

Oregon Board of Medical Examiners  
**BOARD ACTION REPORT**  
**June 16, 2006 -- July 15, 2006**

The information contained in this report summarizes new interim and final actions taken by the Oregon Board of Medical Examiners between **June 16, 2006 -- July 15, 2006**.

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 are not posted as they are not disciplinary action and impose no practice limitations. These 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 Board of Medical Examiners**  
**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.*

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**\*BLATCHFORD, DOUGLAS MILLS, MD; MD07450; GRESHAM, OR**

Licensee entered into a Stipulated Order with the Board on June 22, 2006. In this Order Licensee agreed to surrender his Oregon medical license while under investigation and agreed to never re-apply for a license to practice medicine in the state of Oregon.

**DRONKOWSKI, CARL WILLIAM, MD; MD12788; PORTLAND, OR**

Licensee entered into a Corrective Action Order with the Board on July 13, 2006. In this Order Licensee agreed to take a documentation course pre-approved by the Board's Medical Director; establish a physician/patient relationship with a physician who is not his practice partner and with whom he is not sharing call; and have a chart audit six months after he completes documentation course. This is not a disciplinary action.

**HANEY, SUSAN THERESA, MD; MD23325; COOS BAY, OR**

Licensee entered into a Corrective Action Order with the Board on July 13, 2006. This Order allows Licensee to resume practice while the Board continues its investigation under the following terms: Enroll in the Health Professionals Program (HPP); obtain a supervising psychiatrist who has been pre-approved by the Board; maintain a physician/patient relationship with a psychiatrist approved by HPP; maintain a physician/patient relationship with a primary care physician; provide a copy of the Order to hospitals/facilities where she maintains credentials. This is not a disciplinary action.

-Continued

**\*HARDY, JOHN HENRY, MD; MD18862; LAKE OSWEGO, OR**

Licensee entered into a Stipulated Order with the Board on July 14, 2006. This Order placed Licensee on probation under the following terms: pre-approved practice setting; CME on professional boundaries; may not treat or consult with patients under 18 years old; use a chaperone when examining or treating the pelvic or breast area of female patients; quarterly reports from Licensee's medical director or supervisor; disclose Order to all employers/facilities where he practices; and quarterly Board reporting.

**\*LEE, GILBERT BROWNELL, MD; MD12003; BEND, OR**

The Board issued an Order Terminating Stipulated Order on July 13, 2006. This Order terminated Licensee's January 16, 2003 Stipulated Order.

**MYERS, CRAIG GILPIN, MD; MD15139; ALOHA, OR**

1. \*The Board issued an Order Terminating Stipulated Order on July 14, 2006. This Order terminated Licensee's March 7, 2006 Stipulated Order.
2. Licensee also entered into a Corrective Action Order on July 14, 2006. In this Order, Licensee agreed to quarterly Board reporting. This is not a disciplinary action.

**\*PANNER, OWEN MURPHY, MD; MD14032; ALTURAS, CA**

Licensee entered into a Stipulated Order with the Board on July 13, 2006. In this Order Licensee agreed to surrender his Oregon medical license while under investigation.

**\*PATEL, JAYANT MUKUNDRAY, MD; MD15991; PORTLAND, OR**

Licensee entered into an Interim Stipulated Order with the Board on July 13, 2006. This Order suspends Licensee's Oregon medical license pending the conclusion of the Australian criminal/administrative process and after all penalties/conditions imposed by that jurisdiction have been satisfied. At that time, Licensee may apply for reinstatement which will cause the Board to resume its current investigation. In this Order, Licensee also agreed not to practice medicine in any jurisdiction of the United States.

**\*REXIN, DOUGLAS ALLEN, MD; MD20317; WILLAMINA, OR**

Licensee entered into an Interim Stipulated Order with the Board on July 13, 2006. In this Order Licensee agreed to withdraw from the practice of medicine pending the completion of the Board's investigation into his competence to practice medicine.

**\*RICHARDS, ROBERT CAMPBELL, MD; APPLICANT; ZIONSVILLE, IN**

Applicant entered into a Stipulated Order with the Board on July 13, 2006. In this Order Applicant was reprimanded and agreed to withdraw his licensure application while under investigation.

