Board Proposes to Revoke Chiropractic License

The Oregon Board of Chiropractic Examiners (OBCE) is proposing to revoke the chiropractic license of Todd Hansen DC, Roseburg. An Amended Notice of Proposed Revocation was issued on October 26, 2011 after a lengthy investigation documented allegations of inappropriate behavior and treatment with a number of mostly female patients. The initial Notice was issued April 22, 2011.

Dr. Hansen has requested a contested case hearing before an impartial administrative law judge. The hearing is currently scheduled for April 2012. Following contested case hearing, the judge makes findings and issues a proposed order for the Board’s consideration. After the Board makes a final decision, the licensee may appeal the decision to the Oregon Court of Appeals.

The OBCE is the state agency responsible for licensing and regulation of the chiropractic profession with a primary mission of public protection. Decisions are made by a seven-member board consisting of five chiropractic physicians and two public members.

Anyone with additional information may contact the OBCE’s investigator at 503-373-1615.

For more information contact Dave McTeague, Executive Director, at 503-373-1620, or by email dave.mcteague@state.or.us

The mission of the Oregon Board of Chiropractic Examiners is to protect and benefit the public health and safety, and promote quality in the chiropractic profession.
B E F O R E T H E
BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OREGON

In the Matter of ) AMENDED
Todd Hansen DC ) NOTICE OF PROPOSED
License No. 3045 ) DISCIPLINARY ACTION
) Case # 2010-1019, 2011-1028

The Board of Chiropractic Examiners (Board) is the state agency responsible for
licensing, regulating and disciplining chiropractic physicians in the State of Oregon. Todd
Hansen DC (Licensee) is licensed by the Board to practice as a chiropractic physician in the State
of Oregon. The Board proposes to discipline Licensee for the following reasons.

1. 

A. On January 25, 2010, the Board served a Proposed Notice of Discipline on
Licensee for his failure to properly train or supervise various Chiropractic
Assistants who worked in his clinic during November and December 2009. On
July 21, 2010, Licensee signed a Stipulated Final Order with the Board which
required that Licensee must abide by the laws regarding Chiropractic Assistant
supervision and all requirements of OAR 811-035-0015. The Order also required
that he had a permanent restriction on his license that all assistants must be trained
by an outside source or course and must be certified prior to beginning
employment with him or his clinic. The Order also stated that failure to complete
the terms of the order may result in further discipline. (Case Number 2009-3024)

B. After the Stipulated Final Order was executed in July 2010, Licensee continued to
leave the clinic while his Chiropractic Assistants provided care to patients. No
other chiropractor was supervising the assistants. On September 20, 2010, Patient
1 received ultrasound from a CA after Licensee left the clinic for the day. In
September 2010, Patient 2 received e-stim from a CA when Licensee was at
lunch.

C. Patient 3 had cold laser therapy and had several early morning appointments with
Licensee. When she would arrive at the office, Licensee was not yet there. The
Chiropractic Assistant would often assist Patient 3 with her therapy prior to
Licensee’s arrival, or often the patient would start the machine herself and would be billed for that therapy.

D. Since signing the stipulated order in July 2010, Licensee was OFTEN late for work each morning, even if patients were scheduled. For patients that were scheduled at 8 a.m., Licensee would OFTEN come in at 8:15 a.m. or later. Often, a Chiropractic Assistant would begin the therapy work when the patient arrived, prior to Licensee’s arrival. The Assistant would not be supervised by any chiropractic physician during that time.

E. In August 2010, Licensee allowed Staff 1 to provide spinal screenings in a booth at the Douglas County Fair and Staff 1 staffed the booth alone without any direct supervision, while he was at the clinic.

F. Licensee has violated his Stipulated Order entered into on July 21, 2010

2. 

A. Patient 4 was treated by Licensee in 2005 for cervical adjustments and ceased going to him for treatment when he hurt her neck when doing a cervical adjustment.

B. Patient 5 went to Licensee in 2008 for a severe back injury and said that Licensee was very forceful and rough in his treatment of him. He described it as Licensee “throwing me around.” After he had received treatment, he was almost unable to walk and had to seek emergency care from his medical doctor the next day. Patient 5 was told by his medical doctor that his back had been damaged further by Licensee’s care. Patient 5 never returned to Licensee for treatment.

C. Patient 6 was seeking treatment in 2003 and was injured by a cervical treatment administered by Licensee. She still suffers from neck pain, migraines and muscle spasms.

