NAME: Colleen Murphy

Master Case # 2011-1510 MD

Profession _____

Respondent Attorney

Staff Attorney _____

AAG _____

HLJ _____

Lawyer Directory

Search in:

Lawyer Directory

Discipline Notices

David H Shoup

WSBA Number:	39131
Admit Date:	08/06/2007
Member Status:	Active
Public/Mailing Address:	508 W 2nd Ave Fl 3 Anchorage, AK 99501-2208 United States
Phone:	
Fax:	(907) 278-8536
TDD:	
Email:	shoup@tindall-law.com
Website:	

Contact Member

Contact this member via email.

Practice Information

Back to top

Firm or Employer:	None Specified
Firm Size:	Not Specified
Practice Areas:	None Specified
Other Languages Spoken:	None Specified

Liability Insurance

Back to top

Private Practice:	Yes
Has Insurance?	Yes - Click for more info
Last Updated:	01/21/2011

Committees

Back to top

Member of these committees/boards/panels:

None

Disciplinary History

No Public Disciplinary History

Only active members of the Washington State Bar Association, and others as authorized by law, may practice law in Washington.

The discipline search function may or may not reveal all disciplinary action relating to a lawyer. The discipline information accessed is a summary and not the official decision in the case. For more complete information, call 206-727-8207.

Disclaimer »

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

April 18, 2012

David Shoup
Tindall Bennett & Shoup PC
508 W 2nd Ave 3rd Floor
Anchorage, AK 99501

RE: Colleen M. Murphy, MD
Master Case No. M2011-1510

Dear Mr. Shoup:

Enclosed please find Declaration of Service by Mail and Notice and Order for Withdrawal of Notice of Decision on Application dated April 12, 2012.

Any questions regarding the terms and conditions of the Order should be directed to Dani Newma, Disciplinary Manager at (360) 236-2764.

Sincerely,

Michelle Singer, Adjudicative Clerk
Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

cc: Colleen M. Murphy, MD, Respondent
Kim O'Neal, AAG
Dani Newman, Disciplinary Manager
Michael Farrell, Legal Unit

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of:	)	
	)	Master Case No. M2011-1510
COLLEEN M. MURPHY	)	
Credential No. MD60236731	)	DECLARATION OF SERVICE
Respondent.	)	BY MAIL
	)	
	)	

I declare under penalty of perjury, under the laws of the state of Washington, that the following is true and correct:

On April 18, 2012, I served a true and correct copy of the Notice and Order for Withdrawal of Notice of Decision on Application, signed by the Panel Chair on April 12, 2012, by placing same in the U.S. mail by 5:00 p.m., postage prepaid, on the following parties to this case:

David Shoup
Tindall Bennett & Shoup PC
508 W 2nd Ave 3rd Floor
Anchorage, AK 99501

Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517-1217

Kim O'Neal, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100

DATED: This 18th day of April, 2012.

Michelle Singer, Adjudicative Clerk Office
Adjudicative Clerk

cc: Dani Newman, Case Manager
Michael Farrell, Legal Unit

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **COLLEEN M. MURPHY, MD** License No. MD60236731 Respondent.	**No. M2011-1510** **NOTICE AND ORDER FOR WITHDRAWAL OF NOTICE OF DECISION ON APPLICATION**

1. FACTS AND NOTICE

1.1 On or about October 28, 2011, the Medical Quality Assurance Commission (Commission) issued a Notice of Decision on Application against Respondent.

1.2 Based on further review of the matter on April 5, 2012, the Commission determined that the Notice of Decision of Application should be withdrawn. The Commission voted to grant Respondent an unrestricted license to practice as a physician and surgeon in the state of Washington.

DATED: April 12, 2012

MICHAEL L. FARRELL, WSBA # 16022
DEPARTMENT OF HEALTH STAFF ATTORNEY

2. ORDER

Based on this Notice, the Commission hereby orders that the Notice of Decision on Application is withdrawn.

DATED: April 12, 2012.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Linda A Ruiz
LINDA RUIZ, PANEL CHAIR

FILED
APR 02 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of:	
COLLEEN M. MURPHY, Credential No. MD60236731	Master Case No.M2011-1510
Respondent.	

CERTIFICATE OF SERVICE

I certify that I am employed at the law offices of Tindall Bennett & Shoup, and that on the 27th day of March, 2012, a copy of Respondent's Witness List was faxed to the following, and the Exhibit List with Exhibits were mailed to the following:

Adjudicative Service Unit
P.O. Box 47879
310 Israel Road SE
Tumwater, WA 98501

Kim O'Neal, AAG
Office of the Attorney General
P.O. Box 40100
Olympia, WA 98504-0100

DATED at Anchorage, Alaska this 27th day of March, 2012.

By: Patty Taylor
Patty Taylor
Legal Assistant

TINDALL BENNETT & SHOUP, P.C.
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 278-8533
FAX (907) 278-8536

EXHIBIT LIST

(There must be a separate exhibit list for each party.)

Court Case No. M2011-1510 **/ XX / Hearing**

Name of Party: Colleen Murphy, Respondent

Party's Attorney: David H. Shoup, Tindall Bennett & Shoup, 508 W. 2nd, 3rd Floor, Anch., AK 99501

Exhibit No. Marked for ID	BRIEF DESCRIPTION OF EXHIBIT	FOR COURT USE ONLY						
		ID by Wit.	Offered	Admitted	With-drawn date	To Jury/ Judge	From Jury/ Judge	To Exhibit Clerk
A	CPEP letter to Dr. Murphy 3/8/12							
B	CPEP Assessment Report							
C	Murphy Response to AK State Medical Board re: PAMC Report							
D								
E								
F								
G								
H								
I								
J								
K								
L								
M								
N								

I certify that exhibits checked "To Jury / Judge" on all pages were given to the jury / judge for delivery / advisement.
Date: _____ In-Court Clerk:_____

I certify that exhibits checked "From Jury / Judge" on all pages were given to the jury / judge for delivery / advisement.
Date: _____ In-Court Clerk:_____

I certify that all exhibits were: / / Placed in Interim Storage / / Returned to counsel per order of the Court
Date: _____ In-Court Clerk:_____ Atty sig.:_____ Date: _____

I certify that the exhibits checked "To Exhibit Clerk" on all pages have been placed in Exhibit storage.
Date: _____ Exhibits Clerk:_____

Civil Rule 43.1
Criminal Rule 26.1
Admin. Bulletin No. 9

4

EXHIBIT A

CPEP The Center for Personalized Education for Physicians

March 8, 2012

Colleen Mary Murphy, M.D.
2811 Illianna Ave.
Anchorage, AK 99517

Sent via electronic mail to: drcolleen@gci.net

Dear Dr. Murphy:

Enclosed is your final CPEP Assessment Report.

Per your release, one (1) copy of the Report has been forwarded to Michael Farrell at the State of Washington Medical Quality Assurance Commission (MQAC).

Thank you for participating in our program. Feel free to contact Paul Price, Assessment Services Manager at 303-577-3232, ext 219, if we can be of further assistance.

Sincerely,

Christopher Leo
Sr. Case Coordinator, Assessment Services

Enclosure

cc: Michael Farrell, MQAC

EXHIBIT A

EXHIBIT B

B

CPEP The Center for Personalized Education for Physicians

ASSESSMENT REPORT

For

Colleen Mary Murphy, M.D.

January 30 – 31, 2012

NATIONALLY RECOGNIZED ▪ PROVEN LEADER ▪ TRUSTED RESOURCE

7351 Lowry Boulevard, Suite 100
Denver, Colorado 80230
Phone: 303-577-3232
Fax: 303-577-3241
www.cpepdoc.org

EXHIBIT B

I. Assessment Findings and Recommendations

A. Background

CPEP, the Center for Personalized Education for Physicians, designed this Assessment for Colleen Mary Murphy, M.D., to evaluate her practice of obstetrics. The CPEP Medical Director and staff reviewed information that the Washington State Medical Quality Assurance Commission (Commission) and Dr. Murphy provided for the Assessment. According to Dr. Murphy, there were previous concerns regarding her obstetric patient care with adverse actions placed on her license and denial of hospital obstetric privileges. The Commission denied her application for a license in 2011. The Commission referred Dr. Murphy to CPEP to complete a clinical skills Assessment as part of her appeal to the Commission to reconsider her license application. Dr. Murphy states that, from her CPEP Assessment, she hopes to gain licensure in Washington. Dr. Murphy has not practiced obstetrics since December 2008. She maintains an active gynecology practice in Alaska.

Dr. Murphy has not practiced obstetrics since 2008; therefore, CPEP did not request charts for review during this Assessment.

B. Assessment Findings

During this Assessment, Dr. Murphy demonstrated medical knowledge that was broad, detailed, and up-to-date. Her clinical judgment and reasoning were good. Dr. Murphy's communication skills were excellent with simulated patients (SPs) and good with peers. Her documentation for the SP encounters was adequate.

The educational needs identified in this Assessment are listed in *Section III: Assessment Findings.*

In the health information submitted, no health conditions were identified that should interfere with Dr. Murphy's medical practice.

Dr. Murphy's scores on the cognitive function screening test were largely normal. On the five major indices, attention/mental control, reasoning/calculation, memory, spatial processing and reaction time, her scores were average relative to her age and education. While a more detailed analysis of the subtests which comprise these indices indicated difficulties in a few select tests of attention/memory and mental arithmetic, most of Dr. Murphy's scores were in the average and above-average ranges. The neuropsychologist who reviewed Dr. Murphy's test results opined that no further neuropsychological testing was warranted.

C. Recommendations

During this Assessment, Dr. Murphy did well overall and demonstrated minimal educational needs. CPEP recommends that Dr. Murphy review the educational topics identified as part of her ongoing professional development.

Limitations

CPEP's findings are based upon the performance of the participant during the Assessment process. No direct observation of the participant in the procedural setting occurs. Therefore, conclusions address only whether the participant possesses the knowledge and judgment necessary to perform, without predicting actual behavior. CPEP is unable to evaluate whether a participant possesses the technical skills required in a procedural setting. Such concerns need to be addressed through direct observation of the participant's abilities by peer professionals. Concerns about complication rates should be addressed through comparison with published data.

II. Personalization of Assessment Process

An Associate Medical Director oversees the Assessment to ensure that the process is reflective of the participant's particular practice and that the results accurately reflect the participant's performance. Selection of testing modalities varies with each Assessment, using specific components from the table below that are determined to be appropriate for each participant's practice.

The table below outlines the processes and test modalities typically used in an Assessment and how each modality contributes to an Assessment.

Assessment Components	Pertinence to ACGME Core Competencies						
	Medical Knowledge	Patient Care	Practice-based Learning	Communication Skills	Professionalism	Systems-based Practice	Other
Pre-Assessment Components							
Telephone Interview with Participant				♦	♦		
Written Intake Questionnaire			♦	♦	♦	♦	
Participant Practice Profile					♦	♦	
Participant Education, Training and Professional Activities			♦		♦	♦	
Referral Source Information, if available		♦		♦	♦		
Assessment Components May Include the Following							
Clinical Interviews	♦	♦	♦	♦	♦	♦	
Simulated Patient Encounters	♦	♦		♦	♦		
Simulated Patient Encounter Note Analysis/Documentation Exercise	♦	♦		♦	♦		
Fetal Monitor Strip (FMS) Interpretation	♦	♦					

Health Information Review							♦
Cognitive Function Screen							♦
Observations of Participant Behavior				♦	♦		♦

Dr. Murphy's Assessment is personalized in the following manner:

Patient Charts: Because Dr. Murphy has not practiced obstetrics since 2008, CPEP did not request charts for review during this Assessment.

- ***Clinical Interviews:*** Three clinical interviews were conducted by board-certified obstetrician-gynecologists. The consultants based the interviews on hypothetical cases and topic-based discussions. Please see *Appendix II: Clinical Content of the Assessment* for a list of cases/topics addressed during these clinical interviews.
- ***Simulated Patient Encounters:*** The exercise included three 20-minute interviews with SPs. The SP cases were selected to represent conditions typically seen in the participant's specialty setting, and included a patient presenting for a hysterectomy, a patient with a pelvic mass, and a patient with nervousness and irritability.
- ***Simulated Patient Documentation exercise:*** The exercise included dictating medical notes of each interview with an SP.
- ***Fetal monitor strip (FMS) interpretation:*** The exercise included 12 FMS tracings for which a written description, interpretation and course of action were requested.

III. Assessment Findings

A. Medical Knowledge and Patient Care

The CPEP findings of Dr. Murphy's Medical Knowledge and Patient Care are based on clinical interviews, an SP documentation exercise, and results of written testing. Please refer to *Appendix II: Clinical Content of the Assessment* for a detailed list of the cases and topics addressed during the clinical interviews.

1. Medical Knowledge

During this Assessment, Dr. Murphy demonstrated a fund of knowledge in the field of obstetrics that was broad, detailed and up-to-date.

Dr. Murphy adequately described an appropriate initial evaluation for patients in early pregnancy, including options for genetic screening. She was knowledgeable regarding dating of pregnancy and estimating fetal size. Overall, Dr. Murphy did well in discussions related to possible fetal illnesses or anomalies. She accurately defined intrauterine growth restriction (IUGR) and correctly discussed possible causes, monitoring of the growth restricted fetus, indications for delivery and potential complications. However, the consultant disagreed with Dr.

Murphy's discussion of the prognosis of a fetus with omphalocele and her assertion that this is always a lethal anomaly.

Dr. Murphy adequately discussed the types of twin pregnancy and associated risks. She was familiar with the recommendations for antenatal fetal surveillance in twin and other high-risk pregnancies and correctly listed the criteria for normal and abnormal tests.

Dr. Murphy performed well in discussions related to infections during pregnancy, including group B streptococcus, genital herpes, cytomegalovirus, hepatitis B, and toxoplasmosis. She adequately discussed the diagnosis and management of chorioamnionitis.

With a few exceptions, Dr. Murphy demonstrated an adequate fund of knowledge regarding the management of medical illness during pregnancy. In discussions related to pre-existing and gestational diabetes, Dr. Murphy accurately described the diagnostic criteria, management, and potential complications. However, the consultant disagreed with her proposal to follow hemoglobin A1c levels during pregnancy. In addition, Dr. Murphy did not specifically mention shoulder dystocia as a potential complication for patients with gestational diabetes. While Dr. Murphy was knowledgeable regarding the diagnosis and management of thrombophilias in the pregnant patient, she was not familiar with measurement of anti-factor Xa for monitoring of enoxaparin dosage. Her discussion of interventions for maternal substance abuse during pregnancy and potential fetal and neonatal risks was satisfactory.

Dr. Murphy performed well during discussions of the indications, contraindications and risks of labor induction as well as predictors of successful vaginal delivery after induction. She adequately discussed the diagnosis and management of preterm labor, placenta previa, chronic marginal placental abruption, and pre-eclampsia. Dr. Murphy was knowledgeable regarding current recommendations for the use of antihypertensive medications in the peripartum period and the guidelines for elective cesarean section. She knew the indications, contraindications and potential risks of forceps and vacuum-assisted delivery and accurately described the techniques for their use. She adequately discussed the management of a fetus with breech presentation and the contraindications and potential complications of vaginal birth after cesarean section. Dr. Murphy was familiar with the National Institute for Child Health and Human Development standardized nomenclature for cardiotocography. Dr. Murphy performed well on the written fetal monitoring strip (FMS) interpretation exercise.

The list below includes the educational needs discussed above as well as additional limited educational needs that were identified during the Assessment.

Educational Needs – Medical Knowledge

- Omphalocele: Prognosis and management;
- Diabetes in pregnancy:
  - Recommendations for monitoring of blood glucose and hemoglobin A1c;
  - Risks for, and significance of, shoulder dystocia;
- Monitoring of anti-Factor Xa in patients treated with enoxaparin.

2. Clinical Judgment and Reasoning

Dr. Murphy's clinical judgment and reasoning, as demonstrated during this Assessment, were good. When presented with hypothetical cases, she gathered adequate clinical information in a logical and organized fashion.

During her clinical interviews, Dr. Murphy demonstrated the ability to formulate thorough and well-structured differential diagnoses for a number of conditions, including oligohydramnios, polyhydramnios, and IUGR. In a number of hypothetical cases, including a patient with painful uterine bleeding at 26 weeks gestation and a diabetic woman with significant vaginal bleeding after a prolonged labor and delivery of a large baby, Dr. Murphy appropriately recognized the potential for serious illness.

In discussions with the consultants, Dr. Murphy demonstrated an awareness of the potential complications of a number of obstetrical interventions and appeared to understand the importance of avoiding iatrogenesis. She adequately discussed the technique for preventing fetal neck and adrenal injury during breech extractions, the safe use of the vacuum and forceps during delivery, avoidance of the use of scalp electrodes in the presence of maternal herpes infection, and situations in which labor induction or a trial of labor after cesarean section would be contraindicated. She also demonstrated an understanding of the importance of practicing evidence-based medicine; she adequately discussed the American College of Obstetrics and Gynecology guidelines for elective labor induction, trial of labor after cesarean section, and cesarean section for large babies. In topic-based and hypothetical case discussions, she appropriately referred to the recommendations for the treatment of chorioamnionitis and the management of infants born to hepatitis B infected mothers.

As charts were not reviewed for this Assessment, CPEP is unable to comment about Dr. Murphy's application of this knowledge in actual patient care.

Educational Needs – Clinical Judgment and Reasoning

- None identified.

3. Patient Care Documentation

Dr. Murphy's patient care documentation was evaluated solely on the basis of notes written at CPEP.

a. Review of Documentation – Simulated Patient (SP) Encounter Notes

Dr. Murphy was asked to document a progress note for each SP encounter.

Dr. Murphy's notes were in a history and physical format. In the history, Dr. Murphy consistently included a presenting complaint, history of present illness, past medical history,

family history, and targeted review of systems. She inconsistently included a medication list, allergies, and history of tobacco and alcohol use. She omitted a history of illicit substance use.

Dr. Murphy consistently included physical exams that were appropriately targeted. She consistently indicated an assessment, with a discussion of her clinical thinking. Dr. Murphy included plans and documented patient education in all three notes. She recorded a prescription in one note, including the name, dose, and instructions, but did not record the number to be dispensed or the number of refills authorized. Timing for follow-up was indicated in two notes.

Overall, Dr. Murphy's SP documentation was adequate. She demonstrated that she understood most of the components of acceptable single encounter patient documentation.

Educational Needs – Documentation

- Consistent inclusion of all the appropriate elements of a single visit encounter note, including medications, allergies, history of substance use, and timing for follow-up;
- Thorough documentation of prescriptions, including amount to be dispensed and number of refills authorized.

B. Practice-based Learning

Dr. Murphy provided CPEP with documentation of 206.85 hours of continuing medical education (CME) activities in the past 36 months. Based on information that Dr. Murphy provided to CPEP, Dr. Murphy appeared to be selecting CME activities that were pertinent to the field of obstetrics. It was not clear how much, if any, of this CME was evidence-based as CPEP did not request the data in this format. She did describe a variety of medical information resources, including the use of medical content Internet sites.

Educational Needs – Practice-based Learning

- None identified.

C. Communication Skills

1. Physician-Patient Communication Evaluation

Dr. Murphy exhibited a number of positive communication behaviors when conducting SP interviews. She was professional in manner and appearance and exhibited a friendly, confident demeanor. Dr. Murphy knocked, introduced herself, addressed the SPs by name and maintained excellent eye contact. She conducted the interviews in a logical, conversational manner that included open and closed questions. Dr. Murphy allowed the SPs to talk and ask questions without interruptions. She utilized imaginary anatomy charts on the wall and her education was concise and logical. She conducted thorough exams, described what she would do during a pelvic exam and reported her findings. The SPs rated her empathy from high to exceptional and all indicated that they would return to her.

The communications consultant opined that Dr. Murphy demonstrated excellent physician-patient communication skills during this exercise.

2. Inter-Professional Communication Skills

Dr. Murphy's communication skills were consistently professional throughout the Assessment, both with the consultants and CPEP staff.

Educational Needs

Physician-Patient Communication Skills

- None identified.

Inter-Professional Communication Skills

- None identified.

D. Professionalism

Nothing that transpired during this Assessment raised questions about Dr. Murphy's professionalism.

E. Systems-based Practice

The Assessment yielded inadequate data upon which to accurately comment on Dr. Murphy's awareness of the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

F. Other

1. Review of Health Information

Dr. Murphy submitted a copy of a history and physical exam conducted in December 2011. Review of this documentation did not reveal any conditions that should affect Dr. Murphy's medical practice.

2. Cognitive Function Screen

Dr. Murphy's scores on the cognitive function screening test were largely normal. On the five major indices, attention/mental control, reasoning/calculation, memory, spatial processing and reaction time, her scores were average relative to her age and education. While a more detailed analysis of the subtests which comprise these indices indicated difficulties in a few select tests of attention/memory and mental arithmetic, most of Dr. Murphy's scores were in the average and above average ranges. The neuropsychologist who reviewed Dr. Murphy's test results opined that no further neuropsychological testing was warranted.

3. Observations of Behavior and Additional Considerations

Dr. Murphy was pleasant and cooperative toward CPEP staff and clinical consultants, and conducted herself in a professional manner throughout the Assessment. She submitted all the required documentation in a timely manner.

Dr. Murphy appeared open to the Assessment process. She appeared to be a caring and experienced physician.

IV. Signatures

The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Directors, and administrative staff. The electronic signatures below authenticate the content of this Assessment Report dated this 8th day of March, 2012.

CPEP Representatives

Patricia Kelly, M.D.
Associate Medical Director

Elizabeth J. Korinek, M.P.H.
Chief Executive Officer

Appendix I

Participant Background:
Review of Education, Training, Professional Activities, and Practice Profile

CPEP obtained this information from conversations with and documents provided by Dr. Murphy.

Education

School	Degree	Years Attended
University of Michigan, Ann Arbor, MI	B.S.	1973 – 1977
Wayne State University School of Medicine, Detroit, MI	M.D.	1977 – 1981

Post-Graduate / Residency Training

Specialty/Institution	Dates Attended
Family Medicine Internship, St. John Hospital, Detroit, MI	1981 – 1982
Obstetrics and Gynecology Residency, Good Samaritan Medical Center, Phoenix, AZ	1984 – 1987
Galloway Fellowship, Gynecologic Oncology, Sloan-Kettering Hospital, New York, NY	September – October 1986

Certifications

Certifying Body	Year	Certification Period
American Board of Obstetrics and Gynecology	*2011	Maintenance of Certification

*Dr. Murphy was originally certified in 1989; most recent recertification exam in 2011.

Licensure

Licensing State(s)	Status
Alaska	Active*
Michigan	Inactive

*Suspended in 2005.

Practice History

Years/Description/Location

2001 – Present: Obstetrician and Gynecologist, solo practice, Colleen Murphy, M.D., FACOG, Corp., Anchorage, AK

1999 – 2001: Obstetrician and Gynecologist, Alaska Women's Health Services, Anchorage, AK

June – July 1999: Obstetrician and Gynecologist , Gallup Native Medical Center, Gallup, NM

1998 – 1999: Obstetrics and Gynecology Consultant, Alaska Native Health Consortium, Statewide, AK

1987 – 1999: Obstetrician and Gynecologist, Alaska Native Medical Center, Anchorage, AK

Assessment Report
Colleen Mary Murphy, M.D.

1982 – 1984: Pediatrician, Chief of Pediatrics, National Health Service Corps, Truk State Hospital, Micronesia

Active Hospital Privileges

Name/Location	# of Beds	Trauma	ICU
Alaska Regional Hospital, Anchorage, AK	250	*	15

*Dr. Murphy did not provide this information.

Current Practice Profile

Dr. Murphy works four days per week, sees approximately 12 patients per day in the office, maintains an average inpatient census of two to three, and is on call 30 days per month.

Commonly Encountered Diagnoses

Gynecology exam with Pap, contraception, sexually transmitted disease screen, menorrhagia, obesity, unwanted pregnancy, symptomatic menopause, pelvic pain, urinary symptoms, tobacco abuse, depression, vaginitis

Inpatient Procedures (monthly volume)

Total vaginal hysterectomy (1-2), sling (1), posterior repair (0-1), hysteroscopy (0-1), laparoscopy (0-1)

Outpatient Procedures (monthly volume)

Medical abortion (6), surgical abortion (4), intrauterine device (8), Implanon (2), colposcopy (2), endometrial biopsy (3), incision and drainage (2), skin biopsy (2) polypectomy (2)

Continuing Education

Dr. Murphy reported earning a total of 231.85 hours of CME credit in the previous 36 months. Dr. Murphy submitted a list of specific CME activities.

Continuing Education

Dr. Murphy reported earning a total of 206.85 hours of CME credit in the previous 36 months. Dr. Murphy submitted a list of specific CME activities.

(The remainder of this page is intentionally blank.)

Appendix II

Clinical Content of the Assessment

A. Patient Charts Reviewed

Dr. Murphy has not practiced obstetrics since 2008; therefore, CPEP did not request charts for review during this Assessment.

B. Clinical Interviews

The clinical consultants were board-certified obstetrician-gynecologists. The consultants based the discussion on hypothetical case scenarios and other topics.

Hypothetical Case Discussions

The consultants presented hypothetical cases for discussion. The following list describes the cases and outlines the topics covered during the discussion.

- **Primiparous woman at 40 weeks gestation with pre-eclampsia and an unfavorable cervix:**
  - Labor induction.

- **27 year-old woman with prolonged labor:**
  - Predictors of successful vaginal delivery;
  - Vacuum-assisted delivery:
    - Technique;
    - Indications;
    - Risks.

- **36 year-old woman with diabetes and postpartum hemorrhage:**
  - Risk factors for postpartum hemorrhage;
  - Management;
  - Use of the Bakri balloon.

- **33 year-old woman at seven weeks gestation:**
  - Routine prenatal testing;
  - Genetic screening.

- **39 year-old woman at eight weeks gestation:**
  - Risks and benefits of chorionic villus sampling versus amniocentesis.

