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

In the Matter of the First Amended Accusation Against: **Douglas Peter Murphy, M.D.** 1551 Bishop St., Ste. A150 San Luis Obispo, CA 93401 Physician's and Surgeon's Certificate No. A65282, Respondent.	Case No. 800-2014-003156 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 22, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number A65282 to Douglas Peter Murphy, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2018, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct that would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence and/or Repeated Negligent Acts related to the care of Patient G.R.)

7. Respondent is subject to disciplinary action under sections 2234 and/or 2234(c) and/or 2234(d) in that Respondent was incompetent and/or committed repeated negligent acts in the care and treatment of Patient G.R. The circumstances are as follows:

8. Respondent treated Patient G.R. during two separate periods of time, with the first period beginning in March 2005 and ending around February 2007. The second period of treatment began in August 2009 and ended when Patient G.R. killed himself on March 23, 2013 at the age of 65.

9. In August 2009, Respondent began prescribing Patient G.R. Clonazepam[1] and Venlafaxine[2]. In November 2009, Respondent added Buproprion (Wellbutrin)[3]. In a letter

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[1] Clonazepam is a benzodiazepine and a central nervous system depressant. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

[2] Venlafaxine, trade name Effexor, is an antidepressant. It is a dangerous drug as defined in section 4022.

[3] Buproprion, trade name Wellbutrin, is an antidepressant. It is a dangerous drug as defined in section 4022.

written to the San Luis Obispo Coroner's Office, Respondent stated that he added Buproprion to address sexual side effects. Patient G.R. was being treated for insomnia, however, a common side effect of Buproprion is to cause insomnia or aggravate pre-existing insomnia.

10. Despite the addition of Buproprion, Respondent did not see Patient G.R. for two months. The record of Patient G.R.'s 20-minute January 26, 2010 visit with Respondent does not reflect significant symptoms of anxiety and does not indicate a plan to prescribe Lorazepam (Ativan)[4]. However, a fax prescription form with the same date indicates Respondent prescribed Patient G.R. Ativan. The progress note indicates a plan to taper off Venlafaxine, but the clinical rationale is not given. The records fail to state a rationale for these changes in medication treatment.

11. Close monitoring and follow-up are the standard of care during anti-depressant tapering since it may be associated with adverse effects, changes in depressive or anxious symptoms, and changes in insomnia. Despite the tapering of Venlafaxine and starting a new medication, Lorazepam, the next scheduled follow-up visit was to be in two months.

12. Respondent next saw Patient G.R. for 20 minutes on April 1, 2010. The record does not reflect what if any changes in sexual functioning occurred with the discontinuation of Venlaflaxine. Patient G.R. reported that he has been "hit and miss" on Bubproprion.

13. Respondent next saw Patient G.R. for 20 minutes on June 21, 2010. Respondent's records are partially illegible. The portion of the record that is legible reflects that Patient G.R.'s primary care physician (PCP) prescribed Patient G.R. Restoril (Temazepam[5]) for sleep. This is incorrect. Prescription records show that Patient G.R.'s PCP had prescribed him Triazolam[6]. Despite Patient G.R.'s need for additional sleep medication, Respondent rated his insomnia the

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[4] Lorazepam, trade name Ativan, is a psychotropic drug for the management of anxiety disorders. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

[5] Temazepam, trade name Restoril, is a hypnotic agent. It is indicated for the short-term treatment of insomnia, generally 7 to 10 days only. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

[6] Triazolam, is a benzodiazepine and a central nervous system depressant. It is used to treat severe insomnia and indicated for short term use only. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

same as the prior visit ("1-2"). Respondent fails to note any inquiry into the nature or the severity of Patient G.R.'s insomnia or the reason why he received an additional prescription for Restoril from his PCP on top of the Lorazepam that Respondent was already prescribing. There is no record that Respondent checked CURES (the Department of Justice Controlled Substance Utilization Review and Evaluation System) or took any other steps to verify the medication prescribed to Patient G.R. There is no record that Respondent consulted with Patient G.R.'s PCP to see why both physicians were treating the same problem and/or to coordinate care as required by the standard of care.

14. Respondent next saw Patient G.R. three months later on September 10, 2010. The records reflect that Patient G.R. is having a "very challenging year" in business and can't sleep because of the stress. The treatment plan was to increase the dose of Triazolam from .25 mg to one or two tablets at bedtime, to add over-the-counter Benadryl (Diphenhydramine) as needed for sleep, and to follow-up six months later. The records do not reflect how much Ativan Patient G.R. was taking at bedtime nor do they reflect any care coordination with Patient G.R.'s PCP who was prescribing the Triazolam.