**SILEN, MARK LAWRENCE, MD; MD22074; PORTLAND, OR**

Licensee entered into a Corrective Action Order with the Board on July 13, 2006. In this Order Licensee agreed to complete a physician/patient boundary course pre-approved by the Board's Medical Director and to only take prescription medications that have been prescribed for him by a licensed physician with whom he has established a physician/patient relationship. This is not a disciplinary action.

-Continued

**\*THOMPSON, VINCENT JOSEPH, MD; MD24259; BROWNS MILLS, NJ**

Licensee entered into a Stipulated Order with the Board on July 13, 2006. In this Order Licensee was placed on five years of probation. Quarterly Board reporting is held in abeyance as long as Licensee is not practicing. Licensee shall enroll in a structured education program with on-going monitoring in areas of need identified in the evaluation report issued by the Center for Personalized Education for Physicians (CPEP).

**\*WEISBERG, STUART GORDON, MD; MD23402; PORTLAND, OR**

Licensee entered into a Stipulated Order with the Board on July 13, 2006. In this Order Licensee was placed on five years of probation with quarterly Board reporting; given a reprimand; must have call coverage; and enroll and complete PEER.

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If you have any questions regarding this service, please call the Board at (971) 673-2700 or toll-free within Oregon at (877) 254-6263.



1 signing of and entry of this Order in the Board's records. Licensee understands that this  
2 document is a public record and is reportable to the National Practitioners Data Bank. Licensee  
3 stipulates that he engaged in the conduct described in paragraph 3.2 (Patient B) of the Amended  
4 Complaint and Notice of Proposed Disciplinary Action, but denies that he engaged in the  
5 conduct described in paragraph 3.1, and 3.3 – 3.10. Nevertheless, the Board finds that Licensee  
6 engaged in misconduct that violated: ORS 677.190(1)(a) unprofessional or dishonorable conduct,  
7 as defined in ORS 677.188(4)(a) and ORS 677.190(18) willful violation or failure to comply  
8 with a Board order.

9 4.

10 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order  
11 subject to the following conditions:

- 12 4.1 Licensee surrenders his license to practice medicine while under investigation.  
13 This surrender becomes effective when the Board Chair signs this Order.
- 14 4.2 Licensee agrees that he will never apply for a license to practice medicine in the  
15 state of Oregon.
- 16 4.3 Licensee stipulates and agrees that any violation of the terms of this Order shall  
17 be grounds for further disciplinary action under ORS 677.190(18).

18  
19 IT IS SO STIPULATED this 7 day of June, 2006.

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22 DOUGLAS MILLS BLATCHFORD, MD

23 IT IS SO ORDERED this 22<sup>nd</sup> day of June, 2006.

24 BOARD OF MEDICAL EXAMINERS  
25 State of Oregon

26   
27 DAVID R. GRUBE, MD  
28 BOARD CHAIR





4.

Licensee has informed the Board that he desires to engage primarily in the practice of administrative medicine with his patient contact strictly limited to adults. The Board desires to settle this matter by the entry of this Stipulated Order, which becomes effective on the date it is signed by the Board Chair. Licensee is placed on probation subject to the following terms and conditions:

4.1 All of Licensee's clinical or administrative practice settings shall be pre-approved by the Board's Medical Director.

4.2 Licensee shall enroll in and successfully complete a continuing medical education course on professional boundaries that is pre-approved by the Board's Medical Director within six-months from the date this Order is signed by the Board Chair.

4.3 Licensee shall not treat or consult with any patients under the age of eighteen (18).

4.4 Licensee shall use a medically trained chaperone at all times when examining or treating the pelvic or breast area of female patients. The presence of a chaperone shall be immediately documented in the medical records.

4.5 Licensee shall ensure that the Board receives quarterly written reports on his practice from his medical director or designated supervisor.

4.6 Licensee shall immediately disclose the existence of this Order to all employers and facilities where he has privileges or practices medicine.

4.7 Licensee shall report in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a probationer interview unless ordered to do otherwise by the Board.

4.8 Licensee's practice setting and charts are subject to random, no-notice review by the Board's Compliance Officers and/or their designee.

