COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

Bernard L. Henderson, Jr.
Director of the Department

Hilary H. Connor, M.D.
Executive Director of the Board

1601 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005
(804) 662-9908
FAX (804) 662-9943

August 26, 1992

Mahlon Douglas Cannon, M.D.
808-A Edgehill Road
Richmond, VA 23202

CERTIFIED MAIL
P 741 100 284

RE: License No.: 0101-025481

Dear Dr. Cannon:

Pursuant to Sections 54.1-110, 54.1-2400 and 9-6.14:12 of the Code of Virginia (1950), as amended ("Code"), you are hereby given notice that the Virginia Board of Medicine ("Board") will convene a formal administrative hearing before a panel of the Board to receive and act upon evidence that you may have violated certain laws governing the practice of medicine in the Commonwealth of Virginia, as set forth in the attached Statement of Particulars.

You have been scheduled to appear before the Board on Friday, October 2, 1992 at 8:00 a.m. in the offices of the Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia. A map of the location is enclosed for your convenience. Your presence is required thirty (30) minutes in advance of the appointed time. Please check at the desk for the exact location of the meeting and wait outside the room. You will be called when the Board is ready to meet with you.

You may be represented by counsel and may summon witnesses on your behalf. Should you wish to subpoena witnesses, requests for subpoenas must be made in writing to Hilary H. Connor, M.D., Executive Director, Virginia Board of Medicine, in accordance with the enclosed Instructions for Requesting Subpoenas. Should you wish to present materials in your support, please have ten (10) copies ready for distribution at the hearing. Please indicate by letter to this office your intention to be present.

Sincerely,

Hilary H. Connor, M.D.
Executive Director
Virginia Board of Medicine

LM:TH0824N1.NOTICES

cc: Bernard L. Henderson, Jr., Director, Dept. of Health Professions
Charles F. Lovell, M.D., President
Carol R. Russek, Assistant Attorney General
Lorraine McGehee, Legal Assistant
Investigations Division (92-00578)
Wayne Farrar, Director of Public Information
Gloria King, Probation Analyst

Enclosures:
Virginia Code Sections:
54.1-110
54.1-2400
54.1-2915
9-6.14:12
Instructions for Requesting Subpoenas
Directions to Board Office

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: MAHLON DOUGLAS CANNON, M.D.
License No.: 0101-025481

STATEMENT OF PARTICULARS

The Virginia Board of Medicine ("Board") alleges that Mahlon Douglas Cannon, M.D. may have violated Section 54.1-2915.A(6) of the Code, in that:

On June 10, 1991, the Division of Medical Quality of the Medical Board of California revoked Dr. Cannon's license to practice medicine and prohibited him from supervising a physician's assistant, effective July 10, 1991, pursuant to findings by an Administrative Law Judge that he was guilty of unprofessional conduct as set forth in the Decision and Proposed Decision, copies of which are attached hereto and incorporated by reference herein.

FOR THE BOARD

Hilary H. Connor, M.D.
Executive Director
Virginia Board of Medicine

DATE: 8-26-92

LM:TH0824P1.SOP

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

In the Matter of the Accusation Against:

MAHLON DOUGLAS CANNON, M.D.
Certificate No. C-36460

Respondent.

No. D-4228
L-50192

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Division of Medical Quality of the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on July 10, 1991.

IT IS SO ORDERED June 10, 1991.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Theresa L. Claassen

THERESA CLAASSEN
Secretary/Treasurer

PARTIES AND JURISDICTION

1

Complainant, Kenneth J. Wagstaff, Director of the Medical Board of the State of California (MBC) brought subject accusation and first supplemental accusation (pleadings) in said official capacity.

2

On 30 April 1975, Mahlon Douglas Cannon, M.D., respondent herein, was issued physician and surgeon certificate number C036460 by the Board of Medical Quality Assurance, predecessor to MBC. That license is in current status at the present time, and was in full force and effect at all times mentioned in this decision.

