

Oregon Medical Board
BOARD ACTION REPORT
January 15, 2013

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between December 16, 2012 and January 15, 2013.

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 Agreements and Consent Agreement 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.

Printed copies of the Board Orders not provided with this report are available to the public. To obtain a printed copy of a Board Order not provided in this report, please complete a Service Request Form (<http://egov.oregon.gov/BME/PDFforms/VerDispMalFillin.pdf>) found under the Licensee Information Request Form link 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.

***Balog, Carl Csaba, MD; MD19519; Portland, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; and prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order reprimands and fines Licensee; prohibits Licensee from prescribing for himself or immediate family members; requires Licensee to complete an education plan designed by CPEP; prohibits Licensee from treating hypogonadism in male patients over the age of 16; and requires that Licensee complete Board-approved courses in appropriate prescribing and pain management.

***Collins, Elbert Campbell, MD; MD14732; Grants Pass, OR**

On January 10, 2013, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's April 30, 2012 Consent Agreement.

***Duran, Michael Gordon, MD; MD27904; Kingman, AZ**

On January 10, 2013, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 8, 2010 Corrective Action Order.

***Field, Frederick George, MD; MD26105; The Dalles, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; and conviction of any offense punishable by incarceration in a Department of Corrections institution. This Order surrenders Licensee's medical license while under investigation and permanently prohibits Licensee from re-applying for a medical license.

***Forsyth, Ashley William, DO; DO14953; Newport, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and violation of the federal Controlled Substances Act. This Order surrenders Licensee's medical license, prohibits Licensee from re-applying for a license for two years, and assesses a civil penalty against Licensee.

***Fritts, Julia Anne, LAc; AC151342; Corvallis, OR**

On January 10, 2013, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's October 6, 2011 Stipulated Order.

Gaekwad, Satyajee Yashwantrao, MD; MD26995; Albany, OR

On January 10, 2013, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to obtain proctoring prior to performing any new procedures or utilizing any new medical device, and have a board-certified surgeon serve as a surgical assistant for the next ten open inguinal hernia repairs and the next ten laparoscopic inguinal hernia repairs performed by Licensee.

***Gage, Arden Jay, Jr., PA; PA01226; Klamath Falls, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; willfully violating a Board rule; and prescribing a controlled substance without a legitimate medical purpose or following accepted procedures for examining or prescribing controlled substances. This Order reprimands and fines Licensee, requires that Licensee complete a Board-approved boundaries course, and continues care from a Board-approved healthcare provider.

***Goering, Edward Keim, DO; DO19450; Portland, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; willfully violating any Board rule or failing to comply with a Board request; and prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order reprimands and fines Licensee; revokes Licensee's osteopathic license, however the revocation is stayed; suspends Licensee's osteopathic license for 90 days; places Licensee on indefinite probation; requires that Licensee's practice setting be pre-approved by the Board; subjects Licensee's practice to no-notice inspections by the Board; requires that Licensee complete pre-approved courses in prescribing, ethics, and medical documentation; requires that Licensee complete a CPEP assessment, obtain and complete an educational plan from CPEP if appropriate; prohibits Licensee from prescribing or dispensing Schedule II medication or Suboxone to chronic pain patients; prohibits Licensee from providing medical care to friends or family members, to include conducting office based surgery; prohibits Licensee from teaching courses in ethics,

prescription of controlled substances or medical documentation; and requires License to provide a copy of his Stipulated Order to any employer or medical school where he may teach.

Harsany, Robert Milton, MD; MD10669; Portland, OR

On January 10, 2013, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a course on urogynecology pre-approved by the Board's Medical Director.

***Hatlestad, Christopher Lien, MD; MD24066; Portland, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board unprofessional or dishonorable conduct, and gross or repeated negligence in the practice of medicine. This Order reprimands Licensee; places Licensee on probation for five years; prohibits Licensee from using DMPS challenge testing, or chelation therapy; prohibits Licensee from treating heavy metal toxicity; and allows for no-notice inspections of Licensee's practice and medical charts.

***Hoffman, Gregory Robert, MD; MD22890; Sandy, UT**

On January 10, 2013, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's October 7, 2010 Stipulated Order.

***Kast, John Michael, MD; MD23327; Portland, OR**

On January 10, 2013, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's July 10, 2008 Stipulated Order and his July 7, 2011 Order Modifying Stipulated Order.

***Lee, Anthony Hyunbo, MD; MD15438; Beaverton, OR**

On January 2, 2013, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from the prescribing or dispensing of any controlled substances pending the completion of the Board's investigation into his ability to safely and competently practice medicine. This Order allows for a two week exception for one time refills of benzodiazepines.

***Lindberg, John Francis, MD; MD12005; Lebanon, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order reprimands and fines Licensee, and requires that Licensee complete a Board-approved boundaries course.

***Marjanovic, Danijela Mozina, MD; MD12634; Roseburg, OR**

On January 2, 2013, the Board issued an Order Terminating Order of License Suspension. This Order terminates Licensee's October 4, 2012, Order of License Suspension.

***Maslona, Andrew Rowe, MD; MD28259; Coos Bay, OR**

On January 10, 2013, the Board issued an Order Terminating Corrective Action Order. This Order terminates Licensee's April 16, 2008 Corrective Action Order and his July 8, 2010 Order Modifying Corrective Action Order.

***McCluskey, Edward Alan, MD; MD18356; Portland, OR**

On January 10, 2013, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 7, 2011 Stipulated Order, granting Licensee an active license and allowing for practice limited to venipuncture/IV therapy; surgical first assist; Independent Medical Examinations (IME); history and physicals on behalf of medicare insurances; and phone triage in clinic.

***Redwine, David Byron, MD; MD09578; Bend, OR**

On January 10, 2013, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 8, 2011 Stipulated Order, allowing the Board to hold term 5.6 of the Order in abeyance.

***Roberts, Charles Anthony, PA; PA00257; Veneta, OR**

On January 10, 2013, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence in the practice of medicine. This Order reprimands and fines Licensee, requires that Licensee prepare written clinic policies and obtain a consultant to review and report to the Board on these policies, requires that consultant conduct an audit of Licensee's adherence to the policies, and requires Licensee to complete a Board-approved course in practice management.

***Skotte, Daniel Mark, DO; DO13485; Sunriver, OR**

On January 10, 2013, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's July 10, 2008 Stipulated Order and his July 7, 2011 Order Modifying Stipulated Order.

***Straumfjord, Marianne, MD; MD07575; Bend, OR**

On January 10, 2013, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's April 30, 2012 Consent Agreement.

Thomas, Paul Norman, MD; MD15689; Portland, OR

On January 10, 2013, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to refrain from conducting simultaneous pediatric and drug addiction practices, and adhere to his Board-approved submitted work schedule.

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 identified condition and in the face of a contrary recent neuropsychological evaluation that did
2 not support Licensee's treatment plan. Licensee also failed to chart a change in medication.

3 3.2 Licensee also wrote prescriptions for controlled substances for Patient B, another
4 family member, without the benefit of an examination or adequate charting. Licensee engaged in
5 this conduct without regard to ethical guidelines that caution against treatment of immediate
6 family members.

7 3.3 Licensee diagnosed himself with a medical condition based upon non-specific
8 symptoms and self-prescribed Testosterone (Schedule III). On February 23, 2010, Joseph
9 Knaus, NP, Licensee's employee, wrote a prescription at Licensee's request for Oxandrolone
10 (Oxandrin, Schedule III), 5 mg, #60. Licensee did not comply with well recognized medical
11 guidelines for the evaluation and treatment of hypogonadism, and disregarded ethical standards
12 that caution against self-treatment.

13 3.4 The Board conducted a review of five charts for chronic pain patients that
14 Licensee treated with testosterone replacement therapy, based upon a diagnosis of opioid
15 induced hypogonadism. Licensee's pattern of treatment did not conform to established
16 guidelines in the diagnosis and treatment of hypogonadism, to include failing to establish patient
17 testosterone levels, failing to establish a consistent time in the morning to test patient
18 testosterone levels, failing to perform digital rectal exams, and failing to regularly monitor
19 patient prostate-specific antigen (PSA) levels and complete blood count (CBC) checks.

20 3.5 The Board conducted a review of charts for three chronic pain patients (Patients
21 C, D and E) that Licensee diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and
22 treated with stimulants. The Board's chart review reveals that Licensee lacks the expertise to
23 establish a diagnosis of ADHD based on a comprehensive clinical and psychological assessment.
24 Licensee failed to establish a diagnosis of ADHD, but proceeded to treat Patient C with
25 methylphenidate (Concerta, Schedule II) and Patients D and E with atomoxetine (Strattera), both
26 of whom had a history of polysubstance abuse. Licensee's treatment of Patients C, D, and E

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1 with stimulants was not medically indicated, and subjected the patients to the risk of serious side
2 effects without active monitoring.

3 4.