4.9 Licensee shall obey all federal, state and local laws, and all rules governing the practice of medicine in the state of Oregon.





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BEFORE THE  
BOARD OF MEDICAL EXAMINERS  
STATE OF OREGON

In the Matter of )  
CRAIG GILPIN MYERS, MD ) ORDER TERMINATING  
LICENSE NO. MD15139 ) STIPULATED ORDER

1.

On March 7, 2002, Craig Gilpin Myers, MD (Licensee) entered into a Stipulated Order with the Board of Medical Examiners (Board). This Order fined and reprimanded Licensee and placed him on probation with conditions. On February 14, 2006, Licensee submitted a written request asking the Board to terminate this Order.

2.

Having fully considered Licensee's request and his compliance with these terms, the Board does hereby terminate his March 7, 2002 Stipulated Order effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 14<sup>th</sup> day of July, 2006

BOARD OF MEDICAL EXAMINERS  
State of Oregon

  
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DAVID R. GRUBE, MD  
BOARD CHAIR



1 any appeal therefrom by the signing of and entry of this Order in the Board's records.  
2 Licensee understands that this document is a public record and is reportable to the National  
3 Practitioners Data Bank. Licensee stipulates that he engaged in the conduct described in  
4 paragraph 2 and that this conduct violates: 677.190(1), unprofessional or dishonorable  
5 conduct, as defined in ORS 677.188(4)(a), and 677.190(16), disciplinary action taken by  
6 another state.

7 4.

8 Licensee and the Board agree to resolve this matter by the entry of this Stipulated  
9 Order subject to the following conditions:

10 4.1 Licensee surrenders his license to practice medicine while under investigation.

11 4.2 Licensee stipulates and agrees that any violation of the terms of this Order  
12 shall be grounds for further disciplinary action under ORS 677.190(18).

13 5.

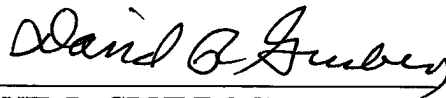
14 This Order becomes effective the date it is signed by the Board Chair.

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16 IT IS SO STIPULATED this 17 day of MAY, 2006.

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19 OWEN MURPHY PANNER, JR, MD

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21 IT IS SO ORDERED this 13<sup>th</sup> day of July, 2006.

22 BOARD OF MEDICAL EXAMINERS  
23 State of Oregon

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25 DAVID R. GRUBE, MD  
26 BOARD CHAIR  
27



1 been satisfied. The Board may then proceed with its pending action to discipline Licensee for  
2 the violations set forth in the Complaint and Notice of October 26, 2005, with any additional  
3 charges that the Board may in its discretion add. Licensee will not resume practice in any state  
4 or territory of the United States until the Board completes its investigation and he receives  
5 written permission from the Board to resume practice.

6 3.2 Licensee stipulates that he will not apply to practice medicine in any state or  
7 United States jurisdiction during the life of this Order.

8 3.3 Licensee shall obey all local, state and federal laws and regulations pertaining to  
9 the practice of medicine in the State of Oregon.

10 3.4 Licensee understands that violating any term of this Order will be grounds for  
11 disciplinary action under ORS 677.190(18).

12 3.5 This Order becomes effective the date it is signed by Licensee.

13 4.

14 This order is issued by the Board pursuant to ORS 677.205(2). Pursuant to ORS 676.175  
15 and ORS 677.425, Board investigative materials are confidential and shall not be subject to public  
16 disclosure, nor shall they be admissible as evidence in any judicial proceeding. This Order,  
17 however, is a public document and is reportable to the National Practitioners Databank.  
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19 IT IS SO STIPULATED THIS 30<sup>th</sup> day of June, 2006.

20  
21   
22 JAYANT MUKUNDRAY PATEL, MD

23 IT IS SO ORDERED THIS 13<sup>th</sup> day of July, 2006.

24 BOARD OF MEDICAL EXAMINERS  
25 State of Oregon

26   
27 DAVID R. GRUBE, MD  
28 Board Chair



6.

This Order becomes effective the date it is signed by the Licensee.