- **17 year-old woman exposed to varicella at 7 months gestation:**
  - Evaluation;
  - Treatment.

- **33 year-old woman with painless vaginal bleeding at 26 weeks gestation:**
  - Potential causes;
  - Evaluation;
  - Management of placenta previa;
  - Considerations for delivery.

- **33 year-old woman with painful vaginal bleeding at 26 weeks gestation:**
  - Potential causes;
  - Management.

- **28 year-old woman with preterm labor at 30 weeks gestation:**
  - Evaluation;
  - Management;
  - Premature rupture of membranes:
    - Diagnosis;
    - Management.

- **40 year-old woman with early pregnancy:**
  - Risk of chromosomal abnormalities;
  - Options for genetic screening.

Topic-based Discussions

In addition to the case discussions, the consultants pursued further discussion of the following topics.

- **IUGR:**
  - Definition;
  - Causes of symmetric IUGR;
  - Causes of asymmetric IUGR;
  - Diagnosis;
  - Monitoring;
  - Estimation of fetal weight;
  - Common neonatal complication;
  - Considerations for intrapartum management.

- **Oligohydramnios:**
  - Potential causes;
  - Diagnosis;
  - Prognosis;
  - Management.

- **Polyhydramnios:**
  - Potential causes;
  - Diagnosis.

- **Induction of labor:**
  - Indications;
  - Contraindications;
  - Potential complications.

- **Estimating gestation age:**
  - Ultrasound;
  - Fetal heart tones and movement.

- **Fetal heart rate tracings:**
  - Definitions of Category 1, 2 and 3 tracings;
  - Management of the fetus with a Category 2 tracing.

- **Isoimmunization:**
  - Pathophysiology;
  - Common antibodies;
  - Management;
  - Screening;
  - Monitoring;
  - Indications for determining paternal karyotype.

- **Vaginal birth after cesarean section:**
  - Contraindications;
  - Non-recurring indications for cesarean section;
  - Predictors of success;
  - Risks;
  - Signs of uterine rupture.

- **Antenatal surveillance:**
  - Non-stress testing:
    - Indications;
    - Reliability;
  - Contraction stress testing:
    - Indications;

        - Scoring;
    - Biophysical profile:
        - Indications;
        - Components;
        - Scoring.

- **Group B streptococcal (GBS) infection:**
    - Screening;
    - Potential risks to neonate;
    - Treatment of bacteruria;
    - Treatment of the patient in labor with unknown GBS status.

- **Herpes genitalis infection:**
    - Management during pregnancy;
    - Antibody measurement.

- **Chorioamnionitis:**
    - Diagnosis;
    - Treatment.

- **Cytomegalovirus infection:**
    - Risk to subsequent pregnancies;
    - Risks to fetus.

- **Toxoplasma infection:**
    - Management during pregnancy.

- **Maternal Hepatitis B infection:**
    - Diagnosis;
    - Treatment of the newborn.

- **Pre-eclampsia:**
    - Diagnosis;
    - Treatment;
    - Indications for labor induction;
    - Indications for cesarean section.

- **Macrosomia:**
    - Indications for cesarean section.

- **Chronic marginal placental abruption:**
    - Diagnosis;
    - Management.

- **Placenta previa:**
  - Decreased incidence as pregnancy progresses.

- **Failure to progress in labor:**
  - Definition;
  - Indications for cesarean section.

- **Forceps-assisted delivery:**
  - Indications;
  - Potential risks.

- **Breech presentation:**
  - Mauriceau maneuver;
  - Use of Piper's forceps;
  - Reduction of a nuchal arm;
  - Indications for cesarean section.

- **Management of the pregnant woman with pre-existing diabetes mellitus:**
  - Initial evaluation;
  - Genetic counseling;
  - Potential fetal anomalies;
  - Fetal surveillance.

- **Gestational diabetes:**
  - Diagnosis;
  - Fetal surveillance.

- **Twin pregnancy:**
  - Potential complications;
  - Fetal surveillance;
  - Indications for cesarean section.

- **Management of the pregnant woman with substance abuse.**
- **Thrombophilias during pregnancy:**
  - Management of Factor V Leiden deficiency;
  - Monitoring of Lovenox therapy.

- **Omphalocele:**
  - Prognosis;
  - Management.

- **Antenatal and postpartum depression:**
  - Use of antidepressants during pregnancy and lactation;

- Treatment options;
- Diagnosis.

C. Fetal Monitor Strip Interpretation

Task #1
Define five terms used in FMS interpretation:

- Dr. Murphy correctly defined all terms, with the exception of marked variability.

Task #2
Provide a description, interpretation, and course of action for 12 FMSs:

- Descriptions/Interpretations:
  - The consultant agreed with Dr. Murphy's diagnoses and interpretations in 11 of the 12 tracings:
    - In one tracing, the consultant opined that Dr. Murphy arrived at a diagnosis of pre-eclampsia somewhat prematurely;
  - Dr. Murphy's differential diagnoses were thorough and inclusive;
- Plans:
  - Dr. Murphy's plans were correct for all tracings;
  - Dr. Murphy recommended appropriately aggressive intervention when the FMSs indicated that the fetus was in peril and was judiciously conservative when the tracings indicated that the fetus was stable.

Overall, Dr. Murphy performed well in the FMS interpretation exercise.

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Appendix III

Description of Evaluation Tools

Selection of the testing modalities varies with each Assessment, using the specific components that are determined to be appropriate for each participant's situation.

Structured Clinical Interviews

Clinical Interviews are oral evaluations of the physician-participant conducted by physician-consultants in the same specialty area. Each consultant is certified through a Board recognized by the American Board of Medical Specialties. The interview is conducted in the presence of the Associate Medical Director. The consultant asks about patient care management based on charts submitted by the participant and hypothetical case scenarios. Radiologic studies or videotapes of surgical procedures may also be used in the interview process. These ninety-minute oral interviews are used to evaluate the physician-participant's medical knowledge, clinical judgment, and peer communication skills.

Note: On occasion, physician-participants are unable to provide charts from their practice, either because they have not been in practice for a number of years or because the facility at which they work is unable or unwilling to release them. In these situations, hypothetical case scenarios are used as the basis for the interviews.

Multiple-Choice Examination

Physician-participants may be given a timed multiple-choice examination. The examinations are provided by the Post-Licensure Assessment System (PLAS) and scored by the National Board of Medical Examiners (NBME).

Technical Skills Assessment

Anesthesiologist physician-participants may complete a series of simulated airway management scenarios using a high fidelity simulator. The scenarios are designed to test both technical and non-technical skills.

Physician-participants performing laparoscopic surgery may participate in the Fundamentals of Laparoscopic Surgery Program, which includes a multiple choice exam and a performance based manual skills exam.

Electrocardiogram (ECG) Interpretation

Physician-participants whose practice includes reading ECG tracings are presented with eleven ECG tracings and asked to provide an interpretation and course of action for each.

Fetal Monitor Strip Interpretation

Physician-participants providing obstetric care in their practice are asked to read twelve fetal monitor strips and provide an interpretation and course of action for each strip.

Physician-Patient Communication Evaluation

Effective communication and formation of therapeutic physician-patient relationships are assessed through the use of Simulated Patient (SP) encounters. The physician-participant conducts patient interviews in an exam-room setting. The patient cases are selected based on the physician-participant's specialty area. Both the SPs and the physician-participant evaluate the interaction. The patient encounters are videotaped and analyzed by a communication consultant.

Patient Care Documentation

Physician-participants are asked to submit redacted copies of patient charts. The charts are reviewed for documentation legibility, content, consistency and accuracy. The physician's attention to pertinent medical details is noted.

Review of Documentation – Simulated Patient Encounter Progress Notes

Following the Simulated Patient (SP) encounters, the physician-participant is asked to document each interaction in a chart note. The physician may hand-write the notes on plain lined paper provided by CPEP, dictate the notes, or use templates that he brings from his practice. Radiologists who do not typically interact with patients in their professional roles are given a documentation exercise using digitally reproduced radiographic images.

Cognitive Function Screen

MicroCog™, a computer-based assessment of cognitive skills, is a screening test to help determine which physician-participants should be given a complete neuropsychological work-up. The test is viewed as a *screening instrument only* and is not diagnostic.

> *This screening test does not require proficiency with computers; a proctor is available to answer questions about test instructions. Test performance or expected test performance can be impacted by a number of factors, including normal aging and background. A neuropsychologist analyzes the test results, taking these factors into account.*

Review of Health Information

The physician-participant is asked to submit the findings from a recent physical examination as well as hearing and vision screens. If indicated, program staff requests information related to specific health concerns.

Appendix IV

CPEP Educational Recommendations: Explanations and Implications

Physician performance on a CPEP Assessment falls along a broad spectrum. Often, for both the physician involved and the referring organization, the critical questions are, "What does this mean" and "How do I/we move forward from here?" CPEP provides direction through the Educational Recommendations that are provided in the Assessment Report.

While the educational activities that would benefit a physician are very specific to that individual, CPEP Educational Recommendations fall into three broad categories.

- *Independently address educational needs*

No physician is expected to perform perfectly during an Assessment, and no physician knows everything. Some physicians who participate in an Assessment demonstrate minimal or limited educational needs, which we believe they should be able to address independently through self-study, continuing medical education, and other resources. We recommend that these physicians incorporate these topics into their ongoing professional education activities. Although CPEP does not use the terms "pass" or "fail," if thinking along those terms, it is reasonable to consider that an individual receiving this recommendation has "passed" the Assessment.

The wording used to convey this in an Assessment Report is typically similar to the following: "CPEP believes that Dr. Smith should have the resources to address these educational needs independently, without the benefit of an Educational Intervention. All professionals have a responsibility for self-directed, ongoing learning and Dr. Smith should continue to make this a part of his work."

- *Residency or residency-like setting*

On the other end of the spectrum, some physicians demonstrate educational needs that are of a quantity or quality such that CPEP believes that they are not equipped with the resources to address their educational needs while they continue to practice. CPEP recommends that these physicians address their educational needs in a residency or residency-like setting. Our opinion is that it would not be safe for this physician to practice independently; they are in need of the structure and rigor of an academic setting to provide an intensive and highly supervised educational experience. As stated previously, CPEP does not use the terms "pass" or "fail." However, it is reasonable to consider that an individual receiving this recommendation has "failed" the Assessment.

CPEP acknowledges that residency positions may be difficult for practicing physicians to secure; therefore, the wording residency-like setting is intended to suggest that other situations may be acceptable, such as a voluntary position in a training setting, a fellowship, or other such situation in which the physician can benefit from learning in a formal training or educational setting. To

further clarify, a recommendation that an individual address their educational needs in a training setting does not necessarily indicate that the equivalent of a full residency be completed; the specific needs of the physician will vary and the training might range from one year or longer.

The wording used in an Assessment Report to convey such a recommendation will be similar to the following: "Because of the extent of the deficiencies identified, CPEP believes that Dr. Smith should retrain in a residency or residency-like setting. CPEP does not believe that Dr. Smith demonstrated the ability to remain in independent practice while attempting to remediate his clinical skills."

- *Structured Educational Intervention*

In the middle of the spectrum are those participants who demonstrate educational needs that CPEP believes should be addressed with external structure, oversight, and/or some level of supervision. These physicians should be able to address their educational needs while they continue or return to practice.

The Educational Recommendations in the Assessment Report will read something comparable to: "CPEP recommends that Dr. Smith participate in structured, individualized education to address the identified areas of need." Physician-participants and referring organizations have found value in CPEP Education Services, through which we provide expertise in developing specific and clear educational objectives, structure in the educational process, and a means by which integration and implementation of new learning and approaches can be demonstrated. CPEP Education Services are available, if desired and requested by the physician participant or referring organization, and would include development of an Educational Intervention Plan (a detailed learning contract) and ongoing support, monitoring, and oversight during the course of the physician's educational process. Please contact CPEP Education Services for additional information.

Note: Although this document refers to physicians, CPEP conducts Assessments and Educational Interventions for physician assistants, advanced practice nurses, podiatrists, and the above is applicable to all healthcare providers that are evaluated by CPEP.

EXHIBIT C

DR. COLLEEN MURPHY'S RESPONSE
TO ALASKA STATE MEDICAL BOARD
RE: PROVIDENCE ALASKA MEDICAL CENTER'S
REPORT OF REVOCATION OF PRIVILEGES

Pursuant to the Providence Alaska Medical Center Investigation, Hearing and Appeals Plan, MS 980-100, Colleen Murphy, M.D., appeals the final decision of the Providence Health & Services Alaska Region Community Ministry Region Board decision revoking her privileges. The decision, upholding a recommendation of the Providence Medical Executive Committee (MEC), should be reversed.

I. Introduction.

After the MEC recommended that Dr. Murphy's privileges be revoked, a six-day hearing was held before a hearing panel of three physicians. Of the three physicians, only one, neonatologist Jack Jacob, M.D., had expertise in the areas in dispute. The other two physicians were Dr. Suzie Dietz, an emergency room doctor, and Dr. Stephen Rosenfield, an anesthesiologist.

The committee voted 2-1 that the MEC's recommendation regarding revocation should be upheld. However, as is clear from the report itself, there was no analysis whatsoever provided by the two physicians who voted in favor of the recommendation. Their decision was rendered in two sentences, and those sentences were devoid of any reasoning, any factual findings, or any basis for the decision at all, aside from a conclusory sentence that the recommendation was supported by substantial evidence.

By contrast, the dissenting opinion by Dr. Jacob was four pages in length and went

EXHIBIT C

into detail regarding why Dr. Murphy's privileges should not be revoked. In the dissent, concerns were raised about the "even-handedness" of the complaints generated within the hospital against Dr. Murphy, found that "Dr. Murphy's evidence established there was no breach of a national standard of care . . .," and concluded there was "no pattern of poor clinical judgment on Dr. Murphy's part." [Dissenting Opinion at 1-2.]

On an objective basis, there is simply no way to determine why the majority voted the way that it did. Certainly, no one reviewing the decision could say there was a reasonable belief that the action was in the furtherance of quality health care, or that there was a reasoned conclusion the action was warranted by the facts.

Importantly, the dissenting opinion supports the opposite conclusion, that the facts do not support the decision. In addition to the finding that there was no breach of the national standard of care and no pattern of poor clinical judgment, the dissenting opinion found the action against Dr. Murphy was arbitrary [Dissenting Opinion at 2], that it disregarded the opinions of Dr. Sherrie Richey, Alaska's only perinatologist, Dr. Julian Parer, a nationally known perinatologist and author of The Handbook of Fetal Heart Rate Monitoring, and Dr. George Stransky, a well-known and well-respected OB/GYN. [Dissenting Opinion at 1-2.] With regard to Drs. Richey and Stransky, the dissent noted that they are "in positions of being knowledgeable on the subject of breaches in the standard of obstetric care at Providence . . .." [Dissenting Opinion at 2.]

At the hearing, Dr. Richey testified she was aware of the practice patterns of all of the OB/GYN's at Providence over the last fifteen years, that she was concerned with the "arbitrary nature" of the proceedings against Dr. Murphy, that physicians responsible for "much more egregious, in my view culpability in regards to . . . bad outcomes" had not

been pursued by Providence, and that Dr. Murphy was being subjected to "unfair treatment" because of her outspoken nature. [Tr. 1252-56.]

As a perinatologist, Dr. Richey is in a unique position to judge. She reviewed all of the Providence cases against Dr. Murphy, [Tr. 1252], even though she is not a friend of Dr. Murphy, and undertook the review without pay. She did this because she was disturbed by the "arbitrary nature" of the peer review proceeding against Dr. Murphy. [Tr. 1252-53.] After having reviewed all of the Providence cases, Dr. Richey concluded there had been no breach of the standard of care in any case. [Tr. 1252, 1280.]

There is substantial evidence that the MEC recommendation was based upon political considerations and faulty information. Some of the information provided to the MEC was false, and the central basis for the MEC action was simply a disagreement over how to interpret fetal heart rate (FHR) monitoring strips. Both the nationally known experts who testified (Dr. Julian Parer and Dr. Paul Sinkhorn) and Alaska's only perinatologist, Dr. Richey, found that Dr. Murphy's interpretation of these strips was correct – and Providence's interpretation incorrect.

In addition, in one of the FHR cases upon which Providence relied (Estelle), four perinatologists, two hired by Providence for external review (Drs. Ian Grable and David Ruedrich) as well as Dr. Richey and Dr. Parer, opined that Dr. Murphy's interpretation was correct – and the hospital's wrong. After Drs. Parer, Grable and Ruedrich all opined in writing that Dr. Murphy was correct in her FHR interpretation, Providence continued to claim Dr. Murphy was in error and used this case as a basis for revocation of her privileges.

In part, the decision by Providence to go forward was based on FHR interpretations of nurses. Instead of relying on nationally known, locally known, and Providence-hired

perinatologists, Providence chose to rely upon the FHR analysis of nurses. [See, e.g., Tr. 1396-1406 (nurse Jahnava Erickson); 1599 - 1615 (nurse Maria Taylor).]

The MEC recommendation and the Board's decision to adopt that recommendation should be reversed.

II. The Individual Cases.[1]

The decision to revoke Dr. Murphy's privileges was based upon fifteen separate cases at Providence and on six cases at Alaska Regional Hospital (ARH) dating back to 2003-04. Of the fifteen Providence cases, only four alleged a breach of the standard of care, and in each of these cases one or more qualified reviewers found there had been **no** such breach. Moreover, the remainder of the cases showed no pattern of poor clinical practice, as alleged.

With regard to the six ARH cases, four went to an extensive evidentiary hearing in 2005 before an administrative law judge acting for the State Medical Board. In those four cases, there was no finding of any breach of the standard of care. [See Hearing Ex. M1 (administrative law judge's written decision).] In the other two ARH cases, at least one qualified outside reviewer, a board-certified OB/GYN hired by ARH, found there had been no breach of the standard of care. Providence relied on these cases anyway.

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[1] This appeal presents Dr. Murphy's side of each case, and is not meant to be a comprehensive review, because the evidence cited herein demonstrates Providence recommended revoking Dr. Murphy's privileges even though there were nationally known, locally known and hospital-hired experts who disagreed with Providence in each and every case.

A. The cases involving FHR monitoring.

1. MR 195315/MR 771624.

In this case, the patient delivered by cesarean section (C-section) in February 2008. Providence alleged a "Level 6" violation, meaning a breach of the standard of care with no adverse patient impact. [Hearing Ex. 29 at 16 (Level 6 means "[s]ignificant departure from established pattern of clinical practice. No adverse patient impact."). Providence alleged that Dr. Murphy should have initiated the C-section sooner than she did. Providence's charge was based upon the FHR monitoring strip. [Hearing Ex. 82 at 2.]

Dr. Julian Parer, a perinatologist on the teaching staff at the University of California, San Francisco (UCSF) and the author of The Handbook of Fetal Heart Rate Monitoring, a widely accepted and authoritative treatise on the subject [Tr. 314-15], testified that Dr. Murphy's interpretation of the strip was appropriate and that her decision to intervene timely. [Tr. 335-40.][2] Dr. Parer directly contradicted Providence. [Parer letter, attached.]

Dr. Parer observed that two other perinatologists, hired by Providence for external review (Drs. Ian Grable and David Ruedrich) also found that Dr. Murphy's decision to initiate the C-section was appropriate and timely. [Tr. 338-39.] In his review for Providence, Dr. Grable wrote: "The decision to proceed with the cesarean section was made at the appropriate time in labor based upon the FHR tracing at that time." [Hearing Ex. 37 at 95.] Dr. Ruedrich agreed: "[a]t that time, the recognition of a non-reassuring pattern was appropriately made by Dr. Murphy and she proceeded to initiate a stat cesarean section that was indicated and timely." [Hearing Ex. 37 at 87.] Nonetheless, the case was cited by

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[2]References to "Tr." are to the transcript of the Fair Hearing proceedings.

Providence as a reason for suspending and then revoking Dr. Murphy's privileges. [Hearing Ex. 82 at 2, 6.]

Dr. Parer testified:

> It sounds a bit strange, doesn't it? It sounds as through there's an agenda somewhere that not's relating to the tracing or the [case] management. [Tr. 340.]

Dr. Paul Sinkhorn, a nationally known OB/GYN who teaches at the U.C.L.A. Geffen School of Medicine, among other places, and a reviewer for 12 years for the Joint Commission for Accreditation of Healthcare Organizations [see Sinkhorn letter, attached], also reviewed the MR 195315/MR 771624 case and found no breach of the standard of care. Dr. Sherrie Richey reviewed the case and reached the same conclusion. [Tr. 423-26 (Sinkhorn), 1265-70 (Richey).] The Providence OB/GYN department reviewer characterized the case as a "judgment call with MD + the patient." [Hearing Ex. 37 at 73.]

2. MR 420068/MR 705608.

Providence alleged inappropriate FHR monitoring and improper use of a vacuum extractor with regard to the patient. The case was dated April 21, 2005. The hospital assigned the case a Level 6 (breach of the standard of care but no patient injury). The baby had Apgar scores of 3 over 7 (3 at one minute, 7 at five minutes, the latter in the normal range) and a cord pH of 7.035 (within normal range).

The Providence OB/GYN department review found no breach of the standard of care, assigning the case a Level 5 [Hearing Ex. 29 at 17; see also hearing Ex. 37 at 10 (Level 5 assigned.] The hospital later elevated the case to a Level 6.

Dr. Parer found no breach of the standard of care and noted there was no injury from the use of the vacuum extractor. [Tr. 319-21.] Dr. Richey found no breach of the

standard of care. [Tr. 1275.] Dr. Sinkhorn, an assistant clinical professor at U.C.L.A. in the medical school's OB/GYN department and a former professor in the OB/GYN department at the U.C. Riverside medical school, also found no breach of the standard of care. [Tr. 434-49.]

> If Dr. Murphy delayed a cesarean, then I'm guilty of the same thing, because I did the same thing three weeks ago. . . . I made the same decision three weeks ago. [Tr. 437-38.]

3. MR 738745/MR 747369.

The patient had a vaginal birth assisted with vacuum delivery on February 17, 2007. Providence assigned a Level 5 (no violation of the standard of care),[3] but alleged the FHR monitoring indicated an earlier intervention. The baby's Apgar scores were 9/9 and the cord pH was 7.19. [Tr. 482.]

Dr. Jan Whitefield proctored the delivery and wrote: "[a]ppropriately applied vacuum. Appropriate competent use." [Hearing Ex. D1.] Drs. Parer, Sinkhorn and Richey all found the FHR monitoring by Dr. Murphy appropriate and found no breach of the standard of care. [Tr. 325-26 (Parer), 482-85 (Sinkhorn), 1252 and 1280 (Richey).] As Dr. Sinkhorn testified:

> The criticism that there should have been earlier intervention I think is unfounded on the basis of the fetal heart rate strip. It's certainly unfounded on the basis of a 9 over 9 Apgar and pH of 7.19. It's pretty hard to imagine getting a better baby than that. So if you deliver this kid a half an hour or an hour earlier, how to you improve on a 9 over 9 Apgar? [Tr. 484.]

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[3] Level 5 is defined by Providence as: "Standard of care met. Not necessarily routine, but not totally unexpected. May be disease related." Hearing Ex. 29 at 17. (emphasis supplied).

4. MR127544/MR786976.

In this case, dated October 2-3, 2008, Providence alleged Dr. Murphy should have performed a C-section earlier than she did based upon the FHR monitoring strip. The baby was born with Apgar scores of 2, 6 and 7. Providence assigned this case a Level 5 ("[s]tandard of care met)." [See hearing Ex. 29 at 16]. Drs. Sinkhorn, Parer and Richey all found the case had been appropriately managed. As Dr. Sinkhorn testified:

> Dr. Parer just taught all of us that that's what we don't want to see. You can tolerate decelerations, you can even tolerate loss of variability, but you can't tolerate them together, because now this baby is being compromised. So appropriate choice, get the kid out, cesarean section.
>
> * * *
>
> I actually agree with Providence in this case. It is a – not that it's a Level 5, but the standard was met in this case, which is what Providence said too. [Tr. 443-44 (emphasis supplied).]

The baby was transferred to the NICU because of pre-existing chorioamnionitis. As Dr. Parer testified, and no witness disputed, chorioamnionitis is not an indication for C-section. [Tr. 325.]

5. MR 32-42-42.

This case, from Alaska Regional Hospital (ARH) and dated September 2004, pre-dated the hearing by nearly five years. While Providence alleged a breach of the standard of care with no patient harm (Level 6), an outside reviewer, Dr. Robert Davis, an OB/GYN hired by ARH, found the standard of care had been met. [Hearing Ex. 37 at 163-65.] Dr. Sinkhorn agreed:

> Q. You understand – and I will represent to you – that prolonged second stage is one of the charges against Dr. Murphy here referred by Providence. You don't think there was a prolonged second stage?

A. No. Whoever made that charge is mistaking the early pushing that the patient did when she wasn't fully dilated as the beginning of the second stage. That's not the beginning of the second stage. She was completely dilated at 20:30 and started pushing at 21:00. [Tr. at 569-70.]

Dr. Robert Davis, the ARH-hired outside reviewer, wrote: " . . . it appears to this reviewer the conduct of labor in delivering this patient was appropriately managed and well documented." [Hearing Ex. 37 at 164.] Dr. Sinkhorn also concluded the standard of care had been met. [Tr. 570.]

6. MR 38-34-33.

Providence alleged a breach of the standard of care in this case, but no adverse patient impact; Providence assigned a Level 6. The case, dated March 10, 2004, was from ARH.

Dr. Wendy Cruz, on the medical staff at ARH and who testified at the 2005 State Medical Board hearing for ARH with regard to this same case, observed that the patient "was getting the appropriate treatment for her infection . ..." [Hearing Ex. M1 at 25.] The hearing officer found that the patient's fetal heart monitoring strips "showed no significant accelerations or decelerations for most of the labor, until shortly before delivery." [Tr. at 25.]

