patient respondent committed or omitted the following particular acts:

(A) Respondent performed surgery on Reina E. without a pre-operative physical examination, including temperature and white blood count.

(B) Respondent failed to administer intravenous antibiotics prior to the abortion.

20

Respondent's conduct set forth in Finding 19 does constitute gross negligence and is, therefore, unprofessional conduct.

21

With regard to patient Reina E. respondent failed to start an intravenous prior to the surgery.

22

Respondent's conduct set forth in Findings 19(A), 19(B) and 21, considered separately, does constitute negligence and, in light of Findings 9, 14, and 17, each is a repeated negligent act and said conduct is, therefore, unprofessional conduct.

23

Respondent recognized said patient's septic incomplete abortion only post-operatively.

Respondent's conduct set forth in Finding 23 does constitute incompetence and is, therefore, unprofessional conduct.

Findings Re: Patient Jolanta N.

On 27 December 1986, Jolanta N., a 24 year old female, gravida 2, para 1, eight weeks pregnant by size, had an elective abortion by respondent. A few days after the procedure, Jolanta N. experienced sharp pain below her abdomen and was unable to eat for several days.

(A) On 23 January 1987, Jolanta N. returned to respondent with a history of pain, and positive urine pregnancy tests at other facilities.

(B) A repeat suction curettage was performed by respondent. Operative findings revealed 15 ml of retained chorionic villi.

With regard to the treatment and care of said patient respondent, in particular, committed the following acts:

(A) On 27 December 1986, respondent performed Jolanta N.'s abortion without a hematocrit.

(B) Respondent denied Jolanta N. pain relief for approximately 45 minutes following her reaspiration, a period during which she was in extreme pain.

Each of the acts set forth in Findings 26(A) and 26(B) is a negligent act and each is, in light of Findings 9, 14, 17, and 22 a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Tracey K. (Betty M.)

On 19 January 1987, Tracey K. (Betty M.) a 17 year old female, gravida 1, para 0, approximately 6 weeks pregnant, went to HMC for oral contraceptives, was informed she was pregnant, and received an elective abortion from respondent.

29

Respondent performed said abortion on Tracey K., and anaesthesia was administered to Tracey K., in the absence of a physical examination, and in the absence of a determination as to the duration of Tracey K.'s pregnancy.

30

Respondent's conduct set forth in Finding 29 does constitute gross negligence and is, therefore, unprofessional conduct.

31

Respondent performed said abortion on Tracey K. without a hematocrit.

32

Each of respondent's acts set forth in Findings 29 and 31 is a negligent act and each is, in light of Findings 9, 14, 17, 22, and 27 a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Tijuanna J.

33

On 18 September 1987, Tijuanna J., a 29 year old female, gravida 4, para 2, tab 1, 11 weeks pregnant, had an elective abortion by respondent. Tijuanna J. returned to respondent on 24 September 1987, complaining of cramping and of vaginal bleeding without fever. Respondent then performed a repeat suction curettage.

34

On 24 September 1987, respondent performed said abortion procedure without a hematocrit.

35

Respondent's conduct set forth in Finding 34 is a negligent act and in light of Findings 9, 14, 17, 22, 27, and 32 is a repeated negligent act and such conduct is, therefore, unprofessional conduct.

Patient Donetta E.

36

On 16 August 1988, Donetta E., a 19 year old female, gravida 5, para 3, tab 1, had an elective abortion by respondent. The procedure was done without prior insertion of laminaria. A local anesthetic was administered t 3:50 p.m., and the abortion was completed at 4:00 p.m.

(A) The patient was administered Methergine at 4:00 p.m., and 4:15 p.m., and respondent sutured her cervix for unusual bleeding. The patient was released to go home at 5:10 p.m. with three tampons in her vagina. She subsequently left HMC at approximately 7:15 p.m.

(B) Following discharge, Donetta E. experienced great pain; she telephoned HMC staff, who told her that her pain was normal and recommended against going to a hospital. A friend called paramedics, and Donetta E. was brought to California Medical Center (CMC) at 10:50 p.m. Examination on admission revealed Donetta E. to be in acute distress with unstable vital signs (i.e., blood pressure 100/64, pulse approximately 100), a rigid tender abdomen with rebound tenderness, scant vaginal bleeding, but diffuse pelvic tenderness, and a hematocrit of 24.5%.

(C) Respondent was telephoned, and the current examination, including the low hematocrit, was related to him. Respondent told Donetta E.'s attending physician that he doubted that her uterus was perforated, that she probably could be sent home, and that he didn't want to see her in the hospital, but that she should be instructed to follow-up in a week or two at HMC.

(D) Donetta E. was admitted and an emergency exploratory laparotomy was performed due to unstable vital signs and a falling hematocrit believed to be secondary to hemorrhage. Operative findings revealed a large amount of retroperitoneal and intraperitoneal blood estimated to be 2,000 cc., secondary to be 3-4 cm. uterine perforation extending from an area superior to the internal cervical os to the mid-fundus. The surgical team performed a supracervical hysterectomy and unilateral salpingo-oophrectomy for uterine perforation.