D. Patient 7, also a chiropractor, went to see Licensee for a neck adjustment in 2007. He said his neck was severely wrenched in a very aggressive treatment. The treatment hurt his jaw so much that he could not chew meat for several weeks.

E. Staff 2 recalled how she watched as a patient had received a broken rib during a session of treatment from Licensee. Staff 2 also had her own neck adjustments from Licensee and had her neck severely wrenched so she stopped going to Licensee.
F. Several staff had patients complain to them that their adjustments from Licensee had caused pain or injury. The forcefulness and aggressive nature of the adjustments made the staff fearful of him injuring patients.

G. Patient 8 was treated by Licensee several times. At one point, Licensee hurt her neck so she stopped getting treatment. She complained that Licensee would rush her treatment, never warming up or loosening the cervical area before the adjustment.

H. Patient 9 received treatments in 2008 that were very rough and Licensee ignored her when she told him that she had difficulty swallowing and her fingers were numb. Once, Licensee injured her collarbone during a treatment. This was confirmed by subsequent treating physicians who told her that the collarbone was frozen. Patient 9 still has neck and shoulder pain.

I. Patient 10 sought treatment in 2009 and her pain would get worse with each treatment. She did not progress so she stopped going to Licensee.

J. Patient 11 saw Licensee in early 2010 and had a treatment that made it hurt to breathe for a week. She could barely dress herself and could not wear a bra. She told Licensee on a subsequent visit that he had injured her and he did not apologize.

K. Patient 12 said that her treatments were very rough and that sometimes she was sore for several days after receiving treatment from Licensee.

L. Patient 13 even told Licensee to adjust her slowly and to let her muscles relax prior to doing the adjustment, but he wouldn’t listen. For three years she said he was “way too rough.” Patient 13 said she practically had to scream at him not to rush the treatment. On one occasion he wrenched her tense neck so severely that she thought she was going to pass out.

M. Patient 14 said her treatments were very rough and that he would put all his weight into it.

N. Patient 15 had neck adjustments while she was staff in 2009 and found the adjustments to be very forceful. She had migraines after the treatment; something she had never had prior.

O. Patient 16 sought care from Licensee in September 2009 for a motor vehicle accident. During a treatment, Licensee caused so much pain while adjusting her that she cried out in pain indicating to Licensee that he had hurt her. During that
treatment Licensee also dug his knuckles into her spine area and Patient 16 again
told him that it was hurting her physically when he did that.

P. Patient 22 was an 84 year old woman who had a plate in her neck and was seen
approximately 9 times from December 2010 through June 2011. Patient 22 told
Licensee about her neck issues and when he adjusted her he would put his entire
body weight down on her causing the breath to be taken out of her and hurt her
chest. Patient 22 also had a pace maker in her chest and Licensee would use a
large amount of force on her chest near the pace maker location. Patient 22 felt
that the treatments which she received were very rough and in the last treatment
on June 6, 2011, she believed that she was injured. During the treatment she said
that she cried out in pain and could barely walk after the treatment she received.

3.

A. Patient 17 saw Licensee in 2006-2007 as a patient. On the first visit, Licensee
made her uncomfortable by telling her he liked her shirt and complimenting how
muscular she was. On the second visit, Licensee asked her a lot of personal, non-
medical questions and started to come into her space, getting very close to her
during treatment. He said to her “I’ll bet you are really good at volleyball, maybe
I could get private lessons from you.” Patient 17 felt like Licensee was outwardly
flirting with her. Licensee then showed up at one of Patient 17’s volleyball
matches. She had not invited him to do so. On one visit when Patient 17 had her
14 year old son with her, Licensee asked her personal questions and stood very
close to her. While she was standing at the front desk Licensee rubbed her
shoulders and asked her what type of perfume she was wearing. Her son
commented how inappropriate Licensee had been toward his mother to her.
Patient 17 discontinued further treatment due to her discomfort with his behavior.

B. Patient 9 saw Licensee in 2005-2006. Licensee was overly complimentary to her
from the first visit, commenting on her muscular back and shoulders. He would
even invite passing staff to look at her shoulders. During one treatment, Licensee
slapped Patient 9 on the bottom while she was lying on her side. She sat up
suddenly and told him never to do that again. Licensee was speechless but did not
apologize.