4 Licensee and the Board desire to settle this matter by entry of this Stipulated Order
5 consistent with the terms of this Order. Licensee understands that he has the right to a contested
6 case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes
7 and fully and finally waives the right to a contested case hearing and any appeal therefrom by the
8 signing of and entry of this Order in the Board's records. Licensee stipulates that he engaged in
9 the conduct described in paragraph 3 above and that this conduct violated ORS 677.190(1)(a)
10 unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a); ORS 677.190(13)
11 gross or repeated negligence in the practice of medicine; and ORS 677.190(24) prescribing
12 controlled substances without a legitimate medical purpose, or prescribing controlled substances
13 without following accepted procedures for examination of patients, or prescribing controlled
14 substances without following accepted procedures for record keeping. Licensee understands that
15 this document is a public record and is reportable to the National Data Bank and the Federation
16 of State Medical Boards.

17 5.

18 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order,
19 subject to the following terms and conditions:

20 5.1 Licensee is reprimanded.

21 5.2 Licensee must pay a fine of \$1,500, payable in full within 60 days from the
22 signing of this Order by the Board Chair.

23 5.3 Licensee must not prescribe or otherwise provide treatment for himself or
24 immediate family members.

25 5.4 Within 24 months from the signing of this Order by the Board Chair, Licensee
26 must successfully complete an education remediation plan designed and managed by the Center

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1 for Personalized Education for Physicians (CPEP) and pre-approved by the Board's Medical
2 Director.

3 5.5 Licensee must not treat male patients over the age of 16 for hypogonadism or
4 otherwise treat such patients with testosterone except in conformance with the American
5 Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for the
6 Evaluation and Treatment of Hypogonadism in Adult Male Patients – 2002 Update.

7 5.6 Within 12 months from the signing of this Order by the Board Chair, Licensee
8 must successfully complete a course on appropriate prescribing and a course on pain
9 management that are pre-approved by the Board's Medical Director.

10 5.7 Licensee stipulates and agrees that he will obey all laws and regulations
11 pertaining to the practice of medicine in Oregon.

12 5.8 Licensee stipulates and agrees that any violation of the terms of this Order would
13 be grounds for further disciplinary action under ORS 677.190(17).

14 5.9 This Order becomes effective on the date it is signed by the Board Chair.

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16 IT IS SO STIPULATED this 21st day of December, 2012.

17

SIGNATURE REDACTED

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CARL CSABA BALOG, M.D.

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IT IS SO ORDERED this 10th day of January, 2013.

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OREGON MEDICAL BOARD
State of Oregon

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SIGNATURE REDACTED

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W. KENT WILLIAMSON, MD
BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
ELBERT CAMPBELL COLLINS, MD) ORDER TERMINATING
LICENSE NO. MD14732) CONSENT AGREEMENT
)

1.

On April 30, 2012, Elbert Campbell Collins, MD (Licensee) entered into a Consent Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon medical license. On October 9, 2012, Licensee submitted a written request to terminate this Agreement.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Agreement, the Board terminates the April 30, 2012 Consent Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2013.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
MICHAEL GORDON DURAN, MD) ORDER TERMINATING
LICENSE NO. MD27904) CORRECTIVE ACTION AGREEMENT
)

1.

On July 8, 2010, Michael Gordon Duran, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon medical license. On November 7, 2012, Licensee submitted a written request to terminate this Agreement.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Agreement, the Board terminates the July 8, 2010 Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2013.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
FREDERICK GEORGE FIELD, MD) STIPULATED ORDER
LICENSE NO. MD26105)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Frederick George Field, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board is prepared to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, 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 by ORS 677.188(4)(a); and ORS 677.190(6) conviction of any offense punishable by incarceration in a Department of Corrections institution.

3.

Licensee entered into an Interim Stipulated Order with the Board on August 4, 2011, in which he agreed to voluntarily withdraw from the active practice of medicine pending completion of the Board's investigation. On September 18, 2012, Licensee was convicted pursuant to his plea of guilty in Wasco County Circuit Court of one count Rape in the First Degree (Class A felony) and 11 counts of Sexual Abuse in the First Degree (Class B felonies). Licensee was sentenced to 23 years of confinement by the Oregon Department of Corrections, as well as to fines and restitution.

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2 Licensee and the Board agree to close this investigation with this Stipulated Order, in
3 which Licensee agrees to surrender his license while under investigation, consistent with the
4 terms of this Order. Licensee understands that he has the right to a contested case hearing
5 under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully
6 and finally waives the right to a contested case hearing and any appeal therefrom by the
7 signing of and entry of this Order in the Board's records. Licensee stipulates that he engaged
8 in the conduct described in paragraph 3 above and that this conduct violated the Medical
9 Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined
10 by ORS 677.188(4)(a); and ORS 677.190(6) conviction of any offense punishable by
11 incarceration in a Department of Corrections institution. Licensee understands that this
12 document is a public record and is reportable to the National Data Bank and the Federation of
13 State Medical Boards.

5.

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15 Licensee and the Board agree to resolve this matter by the entry of this Stipulated
16 Order, subject to the following conditions:

17 5.1 Licensee permanently surrenders his license to practice medicine while under
18 investigation. This surrender of license becomes effective the date the Board Chair signs this
19 Order.

20 5.2 Licensee is permanently prohibited from applying for a license to practice
21 medicine.

22 5.3 The Interim Stipulated Order of August 4, 2011, will terminate upon the
23 signing of this Stipulated Order by the Board Chair.

24 5.4 Licensee stipulates and agrees that any violation of the terms of this Order
25 would be grounds for further disciplinary action under ORS 677.190(17).

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
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ASHLEY WILLIAM FORSYTH, DO) STIPULATED ORDER
LICENSE No. DO14953)
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1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including osteopathic physicians, in the state of Oregon. Ashley William Forsyth, DO (Licensee) holds an active license to practice medicine in the state of Oregon.

2.

On August 1, 2012, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action, in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, 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(13) gross or repeated acts of negligence; and ORS 677.190(23) violation of the federal Controlled Substances Act.

3.

Licensee engaged in the following conduct:

3.1 Licensee formerly worked as an emergency room (ER) physician at Samaritan Pacific Communities Hospital (SPCH) in Newport, Oregon, which is part of Samaritan Health Services (SHS). On April 14, 2007, Patient A, a 24-year old female, was admitted to the SPCH at 6:50 pm, and presented to Licensee at the ER complaining of headache and neck pain. Patient A indicated that when she awoke from a nap, she found that she had difficulty speaking, was dizzy, and was unable to move or walk normally. She also complained of vomiting, slurred

1 speech and decreased vision. The paramedics who transported her to the ER noted that they
2 thought Patient A had suffered a stroke. In the ER, it was disclosed that Patient A had reportedly
3 suffered domestic physical abuse in March of 2007, to include being beaten on the head and neck
4 and strangled around the neck. Licensee conducted a neurological examination, which he
5 described as normal. By 7:15 pm, Licensee had ordered a CT head scan and cervical spine x-
6 rays. At 7:38 pm, Patient A was treated with Reglan 5mg IV, Ativan 0.5 mg IV, and Toradol 30
7 mg IV. At 7:55 pm, Licensee treated Patient A with Reglan, 5 mg IV, Ativan 0.5 mg IV and
8 morphine 4 mg IV. Patient A returned to the ER from the CT head scan at about 8:45 pm, when
9 she began to exhibit additional symptoms, to include nystagmus—with her eyes looking to the
10 left, posturing on the left side, and becoming unresponsive. Licensee thought she was having a
11 seizure and treated her with Ativan 1 mg IV. Her Glasgow Coma Score was 6. The CT scan
12 was interpreted by a teleradiology service at about 9:30 pm, which was read as negative. At 9:40
13 pm, Patient A was noted to have nystagmus, “mumbles – rarely,” with shaking and sweating.
14 Licensee called a hospitalist (who consulted with a neurologist) at the Good Samaritan Regional
15 Medical Center (GSRMC) in Corvallis. The medical chart shows that at 10:00 pm, Licensee
16 arranged to have Patient A transported by ambulance to GSRMC. Licensee remained on site
17 until at least 10:30 pm. Patient A was taken from the Newport ER by ambulance at 12:02 am,
18 and arrived at GSRMC at about 1:02 am on April 15, 2007. Patient A was examined by a
19 neurologist and underwent an magnetic resonance angiogram. Patient A was diagnosed with a
20 vertebral artery dissection and pontine infarction, which is a stroke involving the mid-portion of
21 the brainstem. Patient A was later determined to have “locked in syndrome.” Patient A is
22 conscious and aware of her surroundings, but she cannot move or speak due to complete
23 paralysis. Licensee’s failure to timely and accurately diagnose Patient A’s condition and to treat
24 and facilitate Patient A’s immediate transfer to GSRMC after she exhibited additional symptoms
25 of a stroke in the ER constituted gross or repeated acts of negligence.