3

(A) On complainant's motion the allegations set forth in paragraph 10(C) of the accusation were stricken and, therefore, dismissed:

(B) All motions and arguments not affirmed or denied herein, or on the record, are found not to be established by the facts or the law and are, accordingly, denied.

4

All pre-hearing jurisdictional requirements have been met. Jurisdiction for that proceeding does exist.

FINDINGS OF FACT RE PLEADINGS

Findings re: Patient Donna H.

5

On 12 August 1986, Donna H., a 20 year old, female, gravida 1 (number of pregnancies) para 0 (number of live births), 21 weeks pregnant, sought an elective abortion from Her Medical Clinic (HMC), a physician's office located at 2700 South Figueroa, Los Angeles, California. Laminaria had been inserted the previous day, 11 August 1986, by another physician at HMC. Donna H.'s first visit to the HMC had been 28 July 1986, at which time she was evaluated as having a pregnancy of approximately 19 weeks,

(A) On 12 August 1986, Donna H., who was a known asthmatic, had a dilation and evacuation, performed by respondent, while under general anesthetic of Brevital and nitrous oxide. The anaesthesia was administered by a Certified Registered Nurse Anaesthetist (CRNA) under respondent's supervision. Donna H. was not intubated at the start of the surgery.

(B) The surgery was performed and the anaesthesia was administered without a proper pre-operative examination.

(C) Donna H.'s history was two weeks old, and was - in light of Donna H.'s asthmatic condition - inadequate at the time that it was taken, and was not updated at the time of surgery and induction of anaesthesia.

(D) Anaesthesia was induced with Brevital, followed by nitrous oxide.

(E) Shortly after induction, the CRNA experienced difficulty in ventilating Donna H. by mask, due to bronchospasm and/or laryngospasm.

(F) Respondent continued with the abortion for a period of no less than 4 to 5 minutes while the CRNA attempted to restore Donna H.'s respiration.

(G) Neither the CRNA nor respondent administered to Donna H. any sufficient medication to reverse bronchospasm.

(H) Respondent then attempted the "Heimlich maneuver" on Donna H. Following that, he returned her to a supine position and tried to clear her airway with his fingers.

(I) Respondent attempted to ventilate said patient for approximately two more minutes; a tracheotomy or a cricothyrotomy was attempted, but said attempt failed to establish an airway.

(J) Paramedics were then called, did appear and they left with Donna H. in full arrest. Donna H. died on 13 August 1986, as a result of the failure to establish an airway or ventilate her.

6

With regard to respondent's treatment and care of patient Donna H. respondent committed or omitted the following particular acts:

(A) Respondent allowed Donna H., a known asthmatic, to be administered general anaesthesia of a barbiturate type, without a physical examination.

(B) Respondent allowed Donna H., a known asthmatic, to be administered a general anaesthesia of a barbiturate type, without an adequate and current medical history.

(C) Donna H. was given an insufficient dosage of medication to dry up secretions.

(D) Following the report of the CRNA that she was having difficulty ventilating Donna H., respondent continued to perform Donna H.'s abortion to completion, rather than assisting the CRNA with Donna H.'s ventilation.

(E) Respondent failed to administer or have administered to Donna H. any sufficient medication to reverse laryngospasm.

(F) Respondent's said acts and omissions caused Donna H.'s preventable death.

7

Respondent's conduct set forth in Finding 6 constitutes gross negligence and is, accordingly, unprofessional conduct.

8

Additionally, with regard to respondent's treatment of patient Donna H. respondent committed the following particular acts:

(A) Respondent performed an abortion on Donna H. without an adequate and current medical history.

(B) Respondent performed an abortion on Donna H. without an adequate physical examination.

9

Respondent's conduct set forth in Finding 6(A) is a negligent act. Respondent's conduct set forth in Findings 6(B), 6(C), 6(D), 6(E), 6(F), 8(A), and 8(B), considered separately, does constitute negligence. Accordingly, said negligent acts subsequent to Finding 6(A) are repeated negligent acts and said conduct is, therefore, unprofessional conduct.

10

Respondent's conduct set forth in Findings 6(C), 6(D), 6(E) does constitute incompetence, and is accordingly unprofessional conduct. Said conduct did cause Donna H.'s preventive death.

