

Oregon Medical Board
BOARD ACTION REPORT
July 21, 2010

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between June 16, 2010 and July 15, 2010.

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 are not posted, as they are not disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report, as they are not final actions by the Board. Both Orders, however, are public and are available upon request as described below.

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

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

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

Cleland-Zamudio, Suzanne, Sophia, MD; Portland, OR

The Board issued an Order Terminating Corrective Action Order on July 8, 2010. This Order terminates Licensee's December 6, 2007 Corrective Action Order.

***Dean, Janet, Carol, MD; Applicant**

Applicant entered into a Stipulated Order with the Board on July 8, 2010. This Order granted Applicant a license to practice medicine in Oregon under conditions that include: probation, pre-approved practice settings, practice under the a supervising physician, enrollment in the Health Professionals Program (or its successor), weekly peer conferences with other physicians, no-notice compliance inspections.

***Druzdel, Maciej, Janusz, MD; MD18563; Gold Beach, OR**

The Board issued an Order Terminating Stipulated Order on July 8, 2010. This Order terminates the Stipulated Order dated January 11, 2008.

Duran, Michael, Gordon, MD; MD27904; Hillsboro, OR

Licensee entered into a Corrective Action Agreement with the Board on July 8, 2010. In this Agreement, [REDACTED]

[REDACTED] and to complete 50 hours of community service no later than one year from the date this Order is signed by the Board Chair. This Agreement is not a disciplinary action.

***Grimm, Robert, John, MD; Portland, OR**

The Board issued an Order Terminating Interim Stipulated Order on July 8, 2010. This Order terminates Licensee's May 6, 2010 Interim Stipulated Order.

Johnson, William, Ellis, MD; MD20044; Portland, OR

Licensee entered into a Corrective Action Agreement with the Board on May 5, 2010. In this agreement Licensee agreed to complete 100 hours of documented community service that is pre-approved by the Board's Medical Director and [REDACTED]

[REDACTED] This Agreement is not a disciplinary action.

***Kovachevich, Larry, Lee, MD; MD09160; Salem, OR**

Licensee entered into a Stipulated Order with the Board on July 8, 2010. In this Order, Licensee was placed on five years of probation with the following terms and conditions: reprimand, fine, quarterly Board reporting, enrollment in the Health Professionals Program's successor, as long as Licensee holds a license to practice medicine in Oregon. Licensee must reestablish and maintain a patient/physician relationship with a primary care physician and must not provide medical care and prescriptions to family members, co-workers, himself and/or friends.

***Lidor, Yaron, Jacob, MD; MD27956**

The Board issued an Order of Emergency Suspension on June 24, 2010. The Board took this action based on its immediate concerns regarding the safety and welfare of Licensee's current and future patients.

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

The Board issued an Order Modifying Corrective Action Order on July 8, 2010. This Order terminates Term 5.4 of Licensee's April 16, 2008 Corrective Action Order.

***Matthews, James, Michael, MD; Newberg, OR**

The Board issued an Order Terminating Stipulated Order on July 8, 2010. This Order terminates Licensee's May 8, 2008 Stipulated Order.

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

Licensee entered into a Second Amended Interim Stipulated Order with the Board on June 22, 2010. This Order places practice restrictions on Licensee's practice. This order replaces Licensee's March 4, 2010 Interim Stipulated Order and March 22, 2010 Order Modifying Interim Stipulated Order.

***Morey, Peter, Samuel, MD; MD24236; Portland, OR**

Licensee entered into a Stipulated Order with the Board on July 8, 2010. In this Order, Licensee surrenders his license while under investigation with the following terms and conditions: reprimand, fine, may not apply for licensure with the Board for a minimum of two years from the signing of this Order by the Board Chair.

***Ono, Alfred, Kazuo, MD; MD08406; Portland, OR**

Licensee entered into a Corrective Action Agreement with the Board on July 8, 2010. In this Agreement, Licensee agreed to continue to participate in a structured, individualized educational program within 30 days from the date this Agreement is signed by the Board Chair. This Agreement is not a disciplinary action.

***Raife, Michael, James, MD; MD23162; Seaside, OR**

Licensee entered into an Interim Stipulated Order with the Board on July 13, 2010. In this Order, Licensee voluntarily withdraws from practice and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

***Rye, Bruce, Michael, MD; Applicant**

The Board issued a Default Final Order on July 8, 2010. In this order, the application of Bruce Michael Rye, MD, for a license to practice medicine as a physician in Oregon, was denied.

***Weisberg, Stuart, Gordon, MD; MD23402; Portland, OR**

The Board issued an Order of Emergency Suspension on June 24, 2010. The Board took this action based on its immediate concerns regarding the safety and welfare of Licensee's current and future patients.

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.

5.
Applicant and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following terms and conditions of probation:

5.1 Applicant is granted an active license to practice medicine in Oregon, consistent with the terms of probation, as set forth in this Stipulated Order.

5.2 Applicant is placed on probation for a minimum of five years. Applicant will report in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a probationer interview unless ordered to do otherwise by the Board. Applicant may request that the requirement to meet for probationary interviews be held in abeyance if she is not actively practicing medicine in Oregon in any calendar year.

