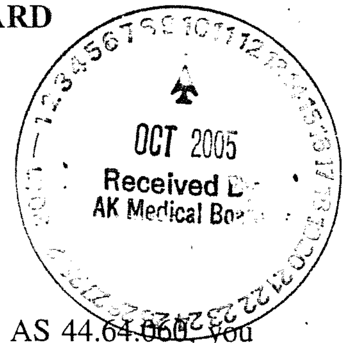
BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE ALASKA STATE MEDICAL BOARD



In the Matter of	)	
Colleen M. Murphy, M.D.	)	OAH No. 05-0553-MED
	)	Board No. 2800-05-026

NOTICE REGARDING PROPOSED DECISION

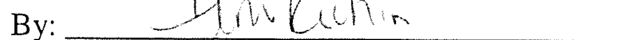
Attached is the administrative law judge's proposed decision. Under AS 44.64.060, you have the right to file a "proposed action" requesting that the final decisionmaker (the State Medical Board) do one of the following:

1. adopt the proposed decision as the final agency decision;
2. return the case to the administrative law judge to take additional evidence or make additional findings or for other specific proceedings;
3. revise the proposed enforcement action, determination of best interests, order, award, remedy, sanction, penalty, or other disposition of the case;
4. reject, modify, or amend a factual finding;
5. reject, modify, or amend an interpretation or application of a statute or regulation.

If you wish to file a "proposed action," the deadline is **September 28, 2005**. Submit your "proposed action" document to the Office of Administrative Hearings at the address below and the office will forward it to the final decisionmaker. You must give the reasons for the "proposed action" you request. If you request "proposed action" 4 above, you should identify which evidence in the record (for example, documents or testimony given to the administrative law judge) supports your request to change the factual finding(s).

You do not have to file a "proposed action." If no party in this case requests a "proposed action" other than adoption of the decision (item 1 above), the proposed decision will become final on the earlier of (1) the date the board adopts the decision as final or (2) the day after adjournment of the next regularly scheduled meeting of the board occurring at least 45 days after the date of this notice, if the board takes no action on the proposed decision.

DATED this 15th day of September, 2005.

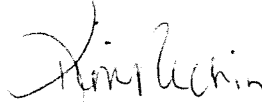
By: 

Office of Administrative Hearings
P.O. Box 110231
Juneau, AK 99811-0231

CERTIFICATE OF DISTRIBUTION

The undersigned certifies that on September 15, 2005 this notice and the accompanying proposed decision were distributed to the following parties in the manner indicated:

Colleen Murphy by certified mail
Paul Stockler by US mail and courtesy email
Rick Urion and Jennifer Strickler by certified mail and courtesy email
Leslie Gallant by courtesy email
Karen Hawkins by US mail and courtesy email
Lt. Governor's Office by mail



Kim Rechin, Paralegal

In the Matter of:)
)
COLLEEN M. MURPHY, M.D.)
)
Respondent) OAH No. 05-0553-MED
) Board No. 2800-05-026

DECISION ON SUMMARY SUSPENSION

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BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTRATIVE 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

DECISION ON SUMMARY SUSPENSION

I. Introduction

This case is a disciplinary action against Colleen Murphy, M.D. On July 7, 2005, the Division of Occupational Licensing filed a Petition for Summary Suspension with the Alaska State Medical Board, asking for summary suspension of Dr. Murphy's license under AS 08.64.331(c). The board, following a teleconferenced executive session, issued an order suspending Dr. Murphy's license that same day.

On July 8, Dr. Murphy filed a notice of defense and requested a hearing. The matter was referred to the Office of Administrative Hearings. The administrative law judge conducted a prehearing conference on July 11. Pursuant to the prehearing order, the division filed an accusation on July 14 and the hearing was convened on July 15. The evidentiary hearing was concluded on July 22; telephonic oral argument was heard on July 24.

This decision is submitted to the board under AS 44.64.060(e). The administrative law judge recommends that the suspension order be vacated pending completion of proceedings on the merits of the amended accusation filed on July 22.

II. Facts[1]

A. <u>Background and Prior Proceedings</u>

Colleen Murphy graduated with distinction from medical school in 1981. [r. 2454, 2492, 2496] Following medical school she interned in family practice in Detroit [r. 2486, 2500] and

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[1] Record citations are to the file provided to the board with the petition [r.], exhibits submitted at the hearing [Ex.], and testimony at the hearing [tape number and side]. Citations are provided for convenience and indicate that the cited references provide support for the stated fact, but do not indicate that the cited portion of the record contains the only or most persuasive evidence for that finding. The text in this section contains the administrative

obtained her medical license in Michigan in 1982. [r. 2488, 2509] She was Chief of Pediatrics at Truk State Hospital in Micronesia, from 1982-84. [r. 2492] She was a resident at Good Samaritan Medical Center in Phoenix, Arizona, in obstetrics and gynecology from 1984-87, [r. 2486] with a two-month break in 1986 for a Galloway Fellowship at Sloan Kettering Hospital in New York City in gynecologic oncology. [r. 2492, 2514]

Dr. Murphy began work as a staff clinician in obstetrics and gynecology at the Alaska Native Medical Center in 1987. [r. 2489, 2492] She was appointed chief of the department of obstetrics and gynecology at the center in 1993. [r. 2492] She worked as a Public Health Services physician in Anchorage in 1996 [r.2476] and in 1998-1999 was employed to provide clinical services in obstetrics and gynecology by the Alaska Native Health Tribal Consortium. She was terminated from that position in March, 1999.[2] Thereafter, Dr. Murphy engaged in the private practice of medicine, with privileges at Alaska Regional Hospital and Providence Hospital.

Dr. Murphy was initially board certified by the American College of Obstetricians and Gynecologists in December, 1989 [r. 2486, 2492, 2515-16] and has maintained her certification since that time, including annual recertifications. She was initially licensed in Alaska in October, 1993. [r. 2475] Through November 20, 2003, there is no evidence in the record of any instance of professional misconduct, substandard medical care, poor medical judgment, patient complaint, or adverse outcome involving a patient of Dr. Murphy's.

On November 21, 2003, a patient in Dr. Murphy's care (No. 37-44-87) at Alaska Regional Hospital suffered a ruptured uterus and bladder during the course of delivery. Dr. Murphy reported this incident to the hospital as a sentinel event. In response to Dr. Murphy's report, the case was reviewed by the hospital's department of obstetrics and gynecology on March 4, 2004, which concluded that "Care was adequate."[3] [Ex. 2]

After the November 21, 2003 case of uterine and bladder rupture, and prior to the ob/gyn department's review of that case on March 4, 2004, two of Dr. Murphy's cases were identified

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law judge's findings of material facts. The basis for those findings may be addressed in footnotes, which are typically summaries or characterizations of the evidence but may contain subsidiary findings of fact.

2 The termination occurred after the employer restricted her privileges. [r. 2468; r. 2471] No evidence or testimony was submitted to establish the reasons for the restriction. According to Dr. Murphy, the matter was "internal & not related to patient care." [r. 2464]

3 Rosemary Craig, Alaska Regional Hospital's head of quality control, testified that the review was by a physician reviewer. However, it appears from Exhibit 2 that the review was by the department, and Ms. Craig also testified that the department chair, Dr. Bertelson, provided information about the department's review. On balance, the weight of the evidence supports a finding that the review was by the department, rather than an individual reviewer.

for routine quality control review through Alaska Regional Hospital's electronic case coding system, which flags cases for review based upon the presence of factors such as readmission within 30 days, return to surgery, or other factors.[4] [7A (Craig direct)] These cases involved a twin delivery, one in total breech, on February 3, 2004 (No. 37-99-97) and a birth on March 10, 2004, involving a patient (No. 38-34-33) with Group B Beta strep. [Ex. 2; r. 214] In both cases, the assigned physician reviewed the cases and found that the care was acceptable; neither was referred to the ob/gyn department for further discussion. [*id.*]

At around this time, Dr. Murphy's credentials at Alaska Regional Hospital were in the process of being renewed. As a routine part of that process, Rosemary Craig, the hospital's quality control supervisor, provided the hospital's Credentials Committee with information regarding the uterine rupture case and the two cases that been identified for review through the electronic case coding system. Based on the information provided, the Credentials Committee asked Ms. Craig to conduct a review of all Dr. Murphy's cases over a six-month period ending around June 30, 2004. She reported back to the Credentials Committee in July, 2004, by which time one additional case had "fallen out" through the electronic case file coding system (No. 38-82-16) and two other cases (No. 21-90-97; No. 37-03-61) were identified for review by Ms. Craig's department. The Credentials Committee instructed her to continue her review of all of Dr. Murphy's cases. [7B (Craig Recross)] In September, 2004, she provided updated information to the committee, by which time two more cases had been flagged by the electronic case coding system (No. 39-34-22 & No. 35-55-67). In response to the September update, the Credentials Committee directed Ms. Craig to send out all of the cases that had been provided to it for external review.

Over the period from November 21, 2003, until the fall of 2004, Ms. Craig reviewed 62 cases, representing all of Dr. Murphy's obstetrics cases at Alaska Regional Hospital over a period of about one year. [7B (Craig Recross)] Ms. Craig sent out a total of ten cases for external review, consisting of the eight cases previously identified and two more: one that occurred in

4 Cases electronically identified are reviewed initially by an employee under Ms. Craig's supervision who gathers the case records for review by a physician assigned by the relevant department. The assigned reviewing physician makes an initial determination as to whether the standard of care was met in the case or if there is an opportunity for minor or major improvement. If the reviewer determines that the standard of care was not met or that there is room for major improvement, the case is sent for review and discussion at a department meeting. If the department agrees with the reviewer's assessment, the department makes a recommendation that is placed in the credentials "performance improvement" file. Typically, for any given physician, the hospital identifies a couple of records for review in a given year. [Lillibridge testimony]

September, 2004, (No. 32-42-42) and one in October, 2004, (No. 35-43-82). Records of those ten cases were provided to an independent peer review entity. Three doctors from that entity reviewed the cases. Initially, Dr. Audrey Pauly reviewed five, Dr. Kathleen McGowan reviewed one, and Dr. Robert Davis reviewed four.[5] Dr. Pauly found a deviation from the standard of care in four of the five cases she reviewed; neither Dr. McGowan nor Dr. Davis found a deviation from the standard of care in any of the five cases they reviewed.

Ms. Craig provided the external review reports to the Credentials Committee. Because it appeared to Ms. Craig and members of the Credentials Committee that Dr. Davis had not reviewed the full medical records, including fetal heart rate monitoring strips, and because of the difference of opinion between Dr. Pauly and the other two reviewers regarding the quality of Dr. Murphy's care, the Credentials Committee directed Ms. Craig to have all the cases reviewed by the external reviewers again, this time without using Dr. Davis. All ten cases were then reviewed again, five by Dr. Pauly and five by Dr. McGowan. Dr. Pauly found a deviation from the standard of care in four of the five cases she reviewed; Dr. McGowan found a deviation in one of five. Following this second round, each of the ten cases had been reviewed by two of the external reviewers.[6] In only one of the ten cases, involving the patient with Group B beta strep (No. 38-34-33), did both external reviewers find a deviation from the standard of care; in that case, the hospital's department of obstetrics and gynecology had deemed the care acceptable. [Ex. 2, r. 214] In no case did the external reviewers and the hospital's internal review process agree that care was unacceptable.