37

Respondent refused to assume care of patient Donetta E. when notified by CMC, and suggested that the patient, with evidence of obvious hypovolemic shock, secondary to blood loss with unstable vital signs and a falling hematocrit, be released home.

10

Respondent's conduct set forth in Finding 37 does constitute gross negligence and is, therefore, unprofessional conduct.

Additionally, with regard to respondent's treatment and care of patient Donetta E. respondent committed the following particular acts:

(A) Respondent performed said abortion on Donetta E. without a physical examination.

(B) Respondent performed said abortion on Donnetta E. without obtaining an adequate medical history of the patient.

(C) Respondent's medical record of his care and treatment of Donetta E. was insufficient and inadequate in view of her known complication.

(D) Respondent administered to Donetta E. an excessive dosage of Methergine.

Each of the acts set forth in Findings 37 and 39 is a negligent act and each is, in light of Findings 9, 14, 17, 22, 27, 32, and 35 a repeated negligent act and such conduct is, accordingly, unprofessional conduct.

Respondent recommended that Donetta E., with evidence of obvious hypovolemic shock secondary to blood loss, with unstable vital signs and a falling hematocrit, be sent home rather than be hospitalized.

Respondent's conduct set forth in Finding 41 does constitute incompetence and is, therefore, unprofessional conduct.

SUPPLEMENTAL FINDINGS

(A) The autopsy Report (opinion) of the Coroner revealed the cause (ascribing) of Donna H.'s death in summary as follows:

- - -

SEQUELAE OF ANOXIS DUE TO RESPIRATORY ARREST
FOLLOWING INDUCTION OF GENERAL ANESTHESIA FOR
THERAPEUTIC ABORTION

- - -

Other Significant Conditions-

Other. bronchial asthma; contact sensitivity
allergy, by history

Said Coroner's Anatomical Summary (opinion) is as follows:

- I. Intrauterine pregnancy of estimated 21 weeks gestation, clinical.
 - A. Status-post uterine dilation and curettage (8-12-86) for therapeutic abortion.
 1. Induction of general anesthesia with methohexital sodium, succinylcholine, and nitrous oxide.
 2. Severe respiratory depression following induction of anesthesia.
 - a. Status-post tracheostomy.
 - b. Anoxic encephalopathy. . .
- II. Bronchial asthma and contact sensitivity allergy, by history.

Said opinions are competent and credible opinions supported by reasonable inferences from the whole of the evidence.

44

Respondent, as physician (healer) and surgeon of record, had a number of opportunities during the course of his physician/patient relationship with Donna H. to prevent that patient's death. The patient disclosed her asthmatic condition on a HMC form but no further history or inquiry in that regard was taken by either respondent or any of HMC's medical staff under respondent's supervision; thus the patient was at risk. Respondent performed no physical examination on the patient prior to surgery and none was done, under respondent's supervision, by any of HMC's medical staff; thus the patient was at risk. When the CRNA, during surgery, was having difficulty ventilating the patient and

respondent had clear notice¹ of same he did not, as healer, timely respond to a major respiratory catastrophe. When he did respond, his course of action included none of the following to make a proper diagnosis of the cause of the catastrophe: he did not listen to and check the patient's lungs to verify that they were empty and then attempt to intubate and ventilate the patient and, failing that, attempt proper medication of the patient to reverse bronchospasm. Thus, unwittingly, respondent became not the patient's healer but the patient's adversary.

45

(A) While under respondent's care patient Donna H. was placed at risk over and above risks routinely associated with the procedure of a therapeutic abortion. The risk (chance of happening) of Anoxia (in lay terms: no oxygen) due to respiratory arrest, became reality (certainty) and the patient died.

(B) Other patients set forth in these Findings were placed at varying degrees of risk over and above those risks routinely associated with the procedure of a therapeutic abortion: Respondent performed TAB surgery on Isabel M., Reina E. (a septic patient) and Donetta E. without a physical examination of those patients and, thus, each patient was exposed to a risk (chance) of some untoward or, potentially, life threatening event. Donetta E. was at further risk had CMC not disregarded respondent's "advice" and administered competent care and treatment to said patient. Cordelia M., Rh negative was at the discernable risk of, potentially, never bearing a live child because she did not timely receive Rogham. Respondent performed TAB surgery on Jolanta N., Tracey K., and Tijuanna J. without a hematocrit and, thus, each patient was at risk. Jolanta N. was not attended to while in pain and, thus, was at further risk. Tracey K. underwent abortion without physical examination and, thus, was at further risk.

46

(A) Respondent received his medical degree from Meharry Medical College, Nashville, Tennessee in 1973. He then interned at Martin Luther King Hospital/Charter Drew Post and did a rotating residency at that same institution with an emphasis in obstetrics and gynecology. Respondent has been licensed since 1975. Upon completion of his residency he engaged in private practice in

¹Among other factors alerting respondent to the catastrophe, including the reported difficulty of his subordinate, the CRNA, respondent would have or should have been alerted by the visible darkening of the patient's blood and once so alerted he knew or should have known he had only a few minutes in which to act to restore the patient's respirations and, thus, save the patient's life.