26 3.2 A lawsuit was brought on behalf of Patient A against Licensee and SPCH for
27 medical malpractice, which ultimately was settled for \$4.7 million. During the course of pretrial
28 depositions associated with the malpractice lawsuit, Licensee testified that he had begun using

1 marijuana on a regular basis in 2003 as a “muscle relaxant,” and he had continued to use
2 marijuana throughout 2007 for chronic pain. He testified that over the years, he customarily
3 used marijuana that was “gifted” to him by different friends, but that more recently, he was
4 receiving his marijuana from a single source. Licensee testified that he used marijuana either by
5 smoking with a pipe or inhaling the marijuana fumes with a vaporizer.

6 3.3 Licensee reports that he has a history of chronic low back pain and degenerative
7 back disease. Licensee has undergone physical therapy, epidural spinal injections and other
8 treatment modalities to address his pain. He has informed the Board that he had an Oregon
9 medical marijuana card in either 2006 or sometime in 2007. His primary care physician signed a
10 medical marijuana authorization for Licensee in September 2009 for “severe pain and persistent
11 muscle spasm.” Licensee’s medical marijuana card expired in 2010.

12 3.4 In a meeting with two Board investigators on August 17, 2011, Licensee informed
13 the investigators that although he forgot to renew his medical marijuana card in 2010, he used
14 marijuana in 2011 on a recurring basis, with an expired medical marijuana card, for his back
15 condition and pain. Licensee stated that on the days that he used marijuana and when he was
16 scheduled to work, he customarily smoked it in the morning at least two hours before he reported
17 on duty at the hospital, in order to make sure that the marijuana effects had “worn off.” Licensee
18 denied ever being impaired at the workplace and stated that “marijuana never compromises my
19 ability” to practice safely and competently. Licensee stated he can safely operate a motor vehicle
20 and drive to work two hours after using marijuana.

21 3.5 Licensee subsequently worked at GSRMC as an academic hospitalist until
22 September 2011. In that capacity, Licensee saw patients with medical students and residents
23 from Western University of Health Sciences in Lebanon, Oregon, and served as a preceptor of
24 medical students. Many of the patients that Licensee saw were admitted through the ER. He
25 reportedly saw between 12 and 15 patients a day. Licensee stated that as a result of his
26 disclosure of prior marijuana use in the context of the medical malpractice case involving Patient
27 A, his employer, SHS, adopted a new policy in 2010 on substance abuse that applies to all
28 employees of SHS, which operates GSRMC, including Licensee.

1 3.6 The SHS written policy expressly prohibits the “manufacture, sale, use or
2 possession of alcohol, any illegal substance (including marijuana, even if medically prescribed
3 pursuant to Oregon law) or any controlled substance that has not been lawfully prescribed to the
4 employee or is not being used as prescribed, is prohibited during work hours, including breaks
5 and lunches.” The policy since November 2010 also states: “It is a violation of this policy for an
6 employee to report to work with any detectable level of an illegal or controlled drug (other than
7 as described under prescription medications), including alcohol or marijuana, in one’s system or
8 to have any noticeable or perceptible impairment of the employee’s mental or physical faculties.”
9 Licensee’s employment at GSRMC ended in September of 2011.

10 3.7 In a letter dated July 12, 2011, Licensee informed the Board that he had learned
11 about the SHS policy, which prohibited the use of medical marijuana, in February of 2011.
12 Licensee also wrote: “I stopped using marijuana and passed a random drug screen in June 2011.
13 However, marijuana is the most effective medication I have found for my condition and I would
14 like to keep it an option in my healthcare.”

15 3.8 On July 25, 2011, Licensee was asked by Board investigators to produce a urine
16 sample. Licensee’s urine tested positive for the marijuana metabolite called THC
17 (tetrahydrocannabinol), with a creatinine level of 28. At that time, Licensee did not have a valid
18 medical marijuana card from any state.

19 3.9 Licensee used marijuana for his medical condition and back pain with and without
20 a valid medical marijuana card. Marijuana is classified as a schedule I controlled substance under
21 federal laws. Licensee has failed to accurately indicate to all of his treating physicians and ER
22 doctors that he has been using marijuana, with or without a valid medical marijuana card, and
23 that these physicians have treated him for depression and other medical conditions with
24 prescription medications, to include narcotics, which may have been contraindicated with
25 marijuana.

26 3.10 Licensee appeared before the Board’s Investigative Committee on May 3, 2012.
27 Licensee informed the Committee that he is receiving ongoing treatment for degenerative disk
28 disease, to include Vicodin (hydrocodone & ibuprofen (Schedule III) and Neurontin

1 (gabapentin). Licensee also stated that he continues to use marijuana daily and employs a
2 vaporizer for his marijuana use. Licensee asserts that marijuana has no adverse effect on his
3 cognitive abilities two hours after use and that he is safe to practice. He indicated that he is not
4 willing to stop using marijuana, or to abstain on days that he would see patients.

5 4.

6 Licensee and the Board agree to close this investigation with this Stipulated Order in
7 which Licensee agrees to surrender his license while under investigation, consistent with the
8 terms of this Order. Licensee understands that he has the right to a contested case hearing under
9 the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally
10 waives the right to a contested case hearing and any appeal therefrom by the signing of and entry
11 of this Order in the Board's records. Licensee neither admits nor denies but the Board finds that
12 Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a)
13 unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13)
14 gross or repeated acts of negligence; and ORS 677.190(23) violation of the federal Controlled
15 Substances Act. Licensee understands that this document is a public record and is reportable to
16 the national Databank and the Federation of State Medical Boards.

17 5.

18 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order
19 subject to the following terms:

20 5.1 Licensee surrenders his license to practice medicine while under investigation.

21 This surrender of license becomes effective the date the Board Chair signs this Order.

22 5.2 Licensee is prohibited from applying for a license to practice medicine in the state
23 of Oregon for a period of two years, starting on the date this Order is signed by the Board Chair.

24 5.3 Licensee must pay a civil penalty of \$2,500 within 60 days from the date this
25 Order is signed by the Board Chair.

26 5.4 The signing of this Order by the Board Chair will terminate all open
27 investigations by the Board pertaining to Licensee.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
JULIA ANNE FRITTS, LAc) ORDER TERMINATING
LICENSE NO. AC151342) STIPULATED ORDER
)

1.

On October 6, 2011, Julia Anne Fritts, LAc (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon acupuncture license. On October 8, 2012, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and her successful compliance with the terms of this Order, the Board terminates the October 6, 2011 Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2013.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair

1 September 21, 2011. On nine of those clinical visits, Patient A was seen by Licensee. On two
2 occasions, Licensee prescribed Phentermine (Schedule IV) for Patient A in response to her desire
3 to lose weight, even though her body mass index did not meet the criteria specified by FDA
4 guidelines or the provisions of OAR 847-015-0010.

5 3.2 Licensee and Patient A began to exchange personal text messages in June, 2011,
6 which continued through September 28, 2011 (over 900 text messages were exchanged between
7 June 22, 2012, and September 28, 2011). Some of Licensee's text messages invited her to join him
8 for social activities in the community, and a few were explicitly sexual, and suggested that he was
9 seeking sexual favors.

10 3.3 Patient A, accompanied by a female adult friend, presented to Licensee on
11 September 21, 2011, for a clinical visit following a recent hospitalization (for an attempted
12 suicide). Licensee conducted an examination that included her pelvic area, with Patient A's friend
13 present in the room. At the end of the visit, Licensee told Patient A that he had something for her,
14 and handed her a bag containing a tank top from a motorcycle rally he had recently attended.
15 Licensee then put Patient A into an examination room, closed the door to be alone with her, placed
16 his arms around her and attempted to kiss her. Patient A pushed Licensee away and told him to
17 stop. After Patient A left the clinic, Licensee sent her a sexually suggestive text message.

18 4.

19 Licensee and the Board desire to settle this matter by entry of this Stipulated Order
20 consistent with the terms of this Order. Licensee understands that he has the right to a contested
21 case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes
22 and fully and finally waives the right to a contested case hearing and any appeal therefrom by the
23 signing of and entry of this Order in the Board's records. Licensee denies in part and admits in
24 part the allegations set forth in paragraph 3, but the Board finds that he engaged in the conduct
25 described in paragraph 3 above, and that this conduct violated ORS 677.190(1)(a) unprofessional
26 or dishonorable conduct, as defined in ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross
27 or repeated acts of negligence, ORS 677.190(17) willfully violating a Board rule; and ORS

1 677.190(24) prescribing a Schedule IV drug without a legitimate medical purpose or following
2 accepted procedures for examining or prescribing Schedule IV drugs. Licensee understands that
3 this document is a public record and is a disciplinary action that is reportable to the national Data
4 Bank and the Federation of State Medical Boards.

5 5.

6 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order,
7 subject to the following terms and conditions:

8 5.1 Licensee is reprimanded.

9 5.2 Licensee must pay a fine of \$2,500, payable in full within 90 days from the
10 signing of this Order by the Board Chair.

11 5.3 Within 12 months from the signing of this Order by the Board Chair, Licensee
12 must successfully complete a course in professional boundaries and an appropriate prescribing
13 course that is pre-approved by the Board's Medical Director.

14 5.4 Licensee must receive ongoing health care from a provider that is pre-approved
15 by the Board's Medical Director, with quarterly reports by the care provider to the Board.