The reports from both sets of external reviews were provided to the Credentials Committee, which recommended the formation of an ad hoc committee to review the ten cases. The Credentials Committee recommendation was adopted by the hospital's Medical Executive Committee, which authorized formation of the ad hoc committee.

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5 Dr. Pauly's reports on cases No. 21-90-97, No. 38-34-33, No. 35-55-67, and No. 35-43-82 are dated December 1, 2004. [Ex. 37;] Dr. McGowan's report on case No. 39-34-22 is dated November 24, 2004. [Ex. C; R. 107] Dr. Davis's reports on cases No. 37-44-87, No. 37-03-61, No. 38-82-16, and No. 32-42-42 are dated December 6, 2004. [Ex. D] It appears that Dr. Pauly also reviewed case No. 37-99-97 in the initial round, since Dr. Davis did not review that case at all and Dr. McGowan's review is dated December 28, 2004, which would have been during the second set of reviews.

6 Dr. McGowan's reports for cases No. 21-90-97, No. 38-34-33, No. 35-55-67, No. 35-43-82, and No. 37-99-97 are dated December 28-30, 2004. [Ex. C] Dr. Pauly's report for case No. 37-44-87 is dated January 4, 2005. Her reports for cases No. 37-03-61, No. 38-82-16, No. 39-34-22, and No. 32-42-42 are not in the record, but she did review each of those cases [Ex. 2] and because each of them was reviewed by either Dr. McGowan or Dr. Davis in the initial review, it may reasonably be inferred that Dr. Pauly reviewed them in the followup review.

The ad hoc committee was composed of five individuals: Dr. Donna Chester, Dr. Wendy Cruz, Dr. George Gilson, Dr. Norman Wilder, and Dr. Clint Lillibridge. Dr. Chester and Dr. Cruz are obstetricians with privileges at Alaska Regional Hospital. Dr. Chester graduated from medical school in 1984 and completed her residency in obstetrics and gynecology in 1988; she is board-certified by the American Board of Obstetrics and Gynecology. [Ex. 21] Dr. Cruz graduated from medical school in 2000 and completed her residency in obstetrics and gynecology in 2004; [Ex. 22] she is not yet board-certified. [2A (Cruz cross)] Dr. Gilson is an obstetrician specializing in perinatolgy[7] who graduated from medical school in 1970 and completed his residency in obstetrics and gynecology in 1982. He has been board-certified in obstetrics and gynecology and a fellow of the American College of Obstetricians and Gynecologists since 1984. From 2001-2004 he was a member of the department of obstetrics and gynecology at the Alaska Native Medical Center. [Ex. 19] Dr. Wilder is an internist and is the Vice President for Medical Affairs at Alaska Regional Hospital with responsibilities including quality assurance, peer review, and patient safety. [Tape 6A] He is a member of the hospital's Credentials Committee. [Ex. 36] Dr. Lillibridge is a pediatrician specializing in gastroenterology. He is a former Chief of Medical Staff at Alaska Regional Hospital (1989) and chairman of the Alaska State Medical Association (1990-95) who graduated from medical school in 1962 and retired from private practice in 2005.

The ad hoc committee met three times. All five members attended the first meeting, on February 2, 2005, at which the external review reports were reviewed and Dr. Murphy was interviewed.[8] Following that meeting, the committee obtained complete medical records, including nursing notes and fetal heart rate monitor tracings. [Ex. 14; r. 232] Only Dr. Chester, Dr. Cruz and Dr. Wilder attended the second meeting of the committee, on February 9, 2005. The members in attendance closely reviewed the medical records, including fetal heart rate tracings, from four cases. [*id.*; r. 233] The third meeting, on February 28, 2005,[9] was attended by Dr. Chester, Dr. Cruz, Dr. Gilson and Dr. Lillibridge. Three additional cases were reviewed. [*id.*; r. 234]

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7 Perinatology is defined as the study of the health of fetuses and neonates during the period around childbirth, roughly from five months prior to delivery, to one month after.

8 Also participating, telephonically, was Dr. James Bertelson, chair of the hospital's department of obstetrics and gynecology. [Ex. 15]

9 The committee minutes state that the meeting was on February 29, 2005; however, 2005 was not a leap year.

On March 9, 2005, the committee issued its report. The committee concluded that in several cases Dr. Murphy had failed to respond appropriately to fetal heart monitor tracings that indicated the potential for neonatal distress. The committee also found that on occasion Dr. Murphy's arrival in response to calls to attend patients at the hospital was delayed. The committee found five instances of substandard performance in the ten cases reviewed and concluded that Dr. Murphy's continued practice at Alaska Regional Hospital would present an imminent danger to her patients. The committee recommended that she obtain retraining in the interpretation and significance of fetal heart tracings and in the management of high risk deliveries, and that she review the literature regarding the long term intellectual and neurological outcomes of difficult deliveries. The committee recommended that unless Dr. Murphy obtained the retraining, her privileges at the hospital should be revoked. [Ex. 16; r. 35]

Dr. Murphy declined to take voluntary leave to obtain retraining and the hospital responded by summarily suspending her privileges on April 6, 2005. As required by law, the hospital reported its action to the Alaska State Medical Board. The investigator for the board is Colin Matthews. He contacted the members of the ad hoc committee and obtained affidavits from each of them. Four of the committee members stated that in their professional opinion, based on the ten cases reviewed, Dr. Murphy posed a clear and immediate danger to public health and safety. Dr. Gilson's opinion was that Dr. Murphy was in need of remedial education in order to bring her standard of practice up to that considered the norm in the community, and that her privileges in operative obstetrics should be limited until she obtained retraining satisfactory to the Alaska Regional Hospital Executive Committee. Based on the findings of the ad hoc committee and affidavits from the members of the committee, the Division of Occupational Licensing presented a Petition for Summary Suspension of Dr. Murphy's medical license to the Alaska State Medical Board, on July 7, 2005. The board met by teleconference and issued an order suspending Dr. Murphy's medical license that same day.

Dr. Murphy requested an evidentiary hearing, which was conducted over the course of six days, beginning July 15 and concluding on July 22. In an accusation and at the hearing, the Division of Occupational Licensing relied on five cases of alleged substandard performance as sufficient to support summary suspension of Dr. Murphy's medical license.[10] Three of the cases

[10] The ad hoc committee's report states it found five instances of substandard performance in the ten cases it reviewed, but did not specifically identify which cases it had deemed substandard, and the division did not provide any testimony to establish how it identified the five cases it relied on for purposes of the summary suspension

involve issues of professional medical judgment (Nos. 37-44-87, 21-90-97, and 38-43-33). The other two cases are instances of failure to timely appear (Nos. 35-55-67 and 35-43-82).

Eight witnesses testified on behalf of the division: the five members of the ad hoc committee (Drs. Chester, Cruz, Gilson, Wilder and Lillibridge), plus Nurse Jennifer Rees-Benyo, Rosemary Craig, and the division's investigator, Colin Matthews. Five witnesses, in addition to Dr. Murphy, testified on behalf of Dr. Murphy: Dr. George Stransky, Dr. John DeKeyser, Dr. Sharon Richey, and two of Dr. Murphy's patients (Nos. 38-34-33 and 35-55-67) in the cases under review. Also in the record are the reports of the external reviewers, the complete medical records from the five cases in question, and medical literature.

B. Case Management

1. Patient No. 37-44-87 (uterine rupture)

In this case, the patient was scheduled for a trial of labor after two prior Cesarean sections. The patient was admitted to the hospital at 4:45 p.m. on November 15. [Ex. 3; r. 279] Upon admission the patient's cervix was dilated to 1 cm. and was 25% effaced, and the fetus was at –4 station. Mild contractions of 60 seconds duration were occurring about every five minutes. The patient was released at 7:30 p.m. and advised to return at 10:00. [Ex. 3; r. 284] When she returned at that time, [Ex. 3; r. 448] her cervix was dilated to 2 cm. and 80% effaced, and the fetus was at –2 station. [Ex. 3; r. 332] Dr. Murphy arrived at the hospital about 10:15 p.m.

Shortly after midnight, the patient was administered oxytocin, [Ex. 3; r. 534] a drug employed when the patient is not progressing satisfactorily. Oxytocin augments the frequency and strength of contractions and thereby speeds delivery. An epidural block was administered at 1:00 a.m. [Ex. 3; r. 534] Contractions 60-90 seconds in duration and moderate intensity were occurring about every 2-2.5 minutes over the course of the next couple of hours. [Ex. 3; r. 535-537] By 2:00 a.m., the patient's cervix was dilated to 4 cm. [Ex. 3; r. 537] At that time, Dr. Murphy retired to an adjacent room to sleep; the patient was already sleeping soundly. [Ex. 3; r. 537] The patient was left under observation by Nurse Jennifer Rees-Benyo. At 3:45 a.m. the patient's cervix was at 6 cm. and 90% effaced, and the fetus was at –1 station; the patient

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hearing. Thus, it is unclear whether the five cases relied on by the division are the same cases that the ad hoc committee had identified as instances of substandard performance.

The division argued at hearing that evidence regarding the five cases in the record that were not included in the accusation may be considered. Dr. Murphy objected to consideration of evidence regarding the other five cases. To the extent that evidence relating to other cases was admitted into evidence, they may be taken into consideration

reported pain, notwithstanding the epidural block. [*id.*, r. 538] At 4:00 a.m. Nurse Rees-Benyo noted three variable decelerations in the fetal heart rate of about 80 seconds duration down to 90-100 bpm (beats per minute) from a baseline of 120 bpm.[11] [Ex. 3; r. 538] About 4:30 a.m., additional oxytocin was terminated; the patient was at 7 cm., with bloody urine showing in her Foley catheter, and the fetus was at 0 station. [Ex. 3; r. 539]

At 4:41 a.m., responding to an episode of severe decelerations in the fetal heart rate over a ten-minute period, [Ex. 3, r. 515-516] Nurse Rees-Benyo awakened Dr. Murphy, informed her of the patient's pain[12] and asked her to observe the patient. Dr. Murphy elected to have the nurse bring her the fetal heart monitor strips. At 4:43 a.m., after reviewing fetal heart monitor tracings, Dr. Murphy called for amnio infusion (insertion of fluid into the uterus) in response to the decelerations; Nurse Rees-Benyo, upon her return to bedside, found the tracings improved and suggested that the amnio infusion be cancelled; Dr. Murphy concurred [Ex. 3; r. 294-295, 453, 539] and ordered administration of another bolus of epidural. Dr. Murphy remained in the sleep room and went back to sleep. Over the next 20 minutes or so, until about 5:05 a.m., the patient, now awake, no longer felt pain [Ex. 3, r. 540] and the fetus showed recurrent moderate decelerations with each contraction. [Ex. 3, r. 517-520] From about 5:05 to 5:15, the fetus had several severe late decelerations to around 70 bpm.[13] [Ex. 3, r. 521] At 5:24, the nurse found the cervix dilated to 8-9 cm. and noted that the fetus showed accelerations in the fetal heart rate with scalp stimulation. [Ex. 3, r. 454, 522] Late decelerations continued, however, [Ex. 3, r. 522-523] and at 5:36, deeming the fetal heart tracings troubling, [Ex. 3, r. 332] Nurse Rees-Benyo called Dr. Murphy into the room to examine the fetal heart monitor strips. [Ex. 3, r. 541] The tracings were showing late decelerations to 70 bpm; [Ex. 3; r. 524] Dr. Murphy found them "quite ominous". [Ex. 3; r. 332] Examining the patient, Dr. Murphy observed a protrusion that indicated

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in making findings based on the five cases identified in the accusation as the basis for summary suspension. None of the other five cases, however, may be relied upon as independent grounds for summary suspension.