C. Patient 18 saw Licensee in 2009. After 6 visits or so, Licensee began to stand too
close to her, was very flirtatious and always over complimented her on her
appearance. He told her she was “so pretty,” continually commenting on her hair
and clothes. Licensee would be providing treatment to her and would leave his
hand on her thigh while he continued to talk to her. He would also let his hand
linger on her neck after adjusting her. Patient 18 also noticed that Licensee would
drape his body over hers while performing treatments, which was not something
she experienced with other physicians' chiropractic treatments. She was so concerned she sought advice from other health professionals who advised her to stop seeing Licensee.

D. Patient 19 was a patient in 2002. During a treatment Licensee slapped her on the bottom and Patient 19 was so upset, she stopped going to him because of this.

E. Patient 20 saw him in approximately 2005. Licensee always commented on her appearance, saying she was very muscular. This made Patient 20 very uncomfortable.

F. Patient 21 has seen Licensee as a patient since January 2010. Between April and July of 2010, Licensee and Patient 21 exchanged over 200 calls or texts between their cell phones. Licensee and Patient 21 also confided in each other almost daily and socialized with one another. Patient 21 admitted that she did not see anything wrong with a patient dating their doctor. In an interview, Licensee admitted to the Board that he had started a sexual relationship with this patient and during September 2010 he and Patient 21 were sexually intimate on at least two occasions. Licensee also admitted that he knew he was in violation of administrative rules regarding boundaries with patients, and further stated that he had not terminated the doctor-patient relationship with Patient 21 prior to the relationship with her.

G. Various staff have also been treated by Licensee as patients. Staff 3 was a patient first in 2004 and staff in 2005. Licensee solicited her for a sexual relationship while she was a patient and then a staff member. Staff 3 said they kissed and embraced in a treatment room. Licensee would spend extended time with her as a patient and would often rub her shoulders and the top of her chest area and below her beltline on her back. Licensee would often text her, trying to get her into a sexual relationship with him and wanted her to confide in him about the status of her marriage. Licensee was often inappropriate during treatments, commenting on her appearance, and telling her how sexy she looked. During one treatment, he cornered her in the x-ray room and shut the door, saying “what do you want to do? Too bad we are not alone.” Licensee wrote her a note stating “I really want to be with you, I hope this happens soon.” Licensee often asked her to administer therapy to him, such as ultrasound, and have her close the door. Licensee later fired Staff 3, telling her his wife made him do so. Licensee then asked Staff 3 to meet him at a park telling her it was about future employment, where he tried to convince her to go to a motel room with him. Licensee tried to hug and kiss her while talking in the car.
H. Staff 4 was first a patient for two months in 2008 and then became staff that same year. She was also his babysitter for his children. During treatment, Licensee asked her to lift up her shirt so he could see her muscular abdominals and back muscles. Over time, Licensee became more touchy and overly complimentary of her appearance. One time he commented “how good you look, I want to go for a ride in your car with you sometime.” Licensee texted Staff 4 about her tanned body, writing “Heels, abs, tanned, attractive, 21. Do you know anyone resembling these characteristic(s)?” Staff 4 never went back for treatment after this, and was extremely upset and disgusted. One treatment, Staff 4 came wearing a lace shirt and Licensee told her “that would look great with nothing underneath.”

I. Patient 8 also worked for Licensee. Patient 8 says he often would compliment her on her body, her looks or clothing. Licensee lent her his car, and paid her $500 to quit smoking. Licensee helped her pay for college tuition.

J. Various staff witnessed the inappropriate compliments to patients, flirting behavior and several staff said that Licensee made comments to them about his patients that were of a sexual nature.

4.

A. Licensee has admitted engaging in the use of illicitly prescribed steroids and HGH (Human Growth Hormone) that he received in 2003-2007 from Palm Beach Rejuvenation Center (PBRC) in Florida. Licensee has failed to provide evidence that his 2003-2007 prescriptions for steroids and HGH were legal or valid. Additionally, Licensee initially provided false statements to the OBCE regarding his use of illicit substances.

B. Licensee divulged to witnesses how he had used steroids and HGH extensively during this time period. Staff members found drug wrappers in the trash of Licensee’s clinic in 2005 and told another DC who was working there. Various small packages were sent to the clinic with the names David Smith or David Rodriguez as the addressee. The packages were from Germany and Mexico, Austria and Greece. Staff noted that Licensee always took possession of these packages, and explained to one that they contained steroids and HGH. Staff also found various syringes in Licensee’s desk drawer as well as containers thought to be HGH, several of them with pictures of animals on the container. Licensee would order staff to leave the packages from Germany and Greece on the refrigerator for a few days, to see if authorities were tracking the packages. Staff also noticed that Licensee was very moody and prone to angry outbursts. Licensee admitted to other staff that he participated in self injecting of steroids in the clinic. Licensee did not have a valid prescription for testosterone from a legitimate medical provider until 2008.
5.
A. For Staff 1, 2, 3 and 4 who also received chiropractic treatment as patients, Licensee did not keep accurate and complete chart notes on the treatment they were provided. In investigation, Licensee admitted that he did not keep ongoing charts when he provided staff with chiropractic care.

