

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

In the Matter of the Accusation Against:

Robert Raymond Harrie, M.D.

Physician's and Surgeon's
Certificate No. G 139544

Respondent.

Case No. 800-2016-028570

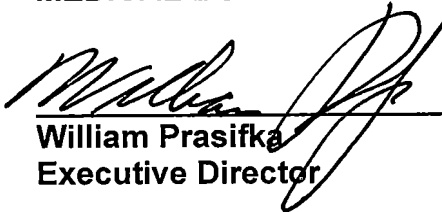
DECISION

The attached Stipulated Surrender of License and 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 April 1, 2021.

IT IS SO ORDERED March 25, 2021.

MEDICAL BOARD OF CALIFORNIA



William Prasifka
Executive Director

1 XAVIER BECERRA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
3 RYAN J. YATES
Deputy Attorney General
4 State Bar No. 279257
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7 *Attorneys for Complainant*
8
9

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

14 In the Matter of the Accusation Against:

15 **ROBERT RAYMOND HARRIE, M.D.**
16 **5670 Kings Valley Road**
Crescent City, CA 95531

17 **Physician's and Surgeon's Certificate No. G**
139544

18 Respondent.

Case No. 800-2016-028570

OAH No. 2019100439

STIPULATED SURRENDER OF
LICENSE AND ORDER

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

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Xavier Becerra, Attorney General of the State of California, by Ryan J. Yates, Deputy
26 Attorney General.

27 2. Robert Raymond Harrie, M.D. (Respondent) is represented in this proceeding by
28 attorney Amelia F. Burroughs, whose address is: 730 Fifth Street, Eureka, CA 95501.

1 ACCEPTANCE

2 I have carefully read the above Stipulated Surrender of License and Order and have fully
3 discussed it with my attorney, Amelia F. Burroughs. I understand the stipulation and the effect it
4 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of
5 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the
6 Decision and Order of the Medical Board of California.

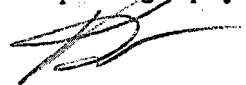
7
8 DATED: 12/17/2020 
9 ROBERT RAYMOND HARRIE, M.D.
Respondent

10 I have read and fully discussed with Respondent Robert Raymond Harrie, M.D. the terms
11 and conditions and other matters contained in this Stipulated Surrender of License and Order. I
12 approve its form and content.

13 DATED: 01.05.2021 
14 AMELIA F. BURROUGHS
Attorney for Respondent

15
16 ENDORSEMENT

17 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
18 for consideration by the Medical Board of California of the Department of Consumer Affairs.

19 DATED: 1/5/21 Respectfully submitted,
20 XAVIER BECERRA
Attorney General of California
21 STEVEN D. MUNI
Supervising Deputy Attorney General
22 
23 RYAN J. YATES
24 Deputy Attorney General
Attorneys for Complainant

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28 Harrie Stipulated Surrender Final.docx

Exhibit A

Accusation No. 800-2016-028570

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 13 20 19
BY K. Voong ANALYST

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

In the Matter of the Accusation Against:

Robert Raymond Harrie, M.D.
5670 Kings Valley Road
Crescent City, CA 95531

Physician's and Surgeon's Certificate
No. G 139544,

Respondent.

Case No. 800-2016-028570

ACCUSATION

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 2, 2015, the Medical Board issued Physician's and Surgeon's Certificate No. G 139544 to Robert Raymond Harrie, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2019, unless renewed.

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1 Patient B by oversewing the area. Due to this mistake, Respondent failed to recognize that the
2 source of Patient B's bleeding was from a hole, lateral to Patient B's gallbladder fossa
3 (depression in liver, which holds the gallbladder), which may have been inadvertently pierced
4 during the surgery.