11 Dr. Pauly's report characterizes the strips during this period [Ex. 3, r. 511-512] as demonstrating a "Prolonged bradycardic episode." [Ex. 37; r. 102] Bradycardia occurs when the baseline is below 110 bpm. [Ex. G, at 1163] A deceleration of more than two minutes but less than ten minutes is a prolonged deceleration, not a change in the baseline. [*id.*] The individual decelerations may not reasonably be characterized as prolonged; taken together, they may reasonably be characterized a single episode of prolonged decelerations, but not as bradycardia.

12 The nurse's note states "updated on PT RT sided abdominal pain, bloody urine, change in cervix and station." [Ex. R, r. 539]

13 Dr. Pauly's report characterizes the strips from 4:06 to 5:30 a.m. as demonstrating "Persistent, continuous late decelerations." [Ex. 37, r. 102] Nurse Rees-Benyo's notes characterize the decelerations as variable, rather than late. [Ex. 3, r. 529 (4:17 a.m.), 540 (5:03 a.m.)] Dr. Murphy, testifying at the hearing, testified that the first late deceleration occurred at about 5:12 a.m. [Ex. 3, r. 521 (strip 25535)]

a possible uterine rupture[14] [Ex. 3; r. 272, 332] and determined to immediately deliver the baby. She attempted a vacuum delivery, which she abandoned after it was unsuccessful.[15] [Ex. 3, r. 530, 541] She then performed a mid-forceps extraction without difficulty. [*id.*] At 5:47 a.m. the baby was delivered with an arterial cord pH of 6.97 [Ex. 3; r. 444] and arterial base excess of –11.8. [Ex. 3, r. 346] The baby weighed 7 lb., 4 oz., and had Apgar scores of 3, 7, and 8 (1, 5 and 10 minutes, respectively). [Ex. 3, r. 344] An operative assistant was called, and Dr. Murphy discovered that both the uterus and bladder had ruptured. A hysterectomy was performed.

2. *Patient No. 21-90-97 (triple nuchal cord)*

This patient was admitted to Alaska Regional Hospital at 1:19 a.m. on February 1, 2004 after experiencing progressively increasing contractions for 12 hours. Her cervix was closed but 30% effaced and the fetus was at –3 station. Over the course of six or seven hours, the fetal heart strips reflect intermittent severe variable decelerations, with moderate beat to beat variability and good recovery. [Ex. 4, r. 671-689; 1B (Cruz direct)] By 4:13 a.m. the patient's cervix was dilated to 2 cm. and was 50% effaced, and the fetus was at –1 station. Ambien was administered beginning at that time; [Ex. 4, r. 624)] consistently with the medication, beat to beat variability decreased. [Ex. 4, r. 672-675] At 4:58 a.m., the cervix was dilated to 5 cm. and 50% effaced, and the fetus remained at –1 station. [Ex. 4, r. 625] Around this time, another of Dr. Murphy's patients, No. 37-99-97, carrying twins, was admitted to the hospital with ruptured membranes, in labor. From this time forward, Dr. Murphy simultaneously attended both patients until they delivered.

At 5:58 a.m. an amnio infusion was provided to patient No. 21-90-97. [Ex. 4, r. 625] After severe decelerations at about 6:05 a.m. [Ex. 4, r. 683] and 6:55 a.m., [Ex. 4, r. 689] three additional severe variable decelerations into the 30-50 bpm range occurred from 7:30-7:45 a.m. [Ex. 4, r. 693-695] The fetus heart rate occillated, indicating difficulty in recovering, [1B (Cruz direct)] following the deceleration at 6:55 a.m., but beat to beat variability remained moderate. At 8:02 a.m. patient No. 21-90-97's cervix was dilated to 5 cm. and 50% effaced, and the fetus

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[14] Nurse Rees-Benyo's note indicates that at 5:50 a.m., after delivery, Dr. Murphy indicated that she believed that the bladder, but not the uterus, had ruptured. [Ex. 3; r. 455] Dr. Murphy's post-operative summary (dictated November 21, 2003) states that prior to delivery the patient's abdominal contour was suggestive of a uterine rupture, [Ex. 3, r. 272] Dr. Murphy testified at the hearing that she observed signs of a uterine rupture when she examined the patient; her testimony on that issue was credible.

[15] Dr. Murphy's notes state that one pull was attempted; she testified that in addition there were popoffs. Nurse Rees-Benyo's notes state that three pulls were attempted.

was at 0 station. [Ex. 4, r. 626] Another severe variable deceleration to 35 bpm occurred at about 8:25 a.m. [Ex. 4, r. 699] Recurrent moderate variable decelerations occurred between 8:45 a.m. and 9:15 a.m., when there was a severe variable deceleration to 30 bpm of over one minute duration. [Ex. 4, r. 705] The fetal heart rate recovered well. Oxytocin was administered beginning around 9:35 a.m. [Ex. 4, r. 627] Around 9:40 a.m., several moderate decelerations occurred, [Ex. 4, r. 708] closely followed by a severe deceleration to 30 bpm, again lasting one minute. [Ex. 4, r. 709] Again the fetal heart rate recovered well.

At 9:50 a.m., Dr. Alex Chang, the anesthesiologist, came into the room to discuss concerns about the possibility of dual Cesarean sections, and anesthesia safety concerns, in light of the pending twin deliveries in an adjacent room. [Ex. 4, r. 627] At 10:21 a.m., when Dr. Murphy examined the fetal heart monitor strips, patient No. 21-90-97 was dilated to 6-7 cm., with the fetus at 0/+1 station. [Ex. 4, r. 627] Dr. Murphy delivered patient No. 37-99-97's first twin by vaginal delivery at 11:01 a.m. and the second at 11:09 a.m. by total breech extraction.[16] [Ex. 2, r. 214; Ex. C, r. 111-112]

At 11:29 a.m., Dr. Murphy had returned from the adjacent delivery room and examined patient No. 21-90-97; her cervix was dilated to 7-8 cm. [Ex. 4, r. 629] At 11:57 a.m., the cervix was dilated to 9 cm. and the fetus was at +2 station. [Ex. 4, r. 629] From about 11:00 a.m. on, the fetus had been experiencing recurrent moderate decelerations, [Ex. 4, r. 718-723] which increased in severity around noon. [Ex. 4, r. 724-725] Dr. Murphy delivered patient No. 21-90-97's baby by vacuum extraction at 12:17 p.m. At birth the baby was found to have the umbilical cord wrapped around the neck three times. [Ex. 4, r. 630] The baby had an arterial cord pH of 7.05, and arterial base excess of –10.9, [Ex. 4, r. 559, 580] and Apgar scores of 3-5-9. [Ex. 4, r. 561]

3. Patient No. 38-34-33 (Group B beta strep)

This patient was admitted at 4:15 p.m. on March 10, 2004. Her temperature was 98.5°. Her membranes had ruptured, her cervix was dilated to 2 cm. and 50% effaced, and the fetus was at –2 station. [Ex. 6, r. 961] Because she was infected with the Group B beta strep, starting at 5:30 p.m. the patient was provided ampicillin, an antibiotic. [*id.* at 918, 963] At 7:30 p.m., her temperature had risen slightly, to 99.4°. [Ex. 6, r. 964] At 8:25 p.m., Dr. Murphy was advised of

[16] This patient was identified for review through the hospital's case coding system; it was one of the ten cases sent for external review. Both of the external reviewers found Dr. Murphy's care in that case to meet the standard of care. [Ex. 2, r. 214]

a lack of fetal heart rate accelerations and diminished variability. [Ex. 6, r. 964] At 9:20 p.m., a second dose of ampicillin was administered. [Ex. 6, r. 965] At 9:40 p.m., when an epidural was put in place, the patient's temperature was 99.9; her cervix was dilated to 3 cm. and was 75% effaced, and the fetus was at –1 station. [*Id.*] Through about 10:00 p.m., the fetal heart tracings maintained a consistent baseline around 150 bpm, with no accelerations or decelerations and minimal to moderate variability. The fetal heart rate became tachycardic (baseline above 160 bpm) around 10:00 p.m., with the baseline heart rate rising to 180 bpm around 10:30 p.m., when Dr. Murphy came in to check on the patient. Oxytocin and zofran were administered at 10:45 p.m.. [Ex. 6, r. 917, 967] At 11:40 p.m., the patient's temperature was up to 102.2°.

The baseline increased gradually to around 200 bpm by midnight, demonstrating minimal variability. [Ex. 6, r. 1035] At 12:15 a.m. on March 11, the patient's temperature was 102°, her cervix was dilated to 4 cm. and was 75% effaced, and the fetus was at –1 station. [Ex. 6, r. 968] Dr. Murphy was informed of the patient status, and another dose of ampicillin was administered at 12:40 a.m. [Ex. 6, r. 969] Gentamicin was administered at 1:00 a.m. [Ex. 6, r. 969] At 1:10, the patient's temperature was 103.7°; her cervix was dilated to 6 cm. and 90% effaced, and the fetus was at 0 station. [*Id.* at 969-970] Following a prolonged deceleration to about 80 bpm, at 1:10 a.m., [*Id.* at 1040] oxytocin was discontinued, scalp stimulation provided,[17] and Dr. Murphy was notified. [Ex. 6, r. 970] Upon examination, she found the patient's cervix was dilated to 8 cm. and was 100% effaced; the fetus was at +1 station. [Ex. 6, r. 970] Dr. Murphy then manually dilated the cervix. [Ex. 6, r. 970] From this time until shortly before delivery the fetal heart baseline remained at about 180, with recurrent oscillations. At 1:25 a.m., the patient's cervix was dilated to 10 cm.; the fetus was at +1 station. [Ex. 6 at 970-971] By 1:35 a.m., the patient was pushing. [Ex. 6, r. 970] At 1:55 a.m. her temperature was 100.5°; [Ex. 6, r. 971] she continued pushing and, following three moderate to severe decelerations, [Ex. 6 at 1046-47] delivered her baby vaginally at 2:10 a.m. with Apgars of 2-3 (1 and 5 minutes), arterial cord pH 7.05, and arterial base excess of –12. [Ex. 6, r. 922] The baby had a tight nuchal cord and transported to the Providence Hospital neonatal intensive care unit.

[17] Testimony differed as to whether the strip showed reactivity in response to scalp stimulation (which would exclude acidosis at that time), reflecting the degree to which such assessments are a matter of opinion. Dr. Murphy identified a distinct episode of acceleration at Ex. 3, r. 1042 as demonstrating reactivity in response to scalp stimulation. Her characterization is not inconsistent with the strip.