Compton, California from 1977 to 1984 and tended to approximately 40 to 45 "medical" or "medicare" patients per day for various obstetrical or gynecological problems. In 1984 he assumed a practice at a second location in Compton consisting of health care for women. In 1985 he relocated his practice to Long Beach and remained there until 1988.

(B) During 1985 he became associated with HMC in order to supplement his income. He entered into a Rental/Management/Service agreement with Mediken Management Corporation (legally, the master lessee of the HMC premises; colloquially the "overseer" of the business conducted at said premises). Under said agreement respondent provided medical services as an independent contractor. In 1988 he terminated his association with HMC.

(C) Respondent is now associated, as an independent contractor with Family Planning Associates, and has been so since March 1988, primarily involved in performing therapeutic abortions.

(D) Respondent is not certified in his specialty by the American Board of Medical Specialties (originally the Advisory Board on Medical Specialties) nor is respondent, presently, Board "eligible". While in practice at HMC respondent was not subject to peer review. HMC, nominally named as a "clinic", was in fact an "office" practice wherein respondent and other MD's routinely engaged in the surgical procedure of abortion. Presently, and at times pertinent herein, there is no known legal or ethical bar from performing such a procedure in an office setting. However, at no time was there in place at HMC any peer review mechanism such as would (or should) be in place in a properly licensed, regulated and insured facility. In regard thereto, it is here noted that respondent's negligent, grossly negligent and incompetent conduct set forth in those Findings began in 1985, his initial year at HMC, and culminated in the rather recent conduct (1988) involving Donetta E. The Findings herein detail a number of breaches of varied nature of respondent's duties, obligations, and responsibilities to patients and thus demonstrate that, at present, respondent cannot safely practice medicine.

47

All factual allegations of the pleadings not hereinbefore found to be established are found to be unproven.

DETERMINATION OF ISSUES

I

(A) Business and Professions Code (BPC) sections 2003 and 2004 provide, in pertinent part, that there is a Division of Medical Quality within the Medical Board of California, responsible

for the enforcement of the disciplinary provisions of the Medical Practice Act (Chapter 5 of Division 2 of the Business and Professions Code); the administration and hearing of disciplinary actions appropriate to findings made by a medical quality review committee, the division, or an administrative law judge; and the suspension, revocation, or the imposition of limitations on certificates after the conclusion of disciplinary actions.

(B) BPC sections 2220, 2227 and 2234 authorize said Division to suspend or revoke a physician's and surgeon's certificate, or to take other disciplinary action against a certificate holder who is guilty of unprofessional conduct.

(C) BPC section 2234(a), provides that violating . . . any provision of the Medical Practice Act, is unprofessional conduct.

(D) BPC section 2234(b) provides that gross negligence is unprofessional conduct.

(E) BPC section 2234(c) provides that performance of repeated negligent acts is unprofessional conduct.

(F) BPC section 2234(d) provides that incompetence is unprofessional conduct.

II

Cause exists for discipline of Certificate Number C036460 for violation of the following sections of the BPC:

Re: Donna H.

(A) Section 2234(b) by reason of Findings 5, 6, and 7, collectively.

(B) Section 2234(c) by reason of Findings 5, 6, 8 and 9 collectively.

(C) Section 2234(d) by reason of Finding 10.

Re: Isabel M.

(D) Section 2234(c) by reason of Findings 13 and 14, collectively.

Re: Cordelia M.

(E) Section 2234(c) by reason of Findings 16 and 17, collectively.

Re: Reina E.

(F) Section 2234(b) by reason of Findings 19 and 20, collectively.

(G) Section 2234(c) by reason of Findings 19, 21 and 22, collectively.

(H) Section 2234(d) by reason of Findings 23 and 24, collectively.

Re: Jolanta N.

(I) Section 2234(c) by reason of Findings 26 and 27, collectively.

Re: Tracey K (Betty M.)

(J) Section 2234(b) by reason of Findings 29 and 30, collectively.

(K) Section 2234(c) by reason of Findings 29, 31, and 32, collectively.

Re: Tijuanna J.

(L) Section 2234(c) by reason of Findings 34 and 35, collectively.

Re: Donetta E.

(M) Section 2234(b) by reason of Findings 37 and 38, collectively.

(N) Section 2234(c) by reason of Findings 37, 39 and 40, collectively.

(O) Section 2234(d) by reason of Findings 41 and 42, collectively.

III

With regard to patient Liliana C. no cause for discipline of said certificate exists, under any provision of the BCP, by reason of Finding 12.

IV

The objective of an administrative proceeding relating to discipline, if any, of a license is to protect the public; to determine whether a licensee has exercised his or her privilege in derogation of the public interest. Such proceedings are not for

the primary purpose of punishing an individual Camacho v. Youde (1979) 95 Cal.App.3d 161, 165; Ex Parte Brounsell (1778) 2 Cowp. 829, 98 Eng. Rep. 1385. In light of the foregoing and by reason of the number and nature of the violations set forth in Determination II, the order which follows is consistent with the public interest.

