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

In the Matter of the Accusation Against: **MURRAY SUSSER, M.D.** 13435 Bayliss Rd. Los Angeles, California 90049 Physician's and Surgeon's Certificate No. G22316; and Physician Assistant Supervisor Certificate No. SA12749 Respondent.	Case No. 07-92-16339 **FIRST AMENDED AND SUPPLEMENTAL ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this First Amended and Supplemental Accusation solely in his official capacity.

2. On or about May 2, 1972, Physician's and Surgeon's Certificate No. G22316 was issued by the Board to Murray Susser, M.D. (hereinafter "respondent"), and at all times relevant to the

charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on September 30, 1996.

3. Physician Assistant Supervisor Certificate No. SA12749 was issued by the Board to respondent on September 18, 1981. Said certificate expired on May 31, 1992.

4. On February 15, 1995, an Accusation was filed against respondent in Case No. 07-92-16339. The Accusation is superseded by this First Amended and Supplemental Accusation.

JURISDICTION

5. This First Amended and Supplemental Accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Sections 2003 and 2004 which provide, in pertinent part, that the Division is responsible for the enforcement of the disciplinary provisions of the Medical Practice Act, for the administration and hearing of disciplinary actions, for carrying out disciplinary actions appropriate to findings made by a medical quality review committee, and for revoking or otherwise limiting certificates after the conclusion of disciplinary actions.

B. Section 2220 which provides:

"Except as otherwise provided by law, the Division of Medical Quality may take action against all persons guilty of violating this chapter. The division shall enforce and

administer this article as to physician and surgeon certificate holders, and the division shall have all the powers granted in this chapter for these purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon."

C. Section 2227 which provides:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in section 11371 of the Government Code, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

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"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board."

D. Section 2234 which provides:

"The Division of Medical Quality 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:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

". . . ."

E. Section 725 which provides:

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist."

F. Section 125.3 provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE OF ACTION

(Gross Negligence - M.S.)

6. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that respondent was grossly negligent in the care, treatment and management of patient M.S.[1/], as follows:

A. FACTS - PATIENT M.S.

(1) On or about January 25, 1988, M.S., a patient, presented with reported intestinal bleeding.

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1. All patient references in this pleading are by initials only. The true names of the patients shall be revealed to respondent upon his request for discovery pursuant to Government Code section 11507.6.

(2) Respondent diagnosed "chronic candide infection."

(3) Respondent treated M.S. with vitamin drips, hydrogen peroxide, garlic, paradidion [a homeopathic treatment for parasites] and chloroquine.

(4) From January 26, 1988 to October 31, 1989, respondent treated patient M.S. for conditions related to her initial complaint of intestinal bleeding using the same anti-parasitic remedies which had been initially applied to M.S. by him.

B. ACTS OF GROSS NEGLIGENCE - PATIENT M.S.

(1) Respondent did not perform a vaginal examination of patient M.S.

(2) Respondent did not perform a rectal examination.

(3) Respondent did not perform a blood stool examination of patient M.S.

(4) Respondent did not perform an anoscope examination of patient M.S.

(5) Respondent did not perform an sigmoidoscopy examination of patient M.S.

(6) Respondent did not perform a colonoscopy examination of patient M.S.

(7) On or about October 31, 1989, respondent released M.S. from his care without referring her to another physician, even though her symptoms, including rectal bleeding, continued.

(8) On or about November 24, 1989, surgery was performed on M.S. (i.e., low anterior resection and

appendectomy with the result that a near obstructing colonic lesion with chronic amebic dysentery and adenocarcinoma was found.

SECOND CAUSE OF ACTION

(Gross Negligence - R.W.)

7. Respondent Murray Susser, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that he committed acts of gross negligence in the care, treatment and management of patient "R.W." Such acts of gross negligence contributed to the delay in treatment of the patient. The circumstances are as follows:

A. FACTS - PATIENT R.W.

(1) On March 10, 1988, patient R.W. saw respondent at his office located at 2730 Wilshire Blvd., Suite 110, Santa Monica, California, for various conditions including sinus infection, respiratory problems, frequent urination and fatigue.

(2) There is no record of a physical examination being done on patient R.W. during this initial visit, other than the notation of the patient's vital signs.

(3) At the conclusion of the examination, respondent did not record any initial diagnostic impression of patient R.W.

(4) Respondent had the patient undergo tests for the Epstein-Barr virus. Respondent diagnosed a condition of Epstein-Barr syndrome and provided a treatment of approximately 10 vitamin supplements.

