

Oregon Medical Board
BOARD ACTION REPORT
June 15, 2011

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between May 16, 2011 and June 15, 2011.

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.

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](#) 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.

***Dew, Leigh, Anne, MD; MD21140; Portland, OR**

Licensee entered into a Stipulated Order with the Board on June 2, 2011. In this Order, Licensee was placed on probation for 5 years with the following terms and conditions: no notice compliance audits and no self-prescribing or prescribing for family members.

***Gomez, Gregory, Rodriguez, MD; MD27099; Medford, OR**

On June 2, 2011, the Board issued an Order of Emergency Suspension due to concerns regarding Licensee's ability to safely and competently practice medicine.

***Levanger, Nathan, Blacker, DO; DO22827; Cascade, ID**

Licensee entered into a Stipulated Order with the Board on June 2, 2011. In this Order, Licensee was reprimanded and must comply with the following terms and conditions: enrollment in a CPEP evaluation, completion of CPEP recommendations, fine, and appropriate prescribing course.

***Stone, Mark, Kendall, LAc; AC00510; Florence, OR**

The Board issued an order that terminated Licensee's Suspension Order on May 25, 2011. Licensee's Oregon acupuncture license is now returned to active status.

***Wenberg, Kenneth, Fred, MD; MD14131; Heppner, OR**

Licensee entered into a Stipulated Order with the Board on June 2, 2011. In this Order, Licensee was placed on probation with the following terms and conditions: full compliance with Washington State Board order, notification to Oregon Medical Board if non-compliant with Washington order, periodic compliance reviews, and notification of CME completed.

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.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
LEIGH ANN DEW, MD) STIPULATED ORDER
LICENSE NO. MD21140)

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. Leigh Ann Dew, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board issued a Complaint and Notice of Proposed Disciplinary Action on February 4, 2011 proposing to take 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) and ORS 677.190(13) gross or repeated acts of negligence.

3.

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

On and between January 2008 and January 2009, Licensee wrote 32 prescriptions to treat Patients A, B, C and D with controlled substances; to include hydrocodone & Guaifenesin (Vi-Q-Tuss, Schedule III), hydrocodone & acetaminophen (Vicodin, Schedule III) and zolpidem (Ambien, Schedule IV). Licensee authorized these prescriptions without conducting appropriate patient examinations and without maintaining a patient chart (except for Patient B and C). Licensee also failed to document in a chart every prescription that she wrote and failed to communicate with the primary care physician (PCP) for Patients A, B, C, and D, even when she knew that both she and the PCP were prescribing controlled substances to treat the same health condition for Patient D.

1 4.

2 License and the Board desire to settle this matter by entry of this Stipulated Order.
3 Licensee understands that she has the right to a contested case hearing under the
4 Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and
5 finally waives the right to a contested case hearing and any appeal therefrom by the signing of
6 and entry of this Order in the Board's records. Licensee neither admits or denies but the
7 Board finds that she engaged in the conduct described in paragraph 3 and that this conduct
8 violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS
9 677.188(4)(a). Licensee understands that this Order is a public record and is reportable to the
10 National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and the
11 Federation of State Medical Boards.

12 5.

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

15 5.1 Licensee is placed on probation for a term of five years and is subject to no
16 notice compliance audits.

17 5.2 Licensee must not prescribe or otherwise provide prescription medications to
18 any family member or for herself.

19 5.3 Licensee must obey all federal and Oregon State laws and regulations
20 pertaining to the practice of medicine.

21 5.4 Licensee stipulates and agrees that any violation of the terms of this Order
22 shall be grounds for further disciplinary action under ORS 677.190(17) (willfully violate a
23 board order).

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
GREGORY RODRIGUEZ GOMEZ, MD) ORDER OF EMERGENCY
LICENSE NO. MD27099) 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. Gregory Rodriguez Gomez, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

The acts and conduct that support this Order for Emergency Suspension follow:

2.1 The Licensee entered into a Stipulated Order, with the Board on September 2, 2010 that placed him on probation for a period of ten (10) years subject to specific terms and obligations. The Stipulated Order, which is incorporated herein by reference, was the resolution from three (3) separate investigations which identified multiple concerns regarding Licensee's ability to safely and competently practice medicine.

2.2 During the Board's compliance monitoring process and quarterly probation interviews, the Licensee has been repeatedly informed of his obligations under the Stipulated Order.