While Dr. Kathleen McGowan, an outside reviewer hired by ARH, wrote a report that said there had been a standard of care breach, her report also stated:

> I found this case difficult to evaluate, given the advantage of already knowing the outcome. I cannot say with certainly that I would not have followed the same course of action followed by Dr. Murphy. [Hearing Ex. 37 at 146 (emphasis supplied).]

Then at the state hearing, neither Dr. McGowan nor Dr. Sherrie Richey, both of whom testified, would say under oath that Dr. Murphy's management of the case fell below

the standard of care. [Hearing Ex. M1 at 25.] The state hearing officer concluded there had been insufficient proof of any breach of the standard of care. [Hearing Ex. M1 at 25.]

7. MR 37-44-87.

This AHR case, dated November 2003, was assigned a "Level 7" by Providence (breach of the standard of care and adverse patient outcome). However, an outside reviewer hired by ARH in 2004, Dr. Robert Davis, found there had been no breach of the standard of care. [Hearing Ex. 37 at 137.] Dr. Davis wrote: "Intraoperative and postoperative management again were expertly managed and the excellent outcome experienced by both the infant and mother despite this true obstetric emergency is noteworthy." [Id. (emphasis added).]

The State Medical Board hearing officer wrote: "both Dr. Richey (an expert in the management of high-risk deliveries) and Alaska Regional Hospital's own internal review found that Dr. Murphy's failure to intervene was acceptable care." [Hearing Ex. M1 at 20 (emphasis supplied).] The hearing officer who conducted the State Medical Board hearing concluded there had been no showing of a breach of the standard of care. [Hearing Ex. M1 at 18-22.]

B. The remaining Providence cases.

1. MR 369562/MR 704464.

This case, perhaps more than any other, has been thoroughly examined because it resulted in a lawsuit against Dr. Murphy by an experienced medical malpractice attorney. The lawsuit alleged, among other things, that Dr. Murphy encouraged a vaginal delivery when the patient came to Providence two weeks before full term in March 2005. This is essentially the same charge leveled by Providence, which assigned the case a Level 5.

[Hearing Ex. 37 at 1.]

The lawsuit resulted in the plaintiff agreeing to a voluntary dismissal of all claims and charges against Dr. Murphy, with Dr. Murphy paying nothing, after the plaintiff was unable to present expert testimony of any breach of the standard of care. [Hearing Ex. G2.] The written stipulation for dismissal of the lawsuit stated: "No funds are being paid by any party to any other party in any amount in consideration for this stipulated dismissal with prejudice." [Id.]

At the Providence hearing this year, Dr. Murphy testified she had not encouraged a vaginal delivery and that full warnings were given.

> Q. Did you later understand that this baby's problem wasn't right arm paralysis but was in fact stretched nerves?
>
> A. Yes.
>
> Q. So you gave her the warning that actually occurred?
>
> A. Yes, sir.
>
> Q. And what did she do?
>
> A. She said she would like to try a vaginal delivery if she was a candidate. [Tr. 1830-31.]

At the Providence hearing, Providence's expert, Dr. Thomas Benedetti, upon whom Providence relied, was unaware that the patient had chosen not to have a C-section, or that the patient in her lawsuit contradicted herself four times about what she had been told by Dr. Murphy about delivering vaginally as opposed to by C-section. [Tr. 735 (did not want C-section); hearing Ex. 4D (chart) at 56 (possibility of C-section discussed); Tr. 727-28 (unaware of contradictions.] No witness called to testify at the hearing disputed any of these facts.

Yet Providence relied on a written affidavit by the plaintiff saying she had not been given adequate warnings of the risk of a vaginal birth, drafted by the plaintiff's lawyer after the plaintiff herself had testified in a sworn deposition that she couldn't recall what she had been told. [Hearing Ex. 71.] The affidavit directly contradicted her earlier sworn testimony. [Tr. 945-46.]

In assigning the case a Level 5 ("[s]tandard of care met. Not necessarily routine, but not totally unexpected, may be disease related," hearing Ex. 29 at 17), Providence appeared to agree with Drs. Jordan Horowitz, Michael Katz and Paul Sinkhorn, all of whom teach medicine at the University of California (Drs. Horowitz and Katz at U.C. San Francisco medical school), who issued detailed reports that concluded there had been no breach of the standard of care. Nonetheless, the MEC continued to rely on this case as a basis for recommending revocation of Dr. Murphy's privileges. [Hearing Ex. 82 at 1.][4]

2. MR-734452/ MR-739858.

Providence did not allege a breach of the standard of care in this case, dated October 2006. It assigned the case a "Level 3a," meaning "behavior-related issue." [Hearing Ex. 37 at 1 (3a); Ex. 29 at 16 ("[b]ehavior-related issue").] The Providence OB/GYN departmental reviewer noted: "[proctor was not present @ delivery. He prob. should have been in house." [Hearing Ex. 37 at 33.]

The day before the delivery, the proctor, Dr. Mark Richey, was called at Dr.

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4 In this case, Providence provided misleading information to the MEC. Providence informed the MEC that the baby's five-minute Apgar score was less than six; meaning abnormal. [Hearing Ex. 32, 6th page.] The five-minute Apgar actually was 7, within the normal range. [Hearing Ex. 4D (medical chart), at 21.]

Murphy's request and updated on the status of the patient. [Hearing Ex. 4D (chart) at 55.] At 2:34 the next morning, Dr. Murphy was summoned by a nurse who noted early and late decelerations on the FHR monitoring strip. [Hearing Ex. 4D at 71.] Dr. Mark Richey was notified 13 minutes later and arrived just after the baby was delivered with vacuum assist. [Hearing Ex. 4D at 32.] He remained, discussed the delivery and completed the proctoring form. [Hearing Ex. J1.] He noted it had been a "precipitious vaginal delivery with no apparent complication." [Id.]

With regard to the proctoring requirement, the department chair had written: "[o]f course, individual mitigating circumstances may arise and will be considered when they do . . . ." [Hearing Ex. I1.] The mitigating circumstance in this case was the "precipitious vaginal delivery." The proctor was notified shortly after it appeared the birth was imminent.

Moreover, the proctoring in this case fully complied with Providence's own proctoring policy. MS-900-050 states:

> Proctoring may be accomplished by one or any combination of the following methods and will be determined with each event of required proctoring:
>
> * * *
>
> * Retrospective chart review within one month of discharge.
>
> * Availability on campus for immediate consultation and concurrent chart review within 24 hours of admission or the procedure in question . . .

In this case, there is no dispute that the proctor remained following the procedure, discussed the case and filled out the proctoring form. Moreover, apparently satisfied with the proctoring that had occurred, Providence voluntarily lifted the proctoring requirement on May 21, 2007, seven months later. [Hearing Ex. I2.]

3. MR 065968.

This case was an emergency delivery, dated September 2006. Providence charged that a proctor was required and was not present in the delivery room. Providence assigned the case a Level 3a (behavior-related issue). [Hearing Ex. 37 at 1.]

As noted above, the OB/GYN department recognized there may be "mitigating circumstances" that would be factored into the proctoring requirement. [Hearing Ex. I1.] In this case, there was "an urgent delivery . . .." [Id.] According to OB/GYN department chair Catherine Gohring, the proctor was not summoned because Dr. Murphy "felt he [the proctor] couldn't get to the hospital in time prior to the delivery . . .." [Id.] Therefore, another OB/GYN, Dr. Brennan, was summoned and, again according to Dr. Gohring, "[h]e concluded that an urgent delivery was indicated and satisfactorily performed." [Id. (emphasis added).] Dr. Brennan then filled out the proctoring form. [Hearing Ex. 37 at 29.]

No breach of the standard of care was alleged by anyone.

4. MR 385479.

Providence assigned the case a Level 6 for alleged poor pain management, and a 3a ("behavior-related issue") for comments made to the patient. The case was dated February 2008. The allegations were that pain medication was withheld and that Dr. Murphy made a disparaging remark about the size of the fetus (which had been born severely prematurely at home).

With regard to pain management, Dr. Murphy wrote: "[t]he patient was comfortable." [Hearing Ex. F1 at 2.] The patient agreed. In a letter to Dr. Murphy, the patient wrote: "Dr. Murphy made sure I was getting pain medicine, which takes time to work . . .." [Hearing Ex. F4.] The patient reported she was exhausted and in pain because she had given birth at

home and had lost a lot of blood, but "I was being well taken care of by Dr. Murphy." In response, Providence alleged the patient must not have known what she was talking about, arguing that even though the letter states the patient was getting "pain medicine," the letter talks about "pain, pain, pain," and therefore Dr. Murphy must not have given pain medication. [Tr. 2058.] Providence seemed unable to explain why the patient would write such a glowing letter on Dr. Murphy's behalf if Dr. Murphy, in fact, had deprived the patient of needed pain medication. [Hearing Ex. F4 (patient letter).]

The allegedly disparaging comment was that Dr. Murphy had referred to the premature fetus as a "stick of butter." Yet Dr. Murphy explained that she was simply comparing with weight of the fetus to the weight of a stick of butter, not that she had made a disparaging remark. [Hearing Ex. F1 at 2.] Nurse Mary Bennett Weiss reported she observed a dispute between Dr. Murphy and a nurse, who complained to the hospital about the alleged comment, and after Nurse Weiss gave the patient every opportunity to complain about anything Dr. Murphy said, and the patient said nothing. [Hearing Ex. F3.] Again, Providence had difficulty explaining why, if any disparaging remark actually had been made, the patient would write such a complimentary letter about Dr. Murphy's conduct. [Hearing Ex. F4.]

Dr. Richey and Dr. Sinkhorn both concluded there had been no breach of the standard of care. [Tr. 1252, 1280; Tr. 493.]

5. MR 255432.

In this case, Providence alleged a Level 3a violation for encouraging the patient not to have an epidural, but instead to remain on I.V. pain medication. The case was dated November 2006.

At 8:34 p.m., the patient was counseled by Nurse Jahnava Erickson regarding an epidural versus an imminent delivery. [Hearing Ex. 4C (chart) at 59.] Sometime after 8:30, the patient refused to push and demanded an epidural. [Hearing Ex. 4C at 16.] However, at 9:40 the patient requested IV fentanyl. [Hearing Ex. 4C at 58.] At 10:34, the patient again was counseled about an epidural versus an imminent delivery, and stated she wanted the epidural. [Hearing Ex. 4C at 59.] Five minutes later, at 10:39, an anesthesia consult was ordered. [Hearing Ex. 4C at 60 (Dr. McCall paged).] Eleven minutes thereafter, the baby delivered. [Hearing Ex. 4C at 60.]

No one alleged a breach of he standard of care in this case.

6. MR 457179.

Of the fifteen Providence cases, this was the only one assigned a Level 7, defined as a breach of the standard of care with adverse patient impact. [Hearing Ex. 37 at 1 (only Providence Level 7); Hearing Ex. 29 at 17 (definition of Level 7).] The case was dated February 13, 2004.

In this case, gynecological surgery was performed, and the MEC was told that Dr. Murphy had lacerated the patient's uterus. [Hearing Ex. 32, 8th page.] However, Dr. Matthew Lindemann, who was assigned by the OB/GYN department to review the case [Tr. 221], testified he had "no problem" with the ureter injury; the fact of the injury, according to Dr. Lindemann, did not breach the standard of care. [Tr. 226.] He testified that if Dr. Murphy visualized the ureter, then there was no breach at all, but if she did not, then there would have been a breach. [Tr. 230-31.] However, he stated he did not know whether Dr. Murphy had actually injured the ureter. [Tr. 259-60.] He said his "impression" was that "it's possible" there could have been a delayed thermal injury, not a lacerated ureter. [Id.]

Dr. Sinkhorn testified that the standard of care did not require visualization of the ureter.

> Well, my reaction is that we do a lot of gynecological surgery and we do a lot of obstetric surgery, too, including the case I did Monday where we don't visualize the ureter. You don't have to visualize the ureter. [Tr. 420.]

Dr. Sinkhorn testified that " the standard of care was met." [Tr. 422.] Dr. Richey concurred:

> But from the standpoint of being managed, you know, through the course of the complications, I can't see where on a step-by-step basis, anything would have or should have been done differently than what was done. [Tr. 1264-65.]

Dr. George Stransky, who testified he has worked with Dr. Murphy on gynecologic surgeries, described Dr. Murphy as an "excellent surgeon." [Tr. 1720.] "She's an excellent surgeon. She has good hands. She doesn't seem to have complications." [Tr. 1720.]

7. MR 772698/ MR 779799.

This case, dated June 30, 2008, was assigned a Level 5 by Providence. The fetus was delivered at term and referred to the Neonatal Intensive Care Unit (NICU).

The OB/GYN department reviewer found maternal fever was due to chorioamnionitis, and that the "5 minute Apgar and rapid response of infant to resuscitation shows no significant acidosis." [Hearing Ex. 37 at 122.] The departmental review was conducted by Dr. Owen Bell, who testified:

> I mean, all I know, as far as peer review, is sort of the cases I've been involved in, the ones that I've reviewed of Dr. Murphy's I haven't had a problem with. [Tr. 1878.]

Dr. Bell described Dr. Murphy as "a competent physician," [Tr. 1879], who had been subject to "the kind of scrutiny [where] you're going to get more things picked up." [Tr. 1878.]

Providence did not allege a breach of the standard of care. [Hearing Ex. 37 at 1 (Level 5 assigned); Hearing Ex. 29 at 17 (Level 5 ("[s]tandard of care met").]

8. MR 634880.

On April 27, 2008, the patient was driven to Anchorage from Seward by her mother while pregnant. Providence assigned the case a Level 5. [Hearing Ex. 37 at 1.]

Providence sent to the case for outside review. One reviewer, Dr. Thomas Strong, found no breach and concluded that Dr. Murphy's care "was reasonable." [Hearing Ex. 37 at 115.] The other reviewer, Dr. Kerri Parks, stated "it was poor judgment for Dr. Murphy to not have [the patient] transferred to PAMC from Providence Seward Medical Center (PSMC) by air transport." [Hearing Ex. 37 at 116-17.] Dr. Parks also criticized Dr. Murphy for the decision to send the patient home when the patient was having contractions and her cervix was dilated. [Hearing Ex. 37 at 117.] The patient lives in Seward, Alaska, about 120 miles from Anchorage.

While the patient did not testify, she forwarded a letter stating that Dr. Murphy did not send her home to Seward, as Dr. Parks alleged, but instead "told me it would be a good idea to stay in town [Anchorage] in case that happened [labor beginning over the weekend." [Hearing Ex. K2.] The patient wrote: "I chose not to stay in town." [Id.]

That weekend, the patient went to Providence Seward where she was seen by Dr. Don Hudson, an emergency room physician. [Tr. 1888-89.] Dr. Hudson testified he contacted Dr. Murphy, and together they decided the patient's mother would drive her to Anchorage. [Tr. 1891.] The trip occurred without incident and the patient delivered at Providence in Anchorage without difficulty. When asked about Dr. Parks' criticism that the patient should have been transferred by air transport, Dr. Hudson – a pilot for 30 years –

stated:

> She's an idiot. That person [Dr. Parks] is an idiot. I mean, we have already killed a bunch of people in airplanes and helicopters. I as a pilot, I as a physician, am not putting one of my patients in an airplane or a helicopter when it's unsafe, end of discussion. [Tr. 1892.]

Dr. Hudson testified the weather conditions that day were "snowing sideways. I can't even see the windsock, because it's rattling around so bad . . .." Dr. Hudson recalled that the Providence emergency department reviewed the case and "[f]rom what I understand, kind of secondhand, passing it back to me, that it was okay and they thought it was a reasonable transport." [Tr. 1894.]

9. MR 449138.

This case, dated February 28 and March 2, 2008, was assigned a Level 5 (standard of care met) and Level 3a (behavior related issue) by Providence. [Hearing Ex. 37 at 1.] The patient was admitted to the hospital after an elective termination of pregnancy in Dr. Murphy's office. The case was sent by Providence for external review.

One reviewer, Dr. Thomas Strong, was critical if, but only if, Dr. Murphy lacked the necessary equipment in her office, which Dr. Strong listed in his report. [Hearing Ex. 37 at 100.] Dr. Murphy had all such equipment, and in fact her office is National Abortion Federation (NAF) certified, meaning she must have such equipment. [Hearing Ex. H1.]

The other reviewer, Dr. Kerri Parks, criticized Dr. Murphy for not performing the procedure in a clinic such as Planned Parenthood or in a hospital. [Hearing Ex. 37 at 102.] Again, however, Planned Parenthood's clinic has the same type of equipment available in Dr. Murphy's NAF-certified office. [Hearing Ex. H1.]

10. MR 263197.

Providence assigned a Level 3a (behavior-related issue) to this case, alleging Dr. Murphy did not respond to an emergency room call in the time prescribed (30 minutes) on August 10, 2006. As a result, the MEC suspended Dr. Murphy's privileges for three years effective August 30, 2006. [Hearing Ex. L1.]

Dr. Murphy asked for a hearing. [Hearing Ex. L2.] The hearing was scheduled for September 18, 2006. [Hearing Ex. L4.] Following an investigation but prior to the hearing date, Providence sent a letter to counsel for Dr. Murphy that stated Providence was reinstating her privileges effective the day of the suspension:

> Pursuant to your attorney's directive, we are sending this letter by e-mail to him for distribution to you. The purpose of this letter is to inform you of the Medical Executive Committee's ("MEC") decision to rescind its three year suspension that you were informed of on August 30, 2006. [Hearing Ex. L6 (emphasis added).]

Dr. Murphy's privileges were "restored to the status quo of August 30, 2006 . . .," the day of the suspension. [Id.]

The Providence letter stated that a stipulation should be drafted between counsel for Providence and Dr. Murphy so that there would be "no further misunderstandings." [Id.]

The case had to do with the refusal of a hospitalist, Dr. Elise Brown, to admit a patient of Dr. Murphy's to the emergency room. [Hearing Ex. L9.] Dr. Cliff Merchant, on the Providence emergency department staff, after speaking with Dr. Murphy, requested that Dr. Brown admit the patient; the patient had acute renal failure. [Id.] Dr. Brown declined to admit the patient. [Id.]

The request from Dr. Merchant to Dr. Brown was between 4:30 and 5:30 p.m. [Id.] The call to Dr. Murphy at issue was at 7:40 p.m. from Dr. Janet Smalley. [Hearing Ex. L12

at 1.] Dr. Murphy arrived at the emergency department at 8:10, 30 minutes later. [Hearing Ex. L12 at 2.]

No one at Providence looked into Dr. Brown's conduct. [Tr. 1232.] According to Dr. Sinkhorn:

> I don't know what the hospital did with Dr. Brown, and maybe they did the correct thing. But if they did nothing, I certainly fault the hospital for that, and I do fault Dr. Brown for not accepting the patient. [Tr. 837.]

11. MR 745731/MR 757738.

In this case, dated July 23, 2007, Providence assigned a Level 3a (behavior-related issue) on a charge that Dr. Murphy spoke negatively about a colleague to a medical student. [Hearing Ex. 37 at 1 (Level 3a).] Dr. Murphy testified she had a discussion with the medical student about whether she and Dr. Matthew Lindemann had been correct that the patient had suffered severe preeclampsia, and that in hindsight she thought the patient had not had the condition. [Tr. 1872-73.] The conversation was at a nurse's station, and Dr. Murphy said that if she had it to do over again, she probably would have had the discussion in a more private setting. [Tr. 1873.]

C. The remaining ARH cases.

The three ARH cases relied upon by Providence and not discussed above all were assigned a Level 6 by Providence. Those cases are MR 38-82-16, MR 35-43-82 and MR 35-55-67. [Hearing Ex. 37 at 1 (all assigned Level 6).

In MR 38-82-16, Dr. Robert Davis, retained by ARH as an outside reviewer, found that the "case was rendered adroitly and expertly." [Hearing Ex. 37 at 152.] Dr. Davis found the standard of care had been met. [Id.]

In MR 35-43-82 , Dr. Kathleen McGowan, retained by ARH as an outside reviewer, found "[t]he standard of care was met in this case." [Hearing Ex. 37 at 172.] In MR 35-55-67, Dr. McGowan found the standard of care was met. [Hearing Ex. 37 at 159.]

Both the MR 35-55-67 and MR 35-43-82 cases were litigated at the State Medical Board hearing in 2005. While MR 38-82-16 had been relied upon by ARH, the State Medical Board did not present it at the hearing for consideration. The hearing officer concluded in both cases that were presented (MR 35-55-67 and MR 35-43-82) there was no showing of a breach of the standard of care. [Hearing Ex. M1 at 29, 33.]

III. Comparison with 29 Other Providers.

Providence prepared a statistical analysis of the 30 physicians in the Providence OB/GYN department and concluded there had been not a single behavioral issue for a span of six years in the entire department except by Dr. Murphy, who had 100 percent of all 3a violations 2003 through 2008. [Hearing Ex. 32, 3rd page (100% of 3a violations 2003 - 2008).] Dr. Sinkhorn testified this was not credible:

> And I don't know, I've never seen a hospital like that either where 20 or 30 are always on their best behavior for a decade and only one doctor has all seven [3a] reports. [Tr. 406.]

Dr. Sherrie Richey testified that Dr. Murphy had been subjected to biased and unfair scrutiny:

> But I do feel like that if the hospital can, in my mind, somewhat arbitrarily remove and investigate people to the degree that Dr. Murphy has been investigated and has been dealt with from the standpoint of hospital privileges, I felt that, like I said, there but for the grace of God would go any of us. . . . I felt like ethnically I should say something in regard to what I left was in a lot of ways unfair treatment [of Dr. Murphy]. [Tr. 1254-55.]

Dr. Murphy requested the underlying data showing how the statistical analysis

prepared by Providence was derived. Providence, through its attorney, refused to provide the data, [Dickson letter, attached], and then went on to rely upon the conclusions Providence reached from this same data as a central argument for why Dr. Murphy's privileges should be revoked.

IV. Practice Patterns.

With regard to practice patterns as alleged by Providence, Dr. Murphy was not terminated from the Alaska Native Medical Center (ANMC) over anything having to do with the practice of medicine. She identified the institution's failure to report disciplinary actions to the State Medical Board and to the National Practitioner Data Bank and was involuntarily transferred out of state. A report by an Inspector General later corroborated her claim.

After her privileges were suspended at ARH, the matter went to a formal hearing in 2005 after which it was found there was insufficient evidence to conclude she had breached the standard of care in any case at issue. [Hearing Ex. M1.]

While Providence sent Dr. Murphy to the Menninger Clinic for a fitness for duty evaluation, no actual fitness for duty evaluation was performed. Instead, Menninger performed a psychological evaluation, which did not address her fitness for duty as a physician.

The Menninger discharge summary noted that it was not addressing this issue. [Hearing Ex. 33 at 6.] "[T]here is some concern about standard of practice as well but this is beyond the capabilities of this assessment to accurately address." [Id.]

Dr. David Sperbeck, Dr. Murphy's treating psychologist, testified at the hearing that Dr. Murphy has no problems functioning as a physician, and has provided a letter stating that Dr. Murphy has been "unfairly maligned." [Sperbeck letter, attached.]

Letters from Drs. Sinkhorn, Richey and Parer also are attached, as is the pre-hearing letter from Providence's counsel declining to share the data Providence complied against her, together with Dr. Jack Jacob's dissent in the Hearing Committee Report.

DATED at Anchorage, Alaska this26th day of May, 2009.

TINDALL BENNETT & SHOUP
Counsel for Dr. Colleen Murphy

By: _____
David H. Shoup

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

DEFENDANT
EXHIBIT NO. M1
ADMITTED ☐
Murphy
(CASE NUMBER)

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. Background and Prior Proceedings

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

[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.2475] 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. Bierlein, 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

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[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 perinatology[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. 517-526] 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 oscillated, 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.

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[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

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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.[33]

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

[33] 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 (Richey 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 any 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, unless there is a compelling and justifiable reason." [*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 review, 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 bradycardia indicates present or impending acidemia), experts "had difficulty reaching consensus on appropriate definitions of certain heart rate patterns...It is impossible to reach consensus on the presumed fetal condition or obstetric management of all other patterns intermediate between the two [exceptions noted]." 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 bradycardia, with absent fetal heart rate variability.

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 resumé 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: _____
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 _____ day of _____, 2005.

By: _____
Signature

_____
Name

_____
Title

Non-Adoption Options

1. The undersigned, on behalf of the Alaska State Medical Board and in accordance with AS 44.64.060, declines to adopt this decision, and instead orders under AS 44.64.060(e)(2) that the case be returned to the administrative law judge to:

☐ take additional evidence about _____;

☐ make additional findings about _____;

☐ conduct the following specific proceedings: _____.

DATED this _____ day of _____, 2005.

By: _____
Signature

_____
Name

_____
Title

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2. The undersigned, on behalf of the Alaska State Medical Board and in accordance with AS 44.64.060(e)(3), revises the enforcement action, determination of best interest, order, award, remedy, sanction, penalty, or other disposition of the case as follows:

DATED this _____ day of _____, 2005.

By: _____
Signature

_____
Name

_____
Title

Hearing Panel Findings & Recommendation
From the Hearing for Colleen Murphy, MD

Hearing Panel Members Present:

Leslie Bryant, MD (Family Medicine)
Aaron Johnson, MD (Pediatric Neurology)
Richard Navitsky, MD (Emergency Medicine)

The issue to be addressed by this panel (per MS 980-100)is to determine if the recommendations and the actions taken by the Medical Staff and Hospital in the case of Dr. Colleen Murphy:

(1) involve substantial procedural compliance with this Fair Hearing Plan,
(2) are not arbitrary or capricious, and
(3) are supported by substantial evidence.

The primary question is whether the recommendation for Dr. Murphy to "undertake additional obstetrical training at a busy, academic training hospital.... as a junior resident...for a minimum of three months" was arbitrary, capricious or not supported by substantial evidence.