C. Physician Availability

1. Patient No. 35-66-67 (voluntary delay)

In this case a patient of Dr. Murphy's went into labor, delivered at home, and was transported to Alaska Regional Hospital, where she was admitted at 6:10 p.m. on August 14, 2004. [Ex. 10, r. 1423] At 6:15 p.m., Dr. Murphy was contacted [Ex. 10, r. 1424] at her home as she was about to leave to deliver a pasta salad to a party for her son's high school soccer team. Dr. Murphy spoke with her patient, who was resting comfortably in the recovery room, and with the attending nurse. She was informed that the patient had incurred a laceration of the perineum upon delivery. Dr. Murphy consulted with the nurse and patient and decided, with the agreement of both, to drop off the pasta salad rather than going directly to the hospital to repair the laceration. The 2° laceration [Ex. 10, r. 1380] was iced down. [Ex. 10, r. 1425] Dr. Murphy arrived at the hospital at 7:45 p.m., [Ex. 10, r. 1425] about an hour later than if she had gone directly there. Dr. Murphy repaired the laceration without incident. The patient suffered no harm due to the delay.

2. Patient No. 35-43-82 (unable to contact)

On the evening of October 16-17, 2004, Dr. Murphy was at home. She had turned off her cellphone and was unable to locate it when it was time for bed. She went to sleep, relying on her telephone as her contact point. She did not realize that one of the telephone receivers, located in her basement, was off the hook, so that the telephone would not ring.

One of Dr. Murphy's patients arrived at Alaska Regional Hospital in labor and was admitted at 1:55 a.m. on the 17th. [Ex. 12, r. 1707] Hospital personnel attempted to contact Dr. Murphy at her home telephone number and at her cellphone, but were unable to do so. Dr. Murphy missed the delivery, which was effected without incident by the on-site physician at 8:43 a.m. [Ex. 12, r. 1654, 1703]

D. Fetal Heart Monitor[18]

The fetal heart monitor provides the clinician with an ongoing, real-time view of the fetal heart rate. The monitor readings are printed on paper strips that show the heartbeat rate of the fetus on a constant basis on a graph that also shows the timing and strength of uterine

[18] Findings in this section are taken from American College of Obstetricians and Gynecologists, INTRAPARTUM FETAL HEART RATE MONITORING (May, 2005) (hereinafter cited as ACOG FHR Guidelines) [Ex. G].

contractions. The strips provide an opportunity for the attending physician to assess the degree to which the changes in the fetal heart rate affect the supply of blood, and thus fetal well being.

The strips show the ongoing heartbeat rate (baseline) as well as short term variability in the heartbeat rate (beat-to-beat variability or baseline variability) and longer term changes in the heart beat rate (accelerations and decelerations) that if continued for a sufficient period of time establish a new baseline. Generally, a normal fetal heart rate baseline is around 120-160 bpm. Tachycardia occurs when the baseline is above 160 bpm; bradychardia occurs when the baseline is below 110 bpm.

The fetal heart rate normally varies from the baseline within a range of 6-25 bpm. Variability is absent when the amplitude range is undetectable, and is minimal when the amplitude is detectable, but 5 bpm or under. Accelerations and decelerations are differentiated from baseline variability by their duration (15 seconds or more) and amplitude (15 bpm). Fetal heart decelerations are of three types: early, variable, and late. Early and late decelerations are gradual and occur in association with contractions: the nadir of an early deceleration coincides with the peak of the contraction; the onset, nadir, and recovery of a late deceleration occur after the beginning, peak, and end of the contraction, respectively. Variable decelerations are more abrupt and may occur at any time. Decelerations are deemed recurrent if they occur with at least half of the contractions.[19] A deceleration is deemed prolonged if it continues for two to ten minutes.

Accelerations are generally reassuring (*i.e.*, indicate that the fetus is not acidemic); in most cases, normal fetal heart rate variability is also reassuring.[20] In the case of a persistently non-reassuring fetal heart rate (*i.e.*, one absent accelerations or normal fetal heart rate variability, but not necessarily indicating that the fetus is acidemic) scalp stimulation is a reliable method of excluding acidosis: when an acceleration follows scalp stimulation, acidosis is unlikely.[21]

Because umbilical cord compression as a result of contractions is a common cause of decelerations, a change in the mother's position or discontinuation of labor stimulating agents such as oxytocin are standard responses to persistently non-reassuring fetal heart rates; amnio infusion is another standard response to recurrent variable decelerations (unless

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19 ACOG FHR Guidelines, Table 1 at 1162. [Ex. G]

20 *Id.* at 1165.

21 *Id.* at 1166.

contraindicated).[22] Other possible responses to non-reassuring fetal heart rates include maternal oxygen[23] or the administration of tocolytic agents to abolish uterine contractions.[24]

Late decelerations begin as a vagal reflex, but when fetal oxygenation is sufficiently impaired to produce metabolic acidosis, direct myocardial depression occurs. When the late deceleration is of the reflex type, the fetal heart tracing characteristically has good variability and reactivity, but as the fetus develops metabolic acidosis, fetal heart rate variability is lost.[25] When the fetal pH is less than 7.20, reactivity, either spontaneous or evoked, may disappear.[26] "If uteroplacental oxygen transfer is acutely and substantially impaired, [*e.g.*, by uterine rupture or total cord occlusion] the resulting fetal heart rate pattern is a prolonged deceleration [*i.e.*, two to ten minutes in length]."[27] Transient cord compression and associated variable decelerations are typically mild and of no concern. However:

> If cord compression is prolonged, significant fetal hypoxia can occur. When this happens, the return to baseline becomes gradual, the duration of the deceleration may increase, and frequently, the fetal heart rate will increase and the baseline fetal heart rate may increase.

Task Force Report at 26.

E. Hypoxic Ischemic Encephalopathy (HIE)

Central to fetal well being is the provision of an adequate supply of oxygenated blood to the brain. Prior to birth, the fetus obtains its blood supply through the maternal placenta and the umbilical cord. Reduction in the ability of the placenta to process the transfer of the maternal oxygen to the fetus, or in the ability of the umbilical cord to carry the fetus' blood supply from the placenta to the fetus, will reduce the amount of oxygenated blood available for use by the fetus, a condition known as intrapartum asphyxia. Intrapartum asphyxia results in acidosis, initially respiratory acidosis and, if continued, metabolic acidosis.[28] Studies have shown that a

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22 *Id.* At 1166-67.

23 According to the ACOG FHR Guidelines, "there are no data on the efficacy or safety of this therapy." *Id.*, at 1166. [Ex. G]

24 This therapy has not been shown to reduce adverse outcomes, however, and therefore is not recommended. ACOG FHR Guidelines at 1166. [Ex. G]

25 American College of Obstetricians and Gynecologists and American Academy of Pediatrics (Hankin, G., M.D., Task Force Chair), NEONATAL ENCEPHALOPATHY AND CEREBRAL PALSY at 26 (hereinafter cited as ACOG Task Force Report) [Ex. L].

26 *Id.*

27 *Id.*

28 *See generally*, Ross, M. and Gala, R., USE OF UMBILICAL ARTERY BASE EXCESS: ALGORITHM FOR THE TIMING OF HYPOXIC INJURY, 187 American Journal of Obstetrics and Gynecology 1 (July, 2002) [Ex. F].

reasonable threshold for identifying the presence of acidosis associated with subsequent adverse effects (*i.e.*, metabolic acidosis) is a pH less than 7 and a base excess of -12 mmol/L or below.[29]

The initial response of the fetus to intrapartum asphyxia is redistribution of blood flow to the vital organs (including the brain) at the expense of less vital organs (including lung, liver, kidney).[30] Because of the fetus's biological ability to preserve neuronal integrity during asphyxia, and for other, unknown factors, "even when asphyxia is prolonged or severe, most newborn infants recover with minimal or no neurological sequelae."[31] Metabolic acidosis produced by intrapartum asphyxia can lead to hypoxic ischemic encephalopathy (HIE), a small subset of a condition known as neonatal encephalopathy, which is much more commonly caused by other factors.[32] Neonatal encephalopathy is characterized by a constellation of findings including abnormal consciousness, tone and reflexes, feeding, respiration, or seizures, and it may or may not result in permanent neurological impairment.[33] The degree of intrapartum asphyxia sufficient to cause measurable neurological or other injury is unclear,[34] but "[t]he clinical data and the experimental evidence agree concerning the rather long duration of asphyxia required to produce recognizable brain damage in infants who survive."[35] In one study of cases of severe fetal brain injury, "the average duration of the prolonged fetal heart deceleration was 32.1…minutes (range: 19-51 minutes)."[36]

III. Analysis

A. Applicable Legal Standards

1. Procedural Matters

Normally, the board may not take disciplinary action until after a hearing.[37] However, the board is authorized to suspend a medical license prior to a hearing upon a finding that "the

29 *Id.* at 74.

30 Task Force Report at 8. [Ex. L]

31 *Id.* "Immature nervous systems have long been recognized to be more resistant to asphyxial injury that the brains of older individuals." Nelson, K. and Ellenberg, J., APGAR SCORES AS PREDICTORS OF CHRONIC NEUROLOGICAL DISABILITY at 42. [Ex. 29, r. 2272]

32 "The overall incidence of neonatal encephalopathy attributable to intrapartum hypoxia, in the absence of any other preconceptional or antepartum abnormalities, is estimated to be 1.6 per 10,000." *Id.* at xviii.

33 *Id.* at xvii.

34 "The critical ischemic threshold for neuronal necrosis in the developing brain remains unclear." Task Force Report at 8. "Selective neuronal necrosis is the most common variety of injury observed in HIE…" *Id.*, at 9.

35 Nelson, K. and Ellenberg, J., APGAR SCORES AS PREDICTORS OF CHRONIC NEUROLOGICAL DISABILITY, at 43 [Ex.29, r. 2273]

36 *Id.* at 30.

37 AS 08.64.326(a).

licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice."[38] Upon request by the licensee, a hearing must be provided within seven days of the summary suspension. A hearing on summary suspension is a proceeding under the Administrative Procedures Act, and is commenced by an accusation or other charging document specifying the grounds for the summary suspension.[39]

At the hearing on summary suspension, the division has the burden of proving, by a preponderance of the evidence, facts sufficient to support a finding of a clear and immediate danger to the public health.[40] The decision of the board following a hearing on summary suspension is final as to the summary suspension order, but absent consolidation of the issues by consent or prior notice to the parties, it is not a final decision on the merits of a pending accusation for final disciplinary action.[41]

2. *Danger to the Public Health and Safety*

The board's regulations define professional incompetence as "lacking sufficient knowledge, skills or professional judgment in that field of practice in which the physician practices...concerned engages, to a degree likely to endanger the health of his or her patients."[42] Under this definition, a finding of professional incompetence requires a finding of danger to

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[38] AS 08.64.331(c).

[39] The division's prehearing brief asserts that "the filing of an accusation is not required for the Board to [summarily] suspend a physician's license." Hearing Brief at 2. But the hearing process is governed by the Administrative Procedures Act, which expressly states that "A hearing to determine whether a...license...should be...suspended...is initiated by filing an accusation." AS 44.62.360. Accordingly, while the board may impose summary suspension in response to a petition for summary suspension, an accusation must be filed after the licensee requests a hearing, in order to initiate the hearing process.

The division may rely on the petition for summary suspension or other charging document as the accusation for purposes of a summary suspension hearing only if the document meets the standards for an accusation as set out in AS 44.62.360. *See, e.g,* In re Cho, Memorandum and Order on Motion to Dismiss Petition, at 2-3 (DCED No. 1200-98-002 *et al.*, December, 2001) (charging document in summary suspension case under AS 08.01.075(c) must comply with AS 44.62.360); *cf.* Department of Law, HEARING OFFICER'S MANUAL at 21 (4th ed. 1999) (In cases of summary suspension, "If an accusation has not already been filed, the hearing officer should set a deadline for the agency to file an accusation that meets the requirements of AS 44.62.360.").

