

Oregon Medical Board
BOARD ACTION REPORT
July 16, 2009 – August 15, 2009

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between **July 16, 2009 – August 15, 2009**.

Scanned copies of Interim Stipulated Orders, Orders of Emergency Suspension, Stipulated Orders, Final Orders, Termination Orders, Modification Orders and Voluntary Limitations are included at the end of this report in the order that they appear in the report. These orders are marked with an * asterisk. **Scanned copies of Corrective Action Orders/Corrective Action Agreements are not posted as they are not disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report as they are not final actions by the Board. Both Orders, however, are public and are available upon request as described below.

Printed copies of the Board Orders listed below are available to the public. To obtain a printed copy of a Board Order, please complete a [service request form](#) on the Board's web site, submit it with the \$10.00 fee *per licensee* and mail to:

**Oregon Medical Board
1500 SW 1st Ave, Ste 620
Portland, OR 97201**

Copies of the Orders listed below are mailed to Oregon hospitals where the Licensee had self-reported that he/she has privileges.

***CAMACHO PEREZ-ARCE, Hector Guillermo, PA01130; Forest Grove, OR**

Licensee entered into a Stipulated Order with the Board on August 6, 2009. In this Order Licensee surrendered his Oregon physician assistant license while under investigation. Licensee may not reapply for an Oregon license for a minimum of two years from the effective date of this Order. Should Licensee reapply, the Board will reopen its investigation and Licensee will be required to demonstrate competency to practice medicine.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
HECTOR GUILLERMO CAMACHO, PA) STIPULATED ORDER
LICENSE NO. PA01130)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physician assistants, in the state of Oregon. Licensee's complete true name is Hector Guillermo Camacho Perez-Arce; however, he commonly goes by Hector Guillermo Camacho. Mr. Camacho (Licensee) is a licensed physician assistant in the state of Oregon.

2.

The Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, as set forth in the Board's Complaint and Notice of Proposed Disciplinary Action, dated January 14, 2009.

3.

Licensee was a physician in Mexico, but he has never been licensed as a physician in the United States because he has taken and failed the United States Medical Licensing Examination four times.

In February 2008, Licensee began to work at the Lancaster Family Health Clinic in Salem, Oregon, and this facility is operated by the Yakima Valley Farm Workers Clinic. After seeing patients during the course of three weeks, Licensee was permanently terminated from his employment, and he was reported to the National Practitioner Data Bank. The Board subsequently opened an investigation and reviewed a number of patient charts, which revealed serious practice and charting concerns. The acts and conduct alleged to violate the Medical Practice Act are:

1 3.1 A review of selected patient charts (Patients A – J) reveals a pattern of
2 substandard care that causes the Board to conclude that Licensee lacks the competence to
3 safely practice medicine as a physician assistant by failing to recognize when patients are
4 seriously ill; failing to consult with a supervising physician when necessary and
5 appropriate; failing to order appropriate medical tests; failing to initiate effective
6 treatment; failing to recognize diagnoses despite the presence of specific laboratory data
7 indicating the correct diagnosis; prescribing inappropriate medications for infectious
8 illness and poor chart documentation. Specific examples of these patient care concerns
9 include the following:

10 a. Patient A, an adult female, presented on March 10, 2008, complaining of
11 abdominal pain, back pain and profuse vaginal bleeding for 3 days. Licensee conducted
12 an inadequate examination, failed to document the uterine size and condition, and did not
13 address the possibility of a sexually transmitted disease, order a complete blood count
14 (CBC), or otherwise address the cause of the excessive bleeding. Licensee discharged
15 Patient A with instructions to “increase fluids and use of Tylenol pm,” but did not consult
16 with a physician or follow-up on this patient.

17 b. Patient B, a 68-year-old adult male, presented to Licensee on March 6,
18 2008, complaining of chronic pain. Patient B reported a history of substance abuse (to
19 include crack cocaine, marijuana and alcohol) and infrequent contacts with health care
20 providers. Licensee ordered vitamin B-12 injections without establishing a medical
21 justification to treat for any vitamin B-12 deficiency. Licensee also failed to refer Patient
22 B for substance abuse treatment, and he failed to offer a screening examination for colon
23 cancer, diabetes and liver function.

24 c. Patient C, a 15-year-old female, presented to Licensee on March 6, 2008,
25 complaining of a sore throat. Licensee ordered a rapid strep screen that was negative. A
26 reflex culture was reported as positive for Group A streptococcus bacterium on

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1 March 10, 2008. Licensee signed the lab report, but he failed to inform the patient of the
2 positive result or initiate any appropriate treatment.