5.3 Applicant's practice setting in Oregon shall be pre-approved, in writing, by the Board's Medical Director.

5.4 Applicant may only practice in Oregon under a supervising physician who has an active license to practice medicine in Oregon, practices medicine on a full time basis, and is Board certified in obstetrics and gynecology. The supervising physician must be approved in advance by the Board's Medical Director. The supervising physician must meet with Applicant on a monthly basis to review a minimum of five randomly selected charts selected by the supervising physician. The supervising physician must provide quarterly reports to the Board's Compliance Officer regarding Applicant's overall work performance 15 days prior to Applicant's quarterly probationary interviews.

5.5 Applicant must participate in a weekly peer conference with other physicians who are board certified in obstetrics and gynecology. Applicant must report quarterly to the Board's Compliance Officer regarding her compliance with this term.

5.6 Applicant must enroll in the Board's Health Professional's Program (HPP) (or its successor) within 15 days of the effective date of this Order. Applicant must remain enrolled in and must fully comply with the terms of her HPP enrollment and requirements for as long as she holds a license to practice medicine in Oregon. Applicant must consent to the disclosure of her complete HPP (or its successor) file to the Board upon request.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
MACIEJ JANUSZ DRUZDZEL, MD) ORDER TERMINATING
LICENSE NO. MD18563) STIPULATED ORDER
)

1.

On January 11, 2008, Maciej Janusz Druzdzal, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On July 8, 2010, Licensee submitted a request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board does hereby order that the January 11, 2008 Stipulated Order be terminated effective at 6:00 p.m. on July 8, 2010.

IT IS SO ORDERED this _____ day of _____, 2010.

OREGON MEDICAL BOARD
State of Oregon

Lisa A. Cornelius, DPM
Board Chair

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
LARRY LEE KOVACHEVICH, MD) STIPULATED ORDER
LICENSE NO. MD09160)
)

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. Larry Lee Kovachevich, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board is now taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7) impairment; ORS 677.190(8) misrepresentation; ORS 677.190(13) gross or repeated negligence; ORS 677.190(15) disciplinary action by another state; ORS 677.190(17) willful violation of any Board statute or rule; ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing a controlled substance following accepted procedures for examination or record keeping; and ORS 677.190(25) failure by the licensee to report to the Board any adverse action taken against the licensee by another licensing jurisdiction.

3.

Licensee's acts and conduct that violated the Medical Practice Act are:

3.1 On March 5, 2009, Licensee entered into a Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Order) with the state of Washington Medical Quality Assurance Commission under the Department of Health. In this Order, Licensee stipulated that he engaged in unprofessional conduct by engaging in the following acts of misconduct: Licensee wrote a prescription for a controlled substance for a family member without documenting the

1 prescription in the patient's records, and Licensee wrote prescriptions on multiple occasions for
2 Schedule II controlled substances, to include oxycodone with acetaminophen (Percocet) and
3 sustained release oxycodone (OxyContin), for a patient with the understanding and mutual
4 agreement that the patient would return some of the medications to Licensee for his own use.
5 Licensee also stipulated that he asked the physician assistant whom he supervised to write
6 prescriptions for controlled substances for Licensee when Licensee's primary care physician was
7 unavailable. In the Order, Licensee was disciplined for falling asleep multiple times during a
8 patient encounter with a particular patient. Licensee agreed to pay a fine of \$1,000, to complete
9 a workshop in medical ethics, and to sign a contract and comply with all terms and conditions of
10 his contract with the Washington Physicians Health Program.

11 3.2 On January 16, 2008, and on February 2, 2008, Licensee signed and subsequently
12 submitted applications for reactivation of his Oregon medical license with the Board. Licensee
13 answered "no" on both forms to question #5 of Category I of the application: "Have you ever
14 had any disciplinary or adverse action imposed against any professional license or certification,
15 or were you ever denied a professional license or certification, or have you entered into any
16 consent agreement, stipulated order or settlement with any regulatory Board or certification
17 agency; *or have you ever been notified of any complaints or investigations related to any license*
18 *or certification?" [Italics added.] Licensee's answer was not true. Licensee was notified by a*
19 letter from the Washington Department of Health, dated February 26, 2007, that the Washington
20 Medical Quality Assurance Commission had received complaints alleging that he had engaged in
21 unprofessional conduct and had opened an investigation.

22 3.3 Licensee failed to submit a timely report to the Board of the existence of the
23 Washington investigation or disciplinary action. Licensee submitted a letter to the Board, dated
24 September 28, 2009, to inform the Board of the Washington disciplinary action. Licensee was
25 obligated to report to the Board not later than ten days after any official action was taken against
26 his medical license, OAR 847-010-0073.

27 ///

1 4.