ORDER

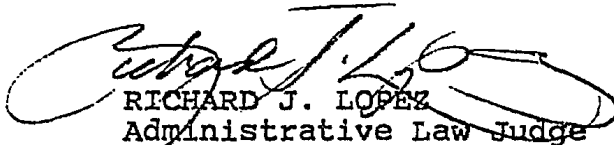
I

Certificate number C036460, previously issued by MBC to Mahlon Douglas Cannon, M.D., is hereby revoked.

II

Said respondent is, hereby, prohibited from supervising a physician's assistant.

Dated: April 25, 1991


RICHARD J. LOPEZ
Administrative Law Judge
Office of Administrative Hearings

RJL:lf

1 JOHN K. VAN DE KAMP, Attorney General
of the State of California
2 LINDA J. VOGEL,
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Los Angeles, California 90010
4 Telephone: (213) 736-3512
5 Attorneys for Complainant

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7
8 BEFORE THE
DIVISION OF MEDICAL QUALITY
9 MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
10 STATE OF CALIFORNIA

11 In the Matter of the Accusation
Against:

NO. D-4228

ACCUSATION

12 MAHLON DOUGLAS CANNON, M.D.
13 5727 Ravenspur #304
Rancho Palos Verdes, CA 90274

14 Physician and Surgeon
15 Certificate Number C036460

16 Respondent.
17

18 Complainant, Kenneth J. Wagstaff, alleges that:

19 1. He is Executive Director of the Medical Board of
20 the State of California (hereinafter the "board"), and brings
21 this accusation solely in his official capacity.

22 2. On April 30, 1975, Mahlon Douglas Cannon, M.D.
23 (hereinafter "respondent") was issued physician and surgeon
24 certificate number C036460 by the Board of Medical Quality
25 Assurance, predecessor to the Medical Board of California. That
26 license is in current status at the present time, and was in full
27 force and effect at all times mentioned herein.

1 3. Business and Professions Code sections 2003 and
2 2004 provide, in pertinent part, that there is a Division of
3 Medical Quality within the Medical Board of California,
4 responsible for the enforcement of the disciplinary provisions of
5 the Medical Practice Act (Chapter 5 of Division 2 of the Business
6 and Professions Code); the administration and hearing of
7 disciplinary actions appropriate to findings made by a medical
8 quality review committee, the division, or an administrative law
9 judge; and the suspension, revocation, or the imposition of
10 limitations on certificates after the conclusion of disciplinary
11 actions.

12 4. Business and Professions Code sections 2220, 2227,
13 and 2234 authorize the Division of Medical Quality to suspend or
14 revoke a physician's and surgeon's certificate, or to take other
15 disciplinary action against a certificate holder who is guilty of
16 unprofessional conduct.

17 5. Business and Professions Code section 2234,
18 subdivision (a), provides that violating or attempting to
19 violate, directly or indirectly, or assisting in or abetting the
20 violation of, or conspiracy to violate, any provision of the
21 Medical Practice Act, is unprofessional conduct.

22 6. Business and Professions Code section 2234,
23 subdivision (b) provides that gross negligence is unprofessional
24 conduct.

25 7. Business and Professions Code section 2234,
26 subdivision (c), provides that performance of repeated negligent
27 acts is unprofessional conduct.

1 8. Business and Professions Code section 2234,
2 subdivision (d) provides that incompetence is unprofessional
3 conduct.

4 Patient Donna H.^{1/}

5 9. On August 12, 1986, Donna H., a 20-year old,
6 female, gravida 1, para 0, 21 weeks pregnant, sought an elective
7 abortion from Her Medical Clinic.^{2/} Laminaria had been inserted
8 the previous day, August 11, 1986, by another physician at the
9 "clinic." Donna H.'s first visit to the "clinic" had been
10 July 28, 1986, at which time she was evaluated as having a
11 pregnancy of 19 weeks.

12 A. On August 12, 1986, Donna H., who was a known
13 asthmatic, had a dilation and evacuation, performed by
14 respondent, while under general anaesthetic of Brevital
15 and nitrous oxide. The anaesthesia was administered by
16 Helen Sims, a Certified Registered Nurse Anaesthetist
17 under respondent's supervision. Donna H. was not
18 intubated at the start of the surgery.

19 B. The surgery was performed and the anaesthesia was
20 administered without a pre-operative examination.

21 C. Donna H.'s history was two weeks old, was
22 inadequate at the time that it was taken, and was not
23 updated at the time of surgery and induction of anaesthesia.

24
25 1. The full names of patients referenced herein are
26 available to respondent upon request for discovery.

27 2. All of the acts and omissions alleged herein occurred
on the premises of "Her Medical Clinic", a physician's office
located at 2700 South Figueroa, Los Angeles, California.

1 D. Anaesthesia was induced with Brevital, followed by
2 nitrous oxide.

3 E. Shortly after induction, Ms. Sims experienced
4 difficulty in ventilating Donna H. by mask, due to
5 bronchospasm and/or laryngospasm.

6 F. Respondent continued with the abortion for several
7 minutes while Ms. Sims attempted to restore Donna H.'s
8 respirations.

