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

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
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Attorneys for Complainant

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 OAH No. 2019100439 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

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

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

3. On or about December 2, 2015, the 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 in Accusation No. 800-2016-028570 and will expire on June 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-028570 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 13, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-028570 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-028570. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2016-028570, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2016-028570 and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges. 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.

10. Respondent understands that by signing this stipulation, he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

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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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ACCEPTANCE

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

DATED: 12/17/2020

ROBERT RAYMOND HARRIE, M.D.
Respondent

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

DATED: 01.05.2021

AMELIA F. BURROUGHS
Attorney for Respondent

ENDORSEMENT

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

DATED: 1/5/21

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

RYAN J. YATES
Deputy Attorney General
Attorneys for Complainant

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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. Young 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

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

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

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

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent's Physician's and Surgeon's Certificate No. G 139544 is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patient A[1] and Patient B as more particularly alleged hereinafter:

Patient A

8. On or about July 28, 2016, at or about 11:56 A.M., Patient A, a then forty-seven (47) year-old female, presented to Respondent's hospital, complaining of anal pain and bright blood emanating from her rectum. Respondent, a general surgeon, performed a physical examination on Patient A, in which he noted a posterior anal fissure[2] and some hemorrhoids. Respondent bypassed recommending second-line treatments for Patient A, such as topical medications, and instead recommended a lateral internal sphinoterotomy,[3] and made additional plans to treat the hemorrhoids simultaneously. During the examination, Respondent failed to either recommend or plan a sigmoidoscopy,[4] in order to rule out colorectal disease as a possible source of the bleeding.

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[1] To protect the privacy of all patients involved, patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[2] A fissure is a small tear in the lining of the anus.

[3] Lateral internal sphincterotomy is an operation performed on the internal anal sphincter muscle for the treatment of chronic anal fissure. During the surgery, a lighted tube (anoscope) is inserted into the anus. Surgical tools are guided through the scope into the anus and make an incision in the internal anal sphincter. This surgery relieves the pressure and allows the anal fissure to heal.

[4] A sigmoidoscopy is a procedure that allows a physician to look inside of a patient's sigmoid colon by using a tube equipped with a light, which allows the doctor to check for abnormalities in the area.

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

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

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

Patient B

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

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

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

[6] Laparoscopic cholecystectomy is the surgery to remove the gallbladder. The operation is performed by inserting a tubed device (laparoscope), equipped with a camera and tools, into the abdomen.

[7] Biliary colic, is when a colic occurs due to a gallstone temporarily blocking the cystic duct.

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

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

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

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

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

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[8] A computed tomography scan makes use of computer-processed combinations of many 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.

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

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

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

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

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

Patient C

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

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[11] A lung nodule is a small abnormal swelling or aggregation of cells of the lungs.

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

[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.

20. During a surgical consultation with Respondent, Patient C presented with abdominal pain in her upper right quadrant, which had been constant over a period of two (2) months, and exacerbated by fatty foods. Respondent performed an ultrasound on Patient C, which revealed biliary sludge in her gallbladder. Although Patient C had substantial co-morbidities, Respondent agreed to remove her gallbladder. Respondent scheduled a laparoscopic cholecystectomy for the next morning, December 9, 2016. Pre-operative platelets were not measured and partial thromboplastin time[16] (PTT) indicated normal function. Patient C was previously reported to be anemic, but hemoglobin/hematocrit was not checked and/or recorded.

21. On or about December 9, 2016, during the operation, Respondent attempted an open port (incision area for insertion of device) placement in the midline area of the abdomen. Due to the presence of surgical mesh from one of Patient C's prior operations, Respondent placed a 5-millimeter trocar[17] in the right upper quadrant of the abdomen, after insufflation,[18] via Veress needle.[19] This was then used to guide placement of an 11-millimeter port, placed at the center of the abdomen, above the navel, through the pre-existing surgical mesh.

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

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

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

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

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

[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.

and artery, which he dissected free, clipped, and divided. The gallbladder was then removed from the gallbladder bed with electrocautery, then fully removed from Patient C's body cavity with the use of an Endopouch[22] bag.

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

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

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

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

DISCIPLINARY CONSIDERATIONS

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

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

PRAYER

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

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

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

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

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

DATED: March 13, 2019

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

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