[40] An initial *ex parte* decision to summarily suspend a license prior to hearing may reasonably be based on allegations of misconduct that are subsequently determined (at a hearing on summary suspension) to lack merit. *See* Horowitz v. Colo. State Board of Medical Examiners, 716 P.2d 131 (Colo. Ct. App. 1985). In order to maintain the suspension following a hearing, however, at least some of the allegations must be proven. *Id.*

[41] After an accusation has been filed, a hearing on summary suspension is an interim hearing limited to the summary suspension, subject to review by petition for review to the superior court under Appellate Rule 611. *See* Renwick v. State, Board of Marine Pilots, 936 P.2d 526, 530 n. 5 (Alaska 1997). The hearing on summary suspension may be consolidated with the hearing on the accusation for imposition of a disciplinary sanction. In this case, neither party expressly or impliedly consented to such a procedure and consolidation of the issues was not ordered.

[42] 12 AAC 40.970.

patients. Because professional incompetence involves a danger to patients, and a licensed physician is authorized to provide medical services to the public, a finding that a licensed physician is professionally incompetent establishes a danger to the public health as a matter of law.

A danger to the public may also be established, depending on the circumstances, if a licensed physician has engaged in repeated negligent conduct, or grossly negligent conduct, that is likely to endanger the health of the physician's patients. Grossly negligence is negligent conduct with willful disregard of the danger to the health of a patient. Negligent conduct by a physician is conduct that does not meet the standard of care in the particular field of practice.[43]

Other grounds for finding a danger to the public health and safety may include any of the other statutory grounds for imposing a disciplinary sanction, none of which has been cited as grounds for summary suspension in this case.[44] Accordingly, in this case a danger to the public health may be found if the board makes a preliminary finding of (a) professional incompetence or (b) gross or repeated negligence that is likely to endanger the health of patients.[45]

3. Clear and Immediate Danger

A danger is clear when it is plain.[46] A danger is immediate, in the context of summary suspension, if the physician is likely to endanger a patient's health before the board conducts a hearing and issues a final decision on the merits of an accusation to impose a disciplinary sanction.[47]

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43 *See* AS 09.55.540. The statutory standard of care applies to medical malpractice actions and does not establish the legal test for a finding of professional incompetence. *See* Halter v. State, 909 P.2d 1035, 1038 (Alaska 1999). Nonetheless, because medical malpractice is a form of negligence, the statute provides an appropriate standard for a finding of negligence or gross negligence in the professional licensing context.

44 *See* AS 08.64.326(a)(1)-(7); (8)(B), (C); (9)-(13). No evidence was submitted in support of any of those grounds for suspension or other disciplinary action.

45 Because the hearing on summary suspension was interim, and the parties may introduce additional evidence or testimony at the hearing on the accusation to impose a disciplinary sanction, and because of the expedited nature of the proceedings, the findings made at this time are necessarily preliminary. They do not bind the board in subsequent proceedings and they should not be given preclusive effect in unrelated proceedings.

46 Webster's Ninth New Collegiate Dictionary at 247 (1990).

47 This conclusion flows from the structure of the statutory disciplinary process. The summary suspension process provides a means by which immediate action can be taken when the normal disciplinary process would take too long to protect the public. Accordingly, the "immediate" danger must, at the outside limit, be a danger likely to manifest itself prior to the time in which, in the normal course of events, a license could be suspended, conditioned, or revoked. Arguably, an "immediate" danger requires a showing that the danger is "close at hand" or "near", which may be a shorter time. *See, e.g.*, In re Gerlay, OAH No. 05-0321, at 25 n. 64 (August, 2005).

B. Negligence[48]

1. *Patient No. 37-44-87 (uterine rupture)*

Count I of the accusation identifies four grounds in this case for finding that Dr. Murphy's care in this case was substandard: (1) attempting a vaginal delivery on a patient with two prior Cesarean section deliveries; (2) failure to recognize signs of uterine rupture; (3) disregard of fetal heart rate changes; and (4) use of two vaginal operative procedures on the same patient.[49]

(1) Some of the obstetricians criticized Dr. Murphy's decision to allow a trial of labor in this case, because the patient's history of two prior Cesarean sections created an increased risk of uterine rupture.[50] However, the patient was informed of the risk of uterine rupture and consented to the procedure,[51] and the standard of care in 2003 allowed a vaginal birth following two prior Cesarean sections.[52] Dr. Murphy specifically reviewed the patient's records and confirmed that the prior Cesareans had been low transverse incisions, which are relatively less likely to result in uterine rupture than other types of Cesareans. Furthermore, the majority of the

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48 The amended accusation in this case does not allege that Dr. Murphy's actions in the cases involving physician availability constitute grounds for summary suspension, except as set forth in Count VI in association with the other cases. The division argued at the hearing that the cases involving physician availability should be considered as evidence of poor professional judgment.

49 Certain other specific aspects of Dr. Murphy's care in this case were criticized by one or more of the obstetricians who reviewed the medical records, but those particular concerns were not set forth in the accusation as constituting substandard care and therefore may not be relied upon as independent grounds for suspension. Nonetheless, those criticisms may be considered insofar as they relate to the specific allegations of the accusation.

For example, Dr. Cruz criticized the use of oxytocin in this case. The guidelines issued by the American College of Obstetricians and Gynecologists do not preclude the use of oxytocin in this case, and therefore administering it was not below the standard of care. The 2004 guidelines note that "among women attempting VBAC, the rate of uterine rupture was not different between those who received oxytocin and those who labored spontaneously." American College of Obstetricians and Gynecologists, VAGINAL BIRTH AFTER PREVIOUS CESAREAN DELIVERY, at 206 (July, 2004). [Ex. K] They specifically advise against the use of prostaglandins, but make no such recommendation concerning the use of oxytocin. [*Id.* and at 207]

However, while not below the standard of care, the administration of oxytocin supports the finding that close monitoring of the patient was necessary, and may be considered in connection with the allegations that Dr. Murphy failed to recognize signs of uterine rupture, or that she disregarded fetal heart rate changes.

50 For example, Dr. Pauly found this a high-risk candidate, whose selection was "at best questionable". [Ex. 37, r. 103]

51 Dr. Murphy's informed consent form for patients undergoing a trial of labor following prior Cesareans specifies the risk of augmentation by oxytocin and notes that the rate of uterine rupture is estimated at 1 in 200. [Ex. O]

52 All of the witnesses agreed that the guidelines and reports issued by the American College of Gynecologists and Obstetricians establish the standard of care for obstetrical practices. In 2003, the standard of care, as set forth in 1999 by the American College of Obstetricians and Gynecolgists, allowed for vaginal birth after two prior Caesarian deliveries with low transverse incisions. American College of Obstetricians and Gynecologists, VAGINAL BIRTH AFTER PREVIOUS CESAREAN DELIVERY, at 668 (July, 1999). [Ex. J] In 2004, the college revised the standard of care to provide for such delivery only after a single Cesarean. American College of Obstetricians and Gynecologists, VAGINAL BIRTH AFTER PREVIOUS CESAREAN DELIVERY, at 206 (July, 2004). [Ex. K]

obstetricians, including the division's own witness Dr. Chester, had no objection to the decision to allow a trial of labor. [3A (Chester direct)] For these reasons, the preponderance of the evidence establishes that Dr. Murphy's decision to proceed with a trial of labor was not below the standard of care.

(2)/(3) Dr. Murphy retired to the sleep room at around 2:00 a.m., at which time there were no significant signs of impending or actual uterine rupture. An attending physician routinely relies on the nursing staff to bring unusual circumstances to the physician's attention, [13A (DeKeyser cross)] and accordingly Dr. Murphy's decision to leave the patient under the supervision of Nurse Rees-Benyo at that time was neither noteworthy nor inappropriate. The testimony at the hearing focussed on Dr. Murphy's conduct after she was awakened by Nurse Rees-Benyo at 4:36 a.m. There are two concerns: first, was it below the standard of care not to intervene by performing a Cesarean section immediately; and second, was it below the standard of care not to return to the birth room to personally monitor the patient.

Because the standard of care calls for immediate intervention in the event of uterine rupture, the central issue regarding the first concern is whether at 4:43 a.m. the evidence of present or impending uterine rupture was sufficient to mandate immediate intervention. Dr. Gilson testified that the standard of care calls for intervention when uterine rupture is "suspected", [8B (Gilson)] without specifying the degree of certainty involved. Dr. Chester's testimony indicates that, for a patient at increased risk of uterine rupture such this patient, the standard of care calls for intervention in the presence of multiple indicators of uterine rupture. Dr. Chester believed that intervention by Cesarean section was appropriate at around 4:00 a.m. [1A (Cruz direct), 4A (Chester cross)] (about 45 minutes before Dr. Murphy was awakened), when there were three successive substantial decelerations [r. 511-512], patient pain notwithstanding an epidural block, and blood in the urine.[53]

Certainly, Dr. Murphy should have considered the possibility of a uterine rupture and the need for immediate intervention by Cesarean section when she was awakened at 4:43 a.m. According to the 1999 guidelines issued by the American College of Obstetricians and Gynecologists, which were current in November, 2003, "[t]he most common sign of uterine rupture is a non-reassuring fetal heart rate pattern with variable decelerations that may evolve

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53 Dr. Chester testified that the blood could be from the labor itself, or from a bladder rupture, but not from a uterine rupture. [3A (Chester direct)]

into late decelerations, bradychardia, and undetectable fetal heart rate. Other findings are more variable and include uterine or abdominal pain, loss of station of the presenting part, vaginal bleeding, and hypovolemia."[54] But while some signs of possible uterine rupture were present at 4:43 a.m., the signs were not compelling: there was no indicated loss of fetal station; the fetal heart tracings during the first couple of hours of the morning had not been particularly noteworthy;[55] and although the episode at around 3:50 a.m. was notable, it was not followed by continuing abnormal tracings. [r. 513-514] In particular, there was no loss of fetal heart rate variability, which indicates the lack of an event sufficient to cause injury due to hypoxic asphyxia.[56] Furthermore, both Dr. Richey (an expert in the management of high-risk deliveries) and Alaska Regional Hospital's own internal review [Ex. 2, r. 213] found that Dr. Murphy's failure to intervene at 4:43 a.m. was acceptable care. It appears that the uterus did not rupture prior to 5:30 a.m.,[57] and although the baby was hypoxic at birth there is no indication that it

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[54] American College of Obstetricians and Gynecologists, VAGINAL BIRTH AFTER PREVIOUS CESAREAN DELIVERY, at 666 (July, 1999). [Ex. J]

[55] Dr. Murphy found them "reactive and reassuring". [Ex. 3, r. 302, 332] Dr. Cruz testified that for much of the time, the decelerations that were not of particular concern but that they got more worrisome as the patient got closer to delivery, with an episode of prolonged bradychardia with fetal heart rate in the 70's. [1A (Cruz direct)] This description, she testified, applies to the strips during the period after about 5:10. [1A (Cruz direct); Ex. 3, r. 521-524]

Dr. Chester, by contrast, testified that from 12:00 midnight on, the strips showed reason for concern. In particular, she characterized the strip at r. 495 (1:20 a.m.) as showing late decelerations, indicating a lack of sufficient oxygen to the fetus. [3A (Chester direct)] Similarly, Dr. Pauly's report characterizes the strips during this period [Ex. 3, r. 488-510] as demonstrating "Persistent, repetitive late decelerations." [Ex. 37; r. 102]

The characterizations of Drs. Murphy, Chester and Pauly are overstated. By comparison with other strips for this patient, the minimal changes in fetal heart rate during the period from 12:00 to 2:00 a.m. [Ex. 3, r. 488-499)] were not noteworthy; the fetal heart rate did not change by more than 15 bpm during that time.