16 5.5 Licensee stipulates and agrees that he will obey all laws and regulations
17 pertaining to the practice of medicine in Oregon.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
EDWARD KEIM GOERING, DO) STIPULATED ORDER
LICENSE NO. DO19450)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including osteopathic physicians, in the state of Oregon. Edward Keim Goering, DO (Licensee) is a licensed osteopathic physician in the state of Oregon.

2.

On October 11, 2012, the Board issued a Complaint and Notice of Proposed Disciplinary Action to impose up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, 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 by ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or repeated negligence in the practice of medicine; ORS 677.190(17) willfully violate any provision of chapter 677, any Board rule or failing to comply with a Board request pursuant to ORS 677.320; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.

Licensee is a family practice physician with a clinic in Milwaukie, Oregon. The Board opened an investigation into Licensee's manner of prescribing controlled substances to various

1 patients. Licensee subsequently signed an Interim Stipulated Order which placed conditions and
2 restrictions on his medical license while this case remained under investigation, which was
3 approved on June 6, 2012. Licensee's acts and conduct that violated the Medical Practice Act
4 are:

5 3.1 The Board opened an investigation after receiving a report that Licensee was
6 prescribing massive doses of opiates to Patient A, a 45 year old diabetic female, who had been
7 treated by Licensee for over 14 years for chronic pain. The Board reviewed Licensee's chart for
8 this patient, and found a neurology consultation in 2005 that stated that Patient A's pain was
9 likely secondary to diabetic thoracic radiculopathy. Licensee appeared to ignore this
10 consultation and treated Patient A's complaints of pain with large doses of Oxycodone (Schedule
11 II). The Board's review in this case was obstructed by Licensee's efforts to materially alter
12 various chart entries before submitting them to the Board. Beginning in 2009, Licensee began to
13 prescribe 220 tablets of Oxycodone, 15 mg, every month. By 2011, this had increased to 800
14 tablets of oxycodone, 30 mg, every month. Between June 13, 2011 and November 8, 2011,
15 Licensee prescribed 3.984 tablets of Oxycodone 30 mg without follow up or comment on Patient
16 A's ability to function or on her requests for early refills. Patient A presented to an emergency
17 room on December 19, 2011 fearful that she might be going into withdrawal. Between May of
18 2011 and January of 2012, Licensee's only contact with Patient A was by phone, and her request
19 for refills of Oxycodone were always granted. A review of Licensee's chart notes reflects that he
20 did not conduct pill counts or consistent urine drug screens, and always granted her frequent
21 requests for early refills of narcotic medication. Licensee's manner of prescribing controlled
22 substances for Patient A was excessive and he failed to monitor this patient's response to the
23 medication, to include her ability to function, and ignored evidence of dependence or diversion.

24 3.2 The Board subsequently conducted a review of randomly selected charts for
25 chronic pain patients B – E, which revealed that Licensee's charts often do not include a material
26 risk notice, contain either no pain contract or an incomplete pain contract, do not include any
27 record of periodic drug screening tests, lack any reference to pill counts, and reflect that Licensee

1 will authorize early refills without stating his reasoning in the chart or requiring his patients to
2 return to his clinic for periodic examination and follow-up. Licensee engaged in a pattern of
3 excessive prescribing of easily abusable and divertible opioid medications while failing to
4 monitor his patients, assess their ability to function, and failing to respond to signs of aberrant
5 behaviors. Licensee ignored the risks associated with the concurrent use of opioids with
6 benzodiazepines, failed to document PARQ conferences he may have had with his patients,
7 failed to document consultations with mental health providers and/or addiction specialists, and
8 failed to perform psychiatric or mental status evaluations. The deficiencies in Licensee's chart
9 notes reflect a manner of practice that did not conform to the standard of care and subjected his
10 patients to the risk of harm. Additional specific concerns follow:

11 a. Patient B, a 51 year old female, was treated by Licensee for chronic thoracic pain.
12 In December of 2009, Licensee was prescribing 450 tablets of MS Contin (Morphine, Schedule
13 II) 30 mg every month. Licensee did not see Patient B in his clinic again until February of 2012.
14 The records reflect that Licensee did not periodically assess the effectiveness of the opioid
15 therapy, her pain level or her ability to function. Licensee also failed to complete a pain contract,
16 failed to conduct a psychiatric or mental status evaluation, and failed to document any
17 discussions related to the risks associated with the use of chronic narcotics.

18 b. Patient C, a 57 year old male, was treated by Licensee for pain associated with a
19 chronic sprain in the rib area, chronic back pain and osteoarthritis. In March of 2009, Licensee
20 provided osteopathic treatment to areas of "somatic dysfunction" and prescribed Norco 10/325
21 (Hydrocodone and Acetaminophen, Schedule III), 1 - 2 tablets every 4 - 6 hours and Oxycodone
22 (dosage not specified in the chart). Beginning in June of 2009, Licensee wrote monthly
23 prescriptions of 560 tablets of Oxycodone 5 mg, with instructions for Patient C to take 4 - 6
24 tablets every 4 to 6 hours. This prescription was written every two months over the course of
25 2009, 2010, and the first four months of 2011. Patient C was seen in Licensee's clinic every two
26 months for osteopathic manipulation, and periodically received trigger point injections of
27 Depomedrol (Methylprednisolone), which afforded Patient C short term pain relief. The only

1 record of a drug screening test occurred in February 2012, when Patient C was seen by
2 Licensee's partner. In April of 2011, Patient C expressed concern about using "too many pain
3 meds" and Licensee unsuccessfully attempted to wean Patient C off of Oxycodone using
4 Suboxone (Buprenorphine & Naloxone, Schedule III). Patient C returned to the clinic on April
5 21, 2011 complaining that he was in withdrawal. On April 25, 2011, Licensee resumed monthly
6 prescribing 560 tablets of Oxycodone 5 mg, 4 – 6 tablets every 4 to 6 hours, which continued
7 throughout the remainder of 2011. Licensee referred to a pain management contract and a drug
8 screening test in a chart note dated February 14, 2012, when Patient C appeared asking for an
9 early refill, but continued to prescribe 560 tablets of Oxycodone 5 mg, with instructions for
10 Patient C to take 4 – 6 tablets every 4 to 6 hours in March of 2012.

11 c. Patient D, a 33 year old female, weighed 87 pounds, with a history of deafness,
12 and complaints of chronic pain associated with temporomandibular joint (TMJ) disorder. Patient
13 D was under Licensee's care in January of 2008, and was prescribed a medication regimen that
14 included Oxycodone, 15 mg, 2 – 4 tablets every 4 – 6 hours, oxycodone extended release
15 (OxyContin) (Schedule II), 80 mg – 5 tablets a day, Carisoprodol (Soma, Schedule IV) 350 mg,
16 12 tablets daily, and Alprazolam (Xanax, Schedule IV) 1 mg, 1 tablet every 8 hours. This
17 regimen of prescribed medications was excessive, not medically indicated and posed a
18 significant danger of harmful drug interaction. On March 4, 2009, Licensee's chart note states
19 that Patient D "was discouraged in sleeping in bed too much" while Licensee maintained Patient
20 D on the following daily dosage of medications: 480 mg of OxyContin (Schedule II) and 120 -
21 180 mg of Oxycodone, as well as Duloxetine (Cymbalta) for depression, Alprazolam (Xanax,
22 Schedule IV) 1 mg, 3 times a day, and Carisoprodol (Soma, Schedule IV), 350 mg, 12 tablets
23 daily, for anxiety. A chart note for July 7, 2009 reflects that Licensee was prescribing 400 mg of
24 OxyContin, 135 mg of Oxycodone, Xanax 1 mg, 3 times a day, and Soma 350 mg, 15 tablets
25 daily. Licensee's note states that he counseled Patient D about sleeping too much and cautioned
26 her about the addictive potential of the medication, but continued the regimen. This continued
27 until the medication load was reduced in July 2010 to a daily dosage of 160 mg of OxyContin,

1 180 mg of Oxycodone, Xanax 1 mg, 3 times a day, and Soma, 350 mg, 8 tablets. Licensee's
2 chart notes for July 27, 2011 reflect that he was prescribing a daily dosage of 300 mg of
3 OxyContin, 30 - 60 mg of Oxycodone every 4 - 6 hours, Xanax 1 mg, 3 tablets, and Soma, 350
4 mg, 8 tablets. Licensee's chart notes for January 16, 2012 reflect a daily dosage of 120 mg of
5 OxyContin, 30 - 60 mg of Oxycodone every 4 - 6 hours, Xanax 1 mg, 3 times a day, and Soma,
6 350 mg, 11 tablets. Licensee wrote the following incongruous note on this same date:
7 "Currently taking 15 pills of Soma and on bad days she is taking 20." Licensee failed to
8 adequately monitor this patient while on a high dosage of narcotic medications with the potential
9 for harmful interaction with other prescribed medications. Licensee also failed to document any
10 PARQ conference or material risk notification.