2 License 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 there from by the signing of and entry into this
6 Stipulated Order in the Board's records. Licensee admits that he engaged in the conduct
7 described in paragraph 3 and that this conduct violated ORS 677.190(1)(a) unprofessional or
8 dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7) impairment; ORS
9 677.190(8) misrepresentation; ORS 677.190(13) gross or repeated negligence; ORS 677.190(15)
10 disciplinary action by another state; ORS 677.190(17) willfully violate any Board statute or rule;
11 ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or
12 prescribing a controlled substance without following accepted procedures for examination or
13 record keeping; and ORS 677.190(25) failure by the licensee to report to the Board any adverse
14 action taken against the licensee by another licensing jurisdiction. Licensee understands that this
15 Order is a public record and is reportable to the National Practitioner Data Bank, Healthcare
16 Integrity and Protection Data Bank 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 sanctions and terms and conditions of probation:

20 5.1 Licensee is reprimanded.

21 5.2 Licensee will pay a fine of \$1,000 within 180 days from the date the Order is
22 signed by the Board Chair.

23 5.3 Licensee is placed on probation for a minimum of five years. Licensee will report
24 in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled
25 times for a probationer interview unless ordered to do otherwise by the Board or a Board
26 Compliance Officer.

27 ///

1 5.4 Licensee must remain enrolled in the Board's Health Professionals Program
2 (HPP), and its successor, for as long as the Licensee holds a license to practice medicine in
3 Oregon. Licensee understands that HPP will terminate as a program on June 30, 2010, pursuant
4 to Oregon House Bill 2345 (2009). Licensee must fully comply with the terms of both of these
5 programs. Licensee must also consent to the disclosure of his complete monitoring files of both
6 of these programs to the Board upon request. All drug and alcohol test results conducted by
7 either program, to include any information pertaining to any concerns and/or non-compliance,
8 will be immediately reported to the Board. Licensee understands that in the event the Board
9 receives information from either program which deems him to be in non-compliance with the
10 program, the Board may consider this as grounds for immediate inactivation of his Oregon
11 license.

12 5.5 Licensee agrees to sign all necessary enrollment and consent for disclosure forms
13 to allow the transfer of his HPP records and enrollment from HPP to the new impaired health
14 professionals program managed by the Oregon Department of Human Services, which is
15 expected to become effective July 1, 2010.

16 5.6 Licensee must establish and maintain a patient/physician relationship with a
17 primary care physician.

18 5.7 Licensee must not provide medical care and prescriptions to family members, co-
19 workers, himself and/or friends.

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

1 5.8 Licensee must obey all federal and Oregon state laws and regulations pertaining
2 to the practice of medicine.

3 5.9 Licensee stipulates and agrees that any violation of the terms of this Order shall
4 be grounds for further disciplinary action under ORS 677.190(17).

5
6 IT IS SO STIPULATED this 14 day of June, 2010.

7
8 SIGNATURE REDACTED

9 CARRY LEE KOVACHEVICH, MD

10
11
12 IT IS SO ORDERED this 8th day of July, 2010.

13 OREGON MEDICAL BOARD
14 State of Oregon

15 SIGNATURE REDACTED

16 LISA A. CORNELIUS, DPM
17 Board Chair

18
19
20
21
22
23
24
25
26
27

1 where she presented with injuries to her face, head, and thoracic spine. She reported that she had
2 been physically assaulted by an unknown intruder in her apartment. During the spring of 2009,
3 Patient A asked Licensee to assist her in becoming pregnant by performing an intrauterine
4 insemination on her.

5 2.2 Throughout the course of Licensee's treatment of Patient A, Licensee engaged in
6 multiple boundary violations by meeting with Patient A outside of the clinic on at least five
7 occasions, to include meeting with her at least two times at a restaurant for dinner, giving her
8 gifts (to include a \$600 laptop computer) and sending Patient A multiple e-mail messages that
9 were sexually explicit. These e-mails directly invited Patient A to think about Licensee in sexual
10 terms and invited her to engage in a sexual relationship with Licensee. When confronted with
11 this information, Licensee asserted that he met with Patient A outside the clinic to engage in
12 "counseling" and that in regard to his sexual e-mails, he was really just "play acting" in order to
13 test the stability of her relationship with her boyfriend. He claimed that if she resisted his sexual
14 overtures--that would mean that she was in a stable relationship, and would, therefore, be a good
15 candidate for a fertility work-up. Licensee informed the Board that he believed that Patient A's
16 boyfriend physically had assaulted Patient A on at least one occasion, and had observed bruises
17 on Patient A's body. Licensee stated that while he expected that Patient A's boyfriend would
18 probably read the e-mails, he did not think that this would provoke him to engage in another
19 assault on Patient A. Licensee's contrived explanation is not credible. Licensee's conduct
20 exploited a vulnerable patient, took advantage of his position of power and trust, and subjected
21 her to the risk of harm.

22 2.3 The Board has also received a report that while working as a locum tenens
23 physician at Mid-Valley OBGYN clinic in Lebanon, Oregon, that Licensee violated clinic policy
24 on repeated occasions by conducting breast and pelvic examinations without a chaperone.
25 Licensee violated this policy even after being counseled. Licensee was also observed by clinic
26 staff to make derogatory comments about some of his patients, and to answer personal phone
27 calls on his cell phone while conducting pelvic examinations.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

3.

