

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

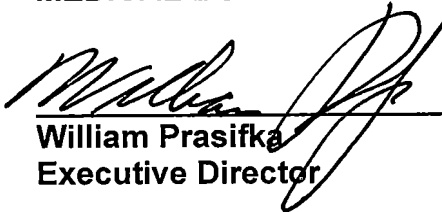
DECISION

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  
1300 I Street, Suite 125  
5 P.O. Box 944255  
Sacramento, CA 94244-2550  
6 Telephone: (916) 210-6329  
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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.





**ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 139544, issued to Respondent Robert Raymond Harrie, M.D., is surrendered and accepted by the Board.

1. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

2. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

3. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-028570 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition. Respondent does not otherwise admit the truth or correctness of the allegations included in Accusation No. 800-2016-028570 for any purpose other than resolution of the Accusation by the Medical Board of California, or any other health care licensing agency in the State of California.

4. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2016-028570 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure. Respondent does not otherwise admit the truth or correctness of the allegations included in Accusation No. 800-2016-028570 for any purpose other than resolution of the Accusation by the Medical Board of California, or any other health care licensing agency in the State of California.

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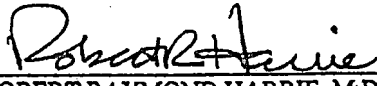
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1 ACCEPTANCE

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.

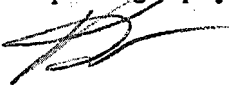
7  
8 DATED: 12/17/2020   
9 ROBERT RAYMOND HARRIE, M.D.  
Respondent

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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XAVIER BECERRA  
Attorney General of California  
ALEXANDRA ALVAREZ  
Supervising Deputy Attorney General  
RYAN J. YATES  
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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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JURISDICTION

1  
2       3.    This Accusation is brought before the Board, under the authority of the following,  
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise  
4 indicated.

5       4.    Section 2227 of the Code provides, in pertinent part, that a licensee who is found  
6 guilty under the Medical Practice Act may have his or her license revoked, suspended for a period  
7 not to exceed one year, placed on probation and required to pay the costs of probation monitoring,  
8 or such other action taken in relation to discipline as the Board deems proper.

9       5.    Section 2234 of the Code states, in pertinent part:

10       “The board shall take action against any licensee who is charged with unprofessional  
11 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not  
12 limited to, the following:

13       “(a) Violating or attempting to violate, directly, or indirectly, assisting in or abetting the  
14 violation of, or conspiring to violate any provision of this chapter.

15       “(b) Gross negligence.

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

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

21       “(2) When the standard of care requires a change in the diagnosis, act, or omission that  
22 constitutes the negligent act described in paragraph (1), including, but not limited to, a  
23 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the  
24 applicable standard of care, each departure constitutes a separate and distinct breach of the  
25 standard of care.

26       “(d) Incompetence.

27       “...”

28       ///



1 9. On or about August 9, 2016, Respondent performed a sphincterotomy and infrared  
2 coagulation<sup>5</sup> of Patient A's internal hemorrhoids. After the operation, Patient A's anal fissure  
3 healed, however, she continued to have hemorrhoid pattern bleeding.

4 10. On or about December 9, 2016, Patient A sought medical treatment for an unrelated  
5 condition, during which time, it was discovered that she had rectal cancer, variously described as  
6 5.5 centimeters and 2.5 centimeters above the anal verge. Due to Respondent's failure to  
7 recommend, order, and/or perform a sigmoidoscopy on Patient A, Patient A's rectal cancer went  
8 undetected for four (4) months, following Respondent's July 28, 2016, examination.

9 11. Respondent committed gross negligence in his care and treatment of Patient A by  
10 failing to recommend, order, and/or perform a sigmoidoscopy on Patient A, which resulted in a  
11 failure to detect Patient A's rectal cancer.

12 **Patient B**

13 12. On or about November 22, 2016, Respondent performed a routine laparoscopic  
14 cholecystectomy<sup>6</sup> on Patient B, a then forty-nine (49) year old overweight female, who was  
15 previously diagnosed with biliary colic.<sup>7</sup> As part of the surgical procedure, Respondent made  
16 four incisions into Patient B's abdomen, which served as port sights for the insertion of surgical  
17 tools. Patient B's gallbladder was then extracted with no complications. After a short time in the  
18 recovery room, Patient B was sent home.

19 13. Approximately three (3) hours later, Patient B returned to the hospital presenting with  
20 bleeding from her upper lateral 5 millimeter trocar site (area of the surgical incision). Respondent  
21 failed to follow correct protocol, such as taking Patient B's vitals, running labs, and/or admitting  
22 Patient B for observation. Instead, Respondent incorrectly assumed that the origin of the bleeding  
23 was from the incision site in Patient B's abdominal wall. Respondent then informally treated

24 <sup>5</sup> Infrared photocoagulation is a medical procedure used to treat small and medium sized  
25 hemorrhoids. During the procedure, a device is inserted rectally and used to apply an intense  
26 beam of infrared light to treat internal hemorrhoids. The heat created by the infrared light causes  
27 scar tissue which cuts off the blood supply to the hemorrhoid.

<sup>6</sup> Laparoscopic cholecystectomy is the surgery to remove the gallbladder. The operation  
27 is performed by inserting a tubed device (laparoscope), equipped with a camera and tools, into the  
28 abdomen.

<sup>7</sup> Biliary colic, is when a colic occurs due to a gallstone temporarily blocking the cystic  
28 duct.

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 tomography<sup>8</sup>  
8 (CT) scan was obtained, which showed a large hematoma<sup>9</sup> at the original surgery site. The  
9 treating physician performed a diagnostic laparoscopy, an evacuation of clots, and a fulguration<sup>10</sup>  
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.

24 ///

25 <sup>8</sup> 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  
27 areas of a scanned object, allowing the user to see inside the object without cutting.

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

28 <sup>10</sup> 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.<sup>11</sup> Additionally,  
14 Patient C had a history of chronic obstructive pulmonary disease,<sup>12</sup> 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 fundoplication<sup>13</sup> for  
18 gastroesophageal reflux disease, and a ventral incisional hernia<sup>14</sup> repair with mesh.<sup>15</sup> 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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22 ///

23 \_\_\_\_\_  
24 <sup>11</sup> A lung nodule is a small abnormal swelling or aggregation of cells of the lungs.

25 <sup>12</sup> 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 <sup>13</sup> 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.

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

<sup>15</sup> 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 time<sup>16</sup> (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 trocar<sup>17</sup> in the right upper quadrant of the abdomen, after insufflation,<sup>18</sup> via Veress  
13 needle.<sup>19</sup> 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 fundus<sup>20</sup> of the gallbladder toward the hilum,<sup>21</sup> as opposed  
22 to the usual hilum-first approach. This allowed Respondent to more easily identify the cystic duct

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

25           <sup>17</sup> 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           <sup>18</sup> An insufflation is the act of blowing air or gas into a body cavity.

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

<sup>20</sup> The fundus is the lower "bulb shaped structure of the gallbladder.

<sup>21</sup> 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 Endopouch<sup>22</sup> 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

27 \_\_\_\_\_  
28 <sup>22</sup> 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:

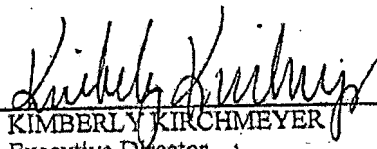
7 1. Revoking or suspending Physician's and Surgeon's Certificate No. G 139544, issued  
8 to Robert Raymond Harrie, M.D.;

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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