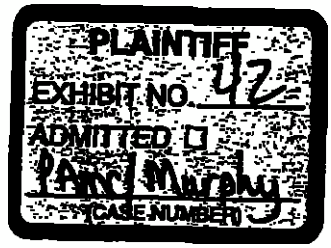
I. **Panel Conclusions:**

1. The recommendation (labeled as Recommendation two, item 2 A-E) is arbitrary and not supported by substantial evidence. None of the evidence or witnesses could provide information regarding this type of retraining in any specialty. There is no precedent for this kind of remediation within her specialty. It does not appear that this type of remediation is readily available in an academic center. In any event it would not serve to address the perceived deficiencies that lead to this whole process. It therefore serves as an insurmountable barrier to successful reinstatement.

2. The termination of Dr. Murphy's staff membership at the time her state medical license was required by Bylaws (MS 980-100, - Automatic Suspension part VI, Section 2A) so no fault was found with that action.

3. Reassessment of Dr. Murphy's qualifications for privileges upon her reapplication for staff membership was justified in light of adverse action by another facility and by the fact that the State of Alaska Medical Licensing Board had revoked her license, even though that decision was subsequently overturned.

4. The exact conduct that was deemed inappropriate and warranting sanctions was never clearly elaborated. It was not clear if the initial charge was due to "errors of judgment", or due to concerns about "professionalism and interpersonal relations, or a combination of the above. The peer reviewers did not reach a consensus on the exact nature of her deficiencies.



5. The imposition of some form of probationary requirements was reasonable because sufficient evidence was presented to indicate that:

   a. Dr. Murphy's clinical judgments about when to perform cesarean delivery during high risk deliveries were perceived by a number of peer reviewers to deviate from community standards, although there were discrepancies.

   b. The frequency with which she did not respond to pages or was otherwise unavailable was also perceived by the peer reviewers to be excessive.

   c. She failed to ensure adequate back up coverage and time off to prevent impairment by fatigue.

   d. She had consumed alcohol while on call.

II. <u>Proposed Reasonable Alternatives to the Recommendation</u>:

1. Concurrent proctoring of patient care without exclusion of any qualified volunteer preceptors.

never done

2. Outside retrospective review of some or all of her obstetrical cases, with reviewed cases blinded to the outside reviewers by the inclusion of similar cases handled by other local obstetricians.

III. <u>Further Stipulations Modifying the Remaining Requirements Regarding Remediation:</u>

1. A list of the specific deficiencies to be monitored by obstetrical peers must be made available to Dr. Murphy and her proctors. This does not preclude the proctors from identifying and addressing other deficiencies brought to light during the probationary period. The same standard needs to be applied in addressing newly discovered problems however. This means that the perceived deficiency must be clearly defined and presented to Dr. Murphy so she knows what is expected of her.

2. The same standards (for example, 10 minute response to page, 30 minutes to presence in hospital) must be applied to all members of her department. If this is found not to be possible, then these requirements must be changed.

2. The duration of probationary status must be defined.

3. Subsequent suspension of privileges for violation of response time should be implemented in a reasonable fashion not deleterious to patient care, and with provision for suspension to be waived if reasonable mitigating circumstances are involved as determined by the department chair.

IV. <u>The panel had several additional concerns related to the process that lead to restrictions being placed on Dr. Murphy's privileges:</u>

1. These concerns have to do with fair process. We should all be aware that we are fallible, and that events such as these could befall any of us.

2. It is vital that evidence to support allegations of a subjective nature such as "poor communications" and "unprofessional conduct" be documented with the greatest of care and clarity. Great lengths should be taken to avoid the inclusion of hearsay evidence. Given the sensitive nature of many of these matters, they will not often be documented in patient records and evidence will rely on the testimony of witnesses. Such testimony needs to be taken under oath and recorded exactly. Communication problems ALWAYS involve two or more parties and responsibility for them is usually shared.

3. The Credentials Committee or any other body involved in due process should never exclude favorable expert testimony from consideration, as was done in this case.

4. Peer review of physician charts must be done equitably. Differences in practice style, response times, and adherence to patient preferences exist and are healthy. Reviews should include similar cases of other department members.

5. In the case of Dr. Murphy, the recommendation to pursue outside training appears to have no rehabilitative purpose. It only appears to be a means to humiliate and punish her.

6. Ultimately, "Due Process" is intended to insure fairness.

Thank you,

Richard Navitsky, MD
Chair of the Hearing Panel

Leslie Bryant, MD
Hearing Panel Member

Aaron Johnson, MD
Hearing Panel Member

Providence | Alaska Medical Center

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September 20, 2006

mailed certified 9/20/06
7000 0520 0019 1755 7470

Dr. Colleen Murphy
4150 Lake Otis Pkwy., Ste. 330
Anchorage, AK 99508

Dear Dr. Murphy:

Pursuant to your attorney's directive, we are sending this letter by e-mail to him for distribution to you. The purpose of this letter is to inform you of the Medical Executive Committee's ("MEC") decision to rescind its three year suspension that you were informed of on August 30, 2006. Your privileges are restored to the status quo of August 30, 2006 with all conditions remaining in place for both your gynecological and obstetrical privileges as outlined in our letters of February 23, 2006 and May 26, 2006.

As discussed between our attorney, Anne M. Preston and your attorney, David Shoup, on or before Friday, September 22, 2006, the two attorneys will meet for the purposes of drafting a detailed Stipulation which will delineate and clarify the parameters of your continued practice at Providence Alaska Medical Center so there are no further misunderstandings. After your review and our review of the Stipulation, we both will sign it and the Stipulation will supersede the letters of February 23, 2006 and May 26, 2006 with respect to the conditions placed upon your gynecological privileges and obstetrical privileges.

We will make a report to the State of Alaska regarding the recession of the August 30, 2006 letter. No report was made to the National Practitioner Data Bank as the 30 day window to make a report had not yet expired.

If you have any questions and your attorney agrees, please do not hesitate to contact to contact me or Dr. Eric Taylor.

Sincerely,

Bruce Lamoureux

Bruce Lamoureux
Administrator
Providence Alaska Medical Center

David J. Sperbeck, Ph.D.

A.K. Cert. AA0233

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Licensed Clinical Psychologist
Fellow, American College of Forensic Psychology
Fellow, National Academy of Neuropsychology
Member, American Psychological Association

April 30, 2009

Re: Colleen Murphy, M.D.

To Whom It May Concern:

I am writing this letter of support and recommendation on behalf of Dr. Colleen Murphy in response to the recent actions taken against her by the Providence Alaska Medical Center (PAMC) Medical Advisory Board. In this recent action, Dr. Murphy's inpatient OB/GYN privileges were summarily and permanently suspended, in part based upon an evaluation conducted by Janet Hickey, M.D. of the Menninger Clinic. Dr. Murphy had been ordered by the PAMC to attend and participate in a professional fitness for duty to be conducted by the Menninger Clinic in October 2008.

I am a clinical and forensic psychologist with nearly 25 years experience serving as the formally designated psychological expert witness for the State of Alaska Court System in all criminal matters from 1982-2006. I have served as the chief psychological and ethics consultant in psychological and psychiatric fitness for duty matters for the State of Alaska Department of Commerce and Licensing for over 20 years. I have been contractually retained by the Alaska Medical Board, the Alaska Psychology Board, the Alaska Bar Association, the Alaska Marine Pilots Association, and several other professional boards to conduct psychological fitness for duty evaluations on behalf of these licensing and regulatory bodies.

I have been treating Dr. Colleen Murphy for work and family stress for the past four years. Dr. Murphy has consistently and vigilantly pursued any and all psychological and self-improvement therapy techniques requested of her.

As part of the Menninger Clinic assessment, I was asked to provide my input and insights into Dr. Murphy's diagnosis and response to treatment. I was interviewed by a medical student and a 2nd year psychiatry resident, both of whom misinterpreted and/or misunderstood/misquoted my remarks. I was later interviewed by Dr. Janet Hickey, whom I later discovered has been practicing for less than one year since the completion of her residency. Dr. Hickey diagnosed Dr. Murphy as suffering from a non-specific personality disorder and offered the prognosis that Dr. Murphy had little chance of ever changing her abrasive interpersonal style. Dr. Hickey further opined that Dr. Murphy was severely disabled in her Global Assessment of Functioning. Dr. Hickey rendered the opinion that Dr. Murphy failed to follow through with recommended psychological interventions.

I have met with Dr. Murphy in person for more than 100 hours over the past 4 years. I could not disagree more with Dr. Hickey's diagnostic and prognostic assessments of Colleen Murphy, M.D. Dr. Murphy does not meet even the most subjective diagnostic criteria for a personality disorder. Even the Menninger Clinics own psychological testing failed to support this diagnosis. The notion that Dr. Murphy is incapable of change is baseless in fact and gratuitous to say the least. This woman has demonstrated significant changes in her interpersonal communications and practice management behaviors over the past several months. It is a sign of extraordinary inexperience for a psychiatrist or any other mental health professional to render the opinion that

a client with whom they have had brief and superficial contact is incapable of substantive change. Finally it is noteworthy that I spoke to Dr. Hickey on the final day of Dr. Murphy's clinic stay. Dr. Hickey absolutely and unconditionally agreed with me that Dr. Murphy needed no further treatment other than weekly ongoing supportive counseling to deal with the professional stressors in her life brought about by the ongoing PAMC questions about her fitness for duty.

Dr. Murphy is a strong, dynamic, charismatic woman who practices with compassion, care, caution, and passion. She is the antithesis of disabled. Rather, she has managed to work 65-70 hours per week with no coverage for the past five years. She has been on-call 7 days per week, 24 hours per day 365 days per year. She has, during this time, managed to not only maintain a busy and diverse practice, but also raise two very well-adjusted, high-achieving, and bright children, while managing to balance her work responsibilities with her marital and family commitments.

In my opinion, Dr. Murphy has been unfairly maligned but has graciously and dutifully followed through with seemingly endless demands to prove her capacity to practice medicine.

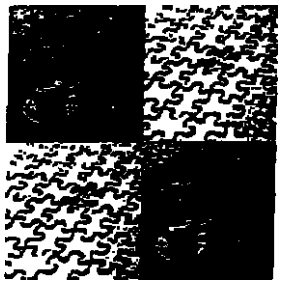
Colleen Murphy, M.D. is unconditionally competent and psychologically fit to practice medicine at this time.

Sincerely,

David J. Sperbeck, Ph.D.
Licensed Clinical Psychologist (#AA0233)

Fellow, National Academy of Neuropsychology
Fellow, American College of Forensic Psychology

Associate Clinical Professor of Psychiatry
University of Washington School of Medicine



C. Paul Sinkhorn, MD, FACOG
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cpaulsinkhorn@earthlink.net

April 29, 2009

Dr. Norman Gant
Executive Director, ABO+G
The Vineyard Center
2915 Vine Street
Dallas, TX 75204

Dear Dr. Gant,

I am writing in support of Dr. Colleen Murphy's application for Maintenance of Board Certification, recently placed in suspense due to a credentialing action at Dr. Murphy's hospital in Anchorage, Providence Alaska Medical Center (PAMC). Last year I became acquainted with Dr. Murphy when I defended her in a medical malpractice case; that case was dropped after my report explained that Dr. Murphy had complied with the appropriate standard of medical care. Dr. Murphy and her attorney again contacted me for assistance when she ran into difficulties with PAMC's Medical Executive Committee. The MEC had decided to remove Dr. Murphy's OB/GYN privileges, and Dr. Murphy requested an appearance before a hearing panel. The latter consisted of a neonatologist (who found in Dr. Murphy's favor), an emergency department physician (who found against Dr. Murphy), and an anesthesiologist (who found against Dr. Murphy). A cynic might note that the latter two doctors have financial contracts with the hospital.

Since the hearing panel found against Dr. Murphy, the decision to revoke her privileges at PAMC stood. Dr. Murphy does have another right of appeal; she is weighing her options at this time. Regardless, she does intend to continue to practice obstetrics and gynecology in Anchorage, and wishes to maintain her board certification. I believe this to be reasonable, for the reasons that I outline below.

I defended Dr. Murphy in the recent Medical Staff hearing, and reviewed 27 different cases culled over the past 10 years from Dr. Murphy's practice at two hospitals. These cases were alleged to show improper practice patterns. Instead, what they showed was impatience on the part of nurses and competing physicians with Dr. Murphy's cesarean rate (~15% primary, compared with a hospital average of ~43%, by far the highest in all of Alaska. One physician on staff at PAMC has a 70% section rate, and two others exceed 60%), and with her outspoken advocacy of women's reproductive rights. PAMC is a Catholic institution, run by a very strong administrator (who personally signs Medical Executive Committee documents, even though he is not a physician), and there is a predictable unfriendliness to any mention of sterilization, abortion, or contraception. If Dr. Murphy is guilty of anything, it is that she doesn't reliably follow Catholic dogma and/or keep her opinions to herself.

In the abovementioned MEC trial I was on the witness stand for two days and, out of 27 charts, found only one where there was even a question of judgment. I explained to the panel that it was highly unusual that every single episode of a "behavioral problem" over the past 5 or more years at PAMC, in a department of more than 30 OB/GYNs, was attributed to Dr. Murphy; not a single other doctor "misbehaved" during those years. I also pointed out that section rates of 40-70% are on the high side, and should be investigated to make sure patient safety is not being threatened. Yet PAMC has never initiated any program to control, or even investigate, its high section rate. This entire action was one of the more blatant instances of sham peer review that I have encountered. Dr. Julian Parer (from UCSF) also testified at the hearing that Dr. Murphy was within the standard of care on all of the cases that he reviewed, and that any action against her privileges was unwarranted. Nonetheless, Dr. Murphy was outvoted 2-1 and has now lost her credentials at PAMC. I would respectfully encourage your committee to find in favor of Dr. Murphy and allow her to proceed with her application for maintenance of certification.

I am a board-certified obstetrician-gynecologist licensed in California and Arkansas. My obstetric and peer review qualifications are partially based upon my experience as: a faculty member (Clinical Professor) at University of California, Riverside Haider School for Biomedical Sciences; a faculty member at Arrowhead Regional Medical Center (the county hospital for the County of San Bernardino); a faculty member (Clinical Associate Professor) at Western University of Health Sciences, Pomona, California; a faculty member at Touro University in Nevada (Adjunct Assistant Professor); a faculty member (Assistant Clinical Professor) at UCLA Geffen School of Medicine; and a past co-director of a Family Medicine residency in OB/GYN at University of Illinois.

Additionally, I have served as chairman of the Professional Liability Committee for the Riverside County Medical Society and currently co-chair the Medical Review Advisory Committee for the San Bernardino County Medical Society. I served as a medical staff reviewer for the Institute for Medical Quality branch of the California Medical Association for 12 years, working with the California Department of Health Services and the Joint Commission for Accreditation of Healthcare Organizations to certify hospital medical staffs for the State of California and for the federal government. I also currently serve on my hospital's Medical Executive Committee, Department of Women's Health peer review committee, and Quality Management Committee. I chair my hospital's Credentials Committee, Information Management Committee, and Utilization Review Committee. I also previously chaired the Credentials Committee at Riverside Community Hospital.

Thank you, Dr. Gant, for your honest and fair appraisal of Dr. Murphy's qualifications to remain a diplomate of our Board.

Respectfully yours,

C. Paul Sinkhorn, MD, FACOG
Vice-Chair, Women's Health Dept.
Arrowhead Regional Medical Center

Alaska Perinatology Associates

APA

April 27, 2009

Norman Gant, MD
The Vineyard Centre
2915 Vine Street
Dallas, TX 75204

Dear Dr. Gant,

This letter is in support of Dr. Colleen Murphy, who is an applicant for Maintenance of Certification for 2009. Her approval has been pended on the basis of what I believe to be an extremely unfair and biased suspension of her privileges at Providence Alaska Medical Center, where I am the Medical Director of Perinatal Services and the Medical Director for Maternal Transport for LifeMed Air Ambulance Service. I have known Dr. Murphy for 15 years and am in a unique position as the only perinatologist in Alaska to comment on her practice of medicine and the standard of care in the community.

Dr. Murphy's troubles began when a few power hungry physicians began to persecute her on the basis of a few incident reports that were of no particular clinical consequence. Because she has made some enemies in the Sisters of Providence System due to her staunch support for women's reproductive rights, she was unfairly subjective to a 100% chart review. 15 charts were pulled and were reviewed in detail by myself and by an outside expert reviewer. Both of us concluded that there were no breaches of the standard of care in any of those cases. A panel of the hospital's choosing took testimony in Dr. Murphy's appeal, and they voted to uphold the suspension of her privileges by a 2 to 1 vote. The dissenting opinion was from Dr. Jack Jacob, a neonatologist who was the first neonatologist in Alaska and the only maternity center panel member in any position of familiarity with Dr. Murphy's care. He provided a long document arguing why Dr. Murphy's privileges should be reinstated, and the other two physicians on the panel did not give any arguments as to why they felt her suspension of privileges should be upheld.

I have worked with Dr. Murphy over many years, and this is a politically driven and unjust action on the part of the hospital, which in my opinion should be litigated. At any rate, I wished to express my support of Dr. Murphy's continued ability to practice medicine, and wanted to express to you my support of her. Please feel free to contact me with any further questions. Thank you very much for your consideration.

Sincerely,

Sherrie D. Richey MD-FACOG-MFM
President, Alaska Perinatology Associates
Medical Director of Perinatal Services
Providence Alaska Medical Center

6/17/08

To: Kim Pakney, CPCS, CPMSM
Medical Staff Services
Providence Alaska Medical Center
Anchorage, AK

At Dr. Colleen Murphy's request, I have reviewed limited documents in the case under review at her hospital in Anchorage. She asked me to review the FHR tracings on the case, and comment on the report by 2 experts reviewing for the QI Committee, Dr. Thomas Strong of Arizona, and Dr. Kerry Parks of Los Angeles:

My review of the FHR tracing shows normal, retained variability until very close to the time the patient was delivered by c-section. This correlates highly with absence of hypoxia and significant acidemia. The experts suggests that standard of care required a c-section at 3:30 am or 4:30 am (the experts differ on the time) on the day of the birth. I disagree strongly with their conclusion and I believe their FHR interpretation is dated and primitive. Indeed one even uses terminology not in accordance with the now well accepted NICHD Consensus Conference on FHR Monitoring (1997), and recently reconfirmed in a further consensus meeting.

A major criticism I have of the management of the case is that after FSE became detached, that the extended device gave uninterpretable data, and an FSE should have been placed. Thus was the responsibility if the nurse in attendance, who was reading the tracings and looking after the patient.

I understand that this case is being based to support withdrawal of Dr. Murphy's privileges. If you want to persist in this endeavor I would suggest an expert or experts who are familiar with current standard of care with regard to FHR monitoring. The experts you have used are certainly not familiar with current interpretation. I would be happy to give you a full opinion after a more complete review of the records.

Sincerely,

J.T. Parer, MD, PhD

DEFENDANT
EXHIBIT NO. B3
ADMITTED ☐
Murphy
(CASE NUMBER)

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F.H.

BRUCE E. GAGNON
ROBERT J. DICKSON
W. MICHAEL MOODY
PATRICK B. GILMORE
RICHARD E. VOLLERTSEN
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OF COUNSEL
JOHN M. CONWAY
KENNETH R. ATKINSON

January 22, 2009

RECEIVED
JAN 23 2009
TINDALL BENNETT & SHOUP

David H. Shoup, Esq.
Tindall Bennett & Shoup, PC
508 W. 2nd Ave., 3rd Floor
Anchorage AK 99501

Re: Dr. C. Murphy

Dear Dave:

This will respond to requests from Dr. Murphy to the hospital for information sought in connection with her peer review hearing in March. We are referring to her letter to Mr. Lamoureux dated December 28, 2008 which she most recently resubmitted on Tuesday, January 20.

The focus of the hearing is on Dr. Murphy's care. The care provided by other physicians is not a material factor in the decisions to be made. The fact that other physicians may have engaged in similar conduct or care has been held to be irrelevant and inadmissible. Smith v. Ricks, 798 F. Supp. 605, 610 (N.D.Cal. 1992); Woodbury v. McMinnon, 447 F.2d 839 (5th Cir. 1971); and Peterson v. Tucson Gen. Hosp., 559 P.2d 186 (Ariz. App. 1976). Consequently, Providence declines to provide the peer review information pertaining to the other physicians sought by Dr. Murphy in her letter of December 28, 2008.

If we have misunderstood her request or there is some other aspect you would like us to consider, please let us know.

Please ask Dr. Murphy to direct her requests for information through your office so that there is one channel of communication between Dr. Murphy and the hospital medical staff services office.

Very truly yours,

ATKINSON, CONWAY & GAGNON

By
Robert J. Dickson

DEFENDANT
EXHIBIT NO. N3
ADMITTED ☐
Murphy
(CASE NUMBER)

Dissenting Opinion

I respectfully disagree with, and dissent from, the opinion of the majority of the Committee members.

I find and conclude that the MEC's recommendation to permanently revoke Dr. Murphy's hospital privileges at Providence is not supported by substantial evidence and is arbitrary.

First, with respect to most of the cases discussed at the hearing, I find that Dr. Murphy's evidence established that there was no breach of a national standard of care, and that there was no pattern of poor clinical judgment on Dr. Murphy's part. While some of Providence's witnesses testified to the contrary, I found Dr. Murphy's witnesses, particularly Drs. Sherrie Richey, Julian Parer, and the reports of other maternal fetal medicine specialists hired by Providence, to be generally more credible than the testimony of Providence's witnesses. To me the disagreement among many experts and clinicians, especially as it relates to decisions for cesarean intervention, speaks to the variation in acceptable practice and does not represent a breach in the standard of care.

Second, I have concerns that the staff's "Power Point" presentation of the cases to the MEC at its September 18, 2008, meeting was in part inaccurate, was biased, and lacked the integrity and rigor called for considering the seriousness of the decision. (Exhibit 32). Specifically, the five-minute APGAR score in Hert / Pingree case was not below 6, as the slide indicated, but was actually a 7. Nor was a ureter lacerated in the Douglas case, as was erroneously described to the MEC on the slide. Apparently, corrected information regarding these cases was not presented to the MEC. In addition,

the presentation to the MEC on cesarean delivery rates lacked statistical validity, lacked national and local hospital comparisons, and was presented in a biased fashion. (Exhibit 32; testimony of Deb Hansen, Tr. At 1479). I am also concerned that Providence's peer review process within the obstetrics department resulted in the process increasing the "levels" assigned to certain cases by the initial reviewers. Thus, for example, the first reviewer in the Estell case rated that case as a Level 5. The rating was subsequently raised by the OB Risk Committee to a Level 6. (Exhibit 37; testimony of Deb Hansen, Tr. At 1485). Similarly, in the Croteau case, the initial review of the case resulted in a Level 5 rating. After a subsequent review by Dr. Siscoe, the Level was raised to a Level 6. (Exhibit 37; testimony of Deb Hansen, Tr. at 1487).

Finally, I find that Providence's peer review process was, to some extent, arbitrary in the sense that Dr. Murphy appears to have been subjected to intense scrutiny while such scrutiny and review were not extended to other members of the OBGYN Department. For example, I find it difficult to believe that Dr. Murphy would be the only physician in the department to receive behavioral complaints (3a) among physician members in the OBGYN Department between 2004 – 2008. (Exhibits 31 and 32; testimony of Deb Hansen, Tr. at 1461). This raises concerns about the even-handedness of such complaints.

More importantly, I find troubling the testimony of Dr. George Stransky and Dr. Sherrie Richey, both of whom are in positions of being knowledgeable on the subject of breaches in the standard of obstetric care at Providence, that other physicians had engaged in questionable judgment calls and actions regarding case management similar

to or worse than those of Dr. Murphy discussed at this hearing, but were not subjected to the same intense peer review scrutiny and disciplinary proceedings as was Dr. Murphy. (Testimony of Dr. Stransky, Tr. At 1722-1729; testimony of Dr. Sherrie Richey, Tr. at 1254). To the extent that Providence's peer review process is not being even-handedly applied and enforced with respect to all physicians at Providence and in the OBGYN Department, I find the process to be arbitrary.

On the other hand, I agree with the majority opinion that there is substantial evidence to support the MEC's contention that Dr. Murphy has communication and collegiality issues with nurses and other physicians at Providence that limit her ability to work collaboratively with her peers and staff.

I am also concerned with certain behavioral problems of Dr. Murphy, such as the instance where Dr. Murphy had apparently consumed alcohol while she was on call or was attending to a patient at Providence. (*See, e.g.*, the Kantor case). In this regard, I find credible Dr. Murphy's testimony that she has stopped using alcohol, has changed her work pattern, is participating in Alanon group sessions, and is under the helpful therapy of her psychologist, Dr. Sperbeck.

I also have concerns about Dr. Murphy's ability to change her behavior in the future. I find some evidence in the record which suggests an inability or unwillingness on Dr. Murphy's part to change her behavior. In this regard, I find Dr. Hickey's testimony and recommendation in her discharge summary that intense, in-patient treatment and therapy would be helpful. (Testimony of Dr. Janet Hickey, Tr. 1573; Ex. 33).

In light of my findings and conclusions in this matter, I would recommend that instead of permanently revoking Dr. Murphy's privileges, the temporary suspension of her privileges at Providence be continued for a sufficient period of time in order to allow Dr. Murphy to obtain the kind of in-patient treatment and therapy recommended by Dr. Hickey in the Menninger Clinic discharge summary. (Exhibit 33). Following such therapy, I would recommend that Dr. Murphy be re-evaluated for her "fitness for duty" as an OBGYN physician at Providence, and that Providence then re-evaluate the issue of Dr. Murphy's privileges.

I would also strongly recommend that Providence conduct an external review and evaluation of its UOR reporting process as it relates to physicians, its peer review process, case rating, and physician complaint and disciplinary process to ensure that these processes are being administered and enforced in an even-handed manner with respect to all physicians at Providence and its OBGYN Department.

DATED this 13th day of April, 2009.

Jack Jacob, M.D.