11 d. Patient E, a 47 year old male, presented to Licensee by referral on April 27, 2009
12 with a history of chronic pain from multiple broken bones caused by an industrial accident. On
13 his first visit, Licensee prescribed 270 tablets of OxyContin per month, 40 mg, 360 mg a day;
14 480 tablets of Oxycodone (Oxycodone Hydrochloride), 30 mg, 90 - 120 mg 6 times a day; and
15 60 tablets of Wellbutrin (Bupropion) 150 mg, 2 a day. On August 7, 2009, Licensee authorized
16 an early refill of his opioid prescriptions after Patient E reported losing his remaining opioids "in
17 the river." Licensee's chart note for June 8, 2010 reflect that he was prescribing 480 tablets of
18 Oxycodone Hydrochloride, 30 mg, 3 - 4 tablets every 4 - 6 hours; 270 tablets of OxyContin, 40
19 mg, 3 tablets every 8 hours; and 60 tablets of Wellbutrin (Bupropion) 150 mg, 1 a day. On June
20 24, 2010, Licensee authorized an early refill after Patient E called from Utah to report that his
21 two month supply of medications had been thrown out after a camping trip. In September of
22 2010, Patient E requested Licensee to discontinue the prescription for OxyContin and to increase
23 the dosage of Oxycodone. Licensee complied and prescribed 660 tablets of Oxycodone
24 Hydrochloride, 30 mg, 3 - 4 tablets every 4 - 6 hours. A chart note for September 21, 2011,
25 reflects that Patient E reported that someone had entered his boat while it was moored in Astoria
26 and stole his Oxycodone on September 13th or 14th. Licensee authorized an early refill of
27 Oxycodone. Licensee maintained Patient E on a high dosage of opioid medication despite

1 various "red flags," to include a positive test for marijuana, and three occasions in which Patient
2 E reported that his opioid medications were either lost or stolen. Licensee always authorized
3 another refill. At Patient E's request, Licensee discontinued the prescriptions of OxyContin, and
4 increased the dosage for Oxycodone to 660 tablets per month without medical indication.
5 Licensee never referred Patient E to a pain specialist.

6 e. Patient F, a 48 year old male, presented to Licensee on December 10, 2008 with
7 chronic pain syndrome and anxiety, and osteoarthritis in his knees and lower back. Licensee
8 treated Patient F with periodic trigger point injections. Licensee's chart notes are brief and
9 difficult to follow. At some point, Licensee put Patient F on a regimen of opioid medication.
10 Licensee's progress note for April 15, 2008 reflects that Patient F's current medications included
11 OxyContin and Norco (Hydrocodone & Acetaminophen). On February 5, 2009, Licensee
12 prescribed OxyContin, 20 mg 2 a day, Oxycodone, 5 mg, 1 - 2 every 4 - 6 hours, Norco
13 10/325mg (amount not stated), Actig (Fentanyl, Schedule II) 800 mcg, 1 tablet every 1-2 hours
14 for breakthrough pain, Fentora (Fentanyl, Schedule II) 400 mcg, 1 - 2 every 1 - 2 hours as
15 needed, and Alprazolam, .5 mg, 1 every 8 hours. On June 20, 2011, Licensee prescribed
16 OxyContin, 20 mg, 2 a day, Oxycodone, 5 mg, 1 - 2 every 4 - 6 hours, Norco 10/325mg, 1 - 2
17 every 4 - 6 hours, Actig (Fentanyl, Schedule II) 100 mcg, 1 tablet every 6 hours, Fentora
18 (Fentanyl, Schedule II) 100 mcg, 1 every 6 hours, and Alprazolam, .5 mg, 1 every 8 hours.
19 Licensee did not enter into a pain contract with Patient F, conducted no drug screening tests,
20 failed to document any PARQ conference or material risk notifications, and did not inquire into
21 Patient F's psychiatric history, or history of drug use.

22 f. Licensee performed a reduction mammoplasty on Patient G, a family member, in
23 his office without maintaining a patient chart. There is no record of a patient work up or
24 indication for this procedure, the amount or type of anesthesia provided, the fluid loss, amount of
25 tissue removed, or information regarding patient outcome.

26 g. Licensee performed two separate hernia repair surgeries on Patient H at his family
27 practice clinic in Milwaukie, Oregon. The procedures were performed under local anesthesia in a

1 clinic exam room, inadequately documented, and without a written PARQ, falling below the
2 standards outlined in OAR 847-017-0015 and OAR 847-017-0020.

3 3.3 During the course of the Board's investigation, Licensee provided false
4 statements and falsified medical records to the Board's investigators. In response to a Board
5 request for medical records pertaining to Patient A, Licensee submitted records that contained
6 references to patient encounters in 2011 and 2012 that never took place. Other examples of
7 falsified chart entries include the following: an office visit on December 15, 2010, a phone
8 encounter on March 24, 2011, a pain contract to reflect a 2011 date (it was really a 2009
9 document that was re-dated), and many occasions where data was inserted into the progress
10 notes in an attempt to justify Licensee's care and treatment of Patient A. Licensee has admitted
11 that he did falsify and substantively alter the charts of Patient A and submitted those altered
12 charts to the Board.

13 The Board's investigation has revealed irregularities in the charting for other patients. For
14 example, a chart entry dated December 22, 2009, refers to Patient B as a man who wanted to
15 resume riding motorcycles and return to his work as a mechanic (she was not employed). Many
16 of Patient B's records pertained to office visits dating as far back as 2009, but were electronically
17 signed by Licensee on March 14, 2012, shortly after midnight. The medical charts for Patient E
18 also reflect various irregularities, which indicate that much of the language for the various
19 patients' visits were cut and pasted from previous encounters, despite the large volume of opiates
20 prescribed, with the electronic signature of Licensee affixed many months thereafter. Board
21 investigators repeatedly asked Licensee to address the authenticity of the medical records he
22 submitted for review, and he repeatedly attested to their authenticity.

23 In a letter dated June 1, 2012 from his counsel, Licensee acknowledged that he had
24 altered the electronic medical records for Patient A before he submitted them to the Board for
25 review. In the Interim Stipulated Order that Licensee signed on June 6, 2012, Licensee admitted
26 "...that he had the medical charts materially altered before it was sent to the Board. This was
27 done with the intent of misleading the Board in regard to the manner of care provided to these

1 patients. Licensee also admits that during the course of the investigation, he provided false and
2 misleading statements to Board investigators. Licensee acknowledges that this was a serious
3 lapse in judgment.”

4 4.

5 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
6 Licensee understands that he has the right to a contested case hearing under the Administrative
7 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
8 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
9 Order in the Board's records. Licensee neither admits or denies, but the Board finds, that he
10 engaged in the conduct described in paragraph 3, and that this conduct violated ORS
11 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a), (b) and
12 (c); ORS 677.190(13) gross or repeated negligence in the practice of medicine; ORS 677.190(17)
13 willfully violate any provision of chapter 677, any Board rule or failing to comply with a Board
14 request pursuant to ORS 677.320; and ORS 677.190(24) prescribing controlled substances
15 without a legitimate medical purpose, or prescribing controlled substances without following
16 accepted procedures for examination of patients, or prescribing controlled substances without
17 following accepted procedures for record keeping. Licensee understands that this Order is a
18 public record and is a disciplinary action that is reportable to the National Data Bank and the
19 Federation of State Medical Boards.

20 5.

21 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order
22 subject to the following sanctions and terms and conditions of probation:

23 5.1 Licensee is reprimanded.

24 5.2 The license of Licensee to practice medicine is revoked, but the revocation is
25 stayed.

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1 5.3 The license of Licensee to practice medicine is suspended for 90 days, effective
2 Friday, May 10, 2013 at 5:00 p.m. Licensee must not engage in any teaching activities in the
3 field of medicine during the time of his suspension.

4 5.4 Licensee is placed on indefinite probation. Licensee must report in person to the
5 Board at each of its quarterly meetings at the scheduled times for a probation interview, unless
6 otherwise directed by the Board's Compliance Officer or its Investigative Committee.

7 5.5 Licensee must pay a fine of \$10,000, payable in full within 270 days from the
8 signing of this Order by the Board Chair. Licensee may make payments of at least \$1,000 with
9 the balance being paid in full within 270 days from the signing of this order.

10 5.6 Any practice setting for Licensee must be approved in advance by the Board's
11 Medical Director.

12 5.7 Licensee's medical practice is subject to no notice inspections by the Board's
13 designees.

14 5.8 Within 12 months from the signing of this Order by the Board Chair, Licensee
15 must successfully complete courses in appropriate prescribing, ethics, and medical
16 documentation that have been pre-approved by the Board's Medical Director.

17 5.9 Within 60 days from the signing of this Order by the Board Chair, at Licensee's
18 expense, Licensee must enroll for an assessment at the Center for Personalized Education for
19 Physicians (CPEP), which must be completed within six months. In the event the CPEP
20 Assessment Report recommends education remediation or other recommendations related to
21 education or training, Licensee must also obtain from CPEP an educational intervention plan
22 addressing the recommendations set forth in the CPEP Assessment Report.