Based on the above information, the Board has determined that from the evidence available to the Board at this time, Licensee's continued practice of medicine would pose an immediate danger to the public and to his patients. Licensee's behavior displays disregard for concepts of professional boundaries and professional ethics as well as the well being of his patients. This behavior causes the Board to conclude that it would be subjecting patients to the risk of harm if he were allowed to continue to practice while this case remains under investigation. Pursuant to ORS 677.205(3), the Board orders that the license of Yaron Jacob Lidor, MD, to practice medicine, including refilling medications, is suspended on an emergency basis. Licensee is directed to immediately cease the practice of medicine until otherwise ordered by the Board. This Order becomes effective at 6:00 p.m. on June 24, 2010.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant to ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practical.

IT IS SO ORDERED THIS 8th day of July, 2010.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

LISA A. CORNELIUS, DPM
Board Chair

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
JAMES MICHAEL MATTHEWS, MD) ORDER TERMINATING
LICENSE NO. MD16811) STIPULATED ORDER

1.

On May 8, 2008, James Michael Matthews, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On May 25, 2010, 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 Stipulated Order, dated May 8, 2008, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 8th day of July, 2010.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

LISA CORNELIUS, DPM
Board Chair

1 surgical assistant, and any assistance he may provide during the course of a surgical procedure,
2 must be timely documented in the patient chart.

3 3.2 Licensee may order urinalysis testing for patients, and document such orders in
4 the applicable patient chart.

5 3.3 Licensee may continue to practice administrative medicine, but other than serving
6 as surgical assistant or ordering urinalysis, as described above, Licensee must not provide any
7 medical care to any patient.

8 3.4 Licensee may provide instruction in group settings to patients on topics pertaining
9 to health care of general interest to the audience.

10 3.5 Licensee understands that violating any term of this Order will be grounds for
11 disciplinary action under ORS 677.190(17).

12 4.

13 At the conclusion of the Board's investigation, Licensee's status will be reviewed in an
14 expeditious manner. Following that review, if the Board determines that Licensee shall not be
15 permitted to return to the practice of medicine with an unlimited license, Licensee may request a
16 hearing to contest that decision.

17 5.

18 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
19 of protecting the public, and making a complete investigation in order to fully inform itself with
20 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
21 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

1 confidential and shall not be subject to public disclosure, nor shall they be admissible as
2 evidence in any judicial proceeding. However, as a stipulation this Order is a public document.

3
4 IT IS SO STIPULATED THIS 21st day of June, 2010.

5
6 SIGNATURE REDACTED

7 EDWARD ALAN McCLUSKEY, MD

8
9 IT IS SO ORDERED THIS 22nd day of June, 2010.

10 State of Oregon
11 OREGON MEDICAL BOARD

12 SIGNATURE REDACTED

13 KATHLEEN HALEY, JD
14 EXECUTIVE DIRECTOR

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
PETER SAMUEL MOREY, MD) STIPULATED ORDER
LICENSE NO. MD24236)
)

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. Peter Samuel Morey, MD (Licensee) is licensed to practice medicine in the state of Oregon.

2.

The Board issued an Order of Emergency Suspension to Licensee on January 6, 2010. Licensee requested a hearing. The Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a), (b) and (c) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(5) willfully or negligently divulging a professional secret to another without written consent; and ORS 677.190(13) gross or repeated negligence.

3.

Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 Licensee is a psychiatrist, who had a full time solo practice in downtown Portland, Oregon, starting in April of 2007. Patient A, an adult female patient, called various health care providers during Memorial Day weekend of 2007, pleading for an appointment. Licensee returned her call and agreed to meet with her on Monday, May 28, which was the Memorial Day holiday, but a regular work day for Licensee. Patient A was seen and diagnosed by Licensee for an adjustment disorder related to the death of her mother. Patient A had a

1 history of abuse and faced emotional and family turmoil. Patient A's history includes mental
2 health treatments and psychotropic medications. At the end of the first clinical visit, Licensee
3 prescribed various medications for Patient A, to include trazodone (an anti-depressant),
4 clonazepam (Schedule IV controlled substance), bupropion (Wellbutrin, an anti-depressant), and
5 fluoxetine (Prozac, an anti-depressant). Patient A returned frequently for clinical visits at
6 Licensee's requests, and Licensee continued to write prescriptions for her. Approximately a
7 month later, Licensee added Adderall (Schedule II controlled substance of dextroamphetamine +
8 amphetamine) to her medication regimen, which Patient A said that she found to be helpful.
9 Licensee continued to see Patient A in his clinic for many sessions and sometimes daily during
10 some weeks in 2007. Patient A eventually relocated to Bend, Oregon, and stopped seeing
11 Licensee on a regular basis for therapy. However, Licensee continued to refill medications for
12 her in 2008. Licensee completed and signed prescription forms and mailed them to Patient A in
13 Bend as she was searching for a new provider in that area. Some of these prescriptions included
14 controlled substances as indicated above. Licensee signed these prescription forms without
15 seeing Patient A for therapy sessions. Licensee also corresponded with her by e-mail for some
16 period of time until she began to receive care from other health care providers. The last time that
17 Licensee prescribed medication (clonazepam) for Patient A occurred in November of 2008.
18 During the time that Licensee was prescribing medications to Patient A, he engaged in
19 unprofessional boundary violations with Patient A by entering into a personal friendship with her
20 and inappropriately touching Patient A. Licensee's conduct contributed to the emotional and
21 mental health destabilization of Patient A. Licensee's boundary violations with Patient A
22 include the following:

- 23 a. Licensee provided Patient A with a key to his office suite and access codes to the
24 building to allow her to enter his clinic. Licensee offered to purchase new office
25 furniture for the vacant office space located near his office suite so that Patient A could
26 provide receptionist and other office administrative assistance to help Licensee in his
27 practice. When Patient A and her boyfriend were facing homelessness, Licensee offered

1 for them to stay in the vacant office space temporarily instead of living in their car.