9 G. Respondent injected Pitressin with epinephrine and
10 Lidocaine into Donna H.'s cervix, while Ms. Sims was
11 attempting intubation, without success.

12 H. Neither Ms. Sims nor respondent administered to
13 Donna H. any medications to reverse bronchospasm.

14 I. After respondent completed the abortion, he held
15 Donna H.'s neck while Ms. Sims attempted to intubate
16 Donna H., without success.

17 J. Respondent then attempted the "Heimlich maneuver"
18 on Donna H. Following that, he returned her to a supine
19 position and tried to clear her airway with his fingers.

20 K. Respondent attempted to ventilate Donna H. for two
21 more minutes; a tracheotomy was then attempted, but failed
22 to establish an airway.

23 L. Paramedics were called, and they left with Donna H.
24 in full arrest. Donna H. died on August 13, 1986, as a
25 direct result of the failure to establish an airway or
26 ventilate her.

27 /

10. Respondent's certificate to practice as a physician and surgeon is subject to discipline under Business and Professions Code section 2234, subdivision (b) for gross negligence, as more particularly alleged as follows:

A. Respondent allowed Donna H., a known asthmatic, to be administered general anaesthesia of a barbiturate type, without a physical examination.

B. Respondent allowed Donna H., a known asthmatic, to be administered a general anaesthesia of a barbiturate type, without an adequate medical history.

C. Donna H. was not intubated at the induction of anaesthesia and the start of surgery.

D. Donna H. was given an insufficient dosage of medication to dry up secretions.

E. Following Ms. Sims' report that she was having difficulty ventilating Donna H., respondent continued to perform Donna H.'s abortion to completion, rather than assisting nurse Sims with Donna H.'s ventilation.

F. Respondent injected Pitressin with epinenphrine and Lidocaine into Donna H.'s cervix, rather than assisting nurse Sims with Donna H.'s respiratory emergency.

G. Respondent failed to administer or have administered to Donna H. any medications to reverse laryngospasm.

H. Respondent's acts and omissions caused Donna H.'s preventable death.

11. Respondent's certificate to practice as a physician and surgeon is subject to discipline under Business and Professions Code section 2234, subdivision (c), for repeated negligent acts, as more particularly alleged as follows:

A. The facts alleged in subdivisions A through H of paragraph 10 are hereby incorporated by reference as though fully set forth at this point.

B. Respondent performed the abortion on Donna H., a known asthmatic, in a medical office rather than in a hospital.

C. Donna H.'s laminaria were removed five hours prior to her surgery on August 12, 1986.

D. Respondent performed an abortion on Donna H. without an adequate medical history.

E. Respondent performed an abortion on Donna H. without an adequate physical examination.

12. Respondent's certificate to practice as a physician and surgeon is subject to discipline under Business and Professions Code section 2234, subdivision (d), for incompetence, as more particularly alleged as follows:

A. The facts alleged in subdivisions D, E, F, G and H of paragraph 10 are hereby incorporated by reference as though fully set forth at this point.

B. Respondent's acts and omissions caused Donna H.'s preventable death.

A

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Patient Liliana C.

13. On September 20, 1986, Liliana C., a 22-year old female, gravida 1, para 0, 18-19 weeks pregnant, a known asthmatic, sought at elective abortion at Her Medical Clinic.

A. On September 20, 1986 at 9:15 a.m., laminaria were inserted. At 2:30 p.m., Liliana C. received a preoperative medication of Librium with Atropine. Following that, respondent removed Liliana C.'s laminaria and administered a paracervical block of 10cc of 2% Xylocaine with epinephrine.

B. The care of Liliana C. was then assumed by Leo Kenneally, M.D., who began the surgery. Liliana C. seized, had slowed respirations, and then developed cardiac arrest.

C. Respondent became involved in the emergency, supervising Liliana C.'s resuscitation while physician Leo Kenneally completed the abortion.

D. Liliana C. developed a full respiratory arrest and cardiac arrest. Liliana C. was administered Atropine, sodium bicarbonate, and epinephrine. She was defibrillated twice and respondent administered intracardiac adrenalin to her.

E. Liliana C. was transported by paramedics to California Hospital Medical Center, where she was brain dead upon arrival. She was pronounced dead a week later.

14. Respondent's certificate to practice as a physician and surgeon is subject to discipline under Business and

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1 Professions Code section 2234, subdivision (b) for gross
2 negligence, as more particularly alleged as follows:

3 A. Liliana C. was administered no medications to
4 prevent further convulsions.

5 B. Liliana C. was administered no medications to dry
6 secretions.

7 C. A cardiac monitor was not applied to Liliana C.
8 until 3:35 p.m., after her arrest.

9 D. Liliana C.'s oxygen and carbon dioxide were not
10 monitored after her convulsion.

11 E. No medication was administered to Liliana C. for
12 the treatment of shock.

13 F. Respondent's acts and omissions caused Liliana C.'s
14 preventable death.

15 15. Respondent's certificate to practice as a
16 physician and surgeon is subject to discipline under Business and
17 Professions Code section 2234, subdivision (c), for repeated
18 negligent acts, as more particularly alleged as follows:

19 The facts alleged in subparagraphs A through F of
20 paragraph 14 are hereby incorporated by reference as though
21 fully set forth at this point.