IT IS SO STIPULATED THIS 28<sup>th</sup> day of June, 2006.

DOUGLAS A. REXIN, MD

IT IS SO ORDERED THIS 13<sup>th</sup> day of July, 2006.

BOARD OF MEDICAL EXAMINERS  
State of Oregon

DAVID R. GRUBE, MD  
BOARD CHAIR

BEFORE THE  
BOARD OF MEDICAL EXAMINERS  
STATE OF OREGON

In the Matter of

ROBERT CAMPBELL RICHARDS, MD  
APPLICANT

}  
} STIPULATED ORDER  
}

1.  
1.

The Board of Medical Examiners (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Robert Campbell Richards, MD (Applicant) has applied for licensure in the state of Oregon.

2.

The Board proposed denying Applicant's request for a license to practice medicine in Oregon based upon violations of the Medical Practice Act, as follows: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(18) willful violation of a Board order or a Board rule; and ORS 677.190(23) refusing an invitation for an informal interview with the Board's Investigative Committee as requested under ORS 677.415. The Board's investigation revealed the following:

2.1 Applicant stated in his application for licensure that his history includes writing prescriptions for hydrocodone combinations (Schedule III) in the name of certain family members and using those medications for his own personal use to manage his chronic pain. After being confronted by authorities in Utah over this self treatment, Applicant surrendered his DEA license on February 7, 2003. Applicant was admitted into a drug treatment program in February of 2003 for the use of controlled substances. Applicant currently participates in a drug diversion program in Utah. On July 3, 2003, Applicant entered a plea of abeyance to criminal charges related to illegally procuring controlled substances. The plea of abeyance and all

1 charges were subsequently dismissed on July 30, 2004. Applicant's DEA license was reinstated  
2 on April 27, 2004.

3 2.2 On April 29, 2003, American Fork Hospital in Utah suspended Applicant's  
4 hospital privileges for 18 months for quality of care issues. The hospital terminated this  
5 suspension on December 8, 2004. Applicant's history with American Fork Hospital includes  
6 other suspensions, to include suspension of Applicant's forceps delivery privilege in December  
7 of 2001 for six months, as well as a five day suspension in May 2002 for disruptive behavior.

8 2.3 Applicant was invited to appear before the Board's Investigative Committee (IC)  
9 on September 1, 2005, to discuss matters of concern to the Board regarding his application, to  
10 include his personal history with substance abuse, his loss of privileges at American Fork  
11 Hospital in Utah, and issues with quality of care related to several malpractice claims filed  
12 against him in Utah. Applicant received notice of this interview, but failed to appear.  
13 Applicant's absence was not excused

14 2.4 Applicant, through his attorney, subsequently reported the following information  
15 to the Board:

16 a) Applicant currently resides in Indiana and is not currently practicing  
17 medicine. Applicant reports being medically disabled and is receiving disability  
18 payments from a disability carrier. Although Applicant reports that his disability is not  
19 permanent, Applicant does not anticipate returning to the practice of medicine in the near  
20 future. Applicant reports that he has limited funds for travel and because he is not  
21 practicing medicine, he did not appear before the Board's Investigative Committee on  
22 September 1, 2005. Based on his disability and Indiana residence, Applicant requested  
23 that his application be withdrawn.

24 3.

25 Applicant and the Board agree to close this investigation and that Applicant will  
26 withdraw his application to practice medicine in the state of Oregon while under investigation,  
27 consistent with the terms of this Order. Applicant understands that he has the right to a contested

1 case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes  
 2 and fully and finally waives the right to a contested case hearing and any appeal therefrom by the  
 3 signing of and entry of this Order in the Board's records. Applicant understands that this  
 4 document is a public record and is reportable to the National Practitioners Data Bank. The  
 5 Board finds that Applicant engaged in the conduct described in paragraph 2 and that this conduct  
 6 violates: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS  
 7 677.188(4)(a); ORS 677.190(18) willful violation of a Board order or a Board rule; and ORS  
 8 677.190(23) refusing an invitation for an informal interview with the Board's Investigative  
 9 Committee as requested under ORS 677.415.

4.