(5) Patient R.W. could not tolerate the combination of all the supplements and stopped taking them. One supplement

contained a tannic acid which is carcinogenic. Another supplement contained adrenaline which caused the patient's blood pressure to rise.

(6) A purged stool specimen was obtained from the patient. The laboratory report indicated the presence of Giardia Lamblia (cysts), an intestinal parasitic infection.

(7) The laboratory report also indicated the finding of "occult blood 4+" in Patient R.W.'s stool specimen.

(8) Respondent did not do any follow-up of the positive occult blood report.

(9) On April 7, 1988, patient R.W. had a follow-up visit with respondent. The patient told respondent he had rectal bleeding. Respondent conducted a digital rectal examination with negative results. Respondent told the patient the bleeding could have been from the rectal purge.

(10) Respondent discussed a sigmoidoscopy with Patient R.W., said the test was not standard procedure at that stage, and they should wait to see if further bleeding occurred.

(11) There are no notations regarding any discussions of a sigmoidoscopy in respondent's records.

(12) Patient R.W. had two additional visits with respondent and then discontinued seeing him.

(13) In 1989, Patient R.W. was subsequently diagnosed and treated for colon cancer by another physician.

(14) In January 1993, Patient R.W. had additional surgery because the cancer spread to his liver.

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(15) Patient R.W. is unable to return to work and is unable to continue his life as he knew it prior to the cancer diagnosis.

B. ACTS OF GROSS NEGLIGENCE - PATIENT R.W.

(1) Respondent fell below the standard of community practice in his failure to properly recognize and investigate signs of colon cancer. Specifically, respondent failed to do the following acts which singularly and collectively represent an extreme departure from the standard of care:

(a) He failed to recognize the significance of and to further investigate the finding of a strongly positive stool occult blood test done in March 1988;

(b) He failed to recognize the significance of and to further investigate the patient's complaint of rectal bleeding in April 1988;

(c) He failed to perform further tests on the patient including a repeat stool occult blood test, barium enema x-ray, and sigmoidoscopy or colonoscopy;

(d) He failed to document in his records any discussions with the patient regarding a sigmoidoscopy;

(e) He failed to properly treat the patient, using only vitamin therapy and homeopathic remedies;

(f) He failed to properly recognize and diagnose colon cancer;

(g) His failure to diagnose colon cancer contributed to the cancer being undiagnosed and untreated for over a year;

(h) His failure to diagnose colon cancer contributed to the cancer spreading to the patient's liver and altered the prognosis of the disease; and

(i) His failure to diagnose colon cancer contributed to the patient's inability to work and to continue life as he knew it prior to the cancer diagnosis.

THIRD CAUSE OF ACTION

(Gross Negligence - A.L.)

8. Respondent Murray Susser, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that he committed acts of gross negligence in the care, treatment and management of patient "A.L." Such acts of gross negligence contributed to the liver and pancreatic damage of patient A.L. The circumstances are as follows:

A. FACTS - PATIENT A.L.

(1) On November 26, 1991, Patient A.L. went to see respondent for symptoms resulting from toxic exposure to chemicals in 1987. She had been referred to respondent for intra-venous vitamin C treatments by her regular physician.

(2) Respondent told Patient A.L. that she was toxic and he would detox her with a series of vitamin C drips.

(3) On December 4, 1991, a complete chemical panel was drawn.

(4) On January 28, 1992, Patient A.L. saw respondent again. The therapy recommended was the intra-venous vitamin C

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drip, 1 or 2 times per week. The patient had one treatment on that date.

(5) Patient A.L. purchased vitamins and supplements manufactured and distributed by respondent per his instructions.

(6) On February 7, 1992, Patient A.L. called respondent complaining of gastrointestinal symptoms. Respondent recommended she try okra pepsin, then pancreatic enzymes. No evaluation of the patient and no diagnosis was made to explain this treatment.

(7) On February 14, 1992, Patient A.L. telephoned respondent's office complaining of nausea. Laboratory studies were ordered.

(8) On February 17, 1992, the results of the laboratory studies were markedly abnormal and significantly changed from the studies of December 4, 1991. The results indicated that her liver function tests were abnormal and the values for the hepatic enzymes were abnormal.

(9) On February 18, 1992, Patient A.L. telephoned respondent's office and reported that she was nauseous and was turning yellow. Respondent told her to force fluids and he referred her to a gastroenterologist.

(10) On February 22, 1992 Patient A.L. experienced persistent and worsening gastrointestinal symptoms and jaundice. Paramedics were summoned to her home. Respondent advised her not to go to the hospital, but to wait until Monday to see a specialist. The paramedics insisted she go to the hospital and took her to St. John's Hospital emergency room.