According to Dr. McGowan, the criteria for a "reactive" strip is 2 accelerations in 10 minutes that are 15 bpm above the baseline for 15 seconds. [Ex. C, r. 120] Dr. Murphy's characterization of the strips as "reactive", under that definition, is inaccurate, although there was a discernable increase in baseline variability. Dr. Chester's characterization is similarly overstated. To qualify as a late deceleration, the deceleration must occur over a significant period of time (onset to nadir of 30 seconds or more). [Ex. G at 1162] Although one of the decelerations on meets that criterion, [r. 495] the reduction in the fetal heart rate in that instance was only 10 bpm. Dr. Chester also remarked on the relatively low beat to beat variability; however, because the patient had been provided Demerol at 12:20 a.m. a decrease in beat to beat variability was to be expected.

[56] *See* page 24, *infra.*

[57] Dr. Richey, who had seen 40-50 cases of uterine rupture, testified [16A (Ritchey direct)] that uterine rupture is difficult to diagnose. Signs of uterine rupture, she testified, include hyperstimulation, or a complaint of pain coupled with severe bradycardia. Severe bradycardia means a reduction in the baseline to well below 110 bpm. While there were significant decelerations to below 110 bpm at the time of the patient's complaint of pain around 3:45 a.m. [Ex. r. 511-512], the baseline did not go below 110 bpm until around 5:36 a.m., at the same time that there were numerous episodes of hyperstimulation. [Ex. 3, r. 524] In retrospect, it seems unlikely that the uterus ruptured prior to the final episode, since a baby would not be expected to survive a uterine rupture for more than half an hour without serious and evident neurological damage, while this baby did survive and to all appearances was normal.

suffered any measurable neurological deficit or other injury.[58] While the more conservative approach would have been to proceed to a Cesarean section at 4:43 a.m., the division did not establish by a preponderance of the evidence that Dr. Murphy's failure to immediately intervene at 4:43 a.m. was below the standard of care, or that at that time (or previously) she negligently disregarded changes in the fetal heart rate.

With respect to returning to the delivery room after she was awakened, it is beyond dispute that given the pre-existing increased risk of uterine rupture, and the presence of signs of possible rupture, careful monitoring of the labor was particularly important. But the attending physician, particularly in a long term labor, necessarily relies upon the nurses to monitor patient well being and to bring concerns to the attention of the attending physician in a timely manner. [13A (DeKeyser cross)] Nurse Rees-Benyo testified that when she awakened Dr. Murphy she had performed a complete nursing assessment and that she did not view matters as urgent. [15A (Rees-Benyo direct)] Furthermore, within minutes after reviewing the strips, Dr. Murphy was informed that the patient showed substantially improved fetal heart rate strips, which was true. Subsequently, after Dr. Murphy had gone back to sleep, beginning around 5:10 a.m., the strips showed substantial deterioration and should have been brought to her attention: they were not.[59] The division did not establish by a preponderance of the evidence that Dr. Murphy's decision to rely on nursing staff rather than returning to the birth room was below the standard of care.

(4) The final ground asserted to constitute substandard care in this case is that Dr. Murphy elected to try two operative vaginal techniques rather than performing a Cesarean section. But the standard of care does not preclude the use of multiple operative techniques: it simply calls upon the physician to avoid <u>any</u> vaginal operative technique "when the probability

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58 Dr. Chester testified that if there was injury, it was not measurable. [4B (Chester cross)] The lack of any neurological injury would be consistent with data from a study included in the Task Force Report, which found no brain damage in any of 11 cases of uterine rupture in VBAC cases. In nine of those cases, there had been bradychardia lasting longer than 15 minutes, [Ex. L at 33] substantially greater than existed in this case, which involved bradychardia only during the final ten minutes, as Dr. Murphy was preparing to deliver the baby. [Ex. 3, r. 523-524]

59 The strips reviewed by Dr. Murphy at 4:43 a.m. shows four moderate to severe late decelerations over an eight minute period, the most severe going to 70 bpm. [Ex. 3, r. 516] The following strips, through about 5:05 a.m., show substantial improvement. [Ex. 3, r. 517-520]. The strips reviewed by Dr. Murphy at 5:36 a.m., by contrast with those seen at 4:43, show continued moderate to severe late decelerations continuing for a period of about half an hour, with dips below 70 bpm. [Ex. 3, r. 521-523] Immediately thereafter, rather than recovery, the strips show severe bradycardia and clearly demonstrate imminent risk to the fetus. [Ex. 3, r. 524] Dr. Richey testified she would have been "extremely upset" not to have been shown strips generated at around 5:10 a.m. [Ex. 3, r. 521; 16A (Richey direct)] Dr. Cruz agreed. [17A (Cruz recross)]

of success is very low".[60] There is nothing in this case to suggest that the vacuum attempt was contrary to that general rule, and the forceps delivery was successful. The testimony at the hearing uniformly was that Dr. Murphy has good operative skills, including forceps deliveries. The baby's head was engaged, and delivery occurred in a much shorter period of time than it would have if a Cesarean section had been performed. The division did not show by a preponderance of the evidence that Dr. Murphy violated the standard of care by utilizing multiple operative vaginal techniques at 5:36 a.m., rather than ordering a Cesarean section at that time.

2. *Patient No. 21-90-97 (triple nuchal cord)*

Count II of the amended accusation cites only one ground for finding substandard care in this case: Dr. Murphy's alleged "failure to recognize abnormalities of fetal heart rate tracings." To the extent that a failure to recognize abnormalities in fetal heart tracings demonstrates a lack of knowledge or professional judgment, it may be considered in connection the allegation of professional incompetence. But for purposes of an allegation of substandard care, the question is not whether Dr. Murphy can recognize "abnormalities" in fetal heart tracings, but rather whether she makes appropriate case decisions in light of them. In this case, as in the others, the central issue to consider is whether Dr. Murphy's decision to allow labor to proceed, rather than intervening by performing a Cesarean section at an earlier time, was within the standard of care.[61]

Some of the obstetricians who reviewed this case felt that the length of the labor, given their interpretation of the fetal heart tracings, was too long, and that at some point well in advance of the actual delivery, intervention by Cesarean section was appropriate: Dr. Chester felt that intervention should have occurred around 5:11 a.m. [3B (Chester direct); 4A (Chester

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[60] *See generally* American College of Obstetricians and Gynecologists, OPERATIVE VAGINAL DELIVERY (June, 2000). [Ex. 32] The report notes that the risk of injury is substantially the same for an infant delivered by multiple vaginal operative techniques as for one delivered by Cesarean section following a single failed operative vaginal technique. [Ex. 32 at 546, r. 2290] The report states, "Although studies are limited, the weight of available evidence appears to be against attempting multiple efforts at operative vaginal delivery with different instruments, <u>unless there is a compelling and justifiable reason</u>." [*id.*, r. at 2291 (emphasis added)] The imminent risk of severe neurological injury at 5:36 a.m. presented a compelling and justifiable reason for attempting a second operative vaginal delivery technique rather than taking the additional time necessary to perform a Cesarean section. As Dr. Chester testified, [3A] at that time the patient was at the point of no return: her criticism was not of the use of multiple vaginal operative techniques, but of the failure to go to a Cesarean section at an earlier time.

[61] As Dr. Cruz testified, the central issue in this case and the others was whether allowing labor to proceed was below the standard of care. In this case, as in others, there was criticism of Dr. Murphy's care in other respects,

cross)] Dr. Gilson, while not specifically addressing this case, described his main overall concern with Dr. Murphy's care as relating to the length of time that she tolerated non-reassuring fetal heart monitoring strips. However, a report issued by the American College of Obstetricians and Gynecologists finds that fetal heart monitor strips are a poor basis for making retrospective judgments about clinical decision-making[62] or predictions about neonatal outcomes,[63] and that their fundamental role is as an ancillary tool for the clinician for case management in the context of full knowledge of the patient, the prenatal course, and the labor process.[64] In this case, for example, the conclusions drawn by different reviewers are at times contradictory.[65] For these reasons, in the absence of consensus, retrospective professional opinions as to the proper interpretation of fetal heart tracings are of limited persuasiveness.[66]

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but none of those matters was alleged in the accusation to constitute grounds for a finding of professional incompetence, substandard care, or license suspension.

62 ACOG FHR Guidelines at 1164. [Ex. G] "Despite the frequency of its use, issues with [electronic fetal monitoring] include poor interobserver and intraobserver reliability, uncertain efficacy, and a high false-positive rate." *Id.* at 1161. "With retrospective reviews, the foreknowledge of neonatal outcome may alter the reviewer's impression of the tracing. Given the same intrapartum tracing, a reviewer is more likely to find evidence of fetal hypoxia and criticize the obstetrician's management if the outcome was supposedly poor versus supposedly good." *Id.* at 1164. "Reinterpretation of the FHR tracing, especially knowing the neonatal outcome, is not reliable." *Id.* at 1167.

63 *Id.* at 1165. "There is an unrealistic expectation that a nonreassuring FHR tracing is predictive of cerebral palsy." *Id.* at 1163.

64 Clinicians should "take gestational age, medications, prior fetal assessment, and obstetric and medical conditions into account when interpreting the [fetal heart rate] patterns during labor." *Id.* at 1162. For example, according to the literature in the record, higher rates of neonatal encephalopathy are associated with low birth weights; all of the babies in these cases were over 3500 grams.

65 Dr. Pauly found a constant string of unacceptable readings throughout the time the patient was in labor. Her report states, "[R]ight from the beginning and throughout the entire 12 hour labor, the FHR monitor strip demonstrates continuous deep variable decelerations as well as intermittent, significant late decelerations. Nowhere on the entire tracing is there a prolonged period of reassuring, reactive FHR pattern." [Ex. 37, r. 68] By comparison, Dr. McGowan, reviewing the same materials, finds "Intermittent variables noted throughout the strip. No lates or late component to the variables. Good BTBV except shortly after narcotics. Overall reassuring strip." Her report concludes: "The decelerations were noted, and the appropriate actions carried out. The monitor strip confirms the presence of good beat-to-beat variability, and this, along with the fact that there was good recovery of heart tones between contractions is reassuring fetal well-being." [Ex. C, r. 115]

Dr. Chester, reviewing these strips from the period of time around 10:00 p.m., found "subtle" late decelerations. But according to the accepted definition, a late deceleration should be "visually apparent." [Ex. G at 1163] The strips referred to by Dr. Chester do not show decelerations meeting the accepted definition of late deceleration: "In association with a uterine contraction, a visually apparent, gradual (onset to nadir in 30 sec or more) decrease in FHR with return to baseline."

