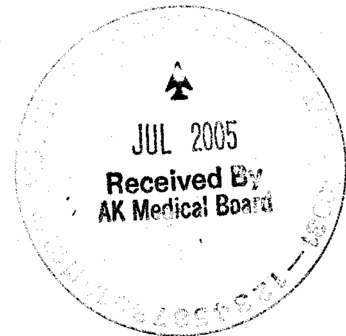
DIVISION OF OCCUPATIONAL LICENSING

Frank H. Murkowski, Governor



CERTIFIED # 7002 3150 0001 1621 0043
RETURN RECEIPT REQUESTED

July 22, 2005

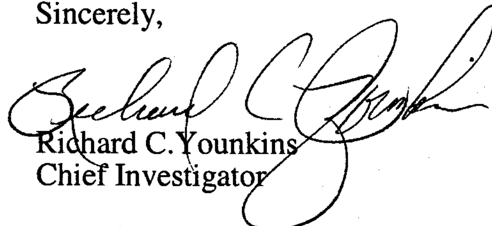
Colleen M. Murphy, M.D.
4100 Lake Otis Parkway
Suite Number 330
Anchorage, Alaska 99508

Dear Dr. Murphy:

You are hereby notified that the enclosed Amended Accusation has been filed with the Division of Occupational Licensing.

Should you have any questions regarding this matter, please do not hesitate to contact me at the address and telephone number listed above, or Karen Hawkins, the assigned Assistant Attorney General in this case, telephone number 269-5200.

Sincerely,



Richard C. Younkins
Chief Investigator

Enclosure: Amended Accusation

cc: Rick Urion, Director
Barbara Gabier, Chief, Occupational Licensing w/original
Hearing Officer Unit
Leslie Gallant, Executive Administrator
Colin Matthews, Investigator
Deborah Finley, Investigator
Paul Stockler, Attorney
Karen Hawkins, Assistant Attorney General
File Number: 2800-05-026, 2800-05-045, 2800-05-048
2800-05-050, 2800-05-051, 2800-05-054

RCY:ab

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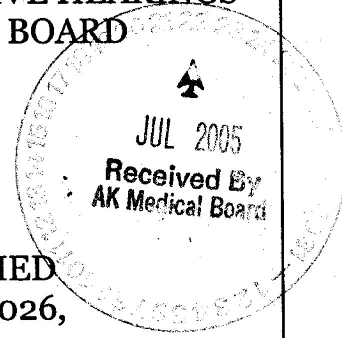
Email: license@commerce.state.ak.us Website: http://www.commerce.state.ak.us/occ/

BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTIVE HEARINGS
ON REFERRAL BY THE ALASKA STATE MEDICAL BOARD



In the Matter of:)
)
Colleen M. Murphy, M.D.,)
)
Respondent.) OAH No. 05-0553-MED
) Board No. 2800-05-026,
2800.05.045, 2800.05.048, 2800.05.050, 2800.05.051, 2800.05.054.

AMENDED ACCUSATION

This Accusation initiates a proceeding pursuant to AS 08.01.075 and AS 08.64.326 to suspend, revoke, or impose other disciplinary sanctions against the physician license issued by the State of Alaska to Colleen M. Murphy, M.D. ("Murphy").

In support of this Accusation, petitioner, Richard Urion, Director, State of Alaska, Department of Commerce, Community and Economic Development, Division of Occupational Licensing ("Division") alleges in his official capacity as follows:

ALLEGATIONS COMMON TO ALL COUNTS

1. On October 27, 1993, Murphy was issued physician #3162. On July 7, 2005, the State Medical Board summarily suspended Murphy's license. The license will expire unless renewed on December 31, 2006.

2. On April 6, 2005, Alaska Regional Hospital ("ARH") suspended Murphy's obstetrical privileges based upon an ARH Ad Hoc Committee

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finding that Murphy posed "an imminent danger to the health and/or safety of hospital patients."

3. ARH patient 37-44-87 was admitted at ARH on November 15, 2003. Patient 37-44-87 had two previous C-Section deliveries. The first C-Section was for failure to progress with labor and the second was a repeat without complications.

4. At 3:45 a.m., patient 37-44-87 complained of pain despite having received an epidural at 1 a.m. Fetal heart rate tracings indicated changes in the unborn child's heart rate. Nurse's notes reflect the draining of bloody urine from patient 37-44-87. The nurse's notes also reflect that Murphy was notified of the patient's complaint of pain and of the bloody urine.

5. At 5:41 a.m., the nurse's notes indicate Murphy attempted three pulls with a vacuum without success. At 5:47 a.m., Murphy delivered patient 37-44-87's baby using a medium to high forceps procedure. At 5:50 a.m., the nurse's notes indicate that Murphy did not believe that the uterus had ruptured, but that the bladder had ruptured. The operation room team was called.