11

Findings re: Patient Liliana C.

On 20 September 1986, Liliana C., a 22 year old female, gravida 1, para 0, approximately 17-19 weeks pregnant, a known asthmatic, sought at elective abortion at Her Medical Clinic.

(A) On 20 September 1986, at 9:15 a.m., laminaria were inserted. At 2:30 p.m., Liliana C. received a preoperative medication of Librium, with Atropine. Following that, respondent removed Liliana C.'s laminaria and administered a paracervical block of 10cc of 2% Xylocaine with epinephrine.

(B) The care of Liliana C. was then assumed by an HMC physician (M.D.) other than respondent who began the surgery. Liliana C. seized, had slowed respirations, and then developed cardiac arrest.

(C) Certain of the staff of HMC became involved in the attempts at Liliana C.'s resuscitation while the M.D. completed the abortion.

(D) Liliana C. developed a full respiratory arrest and cardiac arrest.

(E) Ultimately, Liliana C. was transported by paramedics to California Hospital Medical Center, where she was brain dead upon arrival. She was pronounced dead a week later.

12

The whole of the evidence and reasonable inferences therefrom did establish that Liliana C., with proper care and treatment at HMC, would not have died. However, it was not established clearly and convincingly, other than as set forth in Finding 11(A), to what extent, if any, respondent provided care and treatment of Liliana C. Accordingly, it was not established that respondent was one of those at HMC who caused or contributed to Liliana C's preventable death.

Findings Re: Patient Isabel M.

13

On 1 November 1985, respondent performed an elective abortion on Isabel M., a 27 year old female, gravida 6, para 4, tab 2 (number of previous therapeutic abortions), who was approximately 9 weeks pregnant. With regard to the treatment and care of said patient respondent performed an abortion on Isabel M. without conducting a physical examination.

14

Respondent's conduct set forth in Finding 13 is a negligent act and is, in light of Finding 9 a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Cordelia M.

15

On 7 January 1986, Cordelia M., a 34 year old female, gravida 3, para 1, approximately 6 weeks pregnant, Rh negative, received an elective abortion from respondent. On 17 January 1986, Cordelia M. returned to respondent with complaints of pelvic pain and bleeding without fever. The procedure was repeated at HMC.

16

As part of respondent's treatment and care, Cordelia M., who was Rh negative, did not receive Rhogam after the 7 January 1986 abortion, nor was her Rh negativity noted at the time of the repeat procedure at HMC.

17

Respondent's conduct set forth in Finding 16 does constitute negligence and is, in light of Findings 9 and 14, a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Reina E.

18

On 2 May 1986, Reina E., a 33 year old female, gravida 8, para 5, tab 2, 11 weeks pregnant by dates and 14 weeks pregnant by size, had an abortion by respondent.

(A) Preoperatively, Reina E. complained of an approximate one week history of chills, fever and pain all over her body.

(B) No pre-operative physical examination was conducted.

(C) Respondent recognized Reina E.'s septic incomplete abortion only post-operatively. Respondent then arranged for Reina E.'s transfer to Martin Luther King Hospital, where she was treated with antibiotics and her uterus was repaired. She was discharged on 7 May 1986.

19

With regard to respondent's treatment and care of said patient respondent committed or omitted the following particular acts:

(A) Respondent performed surgery on Reina E. without a pre-operative physical examination, including temperature and white blood count.

(B) Respondent failed to administer intravenous antibiotics prior to the abortion.

20

Respondent's conduct set forth in Finding 19 does constitute gross negligence and is, therefore, unprofessional conduct.

21

With regard to patient Reina E. respondent failed to start an intravenous prior to the surgery.

22

Respondent's conduct set forth in Findings 19(A), 19(B) and 21, considered separately, does constitute negligence and, in light of Findings 9, 14, and 17, each is a repeated negligent act and said conduct is, therefore, unprofessional conduct.

23

Respondent recognized said patient's septic incomplete abortion only post-operatively.