23 5.10 Within 18 months from the signing of this Order by the Board Chair, at
24 Licensee's expense, Licensee must complete the CPEP educational intervention plan if one is
25 required per term 5.9 of this Order.

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1 5.11 Within 30 days from the signing of this order by the Board Chair, Licensee must
2 sign all releases necessary to allow CPEP and the Board to communicate with each other.

3 Licensee will not revoke such releases prior to successful completion of Term 5.10 of this Order.

4 5.12 Licensee is prohibited from prescribing or dispensing any Schedule II medication
5 or buprenorphine/naloxone (Suboxone) to any chronic pain patient. For purposes of this Order,
6 "chronic pain patient" is defined as any patient that receives a prescription from Licensee for a
7 scheduled medication to address symptoms associated with pain in excess of 30 consecutive
8 days. Licensee shall be permitted to continue prescribing Schedule II or narcotic medication to
9 acute pain patients.

10 5.13 Licensee must not provide any medical care to any friend or family member.

11 5.14 Licensee is prohibited from conducting any office based surgery on any patient in
12 his clinic or any other clinic. This term does not prohibit Licensee from conducting minor
13 procedures, to include wart removal, suturing minor wounds (less than 10 sutures), relieving
14 ingrown toe nails, and injection based therapies approved in advance by the Board's Medical
15 Director.

16 5.15 Licensee is prohibited from teaching ethics, prescribing of controlled substances
17 and medical documentation in any medical school or teaching these subjects to any medical
18 student (to include residents) in any setting. Upon completion of, or substantial completion of
19 the ethics course described in term 5.8 of this Order, Licensee is permitted to teach osteopathic
20 manipulative therapy and treatment.

21 5.16 Licensee must provide a copy of this Order to any medical school where he may
22 teach and to any employer in a healthcare setting that may employ him. After one year of
23 demonstrated compliance with the terms of this Order, and completion of terms 5.9 and 5.10 of
24 this Order, Licensee may submit a written request to modify this term.

25 5.17 Upon successful completion of two years of probation with demonstrated
26 compliance, Licensee may submit a written request to modify the terms of the Stipulated Order.

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1 5.18 The Interim Stipulated Order of June 6, 2012, terminates when the Board Chair
2 signs this Order.

3 5.19 Licensee stipulates and agrees that he will obey all laws and regulations
4 pertaining to the practice of medicine in Oregon.

5 5.20 Licensee stipulates and agrees that this Order becomes effective the date it is
6 signed by the Board Chair.

7 5.21 Licensee stipulates and agrees that any violation of the terms of this Order shall
8 be grounds for further disciplinary action under ORS 677.190(17).

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IT IS SO STIPULATED THIS 27 day of December, 2012.

SIGNATURE REDACTED

EDWARD KEIM GOERING, DO

IT IS SO ORDERED THIS 10th day of January, 2013.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
CHRISTOPHER LIEN HATLESTAD, MD) STIPULATED ORDER
LICENSE NO MD 24066)
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1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Christopher Lien Hatlestad, MD (Licensee) is a licensed physician in the state of Oregon.

2.

In a Complaint and Notice of Proposed Disciplinary Action issued on April 5, 2012, the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, 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 by ORS 677.188(4)(a), (b) and (c) and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

3.

Licensee is board certified in family practice and practices medicine at the Center for Environmental Medicine in Portland, Oregon. Licensee's acts and conduct that violated the Medical Practice Act are:

3.1 A review of the medical records in this case reveals that Patient A, a 68 year old male, sought treatment from a number of naturopathic and allopathic physicians in the fall of 2010 and early 2011. Patient A presented to a naturopathic physician on November 4, 2010,

1 complaining of lack of energy and severe constipation. The naturopath conducted an oral
2 chelation dimercaptosuccinic (DMSA) challenge, assessed Patient A with “heavy metal burden”
3 and placed him on a series of Ethylenediaminetetraacetic Acid (EDTA) IV (intravenous)
4 chelation treatments. On November 30, 2010, Patient A presented to Licensee for evaluation of
5 what the patient thought was possible heavy metal toxicity. Patient A complained of ringing in
6 his ears, constipation, urinary frequency, burning in his ankles, cold feet, and fatigue. Licensee
7 noted that Patient A’s previous allopathic PCP could not find “any reasonable explanation” to
8 explain his symptoms. Patient A also reported feeling “slightly queasy” during his last chelation
9 treatment. Licensee relied upon the naturopath’s DMSA challenge to conclude that Patient A
10 had “fairly high levels of lead and mercury.” Licensee recommended a general detoxification
11 but also encouraged Patient A to delay doing additional medical chelation therapy. Licensee
12 accepted Patient A’s report that he had been exposed to heavy metals at the workplace (Patient A
13 worked in drywall and plaster) without further investigation. Licensee put Patient A on Thyroid,
14 30 mg and placed Patient A on various supplements, ostensibly to help “cleanse” his body of
15 toxins. Licensee’s diagnosis of lead and mercury toxicity and his treatment plan was not
16 medically indicated. The American College of Medical Toxicology disapproves of the use of
17 post-chelator challenge urinary metal testing in clinical practice.

18 3.2 On December 20, 2010, Patient A presented to Licensee for follow-up. Licensee
19 noted that Patient A had repeated an IV challenge and heavy metal analysis against the advice of
20 his naturopathic physician. Patient A complained that “his bowels are shutting down.” Licensee
21 recommended titrating a dose of magnesium citrate liquid until he had regular bowel movements
22 and to “avoid further chelation treatments.” On December 24, 2010, Patient A established care
23 with a new primary care physician (PCP), and presented with complaints of generalized malaise
24 and diffuse myalgia and fatigue. Patient A told his PCP that he had been exposed to heavy metal
25 poisoning when he was sanding boards to help construct a Masonic lodge. This physician noted
26 that Patient A had recently undergone laboratory blood testing that was negative for lead or
27 mercury, but that naturopathic lab work reported elevated levels of lead and mercury. The PCP

1 ordered another blood test, which was negative for heavy metals. The PCP offered to refer
2 Patient A to OHSU's occupational medicine department and recommended that Patient A
3 consider Seroquel (Quetiapine) to reduce his anxiety. The PCP charted that he did not think that
4 Patient A's multiple somatic complaints were related to his exposure to mercury or lead. In
5 January 2011, the PCP put Patient A on a course of Ativan (Lorazepam, Schedule IV) and Xanax
6 (Alprazolam, Schedule IV). Patient A subsequently presented to Licensee for follow-up on
7 January 13, 2011. Licensee noted that Patient A was under the care of a PCP, who had run
8 several serum levels for lead and mercury that were both negative. Nevertheless, Licensee
9 concluded that Patient A had mercury, lead and cadmium toxicity that "are likely contributing if
10 not the primary cause of a number of his health issues." Licensee treated Patient A with 10 cc of
11 calcium EDTA IV (intravenous) chelation therapy. Licensee also recommended that Patient A
12 use rectal EDTA suppositories with oral DMSA and other supplements "to facilitate continued
13 removal of the heavy metals." Patient A subsequently underwent an independent medical
14 examination (IME) in January 2011 by a physician with board certification in medical toxicology
15 for the purpose of evaluating his complaints in regard to his alleged exposures to lead and other
16 substances encountered during the course of his work activities at a Masonic Lodge. Laboratory
17 testing for blood lead and mercury were negative. This IME report concluded that there was no
18 historical or medical data to substantiate a conclusion that Patient A had been exposed to heavy
19 metals through the course of his work activities and that his multiple somatic complaints did not
20 correspond with objective findings. On February 16, 2011, Patient A's PCP diagnosed him with
21 depressive disorder and prescribed Seroquel XR 50 mg. An occupational medicine referral was
22 made to Harborview Medical Center, which did extensive lab work and concluded that "[t]his
23 patient does not have heavy metal toxicity. He should not pursue additional chelation therapy
24 with his naturopath." Licensee's diagnosis of heavy metal toxicity was not supported by
25 evidence based medical science. Licensee's treatment plan was not medically indicated, and
26 exposed Patient A to the risk of harm, to include increased urinary excretion of essential
27 minerals, while failing to consider other potential etiologies for Patient A's complaints.

1 3.3 The Board conducted a review of Licensee's charts for Patients B - F, which
2 revealed the following pattern of practice: Licensee failed to document a complete occupational
3 and environmental exposure history to assess his patients' possible sources of exposure to heavy
4 metals; Licensee failed to document objective findings based upon an appropriate neurological
5 examination to establish symptoms related to heavy metal toxicity; Licensee failed to rely upon
6 appropriate diagnostic testing to establish or rule out a diagnosis of heavy metal toxicity;
7 Licensee relied upon post-chelator challenge urinary metal testing as an indication for the
8 administration of chelating agent to treat heavy metal toxicity (according to the American
9 College of Medical Toxicology, this form of testing "has not been scientifically validated, has no
10 demonstrated benefit, and may be harmful when applied in the assessment and treatment of
11 patients in whom there is concern for metal poisoning.") Licensee also provided his patients
12 with unnecessary treatment, to include repeated intravenous chelation therapy, and used dietary
13 supplements to treat heavy metal toxicity and other medical conditions, in a manner that lacked
14 adequate support in medical science to address the asserted diagnosis. These treatments caused
15 Licensee's patients to incur unnecessary expense and exposed his patients to the risk of harm, to
16 include increased urinary secretion of essential minerals, such as iron, copper and zinc. Finally,
17 Licensee failed to consider and rule out other etiologies, but relied upon a diagnosis of heavy
18 metal toxicity, to explain his patients' complaints. Examples include, but are not limited to, the
19 following patients.