6.
The Board finds that Licensee’s conduct during investigation are violations as follows; for conduct described in paragraph 1, this violates ORS 684.100 (1)(f) and (p); OAR 811-035-0015(3), (10) and (23) and 811-010-0110(5) and (6). For conduct alleged in paragraph 2 this violates ORS 684.100(f)(A) and (C), (q), OAR 811-035-0015(6). For conduct alleged in paragraph 3, this violates ORS 684.100(1)(f)(A) and OAR 811-035-0015(1)(a) through (e). For conduct alleged in paragraph 4, this violates ORS 684.100(f)(A), and OAR 811-035-0015(9) and (13). For conduct alleged in paragraph 5 this violates ORS 684.100(f)(A) and OAR 811-015-0005(1) and (3).

7.
Due to the aforementioned violations, the OBCE proposes to revoke Licensee’s license.

8.
Licensee shall pay costs of this disciplinary proceeding, including investigative costs and attorney fees pursuant to ORS 684.100(9)(g).

9.
Licensee has the right, if Licensee requests, to have a formal contested case hearing before the Office of Administrative Hearings to contest the matter set out above. At the hearing, Licensee may be represented by an attorney and subpoena and cross examine witnesses. That request for hearing must be made in writing to the OBCE, must be received by the OBCE within 30 days from the mailing of this notice (or if not mailed, the date of personal service), and must be accompanied by a written answer to the charges contained in this notice.

10.
The answer shall be made in writing to the OBCE and shall include an admission or denial of each factual matter alleged in this notice, and a short plain statement of each relevant affirmative defense Licensee may have. Except for good cause, factual matters alleged in this notice and not denied in the answer will be considered a waiver of such defense; new matters alleged in this answer (affirmative defenses) shall be presumed to be denied by the agency and evidence shall not be taken on any issue not raised in the notice and answer.
If Licensee requests a hearing, before commencement of that hearing, Licensee will be given information on the procedures, rights of representation and other rights of the parties relating to the conduct of the hearing as required under ORS 183.413-415.

12.

If Licensee fails to request a hearing within 30 days, or fails to appear as scheduled at the hearing, the OBCE may issue a final order by default and impose the above sanctions against Licensee. Upon default order of the Board or failure to appear, the contents of the Board’s file regarding the subject of this automatically become part of the evidentiary record of this disciplinary action upon default for the purpose of proving a prima facie case.

DATED October 26, 2011.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

Original signatures on file at OBCE office

By:  

Dave McTeague, Executive Director
County of Marion ) Case # 2010-1019, 2011-1028

I, Dave McTeague, being first duly sworn, state that I am the Executive Director of the Board of Chiropractic Examiners of the State of Oregon, and as such, am authorized to verify pleadings in this case: and that the foregoing Notice is true to the best of my knowledge as I verily believe.

Original signatures on file at OBCE office

DAVE McTEAGUE, EXECUTIVE DIRECTOR
OREGON BOARD OF CHIROPRACTIC EXAMINERS

SUBSCRIBED AND SWORN to before me
this 25th day of October, 2011.

Original signatures on file at OBCE office

NOTARY PUBLIC FOR OREGON
My Commission Expires: 10/7/2015

Amended Notice of Proposed Disciplinary Action, Case # 2010-1019, 2011-1028 (Todd Hansen DC)
Certificate of Service

I, Dave McTeague, certify that on October 26, 2011, I served the foregoing Amended Notice of Proposed Disciplinary Action upon the party hereto by mailing, certified mail, postage prepaid, a true, exact and full copy thereof to:

Todd Hansen, DC
Pacific Crest Chiropractic & Wellness Center
2270 NW Troost St.
Roseburg, OR 97471

By regular mail to:

Charles E. Bolen, Attorney at Law
Hornecker, Cowling, Hassen & Heysell, L.L.P.
717 Murphy Road
Medford, Oregon 97504

Original signatures on file at OBCE office

Dave McTeague  
Executive Director  
Oregon Board of Chiropractic Examiners