---- Original Message -----
From: Ed Weiss
To: 'Dr. Colleen Murphy M.D.'
Sent: Sunday, March 08, 2009 10:25 PM
Subject: Dr. Murphy

2/25/2009

To whom it may concern,

This letter is in reference to Dr Colleen Murphy.

My name is Mary Bennett Weiss. I have been a Registered Nurse for over 33 years. I have been employed at Providence Alaska Medical Center for 17 years as a staff nurse in Labor and Delivery .

I have known Dr. Murphy since she began working at Providence Alaska Medical Center. I know her through work. She is not my personal or family's physician. We have not socialized outside of work.

Dr. Murphy's patients speak highly of her. They respect her and her opinion. They and their families go to her for their care and she has delivered several babies on many of them.

Dr. Murphy has always been very involved in her patients care and their decisions regarding their care. I have never felt Dr Murphy made medical decisions for her personal gain (monetarily or to fit her schedule).

As a Charge Nurse in Labor and Delivery I was involved in a situation in which a staff RN said Dr Murphy had made several offensive remarks to a patient who delivered a preterm fetus that did not live. I went into the patient's room 2 times and spoke to the patient and her partner. Neither she nor her partner ever commented about any remarks that Dr. Murphy had made.

I had Dr Murphy and the RN go into a private area and discuss the situation. The RN still verbalized that the remarks Dr Murphy had made to the patient were inappropriate and she felt an Unusual Occurrence Report needed to be filed.

Since I did not hear the remarks nor had the patient complained to me in the several opportunities she was given I could not file the complaint. I advised the RN that if she felt an UOR was needed to be completed she would need to do the form.

I notified my Clinical Supervisor of the situation.

DEFENDANT
EXHIBIT NO. F3
ADMITTED

3/13/09

To whom it may concern:

On Feb. 2, 2008, I , was in Providence hospital under the care of your nurses and Dr. Colleen Murphy. I had my baby at home at just over 19 weeks of carrying around 5:15 am. The baby was wrapped in a blanket and none of your nurses bothered to check to see if she was moving. She still was moving her arms and legs.

Dr. Murphy made sure I was getting pain medicine, which takes time to work. She made sure I was doing okay under the circumstances. I was in pain because I had just home delivered a tiny infant, 8.8oz, and I was losing blood rapidly. I was exhausted and in pain, but I was being well taken care of by Dr. Murphy.

The tiny fetus lived for 2 hours about 7:30AM.

Sincerely,

To: Dr. Murphy

Fax #:

From:

3/21/09

To whom it may concern,

Dr. Murphy was my doctor when I was having my son. I went to Anchorage for my appointment on Thursday and we talked about how I had a Breech presentation and that my cervix had changed a little. We talked about trying to turn baby the following Wednesday and she explained that I could possibly go into labor over the weekend. She told me it would be a good idea to stay in town incase that happened. I chose not to stay in town. I did end up going into labor early Sunday morning and had to drive to Anchorage, which I didn't see a problem in. I was given a shot for my contractions and everything was good. Dr. Murphy met me at the hospital and did an ultra sound to see if baby had turned or not and we had to do a C-section. I had a perfectly healthy baby with no problems with him or me. I am now [redacted] again and have asked Dr. Murphy to be my doctor again for this one.

Sincerly,

21 PATIENT SUMMARY TABLE

Patient # (Date of Procedure)	Level assigned	PAMC synopsis	Chart records	Outcome	Met Standard of Care	Miscellaneous
#1 (2/13/04)	7 Significant departure from established pattern of clinical practice contributed to unexpected outcome	"Pt developed worsening lower abdominal pain after laproscopic RSO. Subsequent work-up revealed lacerated ureter. Did not check ureters intraop"	Laparoscopic adhesiolysis, RSO, + colonic pelvic adhesions (CMM @ PAMC)	2/2/05: Left Ureteroneocystostomy w/Psoas hitch, post-op wound hematoma, transfused, return to OR 2/7/05 (Lance & CMM @ PAMC)	Jack Jacobs Sherrie Richey Paul Sinkhorn	Malpractice case filed 2/9/06, Case Dismissed by Stipulation or Unopposed Motion 4/27/07.
#2 (4/17/05)	6 Significant Departure from Clinical practice. No adverse impact	"Fetal strip monitoring and delay to Csxn"	26 y/oG2P0 w/PPROM, Beta strep pos, antibiotics given, epidural & Pitocin augmentation, FSE dislodged in 2nd stage X 40 minutes, FSE reapplied by MD, Category 2 tracing @ complete & +2 station	Stat Csxn, 17 min incision to decision, 7#7oz female, Apgars 1/5/7, cord Ph 7.07,BE –9.5, pCO2 77, Baby extubated to room air @ 40 minutes, Baby's antibiotics DC'd @ 48 hrs, Mother & baby discharged home POD #3	Jack Jacobs Sherrie Richey Paul Sinkhorn Julian T Parer	I reported the case to Risk Management as a "near miss"
#3 (4/17/05)	6 Significant Departure from Clinical practice. No adverse impact	IUP at term with nonreassuring strip, failure to descend, failed vacuum extraction, and admission of depressed baby to NICU. Inappropriate use of vacuum extraction, delayed c-section	38 5/7 wks GA, SOOL, AROM @ 3 cm, epidural & Pitocin, intermittent decels, 2 + hr 2nd stage, left occiput anterior at +2 station, failed vacuum X 4 pulls.	21 minute interval to decision to incision for Csxn, 7#7oz male, Apgars 3/7, cord pH 7.03, pCO2 74, BE –13. Placenta showed marked chorioamnionitis with cord involvement. Baby required bag and mask ventilation at birth. A right-sided pneumothorax was diagnosed & was treated with 100% hood for 12 hours. Mother discharged breastfeeding POD #4. Baby hospitalized 7 days total.	Jack Jacobs Sherrie Richey Paul Sinkhorn Julian T Parer	Congenital pneumonia was diagnosed; blood cultures were negative, 7 days IV antibiotics given, discharged home breastfeeding after 7 days treated with 100% hood for 12 hours. Hypo perfusion improved w/ initial IV fluid bolus.

Patient # (Date of Procedure)	Level assigned	PAMC synopsis	Chart records	Outcome	Met Standard of Care	Miscellaneous
4 (10/3/08)	5 Not necessarily routine, but not totally unexpected. May be disease related	Focus review, fetal strip monitoring, unexpected transfer of baby to NICU	24 y/o G2P0Sab1 @ term ROM > 24 hrs, Beta strep neg, Pit aug, epidural, 2 cm to 4 cm over 6 hrs, T max 100.6, Unasyn in labor, Category 2 tracing	Primary LTCsxn, 8#10oz female, Apgars 2/6/7, cord ph 7.21, BE –4.4, pCO2 63.9, baby extubated @ 12 hours, CXR c/w congenital pneumonia, cultures neg, Baby discharged after 7days antibiotics,	Jack Jacobs Sherrie Richey Paul Sinkhorn Julian T Parer	Mother had mild wound infection, Rx'd w/ IM Rocephin, discharged POD #7 w/ baby
5 (2/17/07)	5 Not necessarily routine, but not totally unexpected. May be disease related	Degree of heart rate monitoring warranted earlier intervention	37 y/oG1P0 SOOL @ 39.0 wks, Beta strep +, Rx'd, Epidural @ 4 cm, pushed 2 hours, Category 2 tracing, Vacuum @ +3 station, 1 pull	6#5oz female, Apgars 9/9, cord pH 7.19, PCO2 57.1, P02 17, short umbilical cord (< 50 cm) with decreased Wharton's jelly & fundally implanted placenta	Jack Jacobs Sherrie Richey Paul Sinkhorn Julian T Parer	Mother and Baby home PPD #2
6 (6/30/08)	5 Not necessarily routine, but not totally unexpected. May be disease related	Term baby to NICU	31 y/o G1P0 @ 40.4 wks, SOOL, AROM @ 4 cm, mod mec, Beta strep +, Rx'd Ampicillin, IV analgesia, then epidural, Gentamycin added for T max 103.1, pushed X 2 hrs, persistent OP	RML performed, then SVD, 7#14 oz female, Apgars 4/9, cord pH 7.15, BE –9.1, no mec below cords, to NICU X 15 min for transition, back to mother	Jack Jacobs Sherrie Richey Paul Sinkhorn Julian T Parer	Mother & Baby discharged PPD #2
7 (2/2/08)	6 Significant Departure from Clinical practice. No adverse impact 3a Behavior related issue	Pain management, inappropriate comments to patient	34 y/o G2P1 delivered nonviable female fetus into toilet @ home, transported by EMS, nurse reported 9/10 patient pain, physician did pelvic exam, no reports of pain by pt, MD at bedside w/ pt X 3 hrs, prescribed Motrin	Fetus moved X 2 hours, weighed 250 g, I described the size of the baby to the pt as the size of a "stick of butter", the nurse was offended and reported an Unusual Occurrence Report.	Jack Jacobs Sherrie Richey Paul Sinkhorn	Mother discharged 12 hours later, brought fetal remains home for burial. Mother wrote letter of support for Fair Hearing panel "I was being well taken care of by Dr. Murphy". Mother returned for PP care & IUD.
8 (3/29/05)	5 Not necessarily routine, but not totally unexpected. May be disease related	Newborn Apgar <6, right arm paralysis in newborn	G2P1, arrived @ 37 6/7 weeks GA, diagnosed breech in active labor w/ SROM, dilated 4 cm to complete in 90 minutes. Patient wanted to avoid Csxn, met criteria for TOL (EFW 3000 g, adequate pelvis, flexed head, complete breech).	Epidural, then Intrathecal placed in OR @ 9 + cm, 2nd assistant present, 3 pushes to deliver to thorax unassisted, bilateral nucchal arms encountered, Lovset's maneuver X 2 in each direction, delivered post arm, 5#15oz female, Apgars 3/7/8, cord pH 7.18, pO2 13, pCO2 64, Right arm weakness noticed @ birth	Jack Jacobs Sherrie Richey Paul Sinkhorn	Baby in physical therapy and progressing well per statement of orthopedic surgeon in CA on 9/11/08. He reports "no loss of external rotation and it has certainly improved a great deal" as of his exam on 4/17/08. Litigation dropped in 9/08.

Patient # (Date of Procedure)	Level assigned	PAMC synopsis	Chart records	Outcome	Met Standard of Care	Miscellaneous
9 (2/28/08 & 3/1/08)	5 Not necessarily routine, but not totally unexpected. May be disease related	Failed surgical Ab, Cervical laceration, 2nd provider had to get involved	25 y/o G4P1Tab2, known chronic pelvic pain patient, Hx of recent DV, Elective Ab @ 12.0 wks in office (NAF certified), unable to remove fetal parts from fundus due to pt pain control, transferred to hospital	D&C completed in ER 2/28/08 under GA, EBL 1000 cc, minor ant lip laceration sutured w/ 3-0 chromic, discharged home on Darvocet. Pt returned to ER 3/1/08 the next night with pelvic pain, evaluated by ER MD X 7 hours, I was called due to unrelieved pain. Reviewed pathology, U/S & labs, did PE, planned discharge on Percocet. Pt requested 2nd opinion. Pt reported ETOH on my breath. I stated that I had 2 glasses of wine earlier	Jack Jacobs Sherrie Richey Paul Sinkhorn	I called the Chief of the Dept for 2nd opinion & discussed case with him. He never requested that I get a blood alcohol. I remained in ER 2 more hours awaiting his decision. He decided to do repeat D&C. Patient remained hospitalized X 2 days on parenteral analgesics for unrelieved pain. NOTE: pt has Hx of 46 ER visits between 9/00-12/07 for pelvic pain & narcotics.
10 (9/24/06)	3a Behavior related issue	Concerned party, proctor not present in delivery room for delivery	29 y/o G1P0, Hx pulmonic stenosis S/P repair age 13 y/o, SOOL 39 1/7 wks, sx asthma in labor, on mask O2 & inhaler used, AROM, mod mec, epidural placed @ 6 cm, IUPC placed @ 8 cm. I went to call room @ 1130 PM and slept until next contacted	Called to bedside @ 340 AM, FHR shows + variables & fetal bradycardia during last 30 min pushing, I called for ASSIGNED PROCTOR (25 min away), another OB was called on stand-by, Vacuum X 2 pulls w/ 2 pop offs @ +3 station, RML performed , delivered @ 351 AM, 6#8oz male, Apgars 8/9, cord ph 7.22,BE –5, pCO2 60,pO2 15, short 52 cm cord w/ decreased Wharton's jelly.	Jack Jacobs Sherrie Richey Paul Sinkhorn	Mother &Baby discharged PPD #2. I notified ASSIGNED PROCTOR & Sherrie Richey next AM. Received a letter from Chief of Dept 10/2/06 stating to call proctor but to proceed under "mitigating circumstances". Released from proctoring requirements 5/27/07.
11 (10/13/06)	3a Behavior related issue	Concerned party, attending did not contact proctor	25 y/oG2P0 39 1/7 week, social induction, AROM @ 2 cm, fingers felt, ambulated X 3 hours, Pit aug started, hand present in vagina @ 4 cm, epidural placed, hand reduced, compound presentation did not recur, to call room to sleep @ 2213 PM	Called by RN @ 234 AM for deep variables. At bedside @ 239 AM. Instructed RN to call proctor @ 247 AM for vacuum delivery. Manual rotation LOP to LOA, Vacuum X 2 pulls, Delivery @ 302AM, 7#7 oz male, Apgars 6/8, ph 7.20, BE –7, pO2 17, pC02 55, Proctor arrived @ 309 AM. No cord complications evident.	Jack Jacobs Sherrie Richey Paul Sinkhorn Julian T Parer	Mother & Baby discharged PPD #2. Released from proctoring requirements 5/27/07.

Patient # (Date of Procedure)	Level assigned	PAMC synopsis	Chart records	Outcome	Met Standard of Care	Miscellaneous
12 (4/27/08)	3a Behavior related issue	Private transportation to PAMC	21 y/o G1P0 seen in office 4/24/08 @ 35.4 wks, 2 cm dilated, breech, scheduled for version @ 36 weeks, advised to stay in town in case of PTL (lives 90 miles away in Seward), went home despite precautions	PROM @ 36 1/7 wks 90 miles away from PAMC , seen in local ER w/ uterine irritability, subQ terb X 1 given, no Cx change X 2 hrs, no local ambulance (6 hr delay), weather too dangerous for air transport, mother drove her to Anchorage by private transportation. Arrived @ 3 cm dilated, Primary LTCsxn done under epidural , 5#9oz breech male, Apgars 9/9	Jack Jacobs Sherrie Richey Paul Sinkhorn	Mother & Baby discharged PPD #3 Mother wrote letter for Fair Hearing Panel that stated "She told me it would be a good idea to stay in town in case it (PTL) happened. I chose not to stay in town."
13 (8/17/06)	3a Behavior related issue	Concerned party, Provider response to ER call	26 y/o G5P2Tab1 admitted @ 15.0 wks GA w/ recurrent severe hyper emesis gravidarum, w/ renal failure and pyelonephritis, K 1.9, Cr 5.5, LFTS & amylase markedly elevated. I discussed case w/ ER MD @ 1420 PM, we agreed pt required ICU & hospitalist care, pt admitted under hospitalist. Hospitalist came to ER ~ 2 hours after ER MD call, never saw patient, left after phone call with me to go to another hospital.	I was called @ 1930 PM by next shift ER MD. No admission orders yet written. I went to ER, arranged for nephrologist to admit patient to Renal ICU. Patient discharged after 7 days w/ persistent electrolyte abnormalities. 1/28/07: I delivered her baby, SVD 7#11 oz male, Apgars 8/9	Jack Jacobs Sherrie Richey Paul Sinkhorn	PAMC MEC subsequently disciplined me. My hospital privileges were suspended for 3 years. On the 9/20/06, this decision was rescinded and my OB-GYN privileges were restored "to the status quo of August 26, 2006". This hospital action was characterized in the letter as a "misunderstanding". Dr. Paul Sinkhorn was very critical of hospitalist abandoning patient.
14 (7/23/07)	3a Behavior related issue	Provider spoke negatively about the care provided by a colleague who was on call to a medical student and RN	24 y/o G2P1 induced @ 33.6 wks w/known chronic hypertension & new onset H/A unrelieved w/Tylenol #3 & Vicodin. BP 140/90's, all labs WNL, no proteinuria, no IUGR, FHRT reassuring. Induction started by another doctor. MgS04 given, Cervidil placed, Pit aug started.	I assumed care in active labor. BP's normal to low in labor, epidural in place, ephedrine required. Delivered 5#2oz male, Apgars 7/8. Reviewed chart after delivery I read that prior headache described as unilateral, that she "feels her pulse in her eye" and she preferred a dark room per RN notes. Educated medical student that this might not have been Severe PIH, but chronic hypertension w/headache syndrome.	Jack Jacobs Sherrie Richey Paul Sinkhorn	Discussed case w/ covering MD & medical student interaction. Head of his call group expressed concern about litigation & Iatrogenic prematurity. Mother had recurrent PP H/A in hospital relieved w/ Imitrex and analgesics. Baby discharged from NICU 2 weeks later.

Patient # (Date of Procedure)	Level assigned	PAMC synopsis	Chart records	Outcome	Met Standard of Care	Miscellaneous
15 (11/16/06)	3a Behavior related issue	Concerned party, Pt requested epidural multiple times, attending encouraged her to remain on IV drugs	25 y/oG4P2Sab1, 2 prior term births, PTL @ 35 4/7 wks GA, dilated 3 cm to 8 cm, IV fentanyl X 3, I stayed @ bedside X 2 + hours coaching patient. Father, Mat GM, and all nurse present in quiet atmosphere. Patient quiet w/ intermittent moaning, 8 + cm X > 40min, low dose Pit aug provided, Pt demanded epidural before pushing @ 9 + cm.	Went to get anesthesiologist due to irate father. Mother developed sudden urge to push, Baby delivered w/ 2 pushes, 6#2 oz female, Apgars 8/9, cord pH 7.348. Mother and Baby discharged after 3 days.	Jack Jacobs Sherrie Richey Paul Sinkhorn	Interviewed mother @ PP visit & discussed her childbirth experience. She said that she had a "lot of back pain", "all a blur", said that her mother "was impressed that I stayed through her labor"
16 (11/15/03)	7 Significant departure from established pattern of clinical practice contributed to unexpected outcome	NOT STATED (Former ARH cases re-reviewed from State Medical Board Hearing 7/05)	32 y/o G3P2, prior LTCsxn X 2 in 4/90, & 4/93, desired TOL, presented in active labor @ term, AROM @ 2 cm, IV analgesia, low dose Pitocin to 3 MU/min, w/ IUPC, epidural @ 4 cm, went to call room @ 202 AM. Woken by RN @ 443 AM. Stated pt @ 7 cm w/ mild variables. Reviewed strip in call room, advised amnioinfusion. RN returned 12 min later, @ 454 AM stated that variables resolved, no amnioinfusion done.	Urgently woken by RN @ 536 AM for nonreassuring FHRT. Terminal bradycardia present, gross hematuria evident w/ suprapubic mass. Complete & +1 station. Vacuum X 3 , then midforceps X 1 pull. Delivered baby w/i 9 minutes of arrival. 7#4oz male, Apgars 3/7/9, cord ph 6.95, no infant sequelae. Bladder & uterine rupture immediately palpated. To OR w/ urologist: supracervical hysterectomy & bladder laceration repaired, 5 U PRBCs, 2 U FFP. Mother & baby discharged PPD #5 doing well. Foley removed POD #7 after cystoscopy.	Jack Jacobs Sherrie Richey Paul Sinkhorn	Notified Risk Management @ ARH about case on 11/17/03. Nursing EMR notes did not correlate w/ operative report as to time of reporting clinical events to physician. I was never interviewed by Dept Chair for Sentinel Event. JCAHO reported as giving citation to ARH for failure to include operating surgeon in Sentinel Event review. ARH subsequently did 100% case review of my OB cases (>90 cases). They suspended my OB privileges in on 4/6/05 over 5 cases, which ultimately resulted in my summary suspension by the State Medical Board on 7/7/05.

FL

FILED
MAR 28 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DEPARTMENT'S EXHIBIT LIST

COMES NOW the State of Washington, Department of Health, Medical Quality Assurance Commission (Department), by and through its attorneys, ROBERT M. MCKENNA, Attorney General, and KIM O'NEAL, Senior Counsel, and provides the following list of exhibits it may use at the hearing scheduled in this matter.

1. Notice of Decision on Application, dated October 28, 2011 (Inv. 6-8)
2. Respondent's Medical Practice Application for Washington (Inv. 26-31)
3. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Affidavit of Investigator, dated June 15, 2005 (Inv. 82-84)
4. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

ORIGINAL

Board, No. 2800-05-026; Petition for Summary Suspension of Physician License, dated July 7, 2005 (Inv. 79-81)

5. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Order for Summary Suspension, dated July 7, 2005 (Inv. 85)
6. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Accusation, dated July 14, 2005 (Inv.178-183)
7. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Order, dated July 14, 2005 (Inv. 95)
8. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Amended Accusation, dated July 22, 2005 (Inv. 187-192)
9. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Decision on Summary Suspension, dated September 14, 2005 (Inv. 34-66)
10. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Memorandum of Agreement, dated June 19, 2006 (Inv. 86-95)
11. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical

ATTORNEY GENERAL OF WASHINGTON
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(360) 664-9006

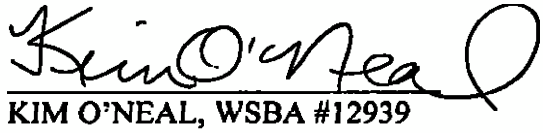
Board, No. 2800-05-026; Notice of Board's Adoption of Memorandum of Agreement, dated August 3, 2006 (Inv. 76)

12. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Memorandum and Order of Dismissal, dated August 21, 2006 (Inv. 77)
13. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Probation Status Change, dated May 24, 2007 (Inv. 78)
14. Providence Alaska Medical Center, Clinical Privileges Status Summary of Respondent, dated June 24, 2011 (Inv. 197)
15. State of Michigan, Department of Community Health; Verification of Licensure (Inv. 194)
16. Federation of Sate Medical Boards of the United States, Inc., Summary of Reported Actions, dated June 30, 2011 (Inv. 198-199)
17. Respondent's Personal Data Questions (Inv. 108)

The Department reserves the right to use any exhibit produced by Respondent. The Department further reserves the right to amend its exhibit list for good cause shown.

DATED this 27th day of March, 2012.

ROBERT M. MCKENNA
Attorney General



KIM O'NEAL, WSBA #12939
Senior Counsel

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

PROOF OF SERVICE

I certify that I served a copy of this document on all parties or their counsel of record on the date below as follows:

DAVID H. SHOUP
ATTORNEY AT LAW
508 WEST 2ND AVE FL 3
ANCHORAGE, AK 99501

☒ US Mail Postage Prepaid via Consolidated Mail Service

☒ Facsimile: (907) 278-8536

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 27th day of March, 2012, at Olympia, WA.

Nerissa Raymond
NERISSA RAYMOND
Legal Assistant

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

Exhibit 1

Notice of Decision on Application

October 28, 2011

Colleen M. Murphy, MD
2811 Illiamna Avenue
Anchorage, Alaska 99517

Re: Application No. MD.MD.60236731

Dear Dr. Murphy:

Thank you for your application for a license to practice as a physician and surgeon in the state of Washington. Following review of your application file, the Medical Quality Assurance Commission (Commission) has decided to deny your application.

Basis for this Decision. The Commission based its decision on the following facts.

You are a physician board-certified in obstetrics and gynecology. On April 6, 2005, the Alaska Regional Hospital summarily suspended your obstetrical privileges.

On July 7, 2005, based on the suspension of your privileges at Alaska Regional Hospital, the Alaska State Medical Board issued an order suspending your license to practice medicine in the state of Alaska. Based on the suspension of your medical license, Alaska Regional Hospital and Providence Alaska Medical Center suspended your privileges at those hospitals. On July 14, 2005, the Board issued an Accusation alleging that your actions in five cases constituted professional incompetence, gross negligence or repeated negligent conduct.

On September 14, 2005, following a hearing, an administrative law judge issued a Decision on Summary Suspension finding that the prosecutor did not establish a failure to meet the standard of care or professional incompetence. The judge recommended that the Alaska State Medical Board vacate the order of summary suspension and address the issues raised in the case in the context of a complete hearing on the merits.

On February 22, 2006, Providence Alaska Medical Center granted you gynecological privileges, but denied you obstetrical privileges. Following a hearing in March 2006, Providence granted you obstetrical privileges and required five precepted vaginal births after cesarean and five precepted operative vaginal deliveries.

On June 19, 2006, you entered into a Memorandum of Agreement (MOA) with the Alaska State Medical Board. The MOA imposed sanctions against your license, including (1) a one-year period of probation, (2) a requirement to comply with conditions of practice of

Providence Alaska Medical Center, (3) a requirement that you notify the Chief of Staff and Administrator of any hospital at which you have privileges of the terms of your probation and provide a copy of the MOA, (4) a requirement to notify the Board's representative immediately of obtaining hospital privileges at any hospital, (5) a requirement to report in person to the Board to allow review of your compliance with probation, and (6) obey all laws pertaining to your license in this state or any other state. On July 14, 2006, the Alaska State Medical Board adopted the MOA.

On August 9, 2006, Alaska Regional Hospital denied you obstetrical privileges. In December 2006, Alaska Regional Hospital granted you gynecological privileges.

On March 21, 2007, you entered into a Stipulation and Consent Order with the Michigan Board of Medicine in which you were restricted from practicing medicine in the state of Michigan until you provided verification that your Alaska license had been reinstated. You subsequently allowed your Michigan license to lapse.

On May 26, 2007, the Alaska State Medical Board terminated your probation. Providence then granted you unrestricted privileges in obstetrics and gynecology.