66 This conclusion is consistent with the findings of the Task Force, which noted that with two exceptions ([1] normal baseline = 110-160 bpm and normal variability = 6-25 bpm, and [2] absent variability with recurrent late or variable decelerations or substantial bradychardia indicates present or impending acidemia), experts "had difficulty reaching consensus on appropriate definitions of certain heart rate patterns...<u>It is impossible to reach consensus on the presumed fetal condition of obstetric management of all other patterns intermediate between the two [exceptions noted]</u>." Task Force Report at 76 (emphasis added). [Ex. L]

Even in the face of an agreed-upon interpretation of tracings as non-reassuring, the determination of when intervention should occur is subject to reasonable professional disagreement.[67] In this particular case, notwithstanding Dr. Chester's and Dr. Gilson's views, other obstetricians who reviewed the records fully, including Dr. Richey and Dr. McGowan, are of the opinion that Dr. Murphy's care was within the standard of care, with Dr. Richey going so far as to characterize the case as "ordinary." Dr. Cruz testified that she was "concerned"; she testified that this case was in a "gray area" but did not state that the failure to intervene was below the standard of care. [2B (Cruz cross)]

Since the purpose of intervention is to avoid intrapartum asphyxia to a degree that is harmful, there is no need for intervention unless the fetal heart tracings, or other evidence, suggest that asphyxia that is potentially harmful to the fetus has occurred or is imminent. According to the Task Force:[68]

> For intrapartum asphyxia to develop in a fetus that was previously normal at the start of labor, some major, or sentinel event must occur. If the fetus is undergoing continuous electronic fetal heart monitoring, the sentinel event should result in either an abnormal tracing with either a prolonged deceleration, repetitive late decelerations, and/or repetitive severe variable decelerations and decreased fetal heart rate variability.

This wording indicates that even in the presence of recurrent late or severe variable decelerations, or substantial bradycardia, neurologic damage is not a predictable outcome unless (1) there has been a major or sentinel event (2) resulting in decreased fetal heart rate variability (also called beat-to-beat variability). In this case, while there were recurrent moderate to severe decelerations, there was no sentinel event and the fetal heart rate showed consistent return to moderate variability.

In addition to the highly subjective nature of a conclusion that the fetal heart rate tracings mandate immediate intervention, and the lack of specific testimony applying the American College of Obstetricians and Gylecologists' criteria to the tracings in the record, it is apparent

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[67] "The high frequency (up to 79%) of nonreassuring patterns found during electronic monitoring of normal pregnancies in labor with normal fetal outcomes make both the decision on the optimal management of the labor and the prediction of current or future neurological status very difficult." Task Force Report at 76. [Ex. L]

A recent study notes that "the lack of consensus on the timing of intrapartum hypoxic injury has limited advances in fetal heart rate monitoring and the development of accepted protocols for treatment of heart rate abnormalities." Ex. F at 1. The study hypothesizes that knowledge of base excess values at the initiation of labor, augmented by fetal pulse oximetry, may ultimately "permit real-time estimation of base excess changes in relation [to] scalp oxygen saturation values and heart rate patterns." Ex. F at 8.

[68] Task Force Report at 29. [Ex. L]

that Dr. Murphy's management of this particular case was affected by her ongoing simultaneous management of another case, involving twins, beginning at around 5:00 a.m., and that the decision to perform a Cesarean section in either case would have created the potential for simultaneous Cesareans. Finally, there is no evidence that the baby suffered metabolic acidosis or any injury: the cord pH was above 7.02, the base excess was above –12, and the ten minute Apgar was 9.[69] In light of the evidence as a whole, the division did not establish, by a preponderance of the evidence, that Dr. Murphy's failure to intervene by Cesarean section was below the standard of care.

3. Patient No. 38-34-33 (Group B beta strep)

In this case, as in the prior one, Count III of the accusation asserts only one ground for finding substandard care: that Dr. Murphy failed to recognize abnormalities in the fetal heart tracings.[70] As in the previous case, the question whether Dr. Murphy recognizes abnormalities in fetal heart tracing goes to her professional competence; her case management decisions based on the strips concern the standard of care.

This patient had a Group B beta strep infection. She was getting the appropriate treatment for her infection, according to Dr. Cruz [1B (Cruz direct)]. The patient's fetal heart monitoring strips, unlike the other two cases, showed no significant accelerations or decelerations for most of the labor, until shortly before delivery. (Accelerations are reassuring, but their absence is not of concern so long as there is adequate baseline variability.) In this case, to the extent fetal heart

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69 Dr. Cruz and Dr. Chester suggested that low Apgar scores in these cases indicate a potential for poor outcomes. But although an Apgar score of 3 or less after five minutes is a potential marker of intrapartum asphyxia, an Apgar score of 3 or less at five minutes or less is a poor predictor of actual neurological deficit. Task Force Report at 54-55. Only one of cases in evidence involves a five minute Apgar of 3 or less (No. 38-34-33; Apgar of 3 at 5 minutes). None involved an Apgar of 3 or less after five minutes. While an Apgar score of 3 or less at five minutes is a potential marker of intrapartum asphyxia, it is a poor predictor of actual neurological deficit. Task Force Report at 54-55. More to the point, Dr. Chester testified that there is no evidence that any of the children suffered any neurogical deficit. [4A (Chester cross)] A base excess of –12 mmol/L, which occurred in this case, is the threshhold at which asphyxial injury may occur, although "most newborns with a base excess of ≤-12 mmol/L do not demonstrate nerological injury." [Ex. F at 7]

70 As in the other cases, some of the obstetricians criticized particular aspects of Dr. Murphy's care: Dr. Cruz criticized the failure to provide a second antibiotic in addition to ampicillin to treat the Group B beta strep infection at an earlier time, and Dr. Chester criticized the manual dilation given the degree of dilation. Appropriate treatment for the Group B beta strep infection was of particular importance, because Group B beta strep can cause chorioamniotis, a potentially dangerous condition for the fetus. [Ex. H, r. 1064] However, there was testimony that Dr. Murphy treated the infection appropriately, and neither Dr. Cruz or Dr. Chester testified that the matters they had identified as of concern warranted the imposition of discipline. In any event, because those matters are not within the scope of the accusation they are not grounds upon which the board may maintain the summary suspension in this case.

rate was of concern, it was because of the ongoing tachychardia (causally related to the high fever), and relatively minimal variability.

Dr. Chester testified that, in light of the lengthy tachychardia and lack of full dilation, delivery by Cesarean section was appropriate in response to a prolonged and severe deceleration that occurred at around 1:10 a.m., with a duration of more than five minutes. [Ex. 6, r. 1040-41] That recommendation substantially reflects the Task Force observation that intrapartum asphyxia placing the fetus at risk occurs when there has been a sentinel event and subsequently the fetal heart tracings show a prolonged deceleration and decreased fetal heart rate variability. In light of the subsequent birth of the baby with a tightly wrapped cord, the evidence indicates that the precipitating event for the acidosis at the time of birth was a cord occlusion that occurred at around 1:10 a.m. Other obstetricians, including both Dr. McGowan and Dr. Richey, concurred that in retrospect, a strong case can be made for intervention at around that time, rather than allowing the labor to proceed until 2:10 a.m., when Dr. Murphy delivered the baby, notwithstanding the increased risk of spreading the Group B beta strep infection in a Cesarean section. Indeed, Dr. Murphy herself expressed concern, in retrospect, that the tachychardia had contributed to the apparent metabolic acidosis reflected in a base excess value of –12 at birth. Nonetheless, both Dr. McGowan and Dr. Richey indicated that their retrospective criticism of Dr. Murphy's failure to intervene by Cesarean section at around 1:10 a.m. does not necessarily reflect what they would have done had they been the attending physician, and neither of them stated that Dr. Murphy's management of this particular case was below the standard of care. Their responses reflect the accepted view that fetal heart tracings are a poor basis upon which to make retrospective case management assessments. In that light, the division did not establish by a preponderance of the evidence that Dr. Murphy's care in this case was below the standard of care.

C. Professional Competence

All counts of the accusation allege that the cases demonstrate conduct constituting a lack of professional competence. Professional incompetence consists of a lack of knowledge, skills or professional judgment to a degree likely to harm patients.

There is no evidence that Dr. Murphy's operative skills are below the standard of care. The common thread in all three cases involving patient care is that in each of them, Dr. Murphy chose to continue with labor when, at times relatively remote from delivery, the fetal heart rate

could reasonably be viewed as warranting immediate intervention by Cesarean section, in light of the circumstances as a whole.[71] The issue raised by those cases is whether her case management decisions establish a lack of adequate knowledge (*i.e.*, inability to recognize abnormalities in fetal heart tracings, or lack of understanding of the long term neurological consequences of intrapartum asphyxia) or a lack of adequate professional judgment.

With respect to the cases involving physician availability, only the case in which Dr. Murphy voluntarily delayed her arrival is relevant, because the exercise of professional judgment involves intentional conduct, not inadvertence as in the case of the lost cell phone.

1. Professional Judgment

A. CASE MANAGEMENT

The evidence and the testimony at the hearing as to Dr. Murphy's case management decisions reflect the ongoing and long-standing debate within the medical community regarding the rate of Cesarean sections in general, as well as regarding the practice of vaginal delivery after a prior Cesarean section (VBAC).

Testimony from multiple witnesses established that Dr. Murphy is well known within the Anchorage medical community as an advocate for vaginal delivery and for her willingness to provide vaginal deliveries after a prior Cesarean section. The thrust of the ad hoc committee's recommendation that Dr. Murphy's obstetrical privileges be suspended, reflected in written reports [Ex 14, r. 231; Ex. 15, r. 238] and in the testimony of its individual members,[72] is that Dr. Murphy's views in that regard have compromised her professional judgment in individual cases, to the point that her predisposition to effect a vaginal delivery may in a particular case create a medically unacceptable degree of risk to the long term health of the child. As discussed above, the division did not establish that Dr. Murphy's care was below the standard of care in any of five cases it brought to the attention of the Board. In order to provide a context for that conclusion, and to directly address the concerns reflected in the ad hoc committee's report, however, it is appropriate to consider Dr. Murphy's conduct as a counselor prior to and during

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71 In some cases, meconium was noted and testimony suggested that would support intervention by Cesarean section. However, the passage of meconium is typically physiological and is rarely a marker of an adverse event, particular with term babies. The presence of meconium is a poor predictor of long-term neurological outcomes. Task Force Report at 47.

72 As Dr. Chester testified, "she pushes her babies too far." [3B (Chester direct)]

the labor process, as well as the evidence concerning the manner in which she approaches case management in individual cases.

The evidence and the testimony support the conclusion that Dr. Murphy does not, in the course of her practice and case management, inappropriately advise or counsel her patients regarding the possibility and risks of vaginal delivery. The ad hoc committee took particular umbrage at a comment they attributed to Dr. Murphy when she was interviewed, to the effect that she believes in effecting a vaginal delivery "at all costs". Dr. Murphy denied making that specific statement. Whatever her precise comments to the ad hoc committee, it is apparent from the evidence that Dr. Murphy does not believe in achieving a vaginal delivery "at all costs": for example, in one of the cases reviewed by the external reviewers (No. 38-82-16), Dr. Murphy performed a Cesarean section over the express and vocal objections of her patient. [Ex. 2, r. 215] Her records show that she carefully considered the specific circumstances and operative history of the patient for whom she provided a trial of labor after two prior Cesareans before offering that opportunity. Within the range of medically acceptable risk to the fetus, the decision whether to proceed to a Cesarean section is a patient choice, to be reached after consultation with the physician. [2A (Cruz cross)] One of the patients who testified strongly emphasized Dr. Murphy's ongoing discussion, through the birthing process, of the possibility of Cesarean section delivery; she called Dr. Murphy the most informative physician she had ever had. Furthermore, Dr. Murphy's demeanor and behavior at the hearing, while amply demonstrating the passion and intensity of her general views regarding vaginal delivery, also showed focus, balance, and clinical detachment in the discussion of the medical details of individual cases. Dr. Murphy's overall rate of Cesarean sections is 10%, compared with a national rate in 2002 (an all-time high) of 26.1%[73] but about the same as the overall rate at the Alaska Native Medical Center. For these reasons, the preponderance of the evidence does not establish that Dr. Murphy fails to appropriately counsel patients or to actively consider Cesarean sections throughout the course of labor.