15. Moreover, the medical records provide little information about Patient G.R.'s psychiatric condition at the time. His insomnia was being treated with three medications: Lorazepam, Triazolam, and Diphenhydramine. At the same time, Respondent continued to prescribe Bubproprion, even though it may cause insomnia or worsen pre-existing insomnia. Despite the presence of worsening insomnia and changes in medication, the next follow-up appointment was to be in six months. Moreover, Respondent never referred Patient G.R. to a sleep specialist or a sleep clinic to assess other possible causes of Patient G.R.'s chronic and worsening insomnia.

16. Respondent next saw Patient G.R. for 20 minutes on December 20, 2010 because the Patient reported he "hit a bit of a stumble." The record notes that the patient is off of Buproprion and "feeling so good" without it. The record does not indicate the state of the patient's insomnia or anxiety, even though medications were changed at the prior visit. The record provides no information as to how much Triazolam, Lorazepam, or Benadryl the patient is using, even though

the dosages were flexible. The treatment plan adds a trial of Lexapro without explanation. Fax prescription forms in the file show a prescription for Celexa (Citalopram[7]) and Lorazepam.

17. Respondent next saw Patient G.R. on January 26, 2011. Respondent notes that there was a misunderstanding with the patient about Buproprion and that the patient did not know he was supposed to still be taking it. The treatment plan was to continue Celexa and resume Buproprion. The rationale for restarting Buproprion is not explained, especially considering the patient's previous statement that he was "feeling so good" without it. The justification for treatment with two anti-depressants is not provided, especially considering the lack of target symptoms.

18. Respondent next saw Patient G.R. on March 8, 2011. Patient G.R. noted a lot of business stress, increased anxiety and early awakening. The treatment plan was to increase Celexa to 40 mg. The target symptoms for increasing the dosage are not stated in the record. The record does not reflect the patient's mood or effects of restarting Buproprion. There is no information about how much Triazolam and Lorazepam are being used. The records fail to indicate the clinical rationale for the medical treatment.

19. Respondent next saw Patient G.R. on May 13, 2011. The medical records fail to describe how Lorazepam and Triazolam are being used, how Patient G.R. responded to the increase in Celexa from the last visit, or any of the patient's symptoms related to mood, sleep or anxiety. At this point, Respondent is prescribing Patient G.R. Celexa, Wellbutrin, Lorazepam and Triazolam.

20. Respondent next saw Patient G.R. five months later on October 10, 2011. The record is minimal regarding this visit.

21. Respondent next saw Patient G.R. four months later on January 6, 2012. The record is very brief but states that Patient G.R. reported, "the inevitable has occurred" and "work stress." Family interviews with the Medical Board indicate that at this time Patient G.R.'s lifelong business was finally coming to an end as he had long feared.

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[7] Citalopram, trade name Celexa, is a selective serotonin reuptake inhibitor (SSRI) used in the treatment of depression. It is a dangerous drug as defined in section 4022.

22. Respondent next saw Patient G.R. for 20 minutes on April 6, 2012. The records are again very brief and contain little information. The treatment plan was to add Trazodone for sleep even though no sleep problems are reported or described, and even though Respondent is already prescribing Lorazepam and Triazolam for sleep.

23. Respondent next saw Patient G.R. on June 18, 2012. The record is sparse as to this visit, stating that his mood is "fine." There is no information as to how much and how often Patient G.R. is using Trazodone and Triazolam. The list of current medications does not include Trazodone, yet there is no indication of why or when this medication was stopped. The Beck Depression Inventory, a 21-question, multiple choice self report inventory used to measure the severity of depression, indicated Patient G.R. produced a score of 8 at this time, out of a possible 63. A score of 8 is considered to be minimal depression.

24. Respondent next saw Patient G.R. four months later on October 15, 2012. The medical record for this visit does not provide any information as to the patient's anxiety, sleep, stressors or changes in his psychosocial situation. Again, there is no indication as to how Trazodone and Triazolam are being used. The Beck Depression Inventory indicates Patient G.R. produced a score of 12 at this time, without further indication as to the reason for this increase. Patient G.R.'s mood is again noted as "fine." The treatment plan was to take Patient G.R. off of Celexa and start him on Lexapro[8], due to heart problems associated with long-term use of Celexa.