22 16. Respondent's certificate to practice as a
23 physician and surgeon is subject to discipline under Business and
24 Professions Code section 2234, subdivision (d), for incompetence,
25 as more particularly alleged as follows:

26 A. Respondent administered a paracervical block to
27 Liliana C. which block contained epinephrine in a solution

1 with sodium metabisulfite, a chemical known to cause
2 allergic reactions, mainly in asthmatics.

3 B. Respondent failed to recognize that giving
4 Liliana C. oxygen by mask was inadequate.

5 C. Respondent's acts and omissions caused Liliana C.'s
6 preventable death.

7 Patient Isabel M.

8 17. On November 1, 1985, respondent performed an
9 elective abortion on Isabel M., a 27 year old female, gravida 6,
10 para 4, tab 2, who was 10 weeks pregnant.

11 18. Respondent's certificate to practice as a
12 physician and surgeon is subject to discipline under Business and
13 Professions Code section 2234, subdivision (c), for repeated
14 negligent acts, as more particularly alleged as follows:

15 A. Respondent performed an abortion on Isabel M.
16 without obtaining an adequate medical history.

17 B. Respondent performed an abortion on Isabel M.
18 without conducting a physical examination.

19 Patient Cordelia M.

20 19. On January 7, 1986, Cordelia M., a 34 year old
21 female, gravida 3, para 1, 6 weeks pregnant, Rh negative,
22 received an elective abortion from respondent. On
23 January 17, 1986 Cordelia M. returned to respondent with
24 complaints of pelvic pain and bleeding without fever. Respondent
25 repeated the procedure.

26 20. Respondent's certificate to practice as a
27 physician and surgeon is subject to discipline under Business and

1 Professions Code section 2234, subdivision (c), for repeated
2 negligent acts, as more particularly alleged as follows:

3 Cordelia M., who was Rh negative, did not receive
4 Rhogam after the January 7, 1986 abortion, nor was her
5 Rh negativity noted at the time of the repeat
6 procedure.

7 Patient Reina E.

8 21. On May 2, 1986, Reina E., a 33 year old female,
9 gravida 8, para 5, tab 2, 11 weeks pregnant by dates and 14 weeks
10 pregnant by size, had an abortion by respondent.

11 A. Preoperatively, Reina E. complained of a one-week
12 history of chills, fever, pain all over her body.

13 B. No pre-operative examination was conducted.

14 C. Respondent recognized Reina E.'s septic incomplete
15 abortion only post-operatively. Respondent then arranged
16 for Reina E.'s transfer to Martin Luther King Hospital,
17 where she was treated with antibiotics and her uterus was
18 repaired. She was discharged on May 7, 1986.

19 22. Respondent's certificate to practice as a
20 physician and surgeon is subject to discipline under Business and
21 Professions Code section 2234, subdivision (b) for gross
22 negligence, as more particularly alleged as follows:

23 A. Respondent performed surgery on Reina E. without
24 a pre-operative physical examination, including temperature
25 and white blood count.

26 B. Respondent failed to administer intravenous
27 antibiotics prior to the abortion.

1 23. Respondent's certificate to practice as a
2 physician and surgeon is subject to discipline under Business and
3 Professions Code section 2234, subdivision (c), for repeated
4 negligent acts, as more particularly alleged as follows:

5 A. The facts alleged in subparagraphs A and B of
6 paragraph 22 are hereby incorporated by reference as though
7 fully set forth at this point.

8 B. Respondent failed to start an intravenous prior to
9 the surgery.

10 24. Respondent's certificate to practice as a
11 physician and surgeon is subject to discipline under Business and
12 Professions Code section 2234, subdivision (d), for incompetence,
13 as more particularly alleged as follows:

14 Respondent recognized Reina E.'s septic incomplete
15 abortion only post-operatively.

16 Patient Jolanta N.

17 25. On December 27, 1986, Jolanta N., a 24 year old
18 female, gravida 2, para 1, eight weeks pregnant by size, had an
19 elective abortion by respondent. A few days after the procedure,
20 Jolanta N. experienced sharp pain below her abdomen and was
21 unable to eat for several days.

22 A. On January 23, 1987, Jolanta N. returned to
23 respondent with a history of pain, heavy bleeding, and
24 positive urine pregnancy tests at other facilities.

25 B. A repeat suction curettage was performed by
26 respondent. Operative findings revealed 15 ml of retained
27 chorionic villi.

1 26. Respondent's certificate to practice as a
2 physician and surgeon is subject to discipline under Business and
3 Professions Code section 2234 subdivision (c) for repeated
4 negligent acts, as more particularly alleged as follows:

5 A. On December 27, 1986, respondent performed
6 Jolanta N.'s abortion without a hematocrit.

7 B. On January 23, 1987 respondent performed
8 Jolanta N.'s reaspiration without informing Jolanta N. that
9 the procedure would be done without anaesthesia.

10 C. Respondent denied Jolanta N. pain relief for
11 approximately 45 minutes following her reaspiration, a
12 period during which she was in extreme pain.