More fundamentally, while the testimony and evidence establish that Dr. Murphy's case management decisions with respect to vaginal delivery constitute an aggressive approach, they do not establish that the degree of risk is medically unacceptable for the fetus in the context of informed consent by the mother.

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[73] Ex. I, at 2; Ex. K at 2.

Dr. Murphy testified that she manages her cases based upon her knowledge of the prenatal history and the fetus's demonstrated ability (adequate recovery time, return to baseline, maintenance of adequate variability, and accelerations) to recover from episodes of recurrent or severe decelerations; to a more conservative obstetrician (as Dr. Chester and Dr. Cruz described themselves) similar episodes would indicate the need to intervene by Cesarean section without regard to the fetus's ability to recover. Dr. Murphy's approach, while aggressive, is consistent with the Task Force report, which states:[74]

> ...[P]atterns [of fetal heart tracings] predictive of current or impending asphyxia placing the fetus at risk for neurologic damage include recurrent late or severe variable decelerations or substantial bradychardia, <u>with absent fetal heart rate variability</u>.

In addition, the literature points out that a fetus is resistant to neurological injury, and that demonstrated harm typically requires lengthy periods of asphyxia, or recurrent decelerations without the opportunity to recover.[75] Finally, the presence of accelerations following scalp stimulation can be used, as Dr. Murphy has used it, to exclude acidosis. For all these reasons, a preponderance of the testimony and evidence does not establish that Dr. Murphy lacks professional judgment to a degree likely to endanger her patients.

B. PHYSICIAN UNAVAILABILITY

In the case of voluntary delay, the patient was hospitalized and had immediately available to her the full resources of Alaska Regional Hospital in the event of an unforeseen emergency of any kind. Voluntary delay without knowledge of the patient's condition, or in circumstances where failure to respond immediately would create a risk of harm, may demonstrate a deficiency of professional judgment. In this case, however, Dr. Murphy had confirmed with the nurse that an immediate response was unnecessary, and her delayed response did not pose a medically unacceptable danger to the patient. The division did not establish a lack of professional judgment to a degree likely to harm a patient.

2. *Knowledge*

A. POTENTIAL FOR NEUROLOGICAL INJURY

The ad hoc committee suggested that Dr. Murphy is insufficiently sensitive to the potential for injury that is not measurable, or that does not manifest itself until later in life. For

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74 Task Force Report at 29. [Ex. L]

75 *Supra*, page 15 and notes 30-36.

purposes of summary suspension, the issue for the board is whether Dr. Murphy's lacks knowledge of the potential for neurological injury, to a degree likely to harm her patients.

The ad hoc committee's concerns, as set forth in their report and in the members' testimony at the hearing, were based on Dr. Murphy's comments to the ad hoc committee to the effect that she considered a delivery a success based upon the short term outcome for the baby. But the ad hoc committee's concerns do not take into account Dr. Murphy's knowledge, amply demonstrated in her testimony at the hearing, of the studies underlying the analysis of neurological injury following hypoxic asphyxia, many of which reflect long-term tracking of infants who have incurred some degree of hypoxia. The testimony and evidence at the hearing establish that Dr. Murphy's case management decisions are not based upon anecdotal short-term outcomes in her own cases, but on the literature in this area: her experience (both in the short term and over the long term) is consistent with those studies, but it is the literature that primarily guides her clinical decisions. The preponderance of the testimony and evidence does not establish that Dr. Murphy lacks knowledge of the potential long term effects of fetal hypoxia to a degree likely to endanger her patients.

B. Interpretation of Fetal Heart Monitor Tracings

The ad hoc committee recommended that Dr. Murphy obtain additional training in the interpretation of fetal heart monitor tracings, on the ground that her understanding of them was lacking.

Several of the obstetricians, including the division's witnesses, described the interpretation of fetal heart tracings as an art; all the witnesses who testified about the strips indicated their interpretation is subject to a reasonable differences of professional opinion. And, as noted previously, the literature specifically notes that with the exception of the extreme ends of the spectrum, there is no agreement among the experts as to how to characterize a broad range of abnormal tracings, and there is a high degree of interpersonal and intrapersonal divergence in reading strips.[76] Given that testimony and evidence, a showing of professional incompetence with respect to the interpretation of fetal heart monitor strips mandates a showing that a practitioner's interpretations fall outside the limits of reasonable professional differences of opinion.

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[76] *Supra*, pages 22-23.

Four of the obstetricians testified in detail as to the appropriate characterization of the fetal heart monitor strips in the record: Dr. Chester, Dr. Cruz, Dr. Murphy and Dr. Richey. Of these witnesses, Dr. Murphy's testimony was the most detailed in terms of the number of strips reviewed. Dr. Murphy's testimony repeatedly referenced the appropriate criteria for interpreting the strips and was consistent with the patterns exhibited. On cross-examination, the division did not point out differences between her characterizations and the data displayed, and in argument the division did not point to instances in which her characterizations were at substantial variance with the testimony of the division's witnesses, Dr. Chester and Dr. Cruz, characterizing those same strips. Upon review of the testimony of Dr. Chester, Dr. Cruz, Dr. Murphy and Dr. Richey regarding the fetal monitor strips, it is apparent that their differences in characterization, to the extent they exist, reflect reasonable differences of professional opinion, and not professional incompetence on any the part of any of them. The preponderance of the testimony and evidence does not establish that Dr. Murphy is professionally incompetent with respect to her knowledge of, and ability to interpret, fetal heart monitor tracings.

D. Clear and Immediate Danger

Two witnesses (Drs. Stransky and DeKeyser) testified that Dr. Murphy is a competent obstetrician who does not pose a danger to her patients, based on their personal knowledge of her clinical and case management practices, as well as on her reputation within the Anchorage medical community, but without having reviewed the medical records for the particular cases brought before the board. The record also includes testimony or reports from eight obstetricians who reviewed the medical records in all or some of the cases before the board:[77] three external reviewers (Drs. Pauly, McGowan and Davis); three members of the ad hoc committee (Drs. Chester, Cruz and Gilson), Dr. Richey (who testified as an expert on behalf of Dr. Murphy), and Dr. Murphy herself. Of these, Dr. Pauly's and Dr. Davis's reports were of less weight.[78] Dr.

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77 Neither Dr. Lillibridge, a pediatrician, nor Dr. Wilder, an internist, was expert in the management of obstetrical cases. Their views about the adequacy of Dr. Murphy's care, as expressed in the ad hoc committee and at the hearing, were largely dependent on the opinions expressed during the ad hoc committee's deliberations by the obstetricians, Drs. Cruz, Chester and Gilson. Dr. Lillibridge testified that the conclusion of the committee were to a large degree based on the fetal heart tracings, which he acknowledged he did not know how to interpret. [5A (Lillibridge direct)] For these reasons, the opinions of Dr. Lillibridge and Dr. Wilder as to the quality of Dr. Murphy's care are less persuasive than those of the obstetricians.

78 Dr. Pauly's resume was not included in the record, but she is not currently a member of the American College of Obstetricians and Gynecologists. [Tape 7B (Craig)] Her reports, although thorough and closely tied to the medical records, are highly negative with respect to both the physician and nurse staff, to a degree well beyond the comments and criticisms of other reviewers and experts. Many of the statements in her reports are conclusionary,

Gilson's telephonic testimony, while persuasive, was general in nature because he did not have the medical records before him as he testified; significantly, he did not find that Dr. Murphy poses a threat to the safety of her patients. The most persuasive testimony was given by the obstetricians who reviewed the records both prior to and at the hearing: Drs. Chester, Cruz, Richey and Murphy. Of those witnesses, Dr. Murphy's testimony was the most clearly and directly tied to the literature, and was persuasive on questions of medical fact and causation. (Dr. Murphy's opinions and conclusions as to the quality of her own care and her case management, of course, should be given less weight.) Dr. Cruz's opinions and conclusions were slightly less persuasive than the other obstetricians due to their substantially greater experience in the field.

All of the obstetricians focussed on the fetal heart rate tracings as central to their conclusions and opinions concerning the quality of Dr. Murphy's care and the risks posed to her patients. All agreed that interpretation of the tracings is a matter of judgment and that there is room for substantial differences of opinion with respect to the appropriate action to be taken in response to any given tracings. The lack of any consensus among the obstetricians who reviewed the records and testified at the hearing is a strong indication that Dr. Murphy does not present a "clear" danger to her patients. Furthermore, the relevant literature cautions against reaching retrospective judgments about case management based on fetal heart tracings. For these reasons, and in the absence of a finding that Dr. Murphy failed to meet the standard of care in any of the cases presented involving patient care, the preponderance of the evidence does not establish that Dr. Murphy poses a clear danger to the safety of her patients.

The testimony and evidence also indicate that Dr. Murphy does not pose an immediate danger. Dr. Murphy testified, credibly, that her case management practices have not substantially altered over the course of a number of years. In the absence of any showing of an actual injury resulting from those same practices over a twenty year period, the risk of injury to a fetus from those practices is more appropriately characterized as remote than as immediate.[79] Her decision to voluntarily delay her arrival at the hospital in one case was based on consultation with the attending nurse. Dr. Murphy testified, credibly, that the experience of undergoing peer

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lacking support in the record or in the literature provided at the hearing, or contradicted by other obstetricians with superior known credentials. *Supra*, notes 11, 13, 50, 55, 65.

Dr. Davis's report, as the ad hoc committee observed, does not indicate that he reviewed the fetal heart monitor strips, which are central to the allegations of poor professional judgment.

[79] Dr. Lillibridge testified that Dr. Murphy's low rate of Cesarean sections did not in itself cause him concern; he added, "If she has good outcomes, that's what's important." [5A (Lillibridge cross)]

review with respect to that incident had thoroughly chastened her, such that she would not entertain the thought of voluntary delay in the future. The division did not establish by a preponderance of the evidence that an injury to her patients is likely to occur before the board can render a final decision in this case.

IV. Conclusion

The division did not establish a failure to meet the standard of care or professional incompetence, and did not demonstrate a clear and immediate danger to the public. I recommend that the Board vacate the order of summary suspension and address the issues raised in this case in the more deliberative and complete context of a hearing on the merits of an accusation for imposition of disciplinary sanctions.

DATED September 14, 2005.

By: [signature]
Andrew M. Hemenway
Administrative Law Judge

Adoption

On behalf of the Alaska State Medical Board, the undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 within 30 days after the date this decision is adopted.

DATED this 21 day of Oct, 2005.

By: [signature]
Signature
David Heard
Name
Board Chair
Title