2 Patient A elected not to accept this offer of a living arrangement from Licensee. This
3 arrangement with Patient A could have compromised the confidentiality of chart
4 information pertaining to other patients.

5 b. Licensee waived all of the co-pays for Patient A for all her office visits, and he
6 did not charge her for prescription refills. Licensee asserts that he has waived the co-pays
7 for other patients facing financial difficulties. During the summer of 2007, Licensee also
8 provided her with one day of on-the-job training with the plan that she could work at his
9 office as his assistant. Licensee paid her \$100 for one day of training, and Licensee
10 admitted that the \$100 was an intentional overpayment.

11 c. During clinical visits, as well as during their informal personal interactions,
12 Licensee made personal disclosures to Patient A about his own personal issues, to include
13 his marital problems with his wife, sexual frustrations, social life, and challenges with
14 other patients. Licensee disclosed to Patient A that he was diagnosed with attention
15 deficit disorder (ADD), was prescribed Adderall for ADD, and suffered health problems
16 with this medication. Licensee revealed personal details regarding his sexual health
17 related to Adderall to Patient A. Such disclosures serve no medical or therapeutic
18 purpose for Patient A.

19 d. Licensee during a therapy session met with Patient A in his office engaged in
20 inappropriate touching, to include embracing her, kissing her on top of her head and
21 check, and stroking her hair while her head was resting on a pillow in his lap. On
22 multiple occasions, Licensee had sexualized conversations with Patient A about his own
23 sexual activities and frustrations, as well as Patient A's sexual relationship with her then-
24 boyfriend. On at least one occasion, Licensee placed a blanket on the floor, requested
25 that Patient A lie down next to him, and caressed her after she complied.

26 e. Licensee sent Patient A numerous e-mails during the course of his treatment and
27 medication management relationship with her. These e-mails were sent during various

1 times of the day and night with discussions about his feelings of the blurring of the
2 therapeutic relationship and their friendship, and his need to see her soon regarding the
3 proper procedure for termination of the therapeutic relationship as she was moving to
4 Bend. Licensee also requested Patient A to meet him immediately at his clinic during the
5 early morning and in the evenings, such as 7 p.m., to discuss their interactions and
6 termination of the therapeutic relationship due to her immediate relocation.

7 f. Licensee called Patient A on her cell phone after some sessions. Licensee also
8 contacted Patient A to inquire if he had stepped over his professional boundaries in his
9 interactions with her, to include hugging her.

10 g. Licensee divulged confidential information regarding other patients to Patient A.
11 Such conduct violates patient confidentiality and served no medical or therapeutic
12 purpose for Patient A.

13 h. At the conclusion of one session, and while still at Licensee's office, Licensee
14 displayed a semi-automatic handgun to Patient A and placed it in her hands. There was
15 no medical or therapeutic purpose for this action.

16 3.2 Licensee, accompanied by his legal counsel, met with two Board investigators on
17 December 30, 2009, at the Board's office. During the course of that interview, Licensee stated
18 that he has not attempted to contact Patient A by any manner after she had moved to Bend.
19 Licensee insisted that his last e-mail to Patient A occurred in March 2008, involving a
20 medication refill. Licensee repeated this assertion in a letter to the Board, dated January 6, 2010.
21 This statement is inconsistent with other information available to the Board. In a letter dated
22 December 16, 2009, Licensee admitted to having a "lapse in judgment in November of 2008,
23 where I received a refill request from [a pharmacy in] Chicago from [Patient A] looking for
24 clonazepam." Licensee admitted to refilling this controlled substance, which Patient A never
25 picked up. In addition, the Board has a copy of an e-mail communication between Licensee and
26 Patient A that is dated October 21, 2009. This e-mail from Licensee consisted of Licensee re-
27 sending the e-mail to Patient A that he had previously sent to her on August 20, 2007, at 12:21

1 p.m. about his need to see Patient A that evening, and that he will not try to talk her "into coming
2 back to work or anything. I just feel like I really need to understand what happened. I am totally
3 confused." Licensee asserts that he does not remember sending the e-mail that was dated
4 October 21, 2009.