13 Patient Tracey K.

14 27. On January 19, 1987, Tracey K., a 17-year-old
15 female, gravida 1, para 0, 6 weeks pregnant, went to Her Medical
16 Clinic for oral contraceptives, was informed she was pregnant,
17 and received an elective abortion from respondent.

18 28. Respondent's certificate to practice as a
19 physician and surgeon is subject to discipline under Business and
20 Professions Code section 2234, subdivision (b), for gross
21 negligence, as more particularly alleged as follows:

22 Respondent performed an abortion on Tracey K., and
23 anaesthesia was administered to Tracey K., in the
24 absence of a physical examination, and in the absence
25 of a determination as to the duration of Tracy K.'s
26 pregnancy.

27 29. Respondent's certificate to practice as a

1 physician and surgeon is subject to discipline under Business and
2 Professions Code section 2234, subdivision (c) for repeated
3 negligent acts, as more particularly alleged as follows:

4 A. The facts alleged in paragraph 28 are hereby,
5 incorporated by reference as though fully set forth at this
6 point.

7 B. Respondent performed an abortion on Tracey K.
8 without a hematocrit.

9 Patient Tijuanna J.

10 30. On September 18, 1987 Tijuanna J., a 29 year old
11 female, gravida 4, para 2, tab 1, 11 weeks pregnant, had an
12 elective abortion by respondent. Tijuanna J. returned to
13 respondent on September 24, 1987, complaining of cramping and of
14 vaginal bleeding without fever. Respondent then performed a
15 repeat suction curettage.

16 31. Respondent's certificate to practice as a
17 physician and surgeon is subject to discipline under Business and
18 Professions Code section 2234 subdivision (c), for repeated
19 negligent acts, as more particularly alleged as follows:

20 On September 24, 1987, respondent performed
21 Tijuanna J.'s abortion without a hematocrit.

22 Patient Donetta E.

23 32. On August 16, 1988, Donetta E., a 19 year old
24 female, gravida 5, para 3, tab 1, had an elective abortion by
25 respondent. The procedure was done without prior insertion of
26 laminaria. A local anaesthetic was administered at 3:50 p.m.,
27 and the abortion was completed at 4:00 p.m.

1 A. The patient was administered Methergine at 4:00
2 p.m., and 4:15 p.m., and respondent sutured her cervix for
3 unusual bleeding. The patient was sent home at 5:10 p.m.
4 with three tampons in her vagina.

5 B. Following discharge, Donetta E. experienced great
6 pain; she telephoned Her Medical Clinic staff, who told her
7 that her pain was normal and recommended against going to a
8 hospital. A friend called paramedics, and Donetta E. was
9 brought to California Medical Center Hospital at 10:50 p.m.
10 Examination on admission revealed a female in acute distress
11 with unstable vital signs (i.e., blood pressure 94/52, pulse
12 106-120), a rigid tender abdomen with rebound tenderness,
13 scant vaginal bleeding, but diffuse pelvic tenderness, and a
14 hematocrit of 23%.

15 C. Respondent was telephoned, and the current
16 examination, including the low hematocrit, was related to
17 him. Respondent told Donetta E.'s attending physician that
18 he doubted that her uterus was perforated, that she probably
19 could be sent home, and that he didn't want to see her in
20 the hospital, but that she should be instructed to follow-
21 up in a week or two at Her Medical Clinic.

22 D. Donetta E. was admitted and an emergency
23 exploratory laparotomy was performed due to unstable vital
24 signs and a falling hematocrit believed to be secondary to
25 hemorrhage. Operative findings revealed a large amount of
26 retroperineal and intraperitoneal blood estimated to be
27 2,000 cc., secondary to be 3-4 cm. uterine perforation

1 extending from an area superior to the internal cervical os
2 to the mid-fundus. The surgical team performed a
3 supracervical hysterectomy and unilateral salpingo-
4 oophrectomy for uterine perforation.

5 33. Respondent's certificate to practice as a
6 physician and surgeon is subject to discipline under Business and
7 Professions Code section 2234, subdivision (b) for gross
8 negligence, as more particularly alleged as follows:

9 A. Respondent allowed medical office personnel to
10 diagnose and render a medical opinion to Donetta E., a
11 patient with a known complication, advising Donetta E. that
12 her pain was normal and that she should not seek hospital
13 care.

14 B. Respondent refused to assume care of the patient
15 when notified by California Medical Center, and suggested
16 that the patient, with evidence of obvious hypovolemic
17 shock, secondary to blood loss with unstable vital signs and
18 a falling hematocrit, be released home.

19 34. Respondent's certificate to practice as a
20 physician and surgeon is subject to discipline under Business and
21 Professions Code section 2234, subdivision (c) for repeated
22 negligent acts, as more particularly alleged as follows:

23 A. Subparagraphs A and B of paragraph 33 are hereby
24 incorporated by reference as though fully set forth at this
25 point.