20 3.4 Patient D, a 44 year old female, presented to Licensee on March 15, 2011 with
21 complaints of chemical sensitivities and requesting that he "assess her hormonal balance."
22 Licensee noted a patient history of bulimia and a current report of psychotic reactions to
23 exposures to certain vitamins and various chemicals and foods. Licensee recommended thyroid
24 screening as well as a heavy metal challenge test. Patient D underwent a "heavy metal
25 challenge test" with Calcium Disodium (CaEDTA) DMPS on April 11, 2011. Licensee
26 diagnosed lead toxicity and noted that the test also revealed "relatively high levels of cadmium
27 and aluminum." On May 27, 2011, Patient D reported a sudden onset of low backache 4 days

1 after the metal challenge test, but Licensee did not conduct further assessment for potential
2 complication associated with the challenge test. Licensee failed to give credence to prior blood
3 testing (all negative) for both lead and mercury and relied upon post-chelator challenge urinary
4 metal testing, resulting in misdiagnosis of heavy metal toxicity. Licensee failed to address
5 Patient D's history of bulimia and current reports of psychotic reactions to various substances.
6 Licensee noted that Patient D brought in a handout that she had received about bipolar disorder,
7 but "would not recommend a mood stabilizer at this time...." Licensee failed to assess or provide
8 referral for Patient D's psychotic symptoms.

9 3.5 Patient F presented to Licensee on March 9, 2010, to continue chelation therapy
10 to address various concerns, to include hypertension, fatigue, difficulty breathing, hearing loss,
11 visual complaints and situational anxiety. Licensee relied upon past CaEDTA/DMPS challenge
12 testing, which "found modestly elevated levels of mercury and lead and cadmium." Patient F
13 reported shortness of breath, elevated blood pressure, and decreased exercise toleration.
14 Licensee recommended repeating heavy metal challenge testing and the need to rule out
15 symptomatic coronary disease. On that same day, Patient F received an IV infusion of CaEDTA.
16 Licensee also referred Patient F for a stress echocardiogram. The results of cardiac testing were
17 "suggestive of at least a mild amount of coronary artery disease." The consulting cardiologist
18 recommended additional diagnostic testing. A review of Licensee's records does not reveal any
19 additional cardiac work-up. Licensee inappropriately treated Patient F's hypertension with
20 dietary supplements (CardioHTN) and treated Patient F's episodes of chest pain with a
21 therapeutic trial of sublingual nitroglycerin. Licensee did not conduct a complete cardiac work-
22 up and failed to provide appropriate treatment. Licensee also inappropriately relied upon
23 chelation challenge testing to establish a diagnosis of heavy metal toxicity and treated Patient F
24 with repeated intravenous chelation therapy that was not medically indicated, unnecessarily
25 exposing this patient to the risk of an adverse reaction.

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1 4.

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

3 Licensee understands that he has the right to a contested case hearing under the Administrative
4 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
5 right to a contested case hearing and any appeal therefrom by the signing of and entry of this

6 Order in the Board's records. Licensee does not contest that he engaged in the conduct described
7 in paragraph 3, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable
8 conduct, as defined by ORS 677.188(4)(a), (b) and (c) and ORS 677.190(13) gross or repeated
9 negligence in the practice of medicine. Licensee understands that this Order is a public record
10 and is a disciplinary action that is reportable to the national Data Bank, and the Federation of
11 State Medical Boards.

12 5.

13 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order
14 subject to the following sanctions and terms and conditions of probation:

15 5.1 Licensee is reprimanded.

16 5.2 Licensee must not use (or approve) DMPS challenge testing (to include but not
17 limited to CaEDTA DMPS) for any patient.

18 5.3 Licensee is prohibited from treating (or authorize treating) any patient for heavy
19 metal toxicity.

20 5.4 Licensee must not treat (or authorize treating) any patient using any form of
21 chelation therapy, to include EDTA IV and CaEDTA chelation therapy.

22 5.5 After one year of successful compliance with the terms of this Order, Licensee
23 may present to the Board's Medical Director for review and request approval for a proposed
24 treatment modality to diagnose and treat heavy metal toxicity. The proposed treatment modality
25 must be evidence based and supported by appropriate peer reviewed studies.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
GREGORY ROBERT HOFFMAN, MD) ORDER TERMINATING
LICENSE NO. MD22890) STIPULATED ORDER
)

1.

On October 7, 2010, Gregory Robert Hoffman, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On August 24, 2012, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the October 7, 2010 Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2013.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURES REDACTED

W. KENT WILLIAMSON, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of

ANTHONY HYUNBO LEE, MD
LICENSE NO. MD15438

INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Anthony Hyunbo Lee, MD (Licensee) is a licensed physician in the state of Oregon and holds an active license.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The Board believes it necessary that Licensee agree to immediately comply with all of the terms of this Order until the Board completes its investigation.

3.

In order to address the concerns of the Board while it conducts the investigation, Licensee and the Board agree to the entry of this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions:

3.1 License is prohibited from prescribing or dispensing any controlled substances, with the exception of benzodiazepines, which he may continue to re-fill one time, per patient, for an additional two (2) weeks from the effective date of this Order.

3.2 Licensee understands that violating any term of this Order may be grounds for disciplinary action under ORS 677.190(17), willfully violating Board order.

3.3 Licensee understands this Order becomes effective the date he signs it.

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At the conclusion of the Board's investigation, the limitation placed on Licensee will be reviewed in an expeditious manner. If the Board determines, following that review, that these limitations shall not be lifted, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.265 while the Board conducts its investigation for the purpose of fully informing itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document and is reportable to the national Data Bank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 2nd day of Jan., 201¹³₂ (P)

SIGNATURE REDACTED

ANTHONY HYUNBO LEE, MD

IT IS SO ORDERED THIS 2nd day of January, 201~~2~~²⁰¹³

OREGON MEDICAL BOARD

SIGNATURE REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
JOHN FRANCIS LINDBERG, MD) STIPULATED ORDER
LICENSE NO. MD12005)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. John Francis Lindberg, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On October 23, 2012, the Board issued a Complaint and Notice of Proposed Disciplinary Action to impose up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, 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) and ORS 676.190(1)(f)(A).

3.

Licensee is a board certified emergency medicine physician. The acts and conduct that violated the Medical Practice Act are described below:

Licensee has a history of polysubstance dependence. Licensee has been enrolled in the Oregon Health Professionals' Services Program (HPSP) for several years. The Board opened an investigation after reviewing a news article and receiving a substantial non-compliance report from HPSP related to a Portland police investigation in October of 2011. The Board's investigation revealed that Licensee engaged in personal conduct that constitutes

1 substantial non-compliance with the terms of his enrollment in HPSP, under ORS
2 676.190(1)(f)(A), which states that licensees in HPSP will not engage in criminal behavior.

3 4.

4 Licensee and the Board desire to settle this matter by entry of this Stipulated Order
5 consistent with the terms of this Order. Licensee understands that he has the right to a
6 contested case hearing under the Administrative Procedures Act (chapter 183), Oregon
7 Revised Statutes and fully and finally waives the right to a contested case hearing and any
8 appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee
9 stipulates that he engaged in the conduct described in paragraph 3 above and that this conduct
10 violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS
11 677.188(4)(a); and ORS 676.190(1)(f)(A) substantial noncompliance with a diversion
12 agreement to the monitoring entity by engaging in criminal conduct. Licensee understands
13 that this document is a public record and is a disciplinary action that is reportable to the
14 National Data Bank and the Federation of State Medical Boards.

15 5.

16 Licensee and the Board agree to resolve this matter by the entry of this Stipulated
17 Order, subject to the following terms and conditions:

18 5.1 Licensee is reprimanded.

19 5.2 Licensee must pay a fine of \$5,000, payable in full within 60 days from the
20 signing of this Order by the Board Chair.

21 5.3 Within 6 months from the signing of this Order by the Board Chair, Licensee
22 must successfully complete a course on appropriate boundaries that is pre-approved by the
23 Board's Medical Director.

24 5.6 Licensee stipulates and agrees that any violation of the terms of this Order
25 would be grounds for further disciplinary action under ORS 677.190(17).