11 Applicant and the Board agree to resolve this matter by the entry of this Stipulated Order  
 12 subject to the following conditions:

13 4.1 Applicant is reprimanded for failing to appear before the Board's Investigative  
 14 Committee.

15 4.2 Applicant withdraws his application for a license to practice medicine while under  
 16 investigation.

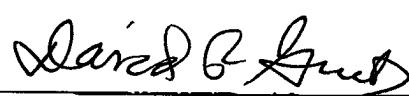
17 4.3 Applicant stipulates and agrees that any violation of the terms of this Order shall  
 18 be grounds for further disciplinary action under ORS 677.190(18).

19 IT IS SO STIPULATED this 22<sup>nd</sup> day of MAY, 2006.

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 22 \_\_\_\_\_  
 ROBERT CAMPBELL RICHARDS, MD

23 IT IS SO ORDERED this 13<sup>th</sup> day of July, 2006.

24 BOARD OF MEDICAL EXAMINERS  
 25 State of Oregon

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 DAVID R. GRUBE, MD  
 BOARD CHAIR

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BEFORE THE  
BOARD OF MEDICAL EXAMINERS  
STATE OF OREGON

In the Matter of )  
VINCENT JOSEPH THOMPSON, MD ) STIPULATED ORDER  
LICENSE NO. MD 24259 )  
)

1.

The Board of Medical Examiners (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Joseph Vincent Thompson, MD (Licensee) is a licensed physician 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, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(14) gross or repeated acts of negligence; and ORS 677.190(25) prescribing controlled substances without following accepted procedures for examining patients, record keeping, or giving the notice required under ORS 677.485. The Board concludes that Licensee engaged in the following conduct:

2.1 Review of Licensee’s management of patients revealed the following pattern in regard to Patients A - E: Licensee failed to document any PARQ conference (procedures, alternatives, risks, and questions by patient, or PARQ discussion) in order to obtain their informed consent. Licensee’s charting was deficient, lacking objective findings to justify the need for chronic pain medications. The patient histories, physical examinations and patient conditions that Licensee documented do not justify his assessments and plans for treatment, and he failed to address drug interactions, risks associated with medications prescribed, or

1 utilize pain contracts. In addition to this conduct, which is common for Patients A - E, the  
2 Board identified the following specific concerns in regard to the patients listed below:

- 3 a. Patient A, a 42-year-old female, with a history of drug seeking behavior, first  
4 presented to Licensee in September 2003 with complaints of pain associated with torn  
5 ligaments (probable medial meniscal tear) in her right knee and lower back pain.  
6 Licensee authorized refills for prescriptions for paroxetine (Paxil), hydrocodone/  
7 acetaminophen (Schedule III) and lorazepam (Ativan, Schedule IV) during her  
8 successive visits to the clinic. Patient A was supposed to return to the clinic every  
9 month, but was noncompliant, and was occasionally angry and belligerent. Licensee  
10 subsequently continued to prescribe hydrocodone/acetaminophen (Schedule III) for  
11 Patient A on a monthly basis. In April 2004, Licensee noted that Patient A was also  
12 taking warfarin (Coumadin), and had a diagnosis of atrial fibrillation. There is no  
13 indication that Licensee considered the risks associated with the concurrent  
14 administration of these medications, nor did he inform Patient A of the risk of adverse  
15 drug interactions. It is not clear from the record who was providing or monitoring this  
16 patient's warfarin. Throughout his care for Patient A, Licensee never utilized a  
17 written pain contract to verify compliance with her prescription regimen. Licensee  
18 last saw Patient A on June 2, 2004. She died from a drug overdose on July 2, 2004.
- 19 b. Patient B, a 42-year-old female, first presented to Licensee on June 19, 2003.  
20 Licensee authorized refills of her regimen of medications, to include temazepam  
21 (Restoril, Schedule IV), hydrocodone/acetaminophen, 10/650 (Schedule III),  
22 methocarbamol (Robaxin), 75 mgs twice a day, citalopram (Celexa) and captopril  
23 (Capoten). Patient B was also using fentanyl (Duragesic patches, Schedule II) for a  
24 herniated disc and fibromyalgia. By mid summer of 2003, Patient B had discontinued  
25 taking fentanyl, and was now taking morphine sulphate (MS Contin, Schedule II)  
26 while her prescription for hydrocodone/acetaminophen, 10/650 was increased to two  
27 tablets, four times a day (equalling an intake of 5.2 grams of acetaminophen per day,