5 14. At approximately 8:00 P.M., Patient B returned to the hospital with pain in her upper
6 abdomen, shortness of breath, and a feeling of bloating. During this time, Patient B was seen by
7 other hospital staff, since Respondent was at home and not on-call. A computed tomography⁸
8 (CT) scan was obtained, which showed a large hematoma⁹ at the original surgery site. The
9 treating physician performed a diagnostic laparoscopy, an evacuation of clots, and a fulguration¹⁰
10 of a bleeder, which was located deep in the liver bed. Due to this complication, Patient B
11 remained in the hospital until her release, on November 28, 2016.

12 15. Respondent committed gross negligence in his care and treatment of Patient B by
13 incorrectly assuming the bleeding, following Patient B's laparoscopic cholecystectomy,
14 originated from her abdominal wall, and failing to follow the correct procedures, such as taking
15 Patient B's vitals, running labs, and/or admitting Patient B for observation.

16 SECOND CAUSE FOR DISCIPLINE

17 (Repeated Negligent Acts)

18 16. Respondent's Physician's and Surgeon's Certificate No. G 139544 is subject to
19 disciplinary action under section 2234, subdivision (c), of the Code, in that Respondent
20 committed repeated negligent acts in his care and treatment of Patient A, Patient B, and Patient C,
21 as more particularly alleged hereinafter:

22 17. Complainant re-alleges paragraphs 7 through 15, and those paragraphs are
23 incorporated by reference as if fully set forth therein.

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25 ⁸ A computed tomography scan makes use of computer-processed combinations of many
26 X-ray measurements taken from different angles to produce cross-sectional images of specific
areas of a scanned object, allowing the user to see inside the object without cutting.

27 ⁹ A hematoma is a localized collection of blood outside of blood vessels, due to either
disease or trauma.

28 ¹⁰ Fulguration is a procedure to destroy and remove tissue using a high-frequency electric
current applied by small electrode.

1 18. Respondent committed repeated negligent acts in his care and treatment of Patient A
2 and Patient B including, but not limited to, the following:

3 (a) Failing to recommend, order, and/or perform a sigmoidoscopy on Patient A, which
4 resulted in a failure to detect Patient A's rectal cancer; and

5 (b) Incorrectly assuming the source of bleeding, following Patient B's laparoscopic
6 cholecystectomy, originated from her abdominal wall, and failing to follow the correct
7 procedures, such as taking Patient B's vitals, running labs, and/or admitting Patient B for
8 observation.

9 Patient C

10 19. On or about December 8, 2016, Patient C presented to Respondent for a surgical
11 consultation. Patient C, a then sixty-four (64) year old woman, had quit smoking cigarettes
12 twenty-one (21) months prior to the consultation and had a documented history of lung cancer
13 (presumed cured); however, she was recently diagnosed with new lung nodules.¹¹ Additionally,
14 Patient C had a history of chronic obstructive pulmonary disease,¹² chronic renal (kidney)
15 insufficiency, congestive heart failure, hypertension (abnormally high blood pressure), bipolar
16 disorder, asthma, and marijuana use on alternate days. Patient C had recently received two (2)
17 prior operations in the upper abdomen, which consisted of a Nissen fundoplication¹³ for
18 gastroesophageal reflux disease, and a ventral incisional hernia¹⁴ repair with mesh.¹⁵ Patient C
19 additionally had a distant history of hysterectomy (surgical removal of the uterus) and
20 appendectomy (surgical removal of the appendix).

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23 _____
24 ¹¹ A lung nodule is a small abnormal swelling or aggregation of cells of the lungs.

25 ¹² Chronic obstructive pulmonary disease is a lung disease characterized by long-term
26 breathing problems and poor airflow. Symptoms include shortness of breath and cough with
27 sputum production. This disease is a progressive disease which typically worsens over time.

28 ¹³ Nissen fundoplication is a laparoscopic procedure, in which a surgeon wraps the top of
the stomach around the lower esophagus. This reinforces the lower esophageal sphincter, making
it less likely that acid will back-up in the esophagus.

¹⁴ A ventral incisional hernia is a bulge through the opening of the abdominal muscles, at
the incision site of a past operation.

¹⁵ Mesh is a flat sheet of prosthetic material that is used to cover, or "patch," a hernia.