2.3 Term 5.7 of the Stipulated Order required Licensee to enter into an agreement with the Center for Personalized Education for Physicians (CPEP) to complete the education plan developed during the Licensee's 2010 CPEP evaluation. Licensee was required to sign this agreement within thirty (30) days from the date the Stipulated Order was signed by the Board

1 Chair. Further, the term required that the CPEP education plan and the selection of the
2 Licensee's practice mentor be pre-approved by the Board's Medical Director. To date, Licensee
3 has not entered into the CPEP education plan agreement and has not proposed a practice mentor.
4 Accordingly, the Licensee has continued to practice without the benefit of the CPEP education
5 plan and a practice mentor.

6 2.4 Term 5.10 of the Stipulated Order requires that Licensee's work settings in the
7 health care field be pre-approved by the Board's Medical Director. The current investigation has
8 identified three (3) clinical settings where the Licensee is currently practicing without the
9 approval of the Board's Medical Director. One of these practice settings is a solo physician
10 private practice clinic opened by the Licensee. The Licensee was advised repeatedly that the
11 Board's Medical Director would not approve that type of a practice setting. The Licensee
12 acknowledged that he did not notify the Board about these two practice settings and did not
13 request review and approval by the Board's Medical Director of these practice settings.
14 Licensee's failure to comply with this requirement prevented the opportunity for no-notice
15 compliance inspections in accordance with Term 5.13 of the Stipulated Order.

16 3.

17 Based on the above information, the Board has determined that from the evidence
18 available to the Board at this time that Licensee's continued practice of medicine would pose an
19 immediate danger to the public and to his patients. Licensee's behavior displays repeated
20 disregard for the terms of the Stipulated Order that were designed to protect the public.
21 Licensee's failure to notify the Board of his practice settings has significantly degraded the
22 Board's ability to monitor his compliance with the Stipulated Order. This behavior causes the
23 Board to conclude that it would be subjecting patients to the risk of harm if Licensee were
24 allowed to continue to practice while this case remains under investigation.

24 4.

25 Licensee is entitled to a hearing as provided by the Administrative Procedures Act
26 (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a

1 hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for
2 hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant to
3 ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the
4 time and place of the hearing and will hold a hearing as soon as practical.

5 5.

6 The Board orders that pursuant to ORS 677.205(3), the license of Gregory Rodriguez
7 Gomez, MD, be suspended on an emergency basis and that Licensee immediately cease the
8 practice of medicine until otherwise ordered by the Board.

9
10 IT IS SO ORDERED THIS 2nd day of June, 2011.

11 OREGON MEDICAL BOARD

12 SIGNATURE REDACTED

13 RALPH A. YATES, DO ✓
14 BOARD CHAIR

1 closed. Patient A informed Licensee that he was accustomed to taking high dosages of
2 controlled substances and had been “stable on his current dose of medication for a number of
3 years.” Licensee reviewed the medical chart from a previous provider, which included an MRI
4 (magnetic resonance imaging) from 2002-2003 that revealed minor disc disease of the lumbar
5 spine, and conducted a brief examination. Licensee noted that he was “uncomfortable” with the
6 “number of meds he [Patient A] was taking.” Nevertheless, Licensee decided that he could trust
7 Patient A and authorized the following refills: clonazepam (Klonopin, Schedule IV), 1 mg, #90,
8 1 tablet t.i.d. (three times a day); doxepin (Sinequan), 150 mg, #60, 2 tablets at bedtime;
9 oxycodone (Schedule II), 30 mg, #1200, 5 tablets q3h (5 tablets every 3 hours); methadone
10 (Schedule II) 10 mg, #1200, 8 tablets, 5 times a day; diazepam (Valium, Schedule IV) 10 mg,
11 #90, 1 tablets, t.i.d.. The estimated street value of just the prescribed oxycodone was about
12 \$36,000. In a clinic visit on October 9, 2009, Patient A informed Licensee that he had been
13 arrested in September, 2009, and had been incarcerated for 20 days. The police report indicates
14 that Patient A was apprehended on September 14, 2009, while driving a vehicle on Interstate
15 Highway 84. A search of his vehicle by the state police revealed over 2400 tablets of methadone
16 and oxycodone along with other medications at the time of Patient A’s arrest. The state police
17 also found evidence that Patient A was selling controlled substances to third parties; to include
18 \$1200 in cash (Patient A is unemployed and supported by his mother), twenty suits of clothes in
19 his car, text messages on his cell phone indicating that Patient A was distributing medications to
20 third parties, and two notebooks containing multiple names, phone numbers and payment
21 amounts, indicative of drug trafficking. Patient A did not exhibit any withdrawal symptoms
22 while in jail, even though he was not taking his regimen of prescription medications. After his
23 release from custody, an Ameritox drug screen was conducted on Patient A on October 21, 2009,
24 which only detected methadone in his bloodstream. Nevertheless, Licensee continued to
25 prescribe the same high dosages of controlled substances for Patient A through February 1, 2010.
26 Licensee failed to conduct a thorough examination of Patient A when he assumed his care, failed
27