25. A fax prescription form dated October 15, 2012 indicates that at this time, Respondent prescribed Patient G.R. Lexapro, Wellbutrin SR, Ativan, Triazolam, and Trazodone. Trazodone had been changed from "as needed" to routine use without explanation. Respondent instructed Patient G.R. to return in six months. The standard of care necessitates that a patient taking five psychiatric medications with changes in medication return for a follow-up visit sooner than six months.

26. On Saturday, March 23, 2013, Patient G.R. killed himself. Moments before his death he told his wife that he felt like he was "in the Twilight Zone." His wife reported that he seemed

[8] Lexapro is a trade name for Escitalopram Oxalate and is an SSRI used in the treatment of depression. It is a dangerous drug as defined in section 4022.

confused and not like himself leading up to his suicide. Patient G.R. had agreed to call Respondent on Monday to check with him about his new medication, rather than waiting until his scheduled appointment in April.

27. In sum, Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(c), and/or 2234(d) of the Code in that Respondent was incompetent and/or committed repeated negligent acts in the practice of medicine regarding his treatment of Patient G.R., including but not limited to the following:

A. Respondent failed to conduct and/or document complete mental status examinations, including symptoms or signs of anxiety, agitation or motor manifestations, confusion or thought constriction, preoccupations or obsessions, and thought content, energy level, work performance or relationship issues, and/or;

B. Respondent failed to conduct and/or document an assessment for alcohol or drug use, and/or;

C. Respondent failed to conduct and/or document an assessment for access to weapons and/or weapons in the home, and/or;

D. Respondent failed to conduct and/or document a discussion with Patient G.R. regarding when or how to contact the Respondent in an emergency, and/or;

E. Respondent failed to obtain and/or document a referral to or consultation with a sleep specialist or clinic to assess other possible causes of Patient G.R.'s chronic insomnia, and/or;

F. Respondent failed to provide follow-up in a timely manner. The standard of care requires that Respondent provide timely follow-up when there are changes in symptoms, changes in treatment, or changes in psychosocial stressors, that may affect a patient's psychiatric condition. Monitoring of treatment is especially important when medications are changed or when multiple medications for the same clinical indication are used. Respondent failed to provide timely follow-up on numerous occasions, including, but not limited to, when he implemented a major change in medication treatment on January 26, 2010, but did not follow-up with Patient G.R. for two months.

G. Respondent failed to appropriately monitor the Major Depressive Disorder, the Generalized Anxiety Disorder and chronic insomnia he diagnosed in Patient G.R.

H. Respondent failed to coordinate treatment with Patient G.R.'s other health care providers as required by the standard of care.

I. Respondent failed to properly assess and diagnose Patient G.R., based on the scant medical records kept by Respondent. The medical records do not reflect the information necessary to support the diagnosis of Major Depressive Disorder, Recurrent, Moderate Severity and of Generalized Anxiety Disorder. The records do not show that relevant clinical laboratory tests were obtained, nor do they contain sufficient descriptions in the clinical history or the systems for accurate assessment and treatment planning.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence and/or Failure to Maintain Adequate and Accurate Records related to the care of Patient G.R.)

28. Paragraphs 7 through 27 above are incorporated as if fully set forth herein.

29. Respondent is subject to disciplinary action under sections 2234 and/or 2266 in that Respondent was incompetent and/or failed to maintain adequate and accurate medical records in the care and treatment of Patient G.R.

30. As detailed above, Respondent failed to maintain adequate and accurate medical records for Patient G.R. throughout his treatment of this patient. Respondent's medical records regarding Patient G.R. are sparse and often illegible. This is particularly concerning because Respondent had recently completed a Medical Record Keeping Course as required by his 2007 probation in a Medical Board disciplinary action, as specified below.

DISCIPLINARY CONSIDERATIONS

31. To determine the degree of discipline, if any, to be imposed on Respondent Douglas Peter Murphy, M.D., Complainant alleges that on or about November 5, 2007, in a prior disciplinary action entitled In the Matter of the Accusation Against Douglas Peter Murphy, M.D. before the Medical Board of California, in Case Number 08-2004-158376, Respondent's license was revoked, revocation stayed during a five-year probation, for gross negligence, repeated

negligent acts, and failure to maintain adequate and accurate records. Respondent was required to complete courses in Medical Record Keeping, Ethics, Professional Boundaries, an Educational Program, and a Clinical Training Program such as the Physician Assessment and Clinical Education Program (PACE). That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A65282, issued to Douglas Peter Murphy, M.D.;

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

3. Ordering Douglas Peter Murphy, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: September 21, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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