1 20. During a surgical consultation with Respondent, Patient C presented with abdominal
2 pain in her upper right quadrant, which had been constant over a period of two (2) months, and
3 exacerbated by fatty foods. Respondent performed an ultrasound on Patient C, which revealed
4 biliary sludge in her gallbladder. Although Patient C had substantial co-morbidities, Respondent
5 agreed to remove her gallbladder. Respondent scheduled a laparoscopic cholecystectomy for the
6 next morning, December 9, 2016. Pre-operative platelets were not measured and partial
7 thromboplastin time¹⁶ (PTT) indicated normal function. Patient C was previously reported to be
8 anemic, but hemoglobin/hematocrit was not checked and/or recorded.

9 21. On or about December 9, 2016, during the operation, Respondent attempted an open
10 port (incision area for insertion of device) placement in the midline area of the abdomen. Due to
11 the presence of surgical mesh from one of Patient C's prior operations, Respondent placed a 5-
12 millimeter trocar¹⁷ in the right upper quadrant of the abdomen, after insufflation,¹⁸ via Veress
13 needle.¹⁹ This was then used to guide placement of an 11-millimeter port, placed at the center of
14 the abdomen, above the navel, through the pre-existing surgical mesh.

15 22. Respondent then became aware that he had accidentally pierced Patient C's liver,
16 when placing the 5-millimeter trocar. The trocar was pulled back, and Respondent observed
17 some bleeding to the liver, which spontaneously stopped soon after. Respondent replaced the
18 port and placed the remaining ports into Patient C's abdomen without incident.

19 23. Prior to removing the gallbladder, Respondent noted that "the gallbladder was very
20 scarred and the anatomy was somewhat confusing." Respondent then performed a "top-down"
21 dissection, where he worked from the fundus²⁰ of the gallbladder toward the hilum,²¹ as opposed
22 to the usual hilum-first approach. This allowed Respondent to more easily identify the cystic duct

23 ¹⁶ Partial thromboplastin time is a screening test that helps evaluate a person's ability to
24 appropriately form blood clots.

25 ¹⁷ A trocar is a surgical instrument with a three-sided cutting point enclosed in a tube, used
26 for withdrawing fluid from a body cavity.

27 ¹⁸ An insufflation is the act of blowing air or gas into a body cavity.

28 ¹⁹ A Veress needle is a spring-loaded needle used to transmit gas into a body cavity, for
use in laparoscopic surgery.

²⁰ The fundus is the lower "bulb shaped structure of the gallbladder.

²¹ The hilum is the central part of the liver, where common hepatic duct, hepatic artery
and portal vein enter into the liver.

1 and artery, which he dissected free, clipped, and divided. The gallbladder was then removed from
2 the gallbladder bed with electrocautery, then fully removed from Patient C's body cavity with the
3 use of an Endopouch²² bag.

4 24. Respondent fully irrigated Patient C's right upper quadrant with saline. Respondent
5 noted that there was some "oozing" from the liver bed, which was cauterized, but continued to
6 ooze. Respondent placed a piece of Surgicel (blood clot inducing material) into the liver bed in
7 an attempt to stop the oozing. He continued to irrigate the abdomen until it was clear of effluent
8 (waste produced during surgery) and the site of the trocar injury to the liver was re-examined.
9 After Respondent determined that the injury had stopped bleeding, Patient C's abdomen was
10 deflated, the trocars were removed, and Respondent reclosed the incisions to Patient C's
11 abdomen. The surgery lasted from approximately 8:30 A.M. until approximately 9:50 A.M.
12 Patient C was then sent to the hospital's recovery room.

13 25. After Patient C awoke from her anesthesia, Respondent visited her in the hospital's
14 recovery area, where she appeared stable. Although it was the same day as a surgical procedure,
15 and despite the fact that Patient C had numerous co-morbid and operative reasons to remain in the
16 hospital, Respondent discharged Patient C from the hospital. Prior to Patient C's discharge,
17 Respondent failed to inform her family of the trocar injury to her liver and/or provide discharge
18 instructions indicating that she should be watched for any signs of internal bleeding.