29

Respondent performed said abortion on Tracey K., and anaesthesia was administered to Tracey K., in the absence of a physical examination, and in the absence of a determination as to the duration of Tracey K.'s pregnancy.

30

Respondent's conduct set forth in Finding 29 does constitute gross negligence and is, therefore, unprofessional conduct.

31

Respondent performed said abortion on Tracey K. without a hematocrit.

32

Each of respondent's acts set forth in Findings 29 and 31 is a negligent act and each is, in light of Findings 9, 14, 17, 22, and 27 a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Tijuanna J.

33

On 18 September 1987, Tijuanna J., a 29 year old female, gravida 4, para 2, tab 1, 11 weeks pregnant, had an elective abortion by respondent. Tijuanna J. returned to respondent on 24 September 1987, complaining of cramping and of vaginal bleeding without fever. Respondent then performed a repeat suction curettage.

34

On 24 September 1987, respondent performed said abortion procedure without a hematocrit.

35

Respondent's conduct set forth in Finding 34 is a negligent act and in light of Findings 9, 14, 17, 22, 27, and 32 is a repeated negligent act and such conduct is, therefore, unprofessional conduct.

Patient Donetta E.

36

On 16 August 1988, Donetta E., a 19 year old female, gravida 5, para 3, tab 1, had an elective abortion by respondent. The procedure was done without prior insertion of laminaria. A local anesthetic was administered t 3:50 p.m., and the abortion was completed at 4:00 p.m.

(A) The patient was administered Methergine at 4:00 p.m., and 4:15 p.m., and respondent sutured her cervix for unusual bleeding. The patient was released to go home at 5:10 p.m. with three tampons in her vagina. She subsequently left HMC at approximately 7:15 p.m.

(B) Following discharge, Donetta E. experienced great pain; she telephoned HMC staff, who told her that her pain was normal and recommended against going to a hospital. A friend called paramedics, and Donetta E. was brought to California Medical Center (CMC) at 10:50 p.m. Examination on admission revealed Donetta E. to be in acute distress with unstable vital signs (i.e., blood pressure 100/64, pulse approximately 100), a rigid tender abdomen with rebound tenderness, scant vaginal bleeding, but diffuse pelvic tenderness, and a hematocrit of 24.5%.

(C) Respondent was telephoned, and the current examination, including the low hematocrit, was related to him. Respondent told Donetta E.'s attending physician that he doubted that her uterus was perforated, that she probably could be sent home, and that he didn't want to see her in the hospital, but that she should be instructed to follow-up in a week or two at HMC.

(D) Donetta E. was admitted and an emergency exploratory laparotomy was performed due to unstable vital signs and a falling hematocrit believed to be secondary to hemorrhage. Operative findings revealed a large amount of retroperineal and intraperitoneal blood estimated to be 2,000 cc., secondary to be 3-4 cm. uterine perforation extending from an area superior to the internal cervical os to the mid-fundus. The surgical team performed a supracervical hysterectomy and unilateral salpingo-oophrectomy for uterine perforation.

37

Respondent refused to assume care of patient Donetta E. when notified by CMC, and suggested that the patient, with evidence of obvious hypovolemic shock, secondary to blood loss with unstable vital signs and a falling hematocrit, be released home.

38

Respondent's conduct set forth in Finding 37 does constitute gross negligence and is, therefore, unprofessional conduct.

39

Additionally, with regard to respondent's treatment and care of patient Donetta E. respondent committed the following particular acts:

(A) Respondent performed said abortion on Donetta E. without a physical examination.

(B) Respondent performed said abortion on Donnetta E. without obtaining an adequate medical history of the patient.

(C) Respondent's medical record of his care and treatment of Donetta E. was insufficient and inadequate in view of her known complication.

(D) Respondent administered to Donetta E. an excessive dosage of Methergine.

40

Each of the acts set forth in Findings 37 and 39 is a negligent act and each is, in light of Findings 9, 14, 17, 22, 27, 32, and 35 a repeated negligent act and such conduct is, accordingly, unprofessional conduct.