1           which is a toxic dose level). Licensee prescribed indomethacin (Indocin) on March  
2           12, 2004. Patient B reported stomach pain and nausea on March 31, 2004. On May  
3           17, 2004, Patient B reported severe pain and vomiting all of her medications.  
4           Licensee examined her, but made very limited physical findings. Licensee also  
5           resumed her prescription for fentanyl (Duragesic patches, Schedule II), and changed  
6           her other medications from oral to transdermal and suppositories. Patient B was  
7           admitted to the Seaside Providence Emergency Room between May 17, 2003 and May  
8           23, 2004 for a perforated bowel. Licensee failed to adequately examine and work up  
9           Patient B, and failed to provide her with a written notice of the material risks  
10          associated with the controlled substances that Licensee prescribed for chronic pain.

11          c.       Licensee first saw Patient C, a 48-year-old female, on July 18, 2003. Licensee  
12          diagnosed her condition as a back disorder unspecified. Licensee continued her  
13          prescriptions of hydrocodone/acetaminophen (Schedule III) and zolpidem (Ambien,  
14          Schedule IV). Licensee failed to provide written notice of the material risks  
15          associated with the controlled substances that Licensee prescribed for chronic pain.

16          d.       Patient D, a 43-year-old female, first presented to Licensee on June 25, 2003  
17          with a complaint regarding a kidney stone. Licensee examined her, recorded a history  
18          and physical, and prescribed trimethoprim/sulfamethoxazole (Bactrim). On May 26,  
19          2004, Patient D reported a severe outbreak of psoriasis on the “lower extremities.”  
20          Licensee prescribed methotrexate, 12 mg, with six weekly injections without adequate  
21          medical justification. Licensee did not record any warning to this patient of the risks  
22          associated with this medication, to include toxicity to the liver, and failed to conduct  
23          any tests, to include liver function studies, either at the outset or during the course of  
24          this medication regimen.

25          e.       Patient E, a 63-year-old male, presented to Licensee on November 13, 2003  
26          complaining of patches of psoriasis. Licensee started Patient E on methotrexate.  
27          Licensee did not record any warning to this patient of the risks associated with this

1 medication, to include toxicity to the liver, and failed to conduct any tests, to include  
2 liver function studies, either at the outset or during the course of this medication  
3 regimen.

4 2.2 Licensee underwent a Board ordered assessment at the Center for  
5 Personalized Education for Physicians (CPEP). This evaluation concluded that  
6 Licensee possessed broad but superficial knowledge of outpatient family medicine,  
7 with gaps in his knowledge regarding pharmacology. Licensee is also deficient in his  
8 knowledge of certain serious health conditions, clinical reasoning and charting.

9 3.

10 Licensee and the Board desire to settle this matter by entry of this stipulated order.  
11 Licensee understands that he has the right to a contested case hearing under the  
12 Administrative Procedures Act (chapter 183), Oregon Revised Statutes, and fully and finally  
13 waives the right to a contested case hearing and any appeal therefrom by the signing of and  
14 entry of this Order in the Board's records. Licensee admits that he engaged in the conduct  
15 described in paragraph 2 and that this conduct violated ORS 677.190(1)(a) unprofessional or  
16 dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(14) gross or repeated  
17 acts of negligence; and ORS 677.190(25) prescribing controlled substances without following  
18 accepted procedures for examining patients, record keeping, or giving the notice required  
19 under ORS 677.485. Licensee understands that this Order is a public record and is reportable  
20 to the National Practitioner Databank.

21 4.

22 Licensee and the Board desire to settle this matter by the entry of this Stipulated  
23 Order, subject to the following terms and conditions of probation:

24 4.1 Licensee is placed on probation for five years. Licensee is excused from  
25 reporting to the Board at each of its quarterly meetings at the scheduled times for a  
26 probationer interview as long as Licensee does not engage in the practice of medicine in  
27 Oregon. Upon his return to Oregon, this requirement shall go back into effect.