(11) Patient A.L.'s symptoms included abdominal pain, nausea, vomiting, fever, overt jaundice, markedly abnormal liver function tests and elevated serum amylase. She was diagnosed as having acute pancreatitis with severe abdominal pain and severe liver disease.

(12) On March 9, 1992, Patient A.L. had an abdominal ultrasound done by another physician. The results revealed multiple gallstones and mild dilatation of the common bile duct.

(13) On May 20, 1992, Patient A.L. saw another physician for a gastrointestinal consultation. He advised her to undergo a cholecystectomy.

B. ACTS OF GROSS NEGLIGENCE - PATIENT A.L.

(1) Respondent fell below the standard of community practice in his use of unconventional treatment which caused Patient A.L.'s medical problems to intensify. Specifically, respondent did the following acts which singularly and collectively represent an extreme departure from the standard of care:

(a) He provided the patient with unorthodox treatment by prescribing vitamins, pancreatic enzymes and okra pepsin products which led to liver and pancreatic damage;

(b) He failed to examine the patient prior to changing his treatment plan and based the treatment solely on the patient's telephone call;

(c) He failed to diagnose the patient's liver problems;

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(d) He inappropriately referred the patient to a specialist based upon a telephone call, abnormal laboratory results and without a proper evaluation;

(e) He ignored the patient's welfare when she became ill, advising her not to go to the emergency room;

(f) His treatment and behavior placed the patient in a life threatening situation.

FOURTH CAUSE OF ACTION

(Repeated Negligent Acts)

9. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), of the Business and Professions Code in that he committed repeated negligent acts in the care, treatment and management of patients M.S., R.W. and A.L. The circumstances of this offense are more particularly alleged in paragraphs 6, 7 and 8, above, and are incorporated herein by reference as though set forth fully.

FIFTH CAUSE OF ACTION

(Incompetence)

10. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (d), of the Business and Professions Code in that he was incompetent in his care, treatment and management of patients M.S., R.W and A.L. The circumstances of this offense are set forth fully in paragraphs 6, 7 and 8, inclusive, above, and are incorporated herein by reference as though set forth fully.

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SIXTH CAUSE OF ACTION

(Excessive Use of Diagnostic Procedures)

11. Respondent is subject to disciplinary action pursuant to section 725 of the Business and Professions Code in that he committed repeated acts of excessive use of diagnostic procedures and diagnostic facilities in the treatment of Patient R.W. The circumstances are as follows:

A. FACTS - PATIENT R.W.

(1) On March 17, 1988, an extensive laboratory analysis was performed on Patient R. W. Respondent's approach was "one of everything, shotgun" type of diagnostic evaluation, rather than a carefully planned, well thought out, cost effective use of laboratory facilities.

(2) The tests respondent had Patient R.W. undergo included an ECG, blood chemistries, Epstein-Barr virus, thyroid, and stool tests with a laxative purge.

(3) Respondent had the patient undergo a Glycohemoglobin A1C test for diabetes mellitus. A simpler, more cost effective approach would have been to initially evaluate blood and urine glucose, with further blood glucose studies if needed.

(4) Respondent had the patient undergo the thymol turbidity test, an old and rarely used liver function test, which has been replaced by more specific markers of hepatic function.

(5) The need for urine creatinine determination is questionable when routine kidney function tests such as blood urea nitrogen (BUN) and serum creatinine determinations were

included on the chemistry panel done on Patient R.W. If the blood urea nitrogen or creatinine values are abnormal, urine creatinine determination is warranted. With Patient R.W., both BUN and creatinine were within normal limits.

(6) Respondent also had the patient undergo the candida antibody panel. Two of the three tests showed undetectable levels, while the third was slightly positive. There is no documented justification for these laboratory studies.

B. ACTS OF EXCESSIVE DIAGNOSTIC PROCEDURES - PATIENT R. W.

(1) He failed to properly use diagnostic procedures and laboratory facilities, but rather had a "one of everything" approach;

(2) He failed to use a simple, cost effective test to detect diabetes;

(3) He failed to use more specific, up-to-date liver function tests;

(4) He failed to show the need for urine creatinine determination tests when routine kidney function tests were normal;

(5) He failed to document justification for candida antibody panel studies.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G22316, heretofore issued to respondent Murray Susser, M.D.;

2. Revoking or suspending Physician Assistant Supervisor Certificate No. SA12749 heretofore issued to respondent Murray Susser, M.D.;

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case; and

4. Taking such other and further action as the Division deems proper.

DATED: January 18, 1996

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