5 3.3 Licensee began to date Patient B, a massage therapist, in the fall of 2007, while he
6 was still married. Patient B is the adult daughter of Patient E, a male. Patient B met Licensee
7 through her father, Patient E, who was a psychiatric patient of Licensee. Following Licensee's
8 divorce, Licensee and Patient B entered into a short-lived marriage. A patient of Licensee
9 attended their wedding. Patient E helped Licensee move out of his previous wife's residence.
10 Patient B approached Licensee with a previous diagnosis of ADD and requested Licensee take
11 over refilling her prescriptions. Without an appropriate or documented workup, Licensee
12 accepted this diagnosis and prescribed dextroamphetamine + amphetamine (Adderall, Schedule
13 II) for Patient B without the benefit of a patient chart. Licensee prescribed multiple medications
14 for Patient B, to include quetiapine (Seroquel), alprazolam (Xanax, Schedule IV), clonazepam
15 (Klonopin, Schedule IV), zolpidem (Ambien, Schedule IV) and temazepam (Restoril, Schedule
16 IV). Licensee and Patient B regularly consumed red wine together, even though Licensee knew
17 that Patient B was taking benzodiazepines and Xanax. This combination exposed Patient B to the
18 risk of over-sedation. Licensee also requested that Patient B provide massage therapy to some
19 of his psychiatric patients at his clinic.

20 3.4 Licensee treated Patient E and saw him only a few times before refilling
21 medications. Licensee called in refills and gave Patient E scripts without therapy sessions,
22 examinations and/or lab tests. Licensee prescribed multiple medications to Patient E, to include:
23 venlafaxine (Effexor), desipramine (anti-depressant), clonidine (Catapres), betaxolol (Kerlone),
24 alprazolam (Xanax, Schedule IV), zolpidem (Ambien, Schedule IV), aripiprazole (Abilify),
25 diazepam (Valium, Schedule IV), and extended release dextroamphetamine + amphetamine
26 (Adderall XR, Schedule II).

27 3.5 Licensee engaged in a boundary violation by providing a personal loan of \$500 to

1 a psychiatric patient for medication. Licensee also formed friendships with two other adult
2 female patients, Patients C and D. Licensee made inappropriate personal disclosures to Patients
3 C and D. Licensee repeatedly told Patient D, who was emotionally fragile, about problems with
4 his marriage and his subsequent dating activity, to include disclosing details of a sexually
5 explicit nature about himself. This type of self-disclosure of a psychiatrist's personal life to a
6 patient constitutes a boundary violation. Over time, Patient D became increasingly reliant upon
7 Licensee, to the point of having multiple sessions with him during the week. Patient D
8 repeatedly told Licensee that she felt suicidal, but Licensee never conducted or documented that
9 he performed a mental status examination and suicide assessment. Licensee failed to obtain a
10 consult, developed a treatment plan or entered into a contract with Patient D that she would not
11 harm herself. Licensee suggested that Patient D see a massage therapist in his office for
12 "treatment." She ignored his remark. Patient D formed a strong attachment to Licensee and
13 gave him personal presents. Licensee abandoned Patient D by abruptly discharging her as a
14 patient in December 2008 by sending her a termination letter that contained the names of several
15 other psychiatrists and that Licensee cut off all other communication with her, failed to order
16 medication refills, and failed to help her immediately transfer care to another provider.

17 3.6 Licensee's solo practice had an office that has several private rooms, which he has
18 sub-leased to several nurse practitioners and a massage therapist. Licensee has no support staff,
19 and does all of his own office administrative work, to include answering messages, sending faxes
20 and making appointments. Licensee does not routinely request charts from other providers or
21 hospitals concerning his patients, stating that he "errs on the side of trusting what they say" about
22 their prescription medications and diagnoses. Licensee frequently accepts complex patients who
23 have been seen by previous providers. After he performs an internal office intake, Licensee
24 frequently writes prescriptions, refills, and/or changes the medication regimen for these new
25 patients without confirming with other providers or hospitals information regarding their
26 diagnoses, medication history, hospitalizations, and/or possible history of abuse or suicidal
27 ideations. Licensee's reliance upon the ability or willingness of his new and often complex

1 patients to accurately recall their diagnoses, prescription medications and dosages, while
2 Licensee continues to prescribe and refill medications, places some of his patients at risk for
3 harm.

4 3.7 Licensee refilled medications for Patient F without examining her, conferring
5 with her treating physician, or maintaining a patient chart.

6 3.8 Licensee met with two Board investigators for an interview on December 30,
7 2009. Licensee denied having any social interactions with any patients outside the clinical
8 setting. His denials were not truthful.

9 4.

10 License and the Board desire to settle this matter by entry of this Stipulated Order.
11 Licensee understands that he has the right to a contested case hearing under the Administrative
12 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
13 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
14 Order in the Board's records. Licensee stipulates that he engaged in the conduct described in
15 paragraph 3 and that this conduct violated ORS 677.190(1)(a), (b) and (c) unprofessional or
16 dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(5) willfully or negligently
17 divulging a professional secret to another without written consent; and ORS 677.190(13) gross or
18 repeated negligence. Licensee understands that this Order is a disciplinary action and is
19 reportable to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank
20 and the Federation of State Medical Boards.

21 5.

22 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order,
23 in which Licensee surrenders his license while under investigation, subject to the following
24 sanctions, terms and conditions:

25 5.1 Licensee surrenders his license to practice as a physician in Oregon while under
26 investigation.

27 5.2 Licensee is reprimanded.

1 5.3 Licensee may not apply for licensure with this Board for a minimum of two years
2 from the signing of this Order by the Board Chair.

3 5.4 Licensee will pay a fine of \$5,000. Of this fine, \$2,500 is payable within 30 days
4 from the date this Order is signed by the Board Chair. The remaining \$2,500 is payable
5 within 180 days from the date this Order is signed by the Board Chair.

6 5.5 Licensee shall obey all federal and Oregon laws and regulations pertaining to the
7 practice of medicine.

8 5.6 Licensee stipulates and agrees that any violation of the terms of this Order shall
9 be grounds for further disciplinary action under ORS 677.190(17).

10
11 IT IS SO STIPULATED this 17 day of June, 2010.

12 SIGNATURE REDACTED

13
14 PETER SAMUEL MOREY, MD

15 IT IS SO ORDERED this 8th day of July, 2010.

16 OREGON MEDICAL BOARD
17

18 SIGNATURE REDACTED

19 LISA A. CORNELIUS, DPM
20 Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

In the Matter of)
)
MICHAEL JAMES RAIFE, MD) INTERIM STIPULATED ORDER
LICENSE NO. MD23162)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Michael James Raife (Licensee) is a licensed physician in the state of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to cease the practice of medicine until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

3.1 Licensee voluntarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

3.2 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. Following that review, if the Board determines that Licensee shall not be permitted to return to the practice of medicine, Licensee may request a hearing to contest that decision.

5.

This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform 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.

IT IS SO STIPULATED THIS 13th day of July, 2010.

SIGNATURE REDACTED

MICHAEL JAMES RAIFE, MD

IT IS SO ORDERED THIS 14th day of July, 2010.

State of Oregon
OREGON MEDICAL BOARD

SIGNATURE REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

JAMES PECK, MD
MEDICAL DIRECTOR

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
BRUCE MICHAEL RYE, MD)
APPLICANT) DEFAULT FINAL 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. Bruce Michael Rye, MD (Applicant) applied for an active license to practice medicine in the state of Oregon.

2.

On February 23, 2010, the Board issued a Notice of Intent to Deny License Application. This Notice designated the Board's file on this matter as the record for purposes of a default order and granted Applicant an opportunity for a hearing, if requested in writing within 60 days of service of the Notice. This Notice was sent by Certified Mail on February 23, 2010, to Applicant, at the address provided by the Applicant. Applicant initially requested a hearing, but in a letter to the Board dated May 4, 2010, Applicant withdrew his request for hearing. As a result, the requisite 60 days to request a hearing has lapsed and Applicant stands in default. The Board elects in this case to designate the record of proceeding to date, which consists of Applicant's file with the Board, as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

3.

In the Notice of Intent to Deny License Application, dated February 23, 2010, the Board informed Applicant that it intended to deny his license application, to assess the costs of the proceeding and to impose a fine against him based upon violations of the Medical Practice Act, as follows: ORS 677.190(1)(a) and (b) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7) habitual or excessive use of intoxicants, drugs or controlled

1 substances; ORS 677.190(13) gross or repeated negligence; ORS 677.190(15) disciplinary
2 actions by another state of a license to practice; and ORS 677.190 (17) failing to comply with a
3 board request pursuant to ORS 677.320.

4 4.

5 NOW THEREFORE, after considering the Board's file relating to this matter, the Board
6 enters the following Order.

7 FINDINGS OF FACT

8 The evidence of record establishes the following findings of fact:

9 4.1 Applicant received a medical license in Arkansas on October 7, 2005. On May
10 15, 2008, the Arkansas State Medical Board issued an Emergency Order of Suspension in regard
11 to Applicant's Arkansas medical license, based upon Applicant having engaged in sexual
12 misconduct with a teenage patient. On June 5, 2008, the Arkansas State Medical Board accepted
13 Applicant's request to permanently surrender his Arkansas medical license based on charges of
14 having sexual relations with a patient.

15 4.2 The Board's review of Applicant's conduct that was the basis for the suspension
16 and eventual surrender of his Arkansas medical license reveals that Applicant provided skin care
17 to Patient A, a 16-year-old male patient, over the course of 5 successive treatment sessions
18 between September 6, 2006, and December 21, 2006. During some of these patient treatment
19 sessions, Licensee put a "cleaner" on Patient A's back as part of his acne treatment. Licensee
20 proceeded to take advantage of this situation by rubbing the cleaner on the sides and upper part
21 of Patient A's buttocks. Patient A's history included an unstable home life and a suicide attempt.
22 Applicant states that Patient A exhibited signs of depression related to his living situation during
23 the course of his dermatologic treatments. Applicant established personal rapport with Patient A
24 during these treatment sessions, although Applicant denies any sexual repartee. Shortly after the
25 last treatment session, Applicant violated professional boundaries by engaging in communication
26 of a personal nature with Patient A. In early January of 2007, Applicant provided a false
27 identification card to Patient A, a minor, so that they could go together to certain social

1 establishments and consume alcohol. Their contact quickly developed into a sexual relationship
2 that included sexual intercourse and the payment of money by Applicant to Patient A. Applicant
3 asserts that he succumbed to the sexual overtures of Patient A. Applicant's explanation is self-
4 serving. Sexual relations with patients by physicians are unethical. Sexual relations with a
5 former patient are unethical if the physician uses or exploits trust, knowledge, emotions, or
6 influence derived from a previous professional relationship. Applicant sexually exploited a
7 young and vulnerable patient with a history of mental health concerns.