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

4 In the Matter of)
5 DANIJELA MOZINA MARJANOVIC, MD)
6 LICENSE NO. MD12634) ORDER TERMINATING ORDER
7) OF LICENSE SUSPENSION
8)

1. 9

10 On October 4, 2012, the Oregon Medical Board (Board) issued an Order of License
11 Suspension regarding Danijela Mozina Marjanovic, MD (Licensee). This Order suspended
12 Licensee's license to practice medicine and was issued pursuant to ORS 677.205 for violating
13 the Medical Practice Act, to wit: ORS 677.190(17) willfully violating a Board rule, specifically
14 OAR 847-008-0070, continuing medical competency (education). On December 19, 2012, the
15 Board received documentation that Licensee has completed the required 60 hours of continuing
16 medical education for the 2010-2011 biennium.

2. 17

18 The Board does hereby terminate the October 4, 2012 Order of License Suspension and
19 orders that Licensee's license be returned to active status effective January 2, 2013.

20 IT IS SO ORDERED this 19th day of December, 2012.

21 OREGON MEDICAL BOARD
22 State of Oregon

23 **SIGNATURE REDACTED**

24 W. KENT WILLIAMSON, MD
25 Board Chair
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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
ANDREW ROWE MASLONA, MD) ORDER TERMINATING
LICENSE NO. MD28259) CORRECTIVE ACTION ORDER

1.

On April 16, 2008, Andrew Rowe Maslona, MD (Licensee) entered into a Corrective Action Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon license. This Order was modified on July 8, 2010. On June 11, 2012, Licensee submitted a written request to terminate the Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the October 7, 2010 Corrective Action Order and the July 8, 2010 Order Modifying Corrective Action Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2013.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
EDWARD ALAN MCCLUSKEY, MD) ORDER MODIFYING
LICENSE NO. MD18356) STIPULATED ORDER
)

1.

On April 7, 2011, Edward Alan McCluskey, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On November 14, 2012, Licensee submitted a written request asking the Board to modify term 5.3 of this Order, which reads:

5.3 *Beginning on the effective date of this Order, Licensee will be granted a medical license limited to administrative medicine in the state of Oregon. At such time that Licensee enrolls into a training program with Center for Personalized Education for Physicians (CPEP), the Board will add conditions allowing Licensee to complete the Education Program recommended by the CPEP, including practice supervision as recommended by CPEP with the intent to protect the public. Licensee may continue to practice administrative medicine, provided he submits a job description, work location, and work schedule to the Board's Medical Director, requesting his review and approval.*

2.

Having fully considered Licensee's request, the Board amends Term 5.3 of the April 7, 2011 Stipulated Order by adding the following language:

5.3 a. Beginning the effective date of this Order, Licensee will be granted an active license limited to venipuncture/IV therapy; surgical first assist; independent Medical Examinations (IME); history and physicals on behalf of medicare insurances; and phone

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1 triage in clinic, provided he submits a job description, work location, and work schedule to
2 the Board's Medical Director, requesting his review and approval.

3 This modification becomes effective the date this Order Modifying Stipulated Order is
4 signed by the Board Chair. All other terms of the April 7, 2011 Stipulated Order are unchanged
5 and remain in full force and effect.

6 IT IS SO ORDERED this 10th day of January, 2013.

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8 OREGON MEDICAL BOARD
9 State of Oregon

10 SIGNATURE REDACTED

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12 W. KENT WILLIAMSON, MD
13 Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
DAVID BYRON REDWINE, MD) ORDER MODIFYING
LICENSE NO. MD09578) STIPULATED ORDER

1.

On April 8, 2011, David Byron Redwine, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed certain conditions on Licensee's medical license. On October 3, 2012, Licensee submitted a written request asking the Board to terminate this Order. Term 5.6 of this Order reads:

5.6 Licensee must obtain psychotherapy from a psychotherapist pre-approved by the Board's Medical Director. Licensee must meet with this psychotherapist on at least a weekly basis. After one year, Licensee may, with the recommendation of his approved psychotherapist, request permission of the Board's Medical Director to meet on a less frequent basis. The psychotherapist shall provide quarterly written reports to the Board. Licensee shall sign all releases to allow the psychotherapist to communicate directly with the Board. In the event of an anticipated absence, Licensee may submit a written request to the Board's Medical Director for permission to miss a psychotherapy meeting.

2.

Having fully considered Licensee's request, the Board amends Term 5.6 of the April 8, 2011 Stipulated Order by adding the following language:

5.6 a. The Board may hold this term in abeyance provided that Licensee is not actively practicing medicine.

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1 This modification becomes effective the date this Order Modifying Stipulated Order is
2 signed by the Board Chair. All other terms of the April 8, 2011 Stipulated Order are unchanged
3 and remain in full force and effect.

4 IT IS SO ORDERED this 10th day of January, 2013.

5 OREGON MEDICAL BOARD
6 State of Oregon

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8 SIGNATURE REDACTED

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10 W. KENT WILLIAMSON, MD
11 Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
CHARLES ANTHONY ROBERTS, PA) STIPULATED ORDER
LICENSE NO PA 00257)
)

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. Charles Anthony Roberts, PA (Licensee) is a licensed physician assistant in the state of Oregon.

2.

In a Complaint and Notice of Proposed Disciplinary Action, dated April 5, 2012, the Board proposed taking disciplinary action, to include development of written clinic policies, continuing education in practice management courses, imposing a reprimand, a fine of \$10,000 and the assessment of costs, 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 by ORS 677.188(4)(a) and (c) and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

3.

Licensee owns the Veneta Medical Clinic, in Veneta, Oregon. The acts and conduct that violated the Medical Practice Act are:

3.1 On January 6, 2010, representatives from the Oregon Radiologic Technologist Board conducted an inspection at the Veneta Medical Clinic and found that Licensee had allowed unlicensed persons to take x-rays at his clinic from October of 2009 until January of 2010. Licensee subsequently signed a Stipulated Agreement and Final Order, dated August 9, 2010, in which Licensee was found to have employed at least one person who was not licensed

1 to take x-rays and allowed the taking of x-rays by unlicensed persons for a four month period, in
2 violation of ORS 688.415(1)(c) (employing a person who is not licensed to practice without a
3 valid permit or license.) Licensee was assessed and agreed to pay a civil penalty of \$1,000.

4 3.2 By allowing unlicensed (and inadequately trained) persons to take x-rays,
5 Licensee's employees were exposed to the potential danger of unnecessary radiation exposure
6 and there was a risk that x-rays were taken that were of inferior quality making it more difficult
7 to properly assess patient conditions.

8 4.

9 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
10 Licensee understands that he has the right to a contested case hearing under the Administrative
11 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
12 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
13 Order in the Board's records. Licensee admits that he engaged in the conduct described in
14 paragraph 3, and that this conduct violated ORS 677.190(1)(a), unprofessional conduct, as
15 defined by ORS 677.188(4)(a) and ORS 677.190(13) repeated negligence in the practice of
16 medicine. Licensee understands that this Order is a public record and is a disciplinary action that
17 is reportable to the national DataBank and the Federation of State Medical Boards.

18 5.

19 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order
20 subject to the following sanctions and terms and conditions of probation:

21 5.1 Licensee is reprimanded.

22 5.2 Licensee must pay a fine of \$2,500, payable in full within 60 days from the
23 signing of this Order by the Board Chair.

24 5.3 Within 90 days from the signing of this Order by the Board Chair, Licensee must
25 prepare written clinic policies, to include but not limited to clinic hiring policies, review of the
26 current license status of prospective and current employees, procedures for imaging practice,

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1 laboratory reports, and the relationship between the clinic owner and the PA's supervising
2 physician.

3 5.4 Within 120 days from the signing of this Order by the Board Chair, Licensee
4 must, at his own expense, obtain a consultation with an expert in practice management that is
5 pre-approved by the Board's Medical Director, who will review, revise as needed, and approve
6 Licensee's office policy manual. Consultant will provide a report to the Board's Compliance
7 Officer in support of the policy manual.

8 5.5 Licensee must enroll in and successfully complete continuing education courses
9 in practice management, which are pre-approved by the Board's Medical Director, within 180
10 days from the signing of this Order by the Board Chair.

11 5.6 Within six to nine months of the completion of the policy manual, at Licensee's
12 expense, the practice management consultant previously approved by the Board's Medical
13 Director will conduct an audit of Licensee's adherence to the policy manual, and provide a report
14 to the Board's Compliance Officer. A second audit must be conducted, at Licensee's expense,
15 one year after the initial audit, with a report to the Board's Compliance Officer.

16 5.7 Licensee stipulates and agrees that this Order becomes effective the date it is
17 signed by the Board Chair.

18 5.8 Licensee stipulates and agrees that he will obey all laws and regulations
19 pertaining to the practice of medicine in Oregon.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
MARIANNE STRAUMFJORD, MD) ORDER TERMINATING
LICENSE NO. MD07575) CONSENT AGREEMENT
)

1.

On April 30, 2012, Marianne Straumfjord, MD (Licensee) entered into a Consent Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon medical license. On October 18, 2012, Licensee submitted a written request to terminate this Agreement.

2.

Having fully considered Licensee's request and her successful compliance with the terms of this Agreement, the Board terminates the April 30, 2012 Consent Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2013.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair