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

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

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 27, 2011.

IT IS SO ORDERED June 27, 2011.

MEDICAL BOARD OF CALIFORNIA

By: _____
Hedy Chang, Chair
Panel B

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

In the Matter of the Accusation Against: **MARY CHARLENE MURPHY, M.D.** **4060 4th Avenue, Suite 115** **San Diego, CA 92103** **Physician's and Surgeon's Certificate No. G 74754** Respondent.	Case No. 10-2008-193683 OAH No. 2010080176 **STIPULATED SETTLEMENT AND DISCIPLINARY 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. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Mara Faust, Deputy Attorney General.

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2. Respondent MARY CHARLENE MURPHY, M.D. (Respondent) is represented in this proceeding by attorney Cary W. Miller, whose address is: Hooper Lundy & Bookman 101 West Broadway, Suite 1200,San Diego, CA 92101.

3. On or about July 23, 1992, the Medical Board of California issued Physician's and Surgeon's Certificate No. G 74754 to MARY CHARLENE MURPHY, 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. 10-2008-193683 and will expire on December 31, 2011, unless renewed.

JURISDICTION

4. Accusation No. 10-2008-193683 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on June 22, 2010. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 10-2008-193683 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 10-2008-193683. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her 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 admits the truth of the first cause for discipline in Accusation No. 10-2008-193683.

9. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Medical Board of California (Board)'s imposition of discipline as set forth in the Disciplinary Order below.

CIRCUMSTANCES IN MITIGATION

10. Respondent MARY CHARLENE MURPHY, M.D. has never been the subject of any disciplinary action. She is admitting responsibility at an early stage in the proceedings.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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 Settlement 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.

13. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. 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 Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 74754 issued to Respondent MARY CHARLENE MURPHY, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. ACTUAL SUSPENSION As part of probation, respondent is suspended from the practice of medicine for 30 days beginning the sixteenth (16th) day after the effective date of this decision, to be taken in increments of no less than 15 days at a time, to be completed within 60 days of the effective date.

2. EDUCATION COURSE Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition.

3. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at

respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

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

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

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

Business and Professions Code sections 2051 and 2052.

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

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

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

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

violation of probation.

ACCEPTANCE

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

DATED: 06 MAY 2011 Mary C. Murphy M.D.
MARY CHARLENE MURPHY, M.D.
Respondent

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

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

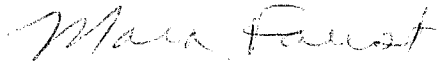
ENDORSEMENT

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

Dated: May 9, 2011

Respectfully submitted,

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



MARA FAUST
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 10-2008-193683

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 22, 2010
BY: ANALYST

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

In the Matter of the Accusation Against: **MARY CHARLENE MURPHY, M.D.** 4060 4th Avenue, Suite 115 San Diego, CA 92103 Physician's and Surgeon's Certificate Number G 74754 Respondent.	Case No. 10-2008-193683 **ACCUSATION**

Complainant alleges:

PARTIES

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

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

JURISDICTION

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

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

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

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

> A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the [B]oard[1], may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the division.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.
>
> (4) Be publicly reprimanded by the division.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

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

> The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> – – –
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

---

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

(1) 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.

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

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

9. Section 2266 provides as follows:

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

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

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

Patient L.M.[2]

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

[2] Patient initials are used throughout this pleading to protect patient privacy.

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

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

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

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

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

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

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

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

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

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

Patient C.R.

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

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

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

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

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

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

Patient S.V.

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

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

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

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

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

Patient N.M.

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

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

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

Patient K.G.

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

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

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

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

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

1. On or about January 5, 2008, Respondent performed a contra-indicated abdominal exploratory surgery on patient S.V.

2. On or about April 25, 2008, Respondent performed a laparoscopic abdominal procedure on patient N.M., when the circumstances warranted an open procedure.

3. Respondent caused devascularization of N.M.'s transverse colon during

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

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

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

THIRD CAUSE FOR DISCIPLINE
(False Documentation)
[B&P Code Section 2261]

Patient C.R.

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

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

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PRAYER

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 number G 74754, issued to Mary Charlene Murphy, M.D.,

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

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

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

DATED: June 22, 2010

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

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