3 d. Patient D, a 7-year-old girl, presented to Licensee on March 10, 11 and 12,
4 2008, with abdominal pain, fever, lethargy and a persistent cough. Licensee examined
5 Patient D on March 10th (a Monday) and ordered a complete blood count (CBC).
6 Licensee did not specify "STAT" to get an immediate result of the CBC. Licensee
7 should have ordered a "STAT" CBC and a "STAT" urinalysis and reviewed the result
8 while the patient was still in the office. Instead, Licensee sent her home without a precise
9 diagnosis. The CBC test result was available on March 11th, but Licensee failed to
10 review the CBC test result until March 12th. The CBC revealed that Patient D was
11 seriously ill, with a white blood count of 41,200 with 36 percent bands that required
12 immediate medical attention, to include hospitalization. Patient D returned to the clinic
13 on March 11th and underwent a chest X-ray, which was positive for pneumonia. Patient
14 D returned to the clinic on March 12th and was re-examined by Licensee. Licensee did
15 not conduct another CBC and did not consult with his supervising physician or another
16 physician at the clinic. However, Licensee diagnosed Patient D with right lower lobe
17 pneumonia, ordered an injection of ceftriaxone (Rocephin), prescribed azithromycin
18 (Zithromax), and sent her home.

19 e. Patient E, a 64-year-old female, presented to Licensee on March 7, 2008,
20 with complaints of fetid urine smell. Licensee ordered a urine analysis with a dipstick
21 result that was positive for nitrates. Licensee prescribed a subtherapeutic dose of
22 acyclovir (Zovirax) 800 mg to be taken twice daily when the appropriate dose is 800 mg
23 five times daily. Licensee tried to justify the subtherapeutic dosage based upon concern
24 regarding the patient's renal and liver function, yet he failed to order renal and hepatic
25 function testing. Instead, Licensee sent Patient E home. On March 10th, the lab result
26 reflected more than 100,000 colonies of an infection of Escherichia coli (E. coli). Patient

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1 E returned to the clinic on March 13th with complaints of "increased confusion, blurred
2 vision and paleness." She was sent to the emergency department at Salem Hospital.

3 f. Patient F, a 64-year-old male, presented to Licensee on March 13, 2008, to
4 review lab testing results from an earlier clinic visit. Licensee reviewed the lab results,
5 which reflected an office glucose level of 33 mg/dl. Licensee failed to recognize that this
6 result, if accurate, would have indicated a medical emergency requiring parenteral fluids
7 and likely immediate hospital admission. Licensee allowed the patient to go home
8 without hospitalization or appropriate treatment. Licensee now asserts to the Board that
9 he assumed that the lab result was typographical error, but Licensee failed to order a
10 repeat study, or to otherwise address this issue of the lab result in the chart.

11 g. Patient G, a 26-year-old male, presented to Licensee on March 12, 2008,
12 complaining of itchy eyes and difficulty breathing. Licensee concluded that Patient G
13 suffered from reactive airway disease and possible seasonal allergic rhinitis. Licensee
14 provided Patient G with a sample of budesonide (Pulmicort), but he did not prescribe a
15 bronchodilator. Licensee did not write a prescription for budesonide or schedule a
16 follow-up visit for reactive airway disease.

17 h. Patient H, a 40-year-old female, presented to Licensee on March 11, 2008,
18 with a complaint of vaginal itching and a history of dysuria (painful urination). Licensee
19 inappropriately prescribed an antibiotic, metronidazole (500 mg, 2 tablets twice a day) for
20 "possible candidal vaginal infection." Licensee also failed to conduct a pelvic
21 examination and did not order any lab tests for a possible sexually transmitted disease.

22 i. Patient I, a 62-year-old female, presented to Licensee on March 11, 2008,
23 complaining of abdominal pain and "recent production of abnormal feces." This patient
24 reported that her symptoms had been present more than six months and was not getting
25 better. Licensee did not explain or otherwise describe what this meant. Patient I also
26 reported a weight loss of more than 13 pounds during the past year. Licensee failed to
27 address the medical issues associated with this history, symptoms, and complaints.

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5.4 Licensee shall obey all federal and Oregon laws and regulations pertaining to the practice of medicine.

5.5 Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for further disciplinary action under ORS 677.190(18).

6.

Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Practitioner Data Bank.

IT IS SO STIPULATED this 7 day of August, 2009.

Signature Redacted on Copies

~~HECTOR GUILLERMO CAMACHO, PA~~

IT IS SO ORDERED this 6 day of August, 2009.

OREGON MEDICAL BOARD

Signature Redacted on Copies

~~DOUGLAS B. KIRKPATRICK, M.D.~~
Board Chair