On December 8, 2009, Providence suspended your privileges in obstetrics and gynecology. On October 6, 2010, Providence made a final decision to permanently revoke your clinical staff privileges and medical staff membership According to an Adverse Action Report to the National Practitioner Data Bank, this action was based on nine cases, including three delayed obstetrical intervention cases, inappropriate vaginal delivery of a large premature breach-positioned infant through an unproven pelvis, inappropriate pain management, alcohol on call, failure or refusal to comply with the spirit of a proctoring program, and poor professional communications/interactions with patients and staff.

Based on Section 18.130.055(1)(b) of the Revised Code of Washington (RCW), the Commission decided to deny your application subject to conditions based on acts defined as unprofessional conduct under RCW 18.130.180(4), which provides in part:

> **RCW 18.130.180 Unprofessional Conduct**
> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. ...

Your Right to a Hearing. If you disagree with this decision, you may request a hearing by completing the enclosed Request for Hearing form and sending it to the Department of Health, Adjudicative Clerk Office, at the following address:

> Adjudicative Clerk Office
> Department Of Health
> PO Box 47879
> Olympia, WA 98504-7879

Your request must be in writing, state your basis for contesting the decision, and include a copy of this Notice of Decision on Application.

The Adjudicative Clerk Office must receive your completed Request for Hearing within 28 days of the date this Notice was sent to you or your Request for Hearing will not be considered and you will not be entitled to a hearing. If the Adjudicative Clerk Office does not receive your Request for Hearing by January 13, 2011 the decision to deny your application will be final.

What Happens at a Hearing? If you decide to present your application to a hearing panel, you will have the burden of proving, more probably than not, that you are qualified for licensure under the Uniform Disciplinary Act (RCW 18.130), Chapter 18.71 RCW, and the rules adopted by the Commission.

Your Right to an Interpreter at Hearing. You may request an interpreter to translate at the hearing if English is not your primary language or the primary language of any of any witness who will testify at hearing. You may also request interpretive assistance if you or any witness has a hearing or speech impairment.

Questions? Please call me at (509) 329-2186 if you have any questions.

Sincerely,

MICHAEL FARRELL, WSBA #16022
DEPARTMENT OF HEALTH STAFF ATTORNEY

Enclosure

DECLARATION OF SERVICE BY MAIL

I declare that today, October 28, 2011, at Olympia, Washington, I served a copy of this document by mailing a copy properly addressed with postage prepaid to the applicant at the following address:

Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517-1217

Dated: October 28, 2011

Signature: Debra Bondurant
Debra Bondurant, Legal Secretary

Exhibit 2

Washington State Department of Health

Background Check Processed
JUN 30 2011
NPDB/HIPDB
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

JUN 29 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Revenue

Medical Practice License Application for MDs only

☒ National Boards ☐ Other State Exam ☐ LMCC (Must have been obtained after 1969)
☐ Flex Examination ☐ USMLE Examination

I. Demographic Information:

Social Security Number (If you do not have a social security number, see instructions.) [redacted]

☐ Male ☒ Female

Name	First	Middle	Last
	Colleen	Mary	Murphy

Birth date (mm/dd/yyyy): 06/10/1955

Place of birth: City Detroit | State MI | Country USA

Address: 2811 Illiamna Ave

City Anchorage | State AK | Zip 99517 | County Anchorage

Country USA

Phone (907) 2431939 | Fax (907) 770.5431 | Cell [redacted]

Email address [redacted]

Mailing address (if different from above) same

City — | State — | Zip — | County —

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☒ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☒ No

If yes, list name(s):

MURPHY, MD
Inv.00026

Medical Specialty

Medical school Wayne State University Year of graduation 1981

Medical specialty OB-GYN

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☒

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☒

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☒
4. Are you currently engaged in the illegal use of controlled substances?	☐	☒

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?	☐	☒

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

MURPHY, MD
Inv.00027

2. Personal Data Questions (Cont.)	Yes	No
a Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☒

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☒
b. Diverted controlled substances or legend drugs?	☐	☒
c. Violated any drug law?	☐	☒
d. Prescribed controlled substances for yourself?	☐	☒
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☒
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☒	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☒
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☒	☐
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☒	☐
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?	☒	☐
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?	☐	☒
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?	☐	☒

MURPHY, MD
Inv.00028

3. Medical Education and Experience

Provide a chronological listing of your educational preparation and post-graduate training. If you need more space, attach a piece of paper.

Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Diploma or degree obtained (Quote titles in original language and translate to English.)	Number of years attended	Dates granted Start mm/yyyy	Dates granted End mm/yyyy
Medical education (list all medical schools attended)				
Wayne State University	MD	4	9/77	5/81
Post graduate training (list all programs attended)				
St John Hospital Detroit Michigan	1st year categorical internship	1	7/81	6/82
Good Samaritan Medical Center	OB-GYN residency	3	7/84	6/87

4. Professional Experience — see attached sheet

In chronological order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Nature of experience or specialty
Truk State Hospital Chuuk State Micronesia	08/02/82	6/30/84	National Health Service Corps, Chief of Pediatrics
Alaska Native Medical Center Anchorage, Alaska	08/87	5/98	Clinical OB-GYN, Chief of Dept, President Med Staff
Alaska Native Tribal Health Consortium, Anchorage, AK	7/98	3/99	Alaska Statewide Women's Health Consultant
Alaska Native Medical Center Area Health Services	4/99	6/14/99	OB-GYN
Gallup Indian Medical Center	6/14/99	7/14/99	OB-GYN

5. Hospital Privileges (Excluding post-graduate training hospital privileges)

Excluding post-graduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended Start date mm/dd/yyyy	Dates attended End date mm/dd/yyyy
Alaska Regional Hospital	12/06	10/4/11
Providence Alaska Medical Center	2/22/06	10/6/10

MURPHY, MD
Inv.00029

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in chronological order, starting with the most current.

State	Date license issued	License Number	Basis of License		Status of license	Any limitations on license
			Exam date passed	Endorsement		
Alaska	10/27/93	3162		X	active	☒ No ☐ Yes
Michigan	7/1/82	4301044939	X		inactive 1/30/2000 lapsed	☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four (4) hours of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

Applicant's initials	Date
CMM	

Applicant's Photograph

Photo Here ▷

Height 5'6"

Weight 190 #

Hair color brown

Color of eyes brown

MURPHY, MD
Inv.00030

9. Applicant's Attestation

I, Colleen Mary Murphy, MD, declare under penalty of perjury under the
(Print applicant name clearly)
laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

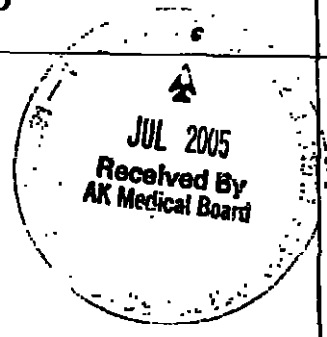
Dated 6/20/11 at Anchorage, AK (city, state)

By: Colleen Murphy MD
Signature of applicant

MURPHY, MD
Inv.00031

Exhibit 3

STATE OF ALASKA
DEPARTMENT OF COMMERCE
COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
BEFORE THE STATE MEDICAL BOARD



In the matter of:)
)
Colleen M Murphy, M.D.)
)
Respondent)
Case No. 2800.05.026

AFFIDAVIT

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

Colin Matthews, being duly sworn, upon oath, deposes and says:

1. That I am an Investigator with the State of Alaska, Division of Occupational Licensing, and I am assigned to supervise and conduct investigations for the State Medical Board.

2. This affidavit concerns investigative actions I took in relation to this investigation.

3. On April 8, 2005, I received written report, from Tina Roy, Director, Medical Staff Services, Alaska Regional Hospital, 2801 DeBarr Road, Anchorage, Alaska 99508, advising that the Medical Executive Committee (Committee), Alaska Regional Hospital, had summarily suspended Murphy's obstetrical privileges. The report advised the action was taken after the Committee received a report from an Ad Hoc Committee stating: Peer review of obstetrical cases found inappropriate operative technique for vaginal delivery, failure to recognize fetal heart rate tracing abnormalities and delayed response for patient care. These findings suggested our failure to take such action may result in imminent danger to the health and/or safety of her patients or to the orderly operation of our hospital. The report was made under AS 08.64.336.

4. On April 8, 2005, I discussed this complaint with G. Bert Flaming, M.D., Member, Alaska State Medical Board (Board). Dr. Flaming opined that based on the report from Alaska Regional Hospital it may be necessary to ask Murphy to temporarily suspend her authority obstetrics privileges.

State Of Alaska
Department Of Commerce, Community and Economic Development
Division of Occupational Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

5. On April 8, 2005, I transmitted a letter to Rosemary Craig, R.N., Quality Assurance Director, Alaska Regional Hospital, 2801 DeBarr Road, Anchorage, Alaska 99508 requesting a copy of the information that lead to the suspension of Murphy's hospital privileges. On April 12, 2005, the requested information was received from Craig. The Ad Hoc Committee were identified as George J. Gilson, M.D., Norman J. Wilder, M.D., Donna L. Chester, M.D., Wendy S. Cruz, M.D., and Clinton B. Lillibridge, M.D.

6 On April 12, 2005, I spoke with Murphy's legal counsel and it was determined that Murphy did not wish to voluntarily suspend her license pending resolution of this matter.

7. On May 12, 2005, George J. Gilson, M.D., Anchorage, Alaska, signed an Affidavit attesting to his participation in the Ad Hoc Committee, that he signed the March 9, 2005 report to the President, Medical Staff, and his concurrence with the findings.

8. On May 17, Clinton B. Lillibridge, M.D., Anchorage, Alaska, signed an Affidavit attesting to his participation in the Ad Hoc Committee, that he signed the March 9, 2005 report to the President, Medical Staff, and his concurrence with the findings reflected in the report.

9. On May 19, 2005, Donna L. Chester, M.D., Anchorage, Alaska, signed an Affidavit attesting to her participation in the Ad Hoc Committee, that she signed the March 9, 2005 report to the President, Medical Staff, and her concurrence with the findings reflected in the report.

10. On May 19, 2005, Wendy S. Cruz, M.D., Anchorage, Alaska, signed an Affidavit attesting to her participation in the Ad Hoc Committee, that she signed the March 9, 2005 report to the President, Medical Staff, and her concurrence with the findings reflected in the report.

11. On June 3, 2005, Norman J. Wilder, M.D., Anchorage, Alaska, signed an Affidavit attesting to his participation in the Ad Hoc Committee, that he signed the March 9, 2005 report to the President, Medical Staff, and his concurrence with the findings reflected in the report.

12. On June 8, 2005, I contacted Gilson, Chester, Cruz, and Wilder and all stated their opinions, as reflected in the March 9, 2005 report, remained the same.

13. On June 15, 2005, I contacted Lillibridge and he stated his opinion, as reflected in the March 9, 2005 report, remained the same.

Further, your Affiant sayeth naught.

Colin Matthews, Investigator

Subscribed and sworn to before me this 16 day of June, 2005.

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Department Of Commerce, Community and Economic Development
Division of Occupational Licensing
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Notary Public, State of Alaska
My commission expires: 09/07/2005

CMM#3/cm

STATE OF ALASKA
NOTARY PUBLIC
Miriam Patredis
My Commission Expires September 7, 2005

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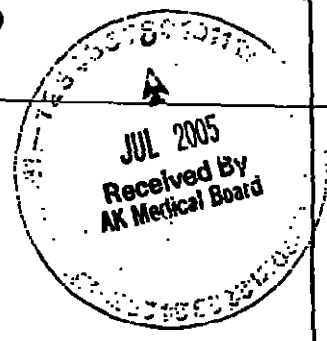
Exhibit 4

STATE OF ALASKA
DEPARTMENT OF COMMERCE
COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
BEFORE THE STATE MEDICAL BOARD



In the Matter of:

Colleen M. Murphy, M.D.

Respondent

Case No. 2800-05-026

PETITION FOR SUMMARY SUSPENSION OF PHYSICIAN LICENSE

Richard Urion, Director, State of Alaska, Department of Commerce, Community and Economic Development, Division of Occupational Licensing (Division), hereby petitions the Alaska State Medical Board (Board) for an order summarily suspending physician license #3162, held by Colleen M. Murphy, M.D. (Murphy). This license was first issued October 23, 1993, and will lapse December 31, 2006 if not renewed by that time.

This petition is made pursuant to AS 08.64.331(c), which provides that the "board may summarily suspend a license before a final hearing ... if the board finds that the licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice." A person whose license is suspended under this section is entitled to a hearing by the Board no later than 7 days after the effective date of the order.

The basis for the Division's petition are the findings of the Alaska Regional Hospital Ad Hoc Committee and the affidavits from each Ad Hoc Committee member. The Board received the report of the Ad Hoc Committee pursuant to AS 08.64.336. Under this statute, the Board is authorized to summarily suspend a license.

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The sitting members of the Alaska Regional Hospital Ad Hoc Committee are Donna L. Chester, M.D. and Wendy S. Cruz, M.D., both specializing in obstetrics and gynecology, George J. Gilson, M.D., specializing in perinatology, Norman J. Wilder, M.D., specializing in sleep disorders, and Clinton B. Lillibridge, M.D., specializing in pediatrics. The Alaska Regional Hospital Ad Hoc Committee was formed when reports from an outside peer review panel generated inconsistent results from ten of Murphy's patients in 2004. The Alaska Regional Hospital Ad Hoc Committee reviewed the hospital records for the same ten patients of Murphy in 2004. As part of its review the Alaska Regional Hospital Ad Hoc Committee interviewed Murphy. After completing its review of medical records and interviewing Murphy and other witnesses, the Alaska Regional Hospital Ad Hoc Committee concluded that Murphy failed to meet the minimum standards for standard of care in providing obstetrical care in five of the ten cases. Such conduct constitutes violations of AS 08.64.326(a)(8)(A). The Alaska Regional Hospital Ad Hoc Committee letter to Rhene C. Merkouris, M.D., (Merkouris) President, Alaska Regional Hospital Medical Staff, in which the Alaska Regional Hospital Ad Hoc Committee reports its findings, and the curriculum vitaes for each Ad Hoc Committee member are attached as exhibits. A letter dated April 6, 2005, from Merkouris to Murphy informing Murphy that her obstetrical privileges at Alaska Regional Hospital had been suspended is also attached as an exhibit.

Further, each Ad Hoc Committee member has concluded that Murphy is clear and immediate danger to the public because of her failure to meet minimum professional standards for standard of care when providing obstetrical care. Affidavits by each member of the Ad Hoc Committee are provided as further evidence for the Board to consider.

The Division's petition is also based on the affidavit of State Medical Board Investigator Colin Matthews (Matthews), which provides a history of the investigation. Briefly, on April 12, 2005, Matthews received a letter from Tina Roy, Director, Medical Staff Services, Alaska Regional Hospital, advising that Murphy's

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obstetrical privileges at Alaska Regional Hospital had been suspended. Ms. Roy's letter is attached as an exhibit. Investigator Matthews conducted an investigation into the matter and attempted to resolve the matter by requesting Murphy to voluntarily agree to suspend her obstetrics practice until the Alaska Regional Hospital Peer Review Hearing was completed. Murphy declined to accept the proposal.

Finally, the Division requests that Murphy not be allowed to return to the practice of medicine until she can prove to the Board that she can do so with skill and safety, and in a manner consisted with public safety.

Respectfully submitted this 7th day of July, 2005 at Anchorage, Alaska.

Edgar Blatchford, Commissioner

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

CMM#12/cm

State of Alaska
Department of Commerce, Community and Economic Development
Division of Occupational Licensing
550 West 7th Ave., Suite 1500
Anchorage, Alaska 99501

Exhibit 5

STATE OF ALASKA
DEPARTMENT OF COMMERCE
COMMUNITY & ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
BEFORE THE STATE MEDICAL BOARD

In the matter of:

Colleen M. Murphy, M.D.

Respondent

Case No. 2800-05-026

ORDER

Upon the petition of the State of Alaska, Department of Commerce, Community and Economic Development, Division of Occupational Licensing (Division) for Summary Suspension of Physician's license, and upon consideration of the evidence presented by the Division with its petition for summary suspension, the State Medical Board (Board) finds that Colleen M. Murphy, M.D./OB Gyn (Murphy), poses a clear and immediate danger to the public health and safety if she continues to practice as an obstetrician. The Board hereby grants the Division's petition and orders pursuant to AS 08.64.331(c), the summary suspension of Murphy's license, #3162.

It is ordered that upon adoption of this order by the Board, Murphy's license to practice medicine will be summarily suspended and will remain suspended until such time as Murphy is able to prove to the Board she is able to practice medicine in a manner consistent with public safety.

This order shall become effective immediately upon approval by the Board.

Dated this 7th of July, 2005, at Anchorage, Alaska.

BY: _____
David M. Head, M.D.
Chair, State Medical Board

CMM#13/cm

State Of Alaska
Department Of Community and Economic Development
Division of Occupational Licensing
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Exhibit 6

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

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

2800.05.045, 2800.05.048, 2800.05.050, 2800.05.051, 2800.05.054.

JUL 2[illegible]
Received [illegible]
AK Medical Bo[illegible]

ACCUSATION

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

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

ALLEGATIONS COMMON TO ALL COUNTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. On August 14, 2005, ARH patient 35-55-67's baby was delivered at her home. Patient 35-55-67 was admitted at ARH at 6:10 p.m. At 6:15 p.m., Murphy was notified that the placenta was intact and that the patient had a two degree laceration. Murphy arrived at the hospital at 7:45 p.m. to repair the laceration.

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

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

Count 1

18. Paragraphs 1-17 are realleged.

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

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Count II

20. Paragraphs 1-19 are realleged

21. Murphy's failure to recognize abnormalities of fetal heart rate tracings constitutes professional incompetence, gross negligence or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A). Murphy's conduct was potentially life-threatening to patient 37-44-87's baby and therefore constitutes a clear and immediate danger to public health and safety under AS 08.64.331(c).

Count III

22. Paragraphs 1-21 are realleged.

23. Murphy's failure to recognize abnormalities of fetal monitory tracings constitutes professional incompetence, gross negligence or repeated negligent conduct and is grounds for discipline pursuant to AS 08.64.326(a)(8)(A). Murphy's conduct was potentially life-threatening to patient 37-44-87's baby and therefore constitutes a clear and immediate danger to public health and safety under AS 08.64.331(c).

Count IV

24. Paragraphs 1-23 are realleged.

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

Count V

26. Paragraphs 1-25 are realleged.

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

Count VI

28. Paragraphs 1-27 are realleged.

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

DATED this 14th day of July, 2005, at Anchorage, Alaska.

EDGAR BLATCHFORD,
COMMISSIONER

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

State of Alaska
Department of Commerce, Community and Economic Development
Division of Occupational Licensing
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Exhibit 7

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
BEFORE THE ALASKA STATE MEDICAL BOARD

In the Matter of:

Colleen M. Murphy, M.D.

Respondent

Case No. 2800-05-026 *et al*

ORDER

The Alaska State Medical Board for the State of Alaska, having examined the MOA and Proposed Decision and Order, Case No. 2800-05-026 *et al*, Colleen M. Murphy, M.D. adopted the MOA and Decision and Order in this matter.

DATED this 14th day of ~~June~~ July, 2006, at Anchorage, Alaska.

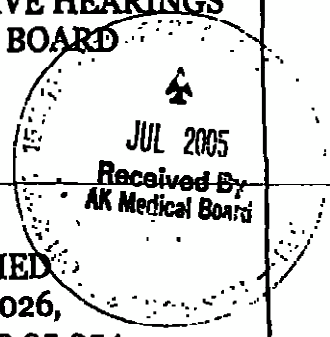
Alaska State Medical Board

By: Ed Hall M-C
Chairperson

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

Exhibit 8

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



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

2800.05.045, 2800.05.048, 2800.05.050, 2800.05.051, 2800.05.054.

AMENDED ACCUSATION

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

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

ALLEGATIONS COMMON TO ALL COUNTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Count 1

18. Paragraphs 1-17 are realleged.

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

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Division of Occupational Licensing
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Count II

20. Paragraphs 1-19 are realleged

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

Count III

22. Paragraphs 1-21 are realleged.

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

Count IV

24. Paragraphs 1-23 are realleged.

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

Count V

26. Paragraphs 1-25 are realleged.

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

Count VI

28. Paragraphs 1-27 are realleged.

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

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

EDGAR BLATCHFORD,
COMMISSIONER

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

State of Alaska
Department of Commerce, Community and Economic Development
Division of Occupational Licensing
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Exhibit 9

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. Background and Prior Proceedings

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

[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

btained 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.

or 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-[illegible]-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 [illegible]entials "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 view 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 perinatology[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 viewed, 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

eported 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

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)]

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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 additiona 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

[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.

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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].

ntractions. 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 ıe 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.

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ontraindicated).[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].

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easonable 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

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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.

AS 08.64.326(a).

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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.

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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).

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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

[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. Q]

[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 tandard 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]

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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

[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.

uffered 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 any 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. 2J-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

[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, unless there is a compelling and justifiable reason." [*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...It is impossible to reach consensus on the presumed fetal condition or obstetric management of all other patterns intermediate between the two [exceptions noted]." 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]

MURPHY, MD
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at 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 or 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.

ıte 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 ontributed 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 hose to continue with labor when, at times relatively remote from delivery, the fetal heart rate

ould 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

[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, with absent fetal heart rate variability.

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.

[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 resumé 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.

Wilson'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

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: _____
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 _____ day of _____, 2005.

By: _____
Signature

_____
Name

_____
Title

MURPHY, MD
Inv.00066

Exhibit 10

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
BEFORE THE ALASKA STATE MEDICAL BOARD

In the Matter of:)
)
Colleen M. Murphy, M.D.)
)
Respondent)
Case No. 2800-05-026, *et. al.*

MEMORANDUM OF AGREEMENT

IT IS HEREBY AGREED by the Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing (Division) and Colleen M. Murphy M.D. (Respondent) as follows:

1. Licensure. Respondent is currently licensed as a physician in the State of Alaska, and holds License number # 3162. This license was first issued on October 27, 1993 and will expire unless renewed by December 31, 2006.

2. Admission/Jurisdiction. Respondent admits and agrees that the Alaska State Medical Board (Board) has jurisdiction over the subject matter of her license in Alaska and over this Memorandum of Agreement (MOA).

3. Admission/Facts. Respondent neither admits nor denies the following allegations:

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

a) On April 12, 2005, the Division received a written report from Alaska Regional Hospital (ARH), advising that the Medical Executive Committee (Committee) had summarily suspended Respondent's obstetrical privileges.

b) On July 7, 2005, the Alaska State Medical Board summarily suspended the Respondent's license. On July 14, 2005, an accusation was filed against the Respondent's license. A summary suspension hearing was held from July 15-22, 2005. On July 22, 2005, an amended accusation was filed against the Respondent's license.

c) On October 21, 2005, the Board adopted the Administrative Law Judge's Proposed Decision and Order that found that there was not a basis for the summary suspension and recommended that the Respondent's license be reinstated. In the decision, the Administrative Law Judge recommended that the issues addressed at the summary suspension hearing could be heard by the Board in the more deliberative and complete context of an administrative hearing on the merits of an accusation for the imposition of any disciplinary sanctions.

d) On March 10, 2006, the Division filed a second amended accusation against the Respondent's license.

e) On July 1st, 2005, Providence Alaska Medical Center issued a letter to the Respondent affirming that Respondent was a member in good standing in the Department of Obstetrics and Gynecology. On July 8th, 2005, Providence Alaska Medical Center terminated medical staff membership of the

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Respondent as a result of her summary suspension by the Alaska State Medical Board. On May 26, 2006, Providence Alaska Medical Center approved an option for Respondent to reinstate her obstetrical privileges, which is attached as Exhibit A and is filed under seal.

f) The Alaska State Medical Board decided that there were grounds for possible suspension, revocation, or other disciplinary sanctions of his or her license pursuant to AS 08.01.075, AS 08.64.326(a)(8)(A) and AS 08.64.331(a).

4. Formal Hearing Process. It is the intent of the parties to this MOA to provide for the compromise and settlement of all issues which have been raised by the second amended accusation, which requests the Board to revoke, suspend, or impose disciplinary sanctions against Respondent's license through a formal hearing process.

5. Waiver of Rights. Respondent understands she has the right to representation by an attorney of her own choosing and has a right to an administrative hearing on the facts in the second amended accusation. Respondent understands and agrees that by signing this MOA, Respondent is waiving her right to a hearing. Further, Respondent understands and agrees that she is relieving the Division of any burden it has of proving the facts listed above. This MOA is for the purposes of settlement only and is not to be considered an admission of wrongdoing by the Respondent. Respondent further understands and agrees that by signing this MOA she is voluntarily and knowingly giving up her right to present oral and documentary evidence, to present

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Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

rebuttal evidence, to cross-examine witnesses against Respondent, and to appeal the Board's decision to Superior Court.

6. Effect of Non acceptance of Agreement. Respondent and the Division agree that this MOA is subject to the approval of the Board. They agree that, if the Board rejects this agreement, it will be void, and a hearing on the second amended accusation will be held. If this agreement is rejected by the Board, it will not constitute a waiver of Respondent's right to a hearing on the matters alleged in the second amended accusation and any admissions contained herein will have no effect. Respondent agrees that, if the Board rejects this agreement, the Board may decide the matter after a hearing, and its consideration of this agreement shall not alone be grounds for claiming that the Board is biased against Respondent, that it cannot fairly decide the case, or that it has received *ex parte* communication.

7. Memorandum of Agreement, Decision and Order. Respondent agrees that the Board has the authority to enter into this MOA and to issue the following Decision and Order.

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

PROPOSED DECISION AND ORDER

IT IS HEREBY ORDERED that the license issued to Respondent is under probation. This license shall be subject to the following terms and conditions of license probation.

A. Duration of Probation

Respondent's license shall be on probation for one (1) year from the effective date of this Order, retroactive to the date of the agreement with PAMC, attached under seal as Exhibit A, May 26, 2006. If Respondent fully complies with all of the terms and conditions of this license probation, the probationary period will end as conditioned under this Order. If Respondent completes the terms of the agreement with PAMC, attached under seal as Exhibit A, the respondent may petition the Board to be released earlier from the terms of this license probation.