6. Patient 37-44-87 was moved to the operating room at 6:10 a.m. Both the uterus and the bladder had ruptured. The bladder was repaired and the patient 37-44-87 underwent a hysterectomy procedure.

7. After delivery patient 37-44-87's baby had an APGAR score of 3-7-8 and the cord PH was 6.95.

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8. In the case of ARH patient 21-90-97, she was admitted at ARH on February 1, 2004, at 1:10 a.m. The fetal heart rate tracings indicated late decelerations shortly after patient was admitted.

9. The nurse's notes indicate that on February 1, 2004, at 9:35 a.m. patient 21-90-97 was started on pitocin.

10. Throughout labor, fetal heart rate tracings indicated decelerations at random times, including severe decelerations.

11. After delivery, patient 21-90-97's baby had an APGAR score of 3-5-9 and the cord PH was 7.05. The baby had heavy meconium and the nuchal cord was wrapped three times.

12. In ARH patient 38-34-33, Murphy saw the patient at her office at 3 p.m. on March 10, 2004. Murphy's notes indicate that patient 38-34-33 was Group B Beta Strep positive, that her membranes had spontaneously ruptured at approximately 10:30 a.m. that same day, and that fluid had been leaking since the rupture.

13. On March 10, 2004, at 4:25 p.m., patient 38-34-33 was admitted to ARH. Shortly after patient's arrival, fetal heart rate tracings indicated late decelerations and tachycardia. Patient 38-34-33's temperature rose from 98.5 to 103.7 during labor. Patient 38-34-33's baby was delivered at approximately 2:09 a.m. Patient 38-34-33's baby had a tight nuchal cord and needed aspiration for meconium. Patient 38-34-33's baby had to be resuscitated.

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14. Patient's 38-34-33's baby had an APGAR Score of 2-3 and cord PH of 7.05. The baby was intubated and transferred to Providence Neonatal Intensive Care Unit.

15. On August 14, 2004, ARH patient 35-55-67's baby was delivered at her home. Patient 35-55-67 was admitted at ARH at 6:10 p.m. At 6:15 p.m., Murphy was notified that the placenta was intact and that the patient had a two degree laceration. Murphy arrived at the hospital at 7:45 p.m. to repair the laceration.

16. ARH patient 35-43-82 was admitted ARH on October 17, 2004 at 2:10 a.m.

17. ARH nurses attempted to reach Murphy beginning at 3:00 a.m. by pager and telephone without success. The baby was delivered by an EMTALA doctor at 8:43 a.m.

Count 1

18. Paragraphs 1-17 are realleged.

19. Murphy's failure to recognize signs of a uterine rupture, her decision to perform a vaginal operative delivery on a patient with two prior C-Sections, her disregard of fetal heart rate changes, and her use of two vaginal operative procedures on the same patient constitutes professional incompetence, gross negligence or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A). Murphy's conduct was potentially life-threatening to patient 37-44-87 and her baby and therefore constitutes a clear and immediate danger to public health and safety under AS 08.64.331(c).

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Count II

20. Paragraphs 1-19 are realleged

21. Murphy's failure to recognize abnormalities of fetal heart rate tracings constitutes professional incompetence, gross negligence or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A). Murphy's conduct was potentially life-threatening to patient 21-90-97's baby and therefore constitutes a clear and immediate danger to public health and safety under AS 08.64.331(c).

Count III

22. Paragraphs 1-21 are realleged.

23. Murphy's failure to recognize abnormalities of fetal monitory tracings constitutes professional incompetence, gross negligence or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A). Murphy's conduct was potentially life-threatening to patient 38-34-33's baby and therefore constitutes a clear and immediate danger to public health and safety under AS 08.64.331(c).

Count IV

24. Paragraphs 1-23 are realleged.

25. Murphy's delayed response to patient 35-55-67 constitutes professional incompetence, gross negligence, or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A).

Count V

26. Paragraphs 1-25 are realleged.

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27. Murphy's unavailability for ARH patient 35-43-82's labor and delivery constitutes professional incompetence, gross negligence, or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A).

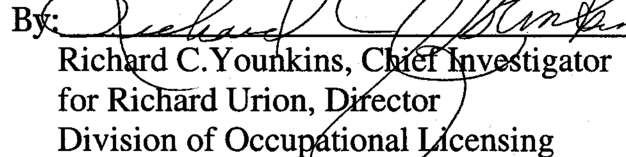
Count VI

28. Paragraphs 1-27 are realleged.

29. Murphy's actions in the above five patient cases constitute professional incompetence, gross negligence, or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A). Murphy's conduct was potentially life-threatening to her patients and her patients' babies and therefore constitutes a clear and immediate danger to public health and safety under AS 08.64.331(c).

DATED this 22nd day of July, 2005, at Anchorage, Alaska.

EDGAR BLATCHFORD,
COMMISSIONER



By: Richard C. Younkins, Chief Investigator
for Richard Urion, Director
Division of Occupational Licensing

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