19 26. After returning home, Patient C began to experience severe distress. At 3:08 P.M.,
20 Patient C's son made an emergency telephone call. Shortly after, Patient C was picked up by
21 ambulance and taken to the hospital. While en route, cardio-pulmonary resuscitation (CPR) was
22 administered on Patient C.

23 27. Upon Patient C's return to the hospital, Respondent became involved in her
24 Emergency Room resuscitation attempts, which included a protracted Code Blue procedure.
25 Patient C appeared unresuscitable, and the Code was terminated. Patient C then spontaneously
26 returned to vital signs and became more stable, however, she had evidence of a severe anoxic

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28 ²² An Endopouch bag is a specimen retrieval system, which utilizes two support arms to
facilitate bag opening and tissue capture during laparoscopic procedures.

1 brain injury. Over the course of the next few hours, a CT scan was performed on Patient C,
2 which showed blood in her abdomen. Respondent re-opened the previously-made incision and
3 found approximately 900 milliliters of blood and blood clot within her abdomen. Respondent
4 noted that the only area where there was active bleeding was the gallbladder bed, where there was
5 some active bleeding in the lower part of the liver bed, Respondent observed the site of the trocar
6 injury to the liver and determined that it was not bleeding. After controlling bleeding from the
7 gallbladder fossa, Respondent removed the hernia mesh and closed the incision site. The
8 operation lasted from approximately 8:36 P.M. until approximately 10:06 P.M.

9 28. Patient C remained in a coma and developed multi-organ dysfunction. On or about
10 December 13, 2016, Patient C died from complications associated with the procedure performed
11 by Respondent.

12 29. Respondent committed repeated negligent acts in his care and treatment of Patient C
13 by discharging Patient C from the hospital despite the fact that she had numerous co-morbid and
14 operative reasons to remain in the hospital.

15 THIRD CAUSE FOR DISCIPLINE

16 (Failure to Maintain Adequate and Accurate Medical Records)

17 30. Respondent's Physician's and Surgeon's Certificate No. G 139544 is further subject
18 to discipline under sections 2227 and 2334, as defined by section 2266, of the Code, in that he
19 failed to maintain adequate and accurate medical records in the care and treatment of Patient A,
20 Patient B, and Patient C. Paragraphs 7 through 29, above, are hereby incorporated by reference
21 and realleged as if fully set forth herein.

22 DISCIPLINARY CONSIDERATIONS

23 31. To determine the degree of discipline, if any, to be imposed on Respondent Robert
24 Raymond Harrie, M.D., the Board should consider that in a prior disciplinary action entitled *In*
25 *the Matter Against Robert Raymond Harrie, M.D., License No. MD22886*, before the Oregon
26 Medical Board, Respondent's license was publicly reprimanded for acting unprofessionally
27 towards co-workers while performing his duties at work, as well as refusing to treat a patient he
28 disliked, while working as an on call surgeon. As part of a stipulated settlement agreement,

1 effective January 9, 2014, Respondent was publicly reprimanded, ordered to pay a civil penalty of
2 \$5,000, and ordered to complete a course in medical ethics. That decision is now final and is
3 incorporated by reference as if fully set forth herein.

4 PRAYER

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

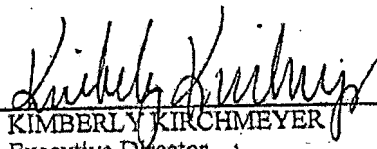
7 1. Revoking or suspending Physician's and Surgeon's Certificate No. G 139544, issued
8 to Robert Raymond Harrie, M.D.;

9 2. Revoking, suspending or denying approval of Robert Raymond Harrie, M.D.'s
10 authority to supervise physician assistants and advanced practice nurses;

11 3. Ordering Robert Raymond Harrie, M.D. if placed on probation, to pay the Board the
12 costs of probation monitoring; and

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

14
15 DATED: March 13, 2019


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

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