B. Conditions for Privileges

Respondent agrees to comply with all required conditions of Providence Alaska Medical Center (PAMC), attached under seal as Exhibit A, and any other conditions imposed on her hospital privileges by PAMC ~~or other hospitals~~ during the probationary period.

7/6/06 RDS
7/5/06 CMM

C. Hospital Privileges

During the probationary period, Respondent shall notify the Chief of Staff and Administrator of any hospital in which Respondent has privileges of the terms of her probation and provide them with a copy of this MOA. Respondent shall also notify

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

the Board's representative immediately of obtaining hospital privileges at any hospital during the probationary period. The Board's representative will be permitted to discuss with the Chief of Staff and Administrator of any hospital at which she has privileges about the subject matter of this agreement during the probationary period. The Respondent shall sign a release of information from PAMC for reports relating to her progress and performance in obstetrics during the probationary period.

D. Periodic Interview With the Board

While under license probation and upon the request of the Board or its agent, Respondent shall report in person to the Board or its agent to allow a review of her compliance with this probation. Respondent shall be excused from attending any interview only at the discretion of the person requesting the interview.

E. Compliance with Laws

Respondent will obey all laws pertaining to her license in this state or any other state.

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

F. **Probation Violation**

If Respondent fails to comply with any term or condition of this Agreement, her license will be subject to disciplinary sanctions according to current regulations and statutes adopted by the Alaska State Medical Board. If Respondent's license is modified, she will continue to be responsible for all license requirements pursuant to AS 08.64

G. **Authorization**

Respondent will sign all authorizations necessary for the release of the information required by the MOA to the Board's agent.

H. **Non cooperation by Reporting Persons**

If any of the persons required by this Order to report to the Board, fails or refuses to do so, and after adequate notice to Respondent to correct the problem, the Board may terminate probation and invoke other sanctions as it determines appropriate.

All costs are the responsibility of the Respondent.

I. **Good Faith**

All parties agree to act in good faith in carrying out the stated intentions of this MOA.

J. **Address of the Board**

All required reports or other communication concerning compliance with this MOA shall be addressed to:

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

Brian Howes, Investigator
Division of Corporations, Business
and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
(907) 269-8109 Fax (907) 269-8195

It is the responsibility of Respondent to keep the Board's agent advised in writing at all times of his or her current mailing address, physical address, telephone number, current employment, and any change in employment. Failure to do so will constitute grounds for suspension of his or her license in accordance with paragraph 'H' above.

IT IS HEREBY FURTHER ORDERED that this Order shall take effect immediately upon its adoption by the Alaska State Medical Board and is a public record of the Alaska State Medical Board and the State of Alaska. The state may provide a copy of it to any person or entity.

DATED this 19th day of June, 2006 at Anchorage, Alaska.

WILLIAM C. NOLL, COMMISSIONER

By: _____
Richard C. Younkins
Chief Investigator for Richard Urion,
Director of Division of Corporations,
Business and Professional Licensing

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

I, Colleen M. Murphy, M.D., have read the MOA, understand it, and agree to be bound by its terms and conditions.

DATED: 7/5/06 Colleen M. Murphy, MD

SUBSCRIBED AND SWORN TO before me this 5TH day of JULY, 2006, at ANCHORAGE, Alaska.

SEAL

SCOTT G. LEFEBVRE NOTARY PUBLIC STATE OF ALASKA My Commission Expires: Dec. 13, 2009

Notary Public in and for Alaska.

SCOTT G. LaFEBVRE

Notary Printed Name

My commission expires: Dec. 13, 2009

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
BEFORE THE ALASKA STATE MEDICAL BOARD

In the Matter of:)
)
Colleen M. Murphy, M.D.)
)
Respondent)
Case No. 2800-05-026 *et al*

ORDER

The Alaska State Medical Board for the State of Alaska, having examined the MOA and Proposed Decision and Order, Case No. 2800-05-026 *et al*, Colleen M. Murphy, M.D. adopted the MOA and Decision and Order in this matter.

DATED this 14 day of ~~June~~ July, 2006, at Anchorage, Alaska.

Alaska State Medical Board

By: _____
Chairperson

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195

Exhibit 11

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

PAUL STOCKLER
AUG 0 4 2006

In the Matter of:	
Colleen M. Murphy, M.D.	
Respondent.	OAH No. 05-0553-MED Case No. 2800-05-026, *et. al.*

NOTICE OF BOARD'S ADOPTION OF MEMORANDUM OF AGREEMENT

The Division of Corporations, Business and Professional Licensing ("Division"), by and through the Attorney General's Office, hereby informs the Administrative Law Judge that the Alaska State Medical Board ("Board") adopted the Memorandum of Agreement on July 14, 2006. As a result of the Board's adoption, the Administrative Law Judge may dismiss this matter. The Division provides a copy of the Board's action as Exhibit 1.

Dated this 3rd day of August, 2006 at Anchorage, Alaska.

DAVID W. MÁRQUEZ
ATTORNEY GENERAL

By: _____
Karen L. Hawkins
Assistant Attorney General
Alaska Bar #: 9206030

1031 W. FOURTH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

Exhibit 12

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

RECEIVED
AUG 23 2006

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

MEMORANDUM and ORDER OF DISMISSAL

The division filed its second amended accusation on March 13, 2006. The parties submitted a Memorandum and Agreement and Proposed Decision and Order to the Alaska State Medical Board, intended to provide for the settlement of all issues raised in the second amended accusation. On July 14, 2006, the Alaska State Medical Board adopted the Memorandum and Agreement and issued a Decision and Order disposing of all issues raised in the second amended accusation. On August 3, 2006, the division notified the Office of Administrative Hearings of the board's action and requested dismissal of this case. The respondent has not objected.

Therefore,

CAM 8/23/06

IT IS HEREBY ORDERED:

1. Dismissal. Pursuant to 2 AAC 64.230(c), this case is DISMISSED.

DATED August 21, 2006.

By: Andrew M. Hemenway
Andrew M. Hemenway
Administrative Law Judge

The undersigned certifies that this date an exact copy of the foregoing was provided to the following individuals:
Colleen Murphy, M.D. (Paul Stockler, Atty)
Leslie Gallant
Rick Urion, Karen Hawkins AAG
Jennifer Strickler, DCCED
Signature Date
Neil Robert 8/21/06

MURPHY, MD
Inv.00077

Exhibit 13

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

Division of Corporations, Business and Professional Licensing

PROBATION STATUS CHANGE

RECEIVED
MAY 29 2007

May 24, 2007

Colleen Murphy MD
4100 Lake Otis Pkwy, Ste 330
Anchorage Alaska 99508

Profession	**Physician/Surgeon**	License/Certificate	**# S 3162**
Probation Start:	**05/26/2006**	Probation End:	**05/26/2007**
Changes to Probation	**Probation End**		
Effective Date	**05/26/2007**	Date Submitted	**05/24/2007**

Investigator: **Brian Howes, Senior Investigator**
Division of Corporations, Business and Professional Licensing

Distribution:
Richard C. Younkins, Chief Investigator
Jennifer Strickler, Chief, Licensing
Leslie Gallant, Executive Administrator
File: 2800-05-026

550 West 7th Avenue, Suite 1500, Anchorage, AK 99501-3567
Telephone: (907) 269-8160 Fax: (907) 269-8195 Website: www.commerce.state.ak.us/occ

Exhibit 14

Providence Alaska Medical Center
3200 Providence Drive
PO Box 196604
Anchorage, Alaska 99519-6604
t: (907) 562 2211
www.providence.org/alaska

June 24, 2011

PROVIDENCE
Alaska
Medical Center

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

Re: Murphy, Colleen M., M.D.

Dear Sir or Madam:

Providence Alaska Medical Center (PAMC) responds to your request dated **June 24, 2011** for information related to the above-referenced practitioner.

Staff Membership/Clinical Privileges status	Date
Original Appointment Date	11/23/1993
Privileges suspended due to state license suspension	7/2005
Reapplied for OB/GYN privileges	10/2005
GYN privileges granted and OB privileges granted with conditions	2/2006
OB privileges approved with proctoring and other conditions	5/2006
Proctoring requirements ended	5/2007
All privileges summarily suspended	12/8/2008
Final revocation of all clinical privileges and staff membership after hearing and appeals	10/6/2010
Department:	OB/GYN
Primary Specialty:	OB/GYN

Disciplinary actions/restrictions/limitations: See National Practitioner Data Bank Reports and Alaska State Medical Board

The foregoing is the extent to which the PAMC will respond to your inquiry regarding the above-referenced practitioner.

Sincerely

Kim Pakney, CPCS, CPMSM

Ms. Kim Pakney, CPCS, CPMSM
Manager, Medical Staff Services

110498/

MURPHY, MD
Inv.00197

Exhibit 15

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 07/06/2011

NAME:	Colleen Mary Murphy			**BIRTHDATE:**	08/10/1955
ADDRESS:	4100 Lake Otis Pkwy #330 Anchorage AK 995080000				
TYPE:	Medical Doctor			**ORIGINAL DATE:**	07/01/1982
LICENSE NUMBER:	4301044939	**STATUS:**	Lapsed - Disciplinary *Limited*	**EXPIRATION DATE:**	01/31/2000
OBTAINED BY:	Endorsement				

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT
07/01/1982	NBME	87.0

DISCIPLINARY ACTION

DSC/BD Vacated Order	07/31/2006
Fine Imposed	03/21/2007 - 03/21/2007
Limited / Restricted	03/21/2007

OPEN FORMAL COMPLAINTS NONE

Our records indicate that there has been disciplinary action taken by the licensing board against the licensee in question, or that there may be a pending formal administrative complaint concerning the licensee. Under the Michigan Freedom of Information Act (FOIA), 1976 PA 442, as amended, you may request a copy of all available disciplinary documents by writing to the Department of Community Health, Bureau of Health Professions, FOIA, P.O. Box 30670, Lansing, Michigan 48909 (Fax: (517) 241-1212). You will be charged pursuant to the Bureau's FOIA policy, if the documents are more than 40 pages total.

This license information was last updated on: 07/06/2011

Exhibit 16

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

June 30, 2011

Attn: Maryella E. Jansen
Washington Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

Re: *Colleen Mary Elizabeth Murphy, MD*

In response to your recent inquiry concerning the above referenced physician, the following summary of the reported information is provided.

Physician Identification:

Name:	**Colleen Mary Elizabeth Murphy, MD**
DOB:	**08/10/1955**
Medical School:	**Wayne State Univ Sch Med**
	Detroit, Michigan USA
Year of Grad:	**1981**

SUMMARY OF REPORTED ACTIONS

Reporting State/Agency: ALASKA
Date Of Order: 07/07/2005

Action(s): SUMMARY/EMERGENCY/IMMEDIATE/TEMPORARY SUSPENSION OF MEDICAL LICENSE
Basis for Action(s): Immediate Danger to the Public Health, Safety, or Welfare

Reporting State/Agency: ALASKA
Date Of Order: 10/21/2005

Action(s): SUSPENSION TERMINATED
Basis for Action(s): Not Applicable

Reporting State/Agency: MICHIGAN
Date Of Order: 02/16/2006
Effective Date: 03/18/2006

Action(s): SUSPENSION OF MEDICAL LICENSE
Term: Indefinite
Additional Detail: License suspended for a minimum period of six months and one day. Based on action taken by the Alaska Medical Board.
Basis for Action(s): Due to Action Taken by Another Board/Agency

Colleen Mary Elizabeth Murphy, MD

Failure to Report Adverse Actions Against Self in Accordance with Laws/Rules of the Board

---

Reporting State/Agency: ALASKA
Date Of Order: 07/14/2006
Form of Order: Memorandum of Agreement

Action(s): MEDICAL LICENSE PLACED ON PROBATION
Term: 1 Year(s)
Additional Detail: Probation retroactive to May 26, 2006. Practitioner agrees to comply with all required conditions of Providence Alaska Medical Center.

Basis for Action(s): Action by Hospital/Clinic/Professional Organization

---

Reporting State/Agency: MICHIGAN
Date Of Order: 07/31/2006
Form of Order: Order on Reconsideration

Action(s): VACATED PRIOR ORDER OF THE BOARD
Additional Detail: Order granting reconsideration, vacating Order of February 16, 2006, and remanding for compliance conference.

Basis for Action(s): Not Applicable

Reporting State/Agency: MICHIGAN
Date Of Order: 03/21/2007
Form of Order: Stipulation And Consent Order

Action(s): RESTRICTED FROM THE PRACTICE OF MEDICINE
Additional Detail: License limited for a minimum of one day. Shall not practice medicine in Michigan until verification is provided to theBoard that her Alaska medical license has been reinstated to a full and unlimited status. Based on action taken by the Alaska Board.

ASSESSED A FINE

Basis for Action(s): Due to Action Taken by Another Board/Agency
Failure to Report Adverse Actions Against Self in Accordance with Laws/Rules of the Board

---

LICENSE HISTORY

State Board	License Number
ALASKA	MED S 3162
MICHIGAN	4301044939

PLEASE NOTE: For more information regarding the above information, please contact the reporting state board or reporting agency. The information contained in this report was supplied voluntarily by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy of such information and assumes no reponsibility for any errors or omissions contained therein.

Exhibit 17

PERSONAL DATA QUESTIONS

1.) Are you now or have you ever been the subject of any investigations, sanctions, revocations, or suspensions of your medical registrations (licenses) or prescribing authority?

7/7/05: Alaska Medical License summarily suspended, 10/21/05 License reinstated following appeal of suspension and hearing, Memorandum of agreement signed with State Medical Board 7/14/06, expiration date 5/26/07, Completed 5/26/07. Was required to comply with terms of Obstetrics recredentialing requirements of Providence Alaska Medical Center, effective 5/26/06. Completed on 5/26/07.

In 3/06, I learned that the State of Michigan suspended my license after being notified by the Federation of State Medical Boards of the State of Alaska action in 2005. The State of Michigan had mailed communication to me in Yap Micronesia (I never lived there) requesting information on the State of Alaska activity. I had not updated my address since leaving the State in 1982 as required by Michigan statute. My license has since being changed to "lapsed". I have paid a $1000 fine for failure to notify and informed the Michigan State Medical Board on 6/1/07 of my completed probation in Alaska State.

2.) Have you ever been denied membership in or privileges at or otherwise investigated, sanctioned, or reprimanded by any medical institution, society, or association?

7/8/05; Automatically suspended from Providence Alaska Medical Center, Alaska Regional Hospital, and Health South Surgery Center following 7/7/05 Alaska State licensure action. 2/22/06: Granted GYN privileges at Providence Alaska Medical Center, OB privileges denied, appealed. Following 3/06 hearing, OB privileges granted on 5/26/06 with requirements of 5 precepted vaginal births after cesarean and 5 precepted operative vaginal deliveries. Denied OB privileges 8/9/06 at Alaska Regional Hospital, GYN privileges approved there in 12/06. Unrestricted OB-GYN privileges restored 5/26/07 at PAMC after 1 year proctor process that included 2 VBAC's and 3 vacuum extractions. OB-GYN privileges suspended by PAMC on 12/8/09. Fair Hearing panel conducted over 6 days in March and April 2009. Decision appealed in April 2009. PAMC Appellate Review Committee met in June 2009. They reversed the Fair Hearing Panel recommendations on 11/25/09 and 12/28/09. The Medical Executive Committee voted against their recommendations and this was again appealed. A final hearing was conducted on 5/17/10. The PAMC decision was finalized by the Providence Health Services Board on 10/6/10, whereby my hospital privileges at PAMC were permanently revoked. I was relicensed on 12/29/10 by the Alaska State Medical Board. I have also since been approved for ongoing recertification on 1/11/11 the American Board of Obstetrics & Gynecology. Based on The PAMC decision , Alaska Regional Hospital renewed my GYN privileges for 1 year on 10/14/10, with the requirement that all GYN cases be proctored.

FL

FILED
MAR 27 2012
Adjudicative Clerk

TINDALL BENNETT & SHOUP
A PROFESSIONAL CORPORATION
LAWYERS
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
TELEPHONE (907) 278-8533
FACSIMILE (907) 278-8536

FACSIMILE TRANSMISSION SHEET

DATE: March 27, 2012 **FAX NO:**

TO: Adjudicative Clerk's Office 360/586-2171
Kim O'Neal, AAG 360/664-0229

RE: Colleen Murphy Exhibit List and Exhibits

FROM: David H. Shoup

CLIENT/MATTER: 3746.00

NUMBER OF PAGES BEING TRANSMITTED (INCLUDING COVER SHEET) 3

ORIGINAL TO FOLLOW: Service copy to follow **VIA:** First Class Mail

SPECIAL INSTRUCTIONS OR MESSAGES:

Please see attached: Colleen Murphy's Exhibit List.

If there are any problems with this transmission, please call **Patty** at (907) 278-8533. Thank you.

EXHIBIT LIST

(There must be a separate exhibit list for each party.)

Court Case No. M2011-1510 **/ XX / Hearing**

Name of Party: Colleen Murphy, Respondent

Party's Attorney: David H. Shoup, Tindall Bennett & Shoup, 508 W. 2nd, 3rd Floor, Anch., AK 99501

Exhibit No. Marked for ID	BRIEF DESCRIPTION OF EXHIBIT	FOR COURT USE ONLY						
		ID by Wit.	Offered	Admitted	With-drawn date	To Jury/ Judge	From Jury/ Judge	To Exhibit Clerk
A	CPEP letter to Dr. Murphy 3/8/12							
B	CPEP Assessment Report							
C	Murphy Response to AK State Medical Board re: PAMC Report							
D								
E								
F								
G								
H								
I								
J								
K								
L								
M								
N								

I certify that exhibits checked "To Jury / Judge" on all pages were given to the jury / judge for delivery / advisement.
Date: _____ In-Court Clerk:_____

I certify that exhibits checked "From Jury / Judge" on all pages were given to the jury / judge for delivery / advisement.
Date: _____ In-Court Clerk:_____

I certify that all exhibits were: / / Placed in Interim Storage / / Returned to counsel per order of the Court
Date: _____ In-Court Clerk:_____ Atty sig.:_____Date: _____

I certify that the exhibits checked "To Exhibit Clerk" on all pages have been placed in Exhibit storage.
Date: _____ Exhibits Clerk:_____

FILED
MAR 27 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of: COLLEEN M. MURPHY, Credential No. MD60236731 Respondent.	Master Case No.M2011-1510

CERTIFICATE OF SERVICE

I certify that I am employed at the law offices of Tindall Bennett & Shoup, and that on the 27th day of March, 2012, a copy of Respondent's Witness List was faxed to the following, and the Exhibit List with Exhibits were mailed to the following:

Adjudicative Service Unit
P.O. Box 47879
310 Israel Road SE
Tumwater, WA 98501

Kim O'Neal, AAG
Office of the Attorney General
P.O. Box 40100
Olympia, WA 98504-0100

DATED at Anchorage, Alaska this 27th day of March, 2012.

By: Patty Taylor
Patty Taylor
Legal Assistant

TINDALL BENNETT & SHOUP, P.C.
502 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 278-8533
FAX (907) 278-8536

FILED
MAR 27 2012
Adjudicative Clerk

Rob McKenna
ATTORNEY GENERAL OF WASHINGTON
Government Compliance & Enforcement Division
PO Box 40100 • Olympia, WA 98504-0100 • (360) 664-9006

FAX COVER SHEET

Date: March 27, 2012

Time: 2:40 PM

Please deliver the following 5 pages (including this page) to:

TO: **ADJUDICATIVE CLERK'S OFFICE** **Fax No. 586.2171**
DOH

CC: **DAVID SHOUP** **Fax No. 907.278.8536**
Attorney at Law

COMMENTS:

RE: ***Colleen M. Murphy***
No. M2011-1510

Attached is the Department's Exhibit List. Hard copy to follow with the exhibits.

FROM: **NERISSA RAYMOND**
Legal Assistant

Fax Number: 360.664.0229
Voice Number: 360.753.1530

If there is a problem receiving this fax, please call Nerissa at 360.753.1530.

THE ATTORNEY GENERAL'S OFFICE DOES NOT ACCEPT SERVICE BY FAX.

FILED
MAR 27 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DEPARTMENT'S EXHIBIT LIST

COMES NOW the State of Washington, Department of Health, Medical Quality Assurance Commission (Department), by and through its attorneys, ROBERT M. MCKENNA, Attorney General, and KIM O'NEAL, Senior Counsel, and provides the following list of exhibits it may use at the hearing scheduled in this matter.

1. Notice of Decision on Application, dated October 28, 2011 (Inv. 6-8)
2. Respondent's Medical Practice Application for Washington (Inv. 26-31)
3. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Affidavit of Investigator, dated June 15, 2005 (Inv. 82-84)
4. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

Board, No. 2800-05-026; Petition for Summary Suspension of Physician License, dated July 7, 2005 (Inv. 79-81)

5. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Order for Summary Suspension, dated July 7, 2005 (Inv. 85)
6. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Accusation, dated July 14, 2005 (Inv.178-183)
7. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Order, dated July 14, 2005 (Inv. 95)
8. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Amended Accusation, dated July 22, 2005 (Inv. 187-192)
9. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Decision on Summary Suspension, dated September 14, 2005 (Inv. 34-66)
10. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Memorandum of Agreement, dated June 19, 2006 (Inv. 86-95)
11. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

Board, No. 2800-05-026; Notice of Board's Adoption of Memorandum of Agreement, dated August 3, 2006 (Inv. 76)

12. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Before the State Medical Board, No. 2800-05-026; Memorandum and Order of Dismissal, dated August 21, 2006 (Inv. 77)

13. State of Alaska Department of Commerce, Community and Economic Development, Division of Occupational Licensing, Probation Status Change, dated May 24, 2007 (Inv. 78)

14. Providence Alaska Medical Center, Clinical Privileges Status Summary of Respondent, dated June 24, 2011 (Inv. 197)

15. State of Michigan, Department of Community Health; Verification of Licensure (Inv. 194)

16. Federation of Sate Medical Boards of the United States, Inc., Summary of Reported Actions, dated June 30, 2011 (Inv. 198-199)

17. Respondent's Personal Data Questions (Inv. 108)

The Department reserves the right to use any exhibit produced by Respondent. The Department further reserves the right to amend its exhibit list for good cause shown.

DATED this 27th day of March, 2012.

ROBERT M. MCKENNA
Attorney General

KIM O'NEAL, WSBA #12939
Senior Counsel

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

PROOF OF SERVICE

I certify that I served a copy of this document on all parties or their counsel of record on the date below as follows:

DAVID H. SHOUP
ATTORNEY AT LAW
508 WEST 2ND AVE FL 3
ANCHORAGE, AK 99501

☒ US Mail Postage Prepaid via Consolidated Mail Service

☒ Facsimile: (907) 278-8536

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 27th day of March, 2012, at Olympia, WA.

Nerissa Raymond
NERISSA RAYMOND
Legal Assistant

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

FL

FILED
MAR 06 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of: COLLEEN M. MURPHY, Credential No. MD60236731 Respondent.	Master Case No.M2011-1510

RESPONDENT'S WITNESS IDENTIFICATION LIST

Respondent, by and through counsel, submits her witness identification list as follows:

1. Colleen Murphy
   c/o Tindall Bennett & Shoup

2. Any witnesses on the Department's Witness List.

3. Any witnesses needed for rebuttal.

DATED this 28th day of February, 2012.

TINDALL BENNETT & SHOUP, P.C.
Attorneys for Respondent

By: _____
David H. Shoup
Alaska Bar No. 8711106
Washington Bar No. 39131

I hereby certify that on the 28th day of February, 2012, a true and correct copy of the foregoing was sent to the following via:

☑ Mail ☐ Hand Delivered ☑ Fax ☐ Email

Kim O'Neal, AAG
Office of the Attorney General
P.O. Box 40100
Olympia, WA 98504-0100

By: _____
Tindall Bennett & Shoup, P.C.

TINDALL BENNETT & SHOUP, P.C.
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 278-8533
FAX (907) 278-8536

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSUANCE COMMISSION

In the Matter of: COLLEEN M. MURPHY, M.D. Application No. MD.MD.60236731, Applicant.	Master Case No. M2011-1510 PREHEARING ORDER NO. 1: ORDER RESETTING PREHEARING CONFERENCE

A prehearing conference in this matter was originally scheduled for June 1, 2012. However, a scheduling conflict has arisen that requires setting a new date.

Pursuant to WAC 246-11-290(2)(b), the Presiding Officer has RESCHEDULED the prehearing conference to **May 30, 2012, at 1:00 p.m.** The parties were notified by the Adjudicative Service Unit and agreed to the new date.

Dated this 1 day of March, 2012.

Frank Lockhart
FRANK LOCKHART, Health Law Judge
Presiding Officer

DECLARATION OF SERVICE BY MAIL
I declare that today I served a copy of this document upon the following parties of record:
DAVID SHOUP, ATTORNEY AT LAW AND KIM O'NEAL, AAG by mailing a copy properly addressed with postage prepaid.

DATED AT OLYMPIA, WASHINGTON THIS 2nd DAY OF MARCH, 2012.

Michelle Singer
Adjudicative Service Unit

cc: DANI NEWMAN
MICHAEL FARRELL

For more information, visit our website at http://www.doh.wa.gov/hearings.

FILED
FEB 28 2012
Adjudicative Clerk

Rob McKenna
ATTORNEY GENERAL OF WASHINGTON
Government Compliance & Enforcement Division
PO Box 40100 • Olympia, WA 98504-0100 • (360) 664-9006

FAX COVER SHEET

Date: February 28, 2012

Time: 12:09 PM

Please deliver the following 2 pages

TO: ADJUDICATIVE CLERKS OFFICE

Fax Number: (360) 586-2171

AND TO: DAVID H. SHOUP, ATTORNEY FOR RESPONDENT

Fax Number: (907) 278-8536

COMMENTS:

Colleen M. Murphy
DOH Master Case No. M2011-1510
Following are the Department's Witness List and Declaration of Service. Copies will follow by mail.