1 who were being treated with methadone to buprenorphine without documenting withdrawal  
2 symptoms and without stating an induction protocol in the chart. In some cases, Licensee  
3 prescribed buprenorphine for chronic pain, which is an off-label use of the drug. On frequent  
4 occasions, Licensee concomitantly prescribed benzodiazepines for patients who were taking  
5 buprenorphine, which placed his patients at risk of potentially life threatening drug interaction.  
6 Licensee also failed to follow the best practice standards of placing medication lists and keeping  
7 duplicate prescriptions in the chart to assist in the management of complex medication regimens  
8 for his patients.

9 The Board's review has identified the following specific concerns in regard to Patients  
10 A - G:

11 a. Patient A, a 28-year-old female, presented at Licensee's clinic in May 14, 2004,  
12 with a six year history of methadone use after two years of abusing both heroin and  
13 methamphetamine and a conviction for the possession of illegal drugs. Licensee  
14 prescribed buprenorphine (Suboxone, 4 mg twice day) with authorized refills. Suboxone  
15 in most circumstances should be ordered once daily rather than twice daily, and no refills  
16 should be authorized. Licensee failed to determine whether Patient A was pregnant,  
17 failed to chart an induction protocol, and failed to document informed consent. Licensee  
18 prescribed methylphenidate (Ritalin, Schedule II) to Patient A without establishing the  
19 requisite diagnosis of attention deficit hyperactivity disorder (ADHD). Licensee also  
20 concomitantly prescribed alprazolam (Xanax, Schedule IV) and methylphenidate to this  
21 patient who was a known methamphetamine abuser. Benzodiazepines, such as  
22 alprazolam, present the risk of adverse interaction, to include reported deaths, when a  
23 patient is taking buprenorphine.

24 b. Patient B, a 25-year-old female, self-referred to Licensee's clinic sometime in  
25 May of 2004, reporting chronic pain associated with an automobile collision that  
26 occurred seven years earlier. Patient B was taking methadone administered by a  
27 methadone clinic. Licensee evaluated Patient B and prescribed clonazepam (Klonopin,

1 Schedule IV), a benzodiazepine that had been previously prescribed by a former  
2 physician, which is inadvisable when a patient is taking methadone. Licensee did not  
3 document communication with the methadone clinic to coordinate his prescribing. After  
4 a number of months, Licensee caused Patient B to discontinue treatment at the methadone  
5 clinic and began prescribing sustained release morphine for chronic pain. Licensee did  
6 not identify the source of the pain or obtain the patient's medical records from her  
7 previous health care providers. Licensee failed to obtain Patient B's informed consent for  
8 his treatments and failed to have her sign a material risk notice for the treatment of her  
9 chronic pain. After several months, Licensee also prescribed methylphenidate (Ritalin,  
10 Schedule II) for Patient B without establishing the requisite diagnosis of ADHD.

11 c. Patient C, a 46-year-old male, was self-referred to Licensee with a history of  
12 abusing hydrocodone and acetaminophen (Vicodin, Schedule III). Licensee determined  
13 that Patient C was a good candidate for buprenorphine without verifying opioid  
14 dependence, and failed to document opioid withdrawal or an induction protocol in the  
15 chart. Licensee prescribed buprenorphine, using an abrupt detoxification schedule, as  
16 well as lorazepam (Ativan, Schedule IV), which is a benzodiazepine and which could  
17 have provoked a dangerous drug interaction.

18 d. Patient D, a 31-year-old female, was referred to Licensee for treatment with  
19 buprenorphine in 2004. Her history included five years of methadone maintenance for  
20 opioid dependence. Again, it should be noted that buprenorphine should generally be  
21 given once per day due to its long half-life of thirty-nine hours. Licensee prescribed  
22 buprenorphine (8 mg twice a day) while Patient D's primary care physician continued to  
23 prescribe clonazepam (Klonopin, Schedule IV) a benzodiazepine, and while Patient D  
24 continued to receive methadone. Licensee failed to document opioid withdrawal or an  
25 induction protocol for this patient. Licensee's chart does not document necessary  
26 coordination of care between Licensee and Patient D's primary care physician or the  
27 methadone clinic. Licensee subsequently prescribed methylphenidate (Ritalin, Schedule

1 II) for Patient D without establishing the requisite diagnosis and without evaluating the  
2 medical efficacy of prescribing multiple controlled substances for a drug dependent  
3 patient with a history of drug abuse.