8 4.3 In his application for a medical license in Oregon that Applicant signed on
9 November 22, 2008, Applicant answered "no" to question #5 in the Category I section: "Have
10 you ever had any disciplinary or adverse action imposed against any professional license or
11 certification?" Applicant's answer was not true. Applicant also failed to supply the Board with
12 any documentation regarding the Arkansas State Medical Board's investigation, the emergency
13 suspension in Arkansas, and the subsequent permanent surrender of his Arkansas medical
14 license.

15 4.4 In his application for a medical license in Oregon, Applicant untruthfully
16 answered "no" to question # 10 (Category I): "Have you ever entered into any formal, informal,
17 out-of-court or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent
18 to sue, and/or criminal action? *This includes whether or not a claim, charge or filing was*
19 *actually made with a court.*" In fact, Patient A brought a civil lawsuit against Licensee, which
20 was settled with a payment of \$75,000 by Licensee. As a result, the lawsuit was dismissed with
21 prejudice on August 20, 2008. Patient A subsequently declined to testify at any criminal trial in
22 Arkansas regarding Applicant's arrest and criminal charges involving felony sexual assault of
23 Patient A.

24 4.5 Applicant failed to answer question # 4 in the Category II section: "Within the
25 past 5 years, have you engaged in the excessive or habitual use of alcohol or illegal drugs, or
26 received any in-patient therapy/treatment or been hospitalized for alcoholism, or illegal drug use,
27 or been arrested for a DUII (Driving Under the Influence of intoxicants) or DWI (Driving While

1 physician in regard to a young and psychologically vulnerable patient by using the clinical
2 setting to initiate sexual contact with a 16-year-old patient and eventually to engage in a sexual
3 relationship with Patient A. This conduct constitutes unprofessional or dishonorable conduct, as
4 well as gross negligence. Applicant engaged in disruptive and unprofessional behavior in a
5 healthcare setting at Northwest Dermatology in Arkansas. Licensee failed to provide the Board
6 with requested documentation during the processing of his application and the subsequent
7 investigation. Licensee also engaged in the excessive use of alcohol, which impaired his ability
8 to safely practice medicine. Finally, Licensee was untruthful in his responses to various
9 questions on his application for licensure in this state. Applicant's conduct violated ORS
10 677.190(1)(a) and (b) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a);
11 ORS 677.190(7) impairment; ORS 677.190(13) gross or repeated negligence; ORS 677.190(15)
12 disciplinary actions by another state of a license to practice; and ORS 677.190 (17) failing to
13 comply with a board request pursuant to ORS 677.320. The Board concludes that based upon its
14 examination of the record in this case, that each alleged violation of the Medical Practice Act is
15 supported by reliable, probative and substantial evidence.

16 6.

17 **ORDER**

18 IT IS HEREBY ORDERED THAT the application of Bruce Michael Rye, MD, for a
19 license to practice medicine as a physician in Oregon is denied.

20
21 DATED this 8th day of July, 2010.

22 OREGON MEDICAL BOARD
23 State of Oregon

24
25 *SIGNATURE REDACTED*

26 LISA A. CORNELIUS, DPM
27 BOARD CHAIR

Right to Judicial Review

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.482. If this Order was personally delivered to you, the date of service is the day it was mailed, not the day you received it. If you do not file a petition for judicial review within the 60 days time period, you will lose your right to appeal.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
STUART GORDON WEISBERG, MD) ORDER OF EMERGENCY
LICENSE NO. MD23402) SUSPENSION

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. Stuart Gordon Weisberg, MD, (Licensee), is a licensed physician in the state of Oregon.

2.

Licensee was previously disciplined by the Board and placed on probation consistent with the terms of a Stipulated Order, dated July 13, 2006. The acts and conduct that support this Order for Emergency Suspension are as follows:

2.1 Licensee is currently required to practice medicine consistent with the terms of a Corrective Action Order, approved by the Board on June 9, 2009, which requires Licensee to practice with the benefit of a practice mentor pre-approved by the Board’s Medical Director and to meet with this mentor at least twice a month to conduct chart review and to discuss ongoing patient care issues. Licensee informed the Board in a letter dated June 14, 2010, that his practice mentor no longer supported his ideas pertaining to practice and requested “removal from his services.” In a letter dated June 22, 2010, Licensee presented the Board with a form purporting to modify his Corrective Action Order that would eliminate the term requiring a practice mentor and offered to meet with a Board member periodically. He also stated that his “practice as a psychiatrist is full.” Licensee is no longer meeting with his Board approved practice mentor, in violation of term 3.1 of the Corrective Action Order.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant to ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practical.

IT IS SO ORDERED THIS 24th day of June, 2010.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

Lisa A. Cornelius, DPM
Board Chair