FROM: Kim O'Neal, Assistant Attorney General

Fax Number: 360-664-0229
Voice Number: 360-586-1913

If there is a problem receiving this fax, please call Meghan Lehnhoff at 360-586-2622.

THE ATTORNEY GENERAL'S OFFICE DOES NOT ACCEPT SERVICE BY FAX.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, *Application No. MD60236731* Respondent.	NO. M2011-1510 DEPARTMENT'S WITNESS LIST

COMES NOW the State of Washington, Department of Health, Medical Quality Assurance Commission (Department), by and through its attorneys, ROBERT M. MCKENNA, Attorney General, and KIM O'NEAL, Senior Counsel, and provides the following witness list.

The Department intends to call Respondent as an adverse witness.

The Department may also call all or some of the following witnesses:

1. Betty Elliott, Licensing Manager, Medical Quality Assurance Commission
2. Any additional witness, as necessary to provide foundational or other necessary evidentiary testimony for the admission of exhibits.

The Department reserves the right to call in its case in chief any witness identified by Respondent. The Department reserves the right to call rebuttal witnesses who may or may not be identified in its witness list. The Department further reserves the right to amend its witness list for good cause shown.

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

DATED this 28th day of February, 2012.

ROBERT M. MCKENNA
Attorney General

Kim O'Neal

KIM O'NEAL, WSBA#12939
Senior Counsel
Attorneys for Department

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DECLARATION OF SERVICE

I declare under penalty of perjury under the laws of the state of Washington that on February 28, 2012, I served a true and correct copy of the Department's Witness List and this Declaration of Service by fax and by placing same in the U.S. Mail via state Consolidated Mail Service to:

DAVID H. SHOUP
TINDALL BENNETT & SHOUP, P.C.
508 W. SECOND AVENUE, THIRD FLR
ANCHORAGE, AK 99501

DATED this 28th day of February, 2012, at Olympia, WA.

MEGHAN LEHNHOFF
Legal Assistant

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

FEB 29 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DEPARTMENT'S WITNESS LIST

COMES NOW the State of Washington, Department of Health, Medical Quality Assurance Commission (Department), by and through its attorneys, ROBERT M. MCKENNA, Attorney General, and KIM O'NEAL, Senior Counsel, and provides the following witness list.

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ORIGINAL

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

DATED this 8th day of February, 2012.

ROBERT M. MCKENNA
Attorney General

KIM O'NEAL, WSBA#12939
Senior Counsel
Attorneys for Department

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

RECEIVED
FEB 29 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DECLARATION OF SERVICE

I declare under penalty of perjury under the laws of the state of Washington that on February 28, 2012, I served a true and correct copy of the Department's Witness List and this Declaration of Service by fax and by placing same in the U.S. Mail via state Consolidated Mail Service to:

DAVID H. SHOUP
TINDALL BENNETT & SHOUP, P.C.
508 W. SECOND AVENUE, THIRD FLR
ANCHORAGE, AK 99501

DATED this 28th day of February, 2012, at Olympia, WA.

MEGHAN LEHNHOFF
Legal Assistant

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

FEB 29 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DEPARTMENT'S WITNESS LIST

COMES NOW the State of Washington, Department of Health, Medical Quality Assurance Commission (Department), by and through its attorneys, ROBERT M. MCKENNA, Attorney General, and KIM O'NEAL, Senior Counsel, and provides the following witness list.

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The Department may also call all or some of the following witnesses:

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2. Any additional witness, as necessary to provide foundational or other necessary evidentiary testimony for the admission of exhibits.

The Department reserves the right to call in its case in chief any witness identified by Respondent. The Department reserves the right to call rebuttal witnesses who may or may not be identified in its witness list. The Department further reserves the right to amend its witness list for good cause shown.

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

DATED this 28th day of February, 2012.

ROBERT M. MCKENNA
Attorney General

KIM O'NEAL, WSBA#12939
Senior Counsel
Attorneys for Department

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

FEB 29 2012
Adjudication

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the Application to Practice as a Physician and Surgeon of: COLLEEN M. MURPHY, Application No. MD60236731 Respondent.	NO. M2011-1510 DECLARATION OF SERVICE

I declare under penalty of perjury under the laws of the state of Washington that on February 28, 2012, I served a true and correct copy of the Department's Witness List and this Declaration of Service by fax and by placing same in the U.S. Mail via state Consolidated Mail Service to:

DAVID H. SHOUP
TINDALL BENNETT & SHOUP, P.C.
508 W. SECOND AVENUE, THIRD FLR
ANCHORAGE, AK 99501

DATED this 28th day of February, 2012, at Olympia, WA.

MEGHAN LEHNHOFF
Legal Assistant

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of:	)	
	)	Master Case No. M2011-1510
COLLEEN M. MURPHY, MD	)	
Credential No. MD.MD.60236731	)	SCHEDULING ORDER/
Respondent.	)	NOTICE OF HEARING
	)	

On January 3, 2012 the presiding officer established the following schedule:

Activity	Date
Witness Identification	February 28, 2012
Exhibits Filed	March 27, 2012
Discovery Completion	April 24, 2012
All Motions including Dispositive Motions	May 1, 2012
Prehearing Memorandum	May 22, 2012
Prehearing Conference	June 1, 2012
Hearing	July 13, 2012

Pursuant to WAC 246-11-070, an attorney wishing to represent a party must submit a Notice of Appearance.

Motions must be filed with the Adjudicative Service Unit [ASU], with a copy provided for the Presiding Officer, and served on the opposing party. The opposing party has eleven (11) days from the date of the motion to respond, unless otherwise directed by the Presiding Officer. Responses must be filed with the Adjudicative Service Unit, with a copy provided for the Presiding Officer, and served on the opposing party.

PREHEARING CONFERENCE

A prehearing conference, pursuant to RCW 34.05.431 and WAC 246-11-390, is scheduled for:

TIME: 1:00 p.m.
DATE: June 1, 2012

This conference will be convened by telephone. At least two working days before the scheduled conference, each party must provide its telephone contact number to the Adjudicative Service Unit.

The names, addresses, and telephone numbers of the presiding officer, the parties, and their representatives are attached. If the telephone number on the attached contact list is correct, no further action is required.

A prehearing conference memorandum must be filed with the Adjudicative Service Unit, with a copy provided for the presiding officer, and served on the opposing party four business days prior to the scheduled prehearing conference. The memorandum should include:

1) Matters that relate to amendments of the pleadings;
2) A written statement of facts prepared by each party or a stipulated statement of the facts. The parties are encouraged to meet prior to the conference and identify those facts that are admitted and those that are at issue;
3) A statement by each party of the issues to be resolved at the hearing. A joint statement of the issues is preferred;
4) A list of all witnesses to be examined at the hearing;
5) A statement by each party of the relief requested and
6) All documents or other exhibits to be admitted at the hearing

The prehearing conference may be recorded. A prehearing order will be issued following the conference. Any materials the parties wish to submit for consideration must be sent to the Adjudicative Service Unit, with a copy provided for the Presiding Officer, and served on the opposing party. This prehearing date may be changed or cancelled at the discretion of the Presiding Officer. If you do not appear at the prehearing, an order of default will be entered against you.

This matter is set for hearing on the following date and time:

TIME: **To be announced**
DATE: **July 13, 2012**
PLACE: **To be announced**

The hearing date may be changed or canceled at the discretion of the Presiding Officer. If a party fails to appear at the scheduled date and time, an order of default will be entered.

This Scheduling Order may be vacated under the following conditions:

1) Upon receipt by the Adjudicative Service Unit of an order disposing of the case (e.g. Stipulation and Agreed Order signed by the parties **and** the disciplining authority) or
2) Upon receipt by the Adjudicative Service Unit of an Amended Statement of Charges

This scheduling order is mandatory on all parties.

DATED THIS 12th DAY OF JANUARY, 2012

Michelle Singer

Michelle Singer, Adjudicative Clerk
Adjudicative Clerk Office

ADJUDICATIVE SERVICE UNIT:
PO Box 47879
Olympia, WA 98504-7879
310 Israel Road SE
Tumwater, WA 98501
Phone: (360) 236-4670
Fax: (360) 586-2171

PRESIDING OFFICER:
Frank Lockhart
PO Box 47879
Olympia, WA 98504-7879
Phone: (360) 236-4677

PARTIES:

Respondent's counsel:
David Shoup
Tindall Bennett & Shoup PC
508 W 2nd Ave 3rd Floor
Anchorage, AK 99501
Phone: (907) 278-8533

Respondent:
Colleen M. Murphy, MD
281 Illiamna Ave
Anchorage, AK 99517
Phone: (907) 243-1939

Assistant Attorney General:
Kim O'Neal, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100
Phone: (360) 586-2747
Fax: (360) 664-0229

Disciplinary Manager:
Dani Newman
Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: (360) 236-2764

Representative for settlement purposes:
Michael Farrell, Staff Attorney
Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: (509) 329-2186

DECLARATION OF SERVICE BY MAIL

I declare that today, at Olympia, Washington, I served a copy of this document upon the following parties of record: David Shoup, Attorney for Respondent; Colleen M. Murphy, MD, Respondent; and Kim O'Neal, AAG; by mailing a copy properly addressed with postage prepaid.

DATED THIS 12th DAY OF JANUARY, 2012

Michelle Singer
Adjudicative Clerk Office

c: *Dani Newman, Disciplinary Manager*
Michael Farrell, Legal Unit

For information on the hearing process please visit our website at www.doh.wa.gov/hearings

AMERICANS WITH DISABILITIES ACT (ADA)- TITLE II

Persons with a disability, as defined under the ADA, requiring accommodations, are requested to contact the Adjudicative Service Unit, PO Box 47879, Olympia, WA 98504-7879 a minimum of seven (7) days before an event they wish to attend.

Telephone (360) 236-4677 FAX (360) 586-2171 TDD (360) 664-0064

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

FILED
JAN 05 2012
Adjudicative Clerk

In the matter of:

COLLEEN M. MURPHY, MD
Credential No. MD.MD.60236731

Respondent.

Master Case No. M2011-1510

ENTRY OF APPEARANCE

David H. Shoup of the firm TINDALL BENNETT & SHOUP, P.C., hereby enters his appearance for and on behalf of respondent in the above-entitled matter and requests that copies of all pleadings and documents be served upon said attorneys at 508 W. Second Avenue, Third Floor, Anchorage, Alaska 99501.

DATED in Anchorage, Alaska this 27th day of December, 2011.

TINDALL BENNETT & SHOUP, P.C.
Attorneys for Respondent

By: _____
David H. Shoup
Alaska Bar No.8711106

TINDALL BENNETT & SHOUP, P.C.
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 278-8533
FAX (907) 278-8536

I hereby certify that on the 27th day of December, 2011, a true and correct copy of the foregoing was sent to the following via:

☑ Mail ☐ Hand Delivered ☐ Fax ☐ Email

Adjudicative Service Unit: PO Box 47879 Olympia, WA 98504-7879 310 Israel Road SE Tumwater, WA 98501 PH: 360/236-4670 Fax:360/586-2171	**Assistant Attorney General** Kim O'Neal, AAG Office of Attorney General P.O. Box 40100 Olympia, WA 98504-0100 PH: 360/586-2747 Fax: 360/664-0229	**Rep for Settlement Purposes:** Michael Farrell, Staff Attorney Dept. Of Health P.O. Box 47866 Olympia, WA 98504-7866 PH: 509/329-2186
Presiding Officer: Frank Lockhart P.O. Box 47879 Olympia, WA 98504-7879 PH: 360/236-4677	**Disciplinary Manager** Dani Newman Dept. Of Health P.O. Box 47866 Olympia, WA 98504-7866 PH: 360/236-2764	

By: _____
Tindall Bennett & Shoup, P.C.

TINDALL BENNETT & SHOUP, P.C.
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 278-8533
FAX (907) 278-8536

FILED
JAN 03 2012
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the matter of: **COLLEEN M. MURPHY, MD** Credential No. MD.MD.60236731 Respondent.	Master Case No. M2011-1510

ENTRY OF APPEARANCE

David H. Shoup of the firm TINDALL BENNETT & SHOUP, P.C., hereby enters his appearance for and on behalf of respondent in the above-entitled matter and requests that copies of all pleadings and documents be served upon said attorneys at 508 W. Second Avenue, Third Floor, Anchorage, Alaska 99501.

DATED in Anchorage, Alaska this 27th day of December, 2011.

TINDALL BENNETT & SHOUP, P.C.
Attorneys for Respondent

By: _____
David H. Shoup
Alaska Bar No.8711106

TINDALL BENNETT & SHOUP, P.C.
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 276-8533
FAX (907) 276-8536

I hereby certify that on the 27th day of December, 2011, a true and correct copy of the foregoing was sent to the following via:

☑ Mail ☐ Hand Delivered ☐ Fax ☐ Email

Adjudicative Service Unit: PO Box 47879 Olympia, WA 98504-7879 310 Israel Road SE Tumwater, WA 98501 PH: 360/236-4670 Fax:360/586-2171	**Assistant Attorney General** Kim O'Neal, AAG Office of Attorney General P.O. Box 40100 Olympia, WA 98504-0100 PH: 360/586-2747 Fax: 360/664-0229	**Rep for Settlement Purposes:** Michael Farrell, Staff Attorney Dept. Of Health P.O. Box 47866 Olympia, WA 98504-7866 PH: 509/329-2186
Presiding Officer: Frank Lockhart P.O. Box 47879 Olympia, WA 98504-7879 PH: 360/236-4677	**Disciplinary Manager** Dani Newman Dept. Of Health P.O. Box 47866 Olympia, WA 98504-7866 PH: 360/236-2764	

By: _____
Tindall Bennett & Shoup, P.C.

TINDALL BENNETT & SHOUP, P.C.
508 WEST 2ND AVENUE, THIRD FLOOR
ANCHORAGE, ALASKA 99501
(907) 278-8533
FAX (907) 278-8536

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of:	)	
	)	Master Case No. M2011-1510
COLLEEN M. MURPHY, MD	)	
Credential No. MD.MD.60236731	)	SCHEDULING ORDER/
	)	NOTICE OF STATUS
Respondent.	)	CONFERENCE AND
	)	PROTECTIVE ORDER

The Respondent requested a hearing in this matter. In accordance with RCW 34.05.419, an adjudicative proceeding has been commenced.

Pursuant to WAC 246-11-070, an attorney wishing to represent a party must submit a Notice of Appearance.

This matter is set for a status conference:

TIME: **10:30 a.m.**
DATE: **January 3, 2012**

This conference will be convened by telephone. At least two working days before the scheduled conference, each party must provide its telephone contact number to the Adjudicative Service Unit.

The names, addresses and telephone numbers of the Presiding Officer, the parties, and their representatives are attached. If the telephone number on the attached contact list is correct, no further action is required.

The case schedule will be set during this status conference. A Scheduling Order/Notice of Hearing will be served on all parties following this status conference.

The status conference may be recorded. This status conference date may be changed or canceled at the discretion of the Presiding Officer. **You must participate in the telephone status conference**. If you do not, a default will be entered. This means your credential may be revoked, suspended or denied without further input from you.

Any request to change the date or time of the status conference must be made **in writing**, at least two working days before the scheduled conference with a copy to the opposing party.

You are hereby notified that this adjudicative proceeding is being conducted to make a determination regarding the Statement of Charges.

This scheduling order may be vacated under the following conditions:

1) Upon receipt by the Adjudicative Service Unit of an order disposing of the case (e.g. Stipulation and Agreed Order signed by the parties **and** the disciplining authority) or

2) Upon receipt by the Adjudicative Service Unit of an Amended Statement of Charges

This scheduling order is mandatory on all parties.

DATED THIS 22nd DAY OF DECEMBER, 2011

Michelle Singer, Adjudicative Clerk
Adjudicative Clerk Office

PROTECTIVE ORDER

This protective order prohibits the release of health care information outside of these proceedings. Unless required by law, anyone involved in these proceedings must keep confidential and not disclose health care information obtained through these proceedings. Health care information includes information in any form "that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care". RCW 70.02.010.

DATED THIS 22nd DAY OF DECEMBER, 2011

John Kuntz, Review Judge
Presiding Officer

ADJUDICATIVE SERVICE UNIT:
PO Box 47879
Olympia, WA 98504-7879
310 Israel Road SE
Tumwater, WA 98501
Phone: (360) 236-4670
Fax: (360) 586-2171

PRESIDING OFFICER:
Frank Lockhart
PO Box 47879
Olympia, WA 98504-7879
Phone: (360) 236-4677

PARTIES:

Respondent's counsel:
Pro se

Respondent:
Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517
Phone: (907) 243-1939

Assistant Attorney General:
Kim O'Neal, AAG
Office of the Attorney General
PO Box 40100
Olympia, WA 98504-0100
Phone: (360) 586-2747
Fax: (360) 664-0229

Disciplinary Manager:
Dani Newman
Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: (360) 236-2764

Representative for settlement purposes:
Michael Farrell, Staff Attorney
Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: (509) 329-2186

DECLARATION OF SERVICE BY MAIL

I declare that today, at Olympia, Washington, I served a copy of this document upon the following parties of record: Colleen M. Murphy, Respondent; and Kim O'Neal, AAG; by mailing a copy properly addressed with postage prepaid.

DATED THIS 22nd DAY OF DECEMBER, 2011.

Adjudicative Clerk Office

c: Dani Newman, Disciplinary Manager
Michael Farrell, Legal Unit

For information on the hearing process please visit our website at www.doh.wa.gov/hearings

AMERICANS WITH DISABILITIES ACT (ADA)- TITLE II

Persons with a disability, as defined under the ADA, requiring accommodations, are requested to contact the Adjudicative Service Unit, PO Box 47879, Olympia, WA 98504-7879 a minimum of seven (7) days before an event they wish to attend.

Telephone (360) 236-4677 FAX (360) 586-2171 TDD (360) 664-0064

FILED
NOV 28 2011
Adjudicative Clerk

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of:	NO. M2011-1510
COLLEEN M. MURPHY, MD Application No. MD.MD.60236731 Applicant.	NOTICE OF APPEARANCE

TO: ADJUDICATIVE CLERK'S OFFICE
AND: COLLEEN M. MURPHY, Applicant

YOU AND EACH OF YOU WILL PLEASE TAKE NOTICE that State of Washington, Department of Health, Medical Quality Assurance Commission, enters its appearance in the above-entitled matter by and through its attorneys, ROBERT M. MCKENNA, Attorney General, and KIM O'NEAL, Senior Counsel, and requests that all further documents, notices, and pleadings in this matter, except original process, be served at the address stated below.

DATED this 23rd day of November, 2011

ROBERT M. MCKENNA
Attorney General

KIM O'NEAL, WSBA No. 12939
Senior Counsel

ORIGINAL

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

PROOF OF SERVICE

I certify that I served a copy of this document on all parties or their counsel of record on the date below as follows:

Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517-1217

☒US Mail Postage Prepaid via Consolidated Mail Service

☐ABC/Legal Messenger

☐State Campus Delivery

☐Hand delivered by _____

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 23rd day of November, 2011, at Olympia, WA.

Tina Bushaw

TINA BUSHAW, Legal Assistant
Tinab@atg.wa.gov

ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100
(360) 664-9006

PROG ATTY LEGAL

REQUEST FOR HEARING

FILED
NOV 07 2011
Adjudicative Clerk

Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517-1217

No. M2011-1510

Request for Hearing

☒ I disagree with the Notice of Decision regarding my application, and I request a hearing. I am contesting the decision because: (attach additional pages if needed)

the Alaska State Medical Board has not proceeded with disciplinary action. The Quality of peer review at Providence Alaska Medical Center was based on the locality rule admittedly not following the national standard of care despite board certification requirements in By laws.

Representation Information

☒ I will be represented by an attorney. (Your attorney must file a notice of appearance with the Adjudicative Clerk Office.)

Request for Interpreter at Hearing

☐ I request that a qualified interpreter be appointed to interpret for me and/or for my witness(es) at hearing for the following language(s):

_____ _____

_____

☐ I request that a qualified interpreter be appointed to interpret for me and/or for my witness(es) at hearing, due to hearing or speech impairment, for the following language(s):

_____

ORIGINAL

Return this form to with a copy of the Notice of Decision of Application to:

Adjudicative Clerk Office
Department Of Health
PO Box 47879
Olympia, WA 98504-7879

Dated: 10/31/11

Signature: _____, Applicant

Notice of Decision on Application

October 28, 2011

Colleen M. Murphy, MD
2811 Illiamna Avenue
Anchorage, Alaska 99517

Re: Application No. MD.MD.60236731

Dear Dr. Murphy:

Thank you for your application for a license to practice as a physician and surgeon in the state of Washington. Following review of your application file, the Medical Quality Assurance Commission (Commission) has decided to deny your application.

Basis for this Decision. The Commission based its decision on the following facts.

You are a physician board-certified in obstetrics and gynecology. On April 6, 2005, the Alaska Regional Hospital summarily suspended your obstetrical privileges.

On July 7, 2005, based on the suspension of your privileges at Alaska Regional Hospital, the Alaska State Medical Board issued an order suspending your license to practice medicine in the state of Alaska. Based on the suspension of your medical license, Alaska Regional Hospital and Providence Alaska Medical Center suspended your privileges at those hospitals. On July 14, 2005, the Board issued an Accusation alleging that your actions in five cases constituted professional incompetence, gross negligence or repeated negligent conduct.

On September 14, 2005, following a hearing, an administrative law judge issued a Decision on Summary Suspension finding that the prosecutor did not establish a failure to meet the standard of care or professional incompetence. The judge recommended that the Alaska State Medical Board vacate the order of summary suspension and address the issues raised in the case in the context of a complete hearing on the merits.

On February 22, 2006, Providence Alaska Medical Center granted you gynecological privileges, but denied you obstetrical privileges. Following a hearing in March 2006, Providence granted you obstetrical privileges and required five precepted vaginal births after cesarean and five precepted operative vaginal deliveries.

On June 19, 2006, you entered into a Memorandum of Agreement (MOA) with the Alaska State Medical Board. The MOA imposed sanctions against your license, including (1) a one-year period of probation, (2) a requirement to comply with conditions of practice of

Providence Alaska Medical Center, (3) a requirement that you notify the Chief of Staff and Administrator of any hospital at which you have privileges of the terms of your probation and provide a copy of the MOA, (4) a requirement to notify the Board's representative immediately of obtaining hospital privileges at any hospital, (5) a requirement to report in person to the Board to allow review of your compliance with probation, and (6) obey all laws pertaining to your license in this state or any other state. On July 14, 2006, the Alaska State Medical Board adopted the MOA.

On August 9, 2006, Alaska Regional Hospital denied you obstetrical privileges. In December 2006, Alaska Regional Hospital granted you gynecological privileges.

On March 21, 2007, you entered into a Stipulation and Consent Order with the Michigan Board of Medicine in which you were restricted from practicing medicine in the state of Michigan until you provided verification that your Alaska license had been reinstated. You subsequently allowed your Michigan license to lapse.

On May 26, 2007, the Alaska State Medical Board terminated your probation. Providence then granted you unrestricted privileges in obstetrics and gynecology.

On December 8, 2009, Providence suspended your privileges in obstetrics and gynecology. On October 6, 2010, Providence made a final decision to permanently revoke your clinical staff privileges and medical staff membership According to an Adverse Action Report to the National Practitioner Data Bank, this action was based on nine cases, including three delayed obstetrical intervention cases, inappropriate vaginal delivery of a large premature breach-positioned infant through an unproven pelvis, inappropriate pain management, alcohol on call, failure or refusal to comply with the spirit of a proctoring program, and poor professional communications/interactions with patients and staff.

Based on Section 18.130.055(1)(b) of the Revised Code of Washington (RCW), the Commission decided to deny your application subject to conditions based on acts defined as unprofessional conduct under RCW 18.130.180(4), which provides in part:

> **RCW 18.130.180 Unprofessional Conduct**
> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. ...

Your Right to a Hearing. If you disagree with this decision, you may request a hearing by completing the enclosed Request for Hearing form and sending it to the Department of Health, Adjudicative Clerk Office, at the following address:

Adjudicative Clerk Office
Department Of Health
PO Box 47879
Olympia, WA 98504-7879

Your request must be in writing, state your basis for contesting the decision, and include a copy of this Notice of Decision on Application.

The Adjudicative Clerk Office must receive your completed Request for Hearing within 28 days of the date this Notice was sent to you or your Request for Hearing will not be considered and you will not be entitled to a hearing. If the Adjudicative Clerk Office does not receive your Request for Hearing by January 13, 2011 the decision to deny your application will be final.

What Happens at a Hearing? If you decide to present your application to a hearing panel, you will have the burden of proving, more probably than not, that you are qualified for licensure under the Uniform Disciplinary Act (RCW 18.130), Chapter 18.71 RCW, and the rules adopted by the Commission.

Your Right to an Interpreter at Hearing. You may request an interpreter to translate at the hearing if English is not your primary language or the primary language of any of any witness who will testify at hearing. You may also request interpretive assistance if you or any witness has a hearing or speech impairment.

Questions? Please call me at (509) 329-2186 if you have any questions.

Sincerely,

MICHAEL FARRELL, WSBA #16022
DEPARTMENT OF HEALTH STAFF ATTORNEY

Enclosure

DECLARATION OF SERVICE BY MAIL

I declare that today, October 28, 2011, at Olympia, Washington, I served a copy of this document by mailing a copy properly addressed with postage prepaid to the applicant at the following address:

Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517-1217

Dated: October 28, 2011

Signature: Debra Bondurant
Debra Bondurant, Legal Secretary

REQUEST FOR HEARING

Colleen M. Murphy, MD
2811 Illiamna Ave
Anchorage, AK 99517-1217

No. M2011-1510

Request for Hearing

☐ I disagree with the Notice of Decision regarding my application, and I request a hearing. I am contesting the decision because: (attach additional pages if needed)

_____
_____
_____
_____
_____
_____
_____
_____

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