41

Respondent recommended that Donetta E., with evidence of obvious hypovolemic shock secondary to blood loss, with unstable vital signs and a falling hematocrit, be sent home rather than be hospitalized.

42

Respondent's conduct set forth in Finding 41 does constitute incompetence and is, therefore, unprofessional conduct.

SUPPLEMENTAL
FINDINGS

43

(A) The autopsy Report (opinion) of the Coroner revealed the cause (ascribing) of Donna H.'s death in summary as follows:

- - -

SEQUELAE OF ANOXIS DUE TO RESPIRATORY ARREST FOLLOWING INDUCTION OF GENERAL ANESTHESIA FOR THERAPEUTIC ABORTION

- - -

Other Significant Conditions-
Other. bronchial asthma; contact sensitivity allergy, by history

Said Coroner's Anatomical Summary (opinion) is as follows:

I. Intrauterine pregnancy of estimated 21 weeks gestation, clinical.

A. Status-post uterine dilation and curettage (8-12-86) for therapeutic abortion.

1. Induction of general anesthesia with methohexital sodium, succinylcholine, and nitrous oxide.

2. Severe respiratory depression following induction of anesthesia.

a. Status-post tracheostomy.

b. Anoxic encephalopathy. . .

II. Bronchial asthma and contact sensitivity allergy, by history.

Said opinions are competent and credible opinions supported by reasonable inferences from the whole of the evidence.

44

Respondent, as physician (healer) and surgeon of record, had a number of opportunities during the course of his physician/patient relationship with Donna H. to prevent that patient's death. The patient disclosed her asthmatic condition on a HMC form but no further history or inquiry in that regard was taken by either respondent or any of HMC's medical staff under respondent's supervision; thus the patient was at risk. Respondent performed no physical examination on the patient prior to surgery and none was done, under respondent's supervision, by any of HMC's medical staff; thus the patient was at risk. When the CRNA, during surgery, was having difficulty ventilating the patient and

respondent had clear notice[1] of same he did not, as healer, timely respond to a major respiratory catastrophe. When he did respond, his course of action included none of the following to make a proper diagnosis of the cause of the catastrophe: he did not listen to and check the patient's lungs to verify that they were empty and then attempt to intubate and ventilate the patient and, failing that, attempt proper medication of the patient to reverse bronchospasm. Thus, unwittingly, respondent became not the patient's healer but the patient's adversary.

45

(A) While under respondent's care patient Donna H. was placed at risk over and above risks routinely associated with the procedure of a therapeutic abortion. The risk (chance of happening) of Anoxia (in lay terms: no oxygen) due to respiratory arrest, became reality (certainty) and the patient died.

(B) Other patients set forth in these Findings were placed at varying degrees of risk over and above those risks routinely associated with the procedure of a therapeutic abortion: Respondent performed TAB surgery on Isabel M., Reina E. (a septic patient) and Donetta E. without a physical examination of those patients and, thus, each patient was exposed to a risk (chance) of some untoward or, potentially, life threatening event. Donetta E. was at further risk had CMC not disregarded respondent's "advice" and administered competent care and treatment to said patient. Cordelia M., Rh negative was at the discernable risk of, potentially, never bearing a live child because she did not timely receive Rogham. Respondent performed TAB surgery on Jolanta N., Tracey K., and Tijuanna J. without a hematocrit and, thus, each patient was at risk. Jolanta N. was not attended to while in pain and, thus, was at further risk. Tracey K. underwent abortion without physical examination and, thus, was at further risk.

46

(A) Respondent received his medical degree from Meharry Medical College, Nashville, Tennessee in 1973. He then interned at Martin Luther King Hospital/Charter Drew Post and did a rotating residency at that same institution with an emphasis in obstetrics and gynecology. Respondent has been licensed since 1975. Upon completion of his residency he engaged in private practice in

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[1]Among other factors alerting respondent to the catastrophe, including the reported difficulty of his subordinate, the CRNA, respondent would have or should have been alerted by the visible darkening of the patient's blood and once so alerted he knew or should have known he had only a few minutes in which to act to restore the patent's respirations and, thus, save the patient's life.