4 e. Patient E, a 28-year-old female, was referred to Licensee in August of 2004 for  
5 treatment of her chronic pain. Patient E had suffered injuries from an automobile  
6 accident five years prior, and was receiving prescriptions from other providers for  
7 hydrocodone & acetaminophen (Vicodin, Schedule III), oxycodone & acetaminophen  
8 (Percocet, Schedule II) and carisoprodol (Soma, Schedule IV). Licensee prescribed 8 mg  
9 of buprenorphine (Subutex) to treat her pain, but without an induction protocol or  
10 diagnosis of opioid dependence stated in the chart. Patient E initially reported a good  
11 response to the buprenorphine, but in September of 2004, reported an allergic reaction.  
12 Licensee subsequently prescribed sustained release oxycodone (OxyContin, Schedule II)  
13 and sertraline (Zoloft). Licensee failed to coordinate care with Patient E's primary care  
14 physician, who wrote a prescription of morphine sustained release (MS Contin, Schedule  
15 II) for Patient E also in September of 2004. In December of 2004, Licensee displayed  
16 poor judgment in directing that a month's prescription (with two refills, which violates  
17 federal standards) of OxyContin be mailed to Patient E's home.

18 f. Patient F, a 19-year-old male with a history of heroin abuse, presented to Licensee  
19 in November of 2004. Licensee diagnosed opioid dependence and attention deficit  
20 disorder without sufficient basis to establish either diagnosis. Licensee prescribed  
21 buprenorphine to detoxify Patient F, but failed to note an induction protocol or  
22 withdrawal symptoms. Licensee concomitantly prescribed the benzodiazepine,  
23 lorazepam (Ativan, Schedule IV), as well as dextroamphetamine & racemic amphetamine  
24 (Adderall, Schedule II) without medical justification.

25 g. Patient G, a 71-year-old female, presented to Licensee with a history that  
26 reportedly included fibromyalgia, opiate escalation and odd behavior. Patient G was  
27 taking a complex regimen of medications that included sustained release oxycodone

1 (OxyContin, Schedule II), oxycodone & acetaminophen (Percodan, Schedule II),  
2 clonazepam (Klonopin, Schedule IV), pramipexole (Mirapex, an anti-Parkinsonian agent)  
3 and valsartan/hydrochlorothiazide (Diovan, for hypertension). Licensee attempted to  
4 detoxify Patient G by substituting MS Contin for Oxycontin and by adjusting the dosage  
5 of her other medications, but he did so without communicating with Patient G's  
6 rheumatologist or her primary care physician. Licensee noted that he was treating Patient  
7 G's "opioid dependence on a slow, steady taper." Licensee's efforts to detoxify Patient G  
8 in an office based setting were inappropriate.

9 4.

10 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.

11 Licensee understands that he has the right to a contested case hearing under the Administrative  
12 Procedures Act (chapter 183), Oregon Revised Statutes, and fully and finally waives the right to  
13 a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the  
14 Board's records. Licensee admits that he engaged in the conduct described in paragraph 3 and  
15 that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined  
16 in ORS 677.188(4)(a) and ORS 677.190(14), gross negligence or repeated acts of negligence in  
17 the practice of medicine; and ORS 677.190(25) prescribing controlled substances without a  
18 legitimate medical purpose, without following accepted procedures for record keeping and  
19 without giving the notice required under ORS 677.485. Licensee understands that this Order is a  
20 public record and is reportable to the National Practitioner Databank.

21 5.

22 Licensee and the Board desire to settle this matter by the entry of this Stipulated Order,  
23 subject to the following terms and conditions of probation:

24 5.1 Licensee is reprimanded.

25 5.2 Licensee will arrange call coverage for his patients. The coverage will be  
26 provided by a psychiatrist who does not have a physician/patient relationship with  
27 the Licensee.