26 B. Respondent performed an abortion on Donetta E.
27 without a physical examination.

1 C. Respondent performed an abortion on Donetta E.
2 without obtaining an adequate medical history.

3 D. Respondent's medical record of his care and
4 treatment of Donetta E. was insufficient in view of her
5 known complication.

6 E. Respondent administered to Donetta E. three times
7 the appropriate dosage of Methergine.

8 35. Respondent's certificate to practice as physician
9 and surgeon is subject to discipline under Business and
10 Professions Code section 2234, subdivision (d), for incompetence,
11 as more particularly alleged as follows:

12 Respondent recommended that Donetta E., with
13 evidence of obvious hypovolemic shock secondary to
14 blood loss, with unstable vital signs and a falling
15 hematocrit, be sent home rather than be hospitalized.

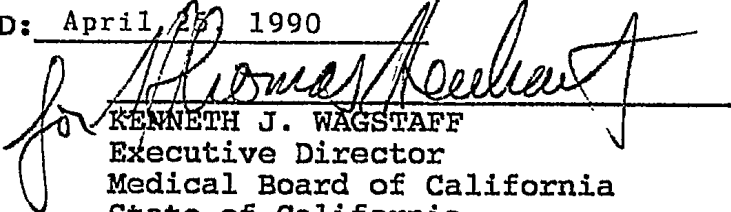
16 WHEREFORE, complainant prays that a hearing be held on
17 the matters alleged herein, and that following said hearing the
18 board issue a decision:

19 1. Revoking or suspending certificate number C036460,
20 heretofore issued to respondent;

21 2. Prohibiting respondent from supervising a
22 Physician's Assistant;

23 3. Taking such other action as it deems proper.

24 DATED: April 25, 1990

25 
26 KENNETH J. WAGSTAFF
27 Executive Director
Medical Board of California
State of California
Complainant

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8

9

10 BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
11 DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

12 In the Matter of the Accusation
Against:

NO. D-4228

13

MAHLON DOUGLAS CANNON, M.D.
14 5727 Ravenspur #304
Rancho Palos Verdes, CA 90274

FIRST SUPPLEMENTAL
ACCUSATION

15

Physician and Surgeon
16 Certificate Number C036460,

17

Respondent.

18

19

Complainant, Kenneth J. Wagstaff, alleges that:

20

21 36. He is Executive Director of the Medical Board of
the State of California (hereinafter the "board"), and brings
22 this supplemental accusation solely in his official capacity.

23

24 37. On April 30, 1975, Mahlon Douglas Cannon, M.D.
(hereinafter "respondent") was issued physician and surgeon

25

certificate number C036460 by the Board of Medical Quality

26

Assurance, predecessor to the Medical Board of California. That
27 license is in current status at the present time, and was in full

1 force and effect at all times mentioned herein.

2 38. Business and Professions Code sections 2003 and
3 2004 provide, in pertinent part, that there is a Division of
4 Medical Quality within the Medical Board of California,
5 responsible for the enforcement of the disciplinary provisions of
6 the Medical Practice Act (Chapter 5 of Division 2 of the Business
7 and Professions Code); the administration and hearing of
8 disciplinary actions appropriate to findings made by a medical
9 quality review committee, the division, or an administrative law
10 judge; and the suspension, revocation, or the imposition of
11 limitations on certificates after the conclusion of disciplinary
12 actions.

13 39. Business and Professions Code sections 2220, 2227,
14 and 2234 authorize the Division of Medical Quality to suspend or
15 revoke a physician's and surgeon's certificate, or to take other
16 disciplinary action against a certificate holder who is guilty of
17 unprofessional conduct.

18 40. Business and Professions Code section 2234,
19 subdivision (a), provides that violating or attempting to
20 violate, directly or indirectly, or assisting in or abetting the
21 violation of, or conspiracy to violate, any provision of the
22 Medical Practice Act, is unprofessional conduct.

23 41. Business and Professions Code section 2234,
24 subdivision (c), provides that performance of repeated negligent
25 acts is unprofessional conduct.

26 42. Business and Professions Code section 2234,
27 subdivision (d) provides that incompetence is unprofessional

1 conduct.

2 Patient Donna H.

3 43. Paragraph 9 of the Accusation, and the
4 subparagraphs to paragraph 9 are hereby incorporated by reference
5 as though fully set forth at this point.

6 44. Respondent's certificate to practice as a
7 physician and surgeon is subject to discipline under Business and
8 Professions Code section 2234, subdivisions (c) and (d) for
9 repeated negligent acts and for incompetence in that respondent
10 performed an incomplete tracheotomy on patient Donna H.

11 WHEREFORE, complainant prays that a hearing be held on
12 the matters alleged herein, and that following said hearing the
13 board issue a decision:

14 1. Revoking or suspending certificate number C036460,
15 heretofore issued to respondent;

16 2. Prohibiting respondent from supervising a
17 Physician's Assistant;

18 3. Taking such other action as it deems proper.

19 DATED: January 10, 1991.

20 Kenneth J. Wagstaff
21 By Colin W. Torrance
22 Dep. Atty. Gen.
23 By direction
24

25 KENNETH J. WAGSTAFF
26 Executive Director
27 Medical Board of California
State of California
Complainant