Compton, California from 1977 to 1984 and tended to approximately 40 to 45 "medical" or "medicare" patients per day for various obstetrical or gynecological problems. In 1984 he assumed a practice at a second location in Compton consisting of health care for women. In 1985 he relocated his practice to Long Beach and remained there until 1988.

(B) During 1985 he became associated with HMC in order to supplement his income. He entered into a Rental/Management/Service agreement with Mediken Management Corporation (legally, the master lessee of the HMC premises; colloquially the "overseer" of the business conducted at said premises). Under said agreement respondent provided medical services as an independent contractor. In 1988 he terminated his association with HMC.

(C) Respondent is now associated, as an independent contractor with Family Planning Associates, and has been so since March 1988, primarily involved in performing therapeutic abortions.

(D) Respondent is not certified in his specialty by the American Board of Medical Specialties (originally the Advisory Board on Medical Specialties) nor is respondent, presently, Board "eligible". While in practice at HMC respondent was not subject to peer review. HMC, nominally named as a"clinic", was in fact an "office" practice wherein respondent and other MD's routinely engaged in the surgical procedure of abortion. Presently, and at times pertinent herein, there is no known legal or ethical bar from performing such a procedure in an office setting. However, at no time was there in place at HMC any peer review mechanism such as would (or should) be in place in a properly licensed, regulated and insured facility. In regard thereto, it is here noted that respondent's negligent, grossly negligent and incompetent conduct set forth in those Findings began in 1985, his initial year at HMC, and culminated in the rather recent conduct (1988) involving Donetta E. The Findings herein detail a number of breaches of varied nature of respondent's duties, obligations, and responsibilities to patients and thus demonstrate that, at present, respondent cannot safely practice medicine.

47

All factual allegations of the pleadings not hereinbefore found to be established are found to be unproven.

DETERMINATION OF ISSUES

I

(A) Business and Professions Code (BPC) sections 2003 and 2004 provide, in pertinent part, that there is a Division of Medical Quality within the Medical Board of California, responsible

for the enforcement of the disciplinary provisions of the Medical Practice Act (Chapter 5 of Division 2 of the Business and Professions Code); the administration and hearing of disciplinary actions appropriate to findings made by a medical quality review committee, the division, or an administrative law judge; and the suspension, revocation, or the imposition of limitations on certificates after the conclusion of disciplinary actions.

(B) BPC sections 2220, 2227 and 2234 authorize said Division to suspend or revoke a physician's and surgeon's certificate, or to take other disciplinary action against a certificate holder who is guilty of unprofessional conduct.

(C) BPC section 2234(a), provides that violating . . . any provision of the Medical Practice Act, is unprofessional conduct.

(D) BPC section 2234(b) provides that gross negligence is unprofessional conduct.

(E) BPC section 2234(c) provides that performance of repeated negligent acts is unprofessional conduct.

(F) BPC section 2234(d) provides that incompetence is unprofessional conduct.

II

Cause exists for discipline of Certificate Number C036460 for violation of the following sections of the BPC:

Re: Donna H.

(A) Section 2234(b) by reason of Findings 5, 6, and 7, collectively.

(B) Section 2234(c) by reason of Findings 5, 6, 8 and 9 collectively.

(C) Section 2234(d) by reason of Finding 10.

Re: Isabel M.

(D) Section 2234(c) by reason of Findings 13 and 14, collectively.

Re: Cordelia M.

(E) Section 2234(c) by reason of Findings 16 and 17, collectively.

Re: Reina E.

(F) Section 2234(b) by reason of Findings 19 and 20, collectively.

(G) Section 2234(c) by reason of Findings 19, 21 and 22, collectively.

(H) Section 2234(d) by reason of Findings 23 and 24, collectively.

Re: Jolanta N.

(I) Section 2234(c) by reason of Findings 26 and 27, collectively.

Re: Tracey K (Betty M.)

(J) Section 2234(b) by reason of Findings 29 and 30, collectively.

(K) Section 2234(c) by reason of Findings 29, 31, and 32, collectively.

Re: Tijuanna J.

(L) Section 2234(c) by reason of Findings 34 and 35, collectively.

Re: Donetta E.

(M) Section 2234(b) by reason of Findings 37 and 38, collectively.

(N) Section 2234(c) by reason of Findings 37, 39 and 40, collectively.

(O) Section 2234(d) by reason of Findings 41 and 42, collectively.

III

With regard to patient Liliana C. no cause for discipline of said certificate exists, under any provision of the BCP, by reason of Finding 12.

IV

The objective of an administrative proceeding relating to discipline, if any, of a license is to protect the public; to determine whether a licensee has exercised his or her privilege in derogation of the public interest. Such proceedings are not for

DECLARATION OF SERVICE BY CERTIFIED MAIL

In the Matter of the Accusation Against:

RE: Mahlon D. Cannon, M.D. No. D-4229

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause, may business address is 1426 Howe Avenue, Sacramento, California 95825. I served a true copy of the attached:

DECISION

by certified mail on each of the following, by placing same in an envelope (or envelopes) addressed (respectively) as follows:

NAME AND ADDRESS	CERT NO.
Mahlon D. Cannon, M.D. ...39 Victory Blvd., #345 Van Nuys, CA 91401	P-884237876
Henry Lewin, Esq. Mark Levin, Esq. 3580 Wilshire Blvd., Suite 1920 Los Angeles, CA 90010-2520	
Calvin W. Torrance Linda Vogel Deputies Attorney General 300 South Spring St. 10th Floor, North Tower Los Angeles, CA 90013-1204	
Richard J. Lopez Administrative Law Judge Office of Administrative Hearings 314 West First St., Los Angeles, CA 90012	

Each said envelope was then, on June 10, 1991, sealed and deposited in the United Stated mail at Sacramento, California, the county in which I am employed, as certified mail, with the postage thereon fully prepaid, and return receipt requested.

Executed on June 10, 1991, at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Suzanne Taylor

DECLARANT

the primary purpose of punishing an individual Camacho v. Youde (1979) 95 Cal.App.3d 161, 165; Ex Parte Brounsell (1778) 2 Cowp. 829, 98 Eng. Rep. 1385. In light of the foregoing and by reason of the number and nature of the violations set forth in Determination II, the order which follows is consistent with the public interest.

ORDER

I

Certificate number C036460, previously issued by MBC to Mahlon Douglas Cannon, M.D., is hereby revoked.

II

Said respondent is, hereby, prohibited from supervising a physician's assistant.

Dated: April 25, 1991

RICHARD J. LOPEZ
Administrative Law Judge
Office of Administrative Hearings

RJL:lf

24

Respondent's conduct set forth in Finding 23 does constitute incompetence and is, therefore, unprofessional conduct.

Findings Re: Patient Jolanta N.

25

On 27 December 1986, Jolanta N., a 24 year old female, gravida 2, para 1, eight weeks pregnant by size, had an elective abortion by respondent. A few days after the procedure, Jolanta N. experienced sharp pain below her abdomen and was unable to eat for several days.

(A) On 23 January 1987, Jolanta N. returned to respondent with a history of pain, and positive urine pregnancy tests at other facilities.

(B) A repeat suction curettage was performed by respondent. Operative findings revealed 15 ml of retained chorionic villi.

26

With regard to the treatment and care of said patient respondent, in particular, committed the following acts:

(A) On 27 December 1986, respondent performed Jolanta N.'s abortion without a hematocrit.

(B) Respondent denied Jolanta N. pain relief for approximately 45 minutes following her reaspiration, a period during which she was in extreme pain.

27

Each of the acts set forth in Findings 26(A) and 26(B) is a negligent act and each is, in light of Findings 9, 14, 17, and 22 a repeated negligent act. Such conduct is, therefore, unprofessional conduct.

Findings Re: Patient Tracey K. (Betty M.)

28

On 19 January 1987, Tracey K. (Betty M.) a 17 year old female, gravida 1, para 0, approximately 6 weeks pregnant, went to HMC for oral contraceptives, was informed she was pregnant, and received an elective abortion from respondent.