1 to verify that the entire course of prescribed medications were medically indicated, or that
2 Patient A was taking the medications as prescribed.

3 4.

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

17 5.

18 In order to address the concerns of the Board, Licensee and the Board agree that the
19 Board will close this investigation and resolve this matter by entry of this Stipulated Order,
20 subject to the following conditions:

21 5.1 Licensee is reprimanded.

22 5.2 Within 30 days from the date this Order is signed by the Board Chair, Licensee
23 must enroll to undergo a comprehensive evaluation at the Center for Personalized Education for
24 Physicians (CPEP). Licensee must complete this evaluation within 180 days from the date this
25 Order is signed by the Board Chair.

26 5.3 Licensee must successfully complete any CPEP recommended education or
27 remediation, including any "Post-Education Evaluation," within 24 months from the date this

1 Order is signed by the Board Chair. Any CPEP recommendation for education or remediation
2 must be pre-approved by the Board's Medical Director.

3 5.4 Licensee must also sign all necessary releases to authorize full ongoing
4 communication between the Board and CPEP, and Licensee will ensure that periodic progress
5 reports, interim reports and the final written evaluation report from CPEP are provided promptly
6 to the Board.

7 5.5 Licensee must provide the Board with written proof from CPEP upon successful
8 completion of any CPEP recommended education or remediation, including successful
9 completion of the post-education evaluation.

10 5.6 Within 120-days from the date of completion of the CPEP program, Licensee
11 must successfully complete an appropriate prescribing course that has been pre-approved by the
12 Board's Medical Director. All costs associated with this course will be borne by the Licensee.

13 5.7 Licensee must pay a fine of \$7500, payable in full within 90 days from the
14 signing of this Order by the Board Chair.

15 5.8 Licensee stipulates and agrees that any violation of the terms of this Order shall
16 be grounds for further disciplinary action under ORS 677.190(17).

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

IT IS SO STIPULATED THIS 20 day of MAY, 2011.

SIGNATURE REDACTED
~~NATHAN BLACKER LEVANGER, DO~~

IT IS SO ORDERED THIS 2nd day of June, 2011.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED
~~RALPH A. YATES, DO~~
BOARD CHAIR

MAY 3 1:00 PM

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
MARK KENDALL STONE, LAc) ORDER TERMINATING ORDER
LICENSE NO. AC00510) OF LICENSE SUSPENSION

1.
2.

On May 5, 2011, the Oregon Medical Board (Board) issued an Order of License Suspension regarding Mark Kendall Stone, LAc (Licensee). This Order was issued pursuant to ORS 25.750, and Licensee's failure to pay child support. On May 23, 2011, the Board received notification from the Oregon Department of Justice Child Support Program informing the Board that Licensee is now in compliance with his child support payments and that his license should be reinstated.

2.

The Board does hereby order that the May 5, 2011 Order of License Suspension be terminated effective the date this Order is signed by the Board Chair and that Licensee's license be returned to active status.

IT IS SO ORDERED this 25th day of May, 2011.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

~~RALPH A. YATES~~/DO
Board Chair

1 2.2 In the morning of February 13, 2008, Patient A fell or slid out of her bed at her
2 residence and became wedged between her bed and her desk. She was unable to dislodge herself
3 from this predicament for approximately five hours. Ultimately, she freed herself and managed
4 to call 911 for medical assistance.

5 2.3 Patient A was found by the emergency responders and was transported to the
6 hospital ED.

7 2.4 At the ED, Patient A complained of right hip and knee pain and pain in her lower
8 back.

9 2.5 Licensee performed a full physical examination of Patient A and treated her for
10 her complaint of pain.

11 2.6 Patient A was in the ED for approximately two and a half hours, during which
12 time she vomited twice, had x-rays taken of her hip, chest and spine. She also had a
13 comprehensive metabolic profile done and her blood count tested. Her white blood cell count
14 was elevated and consistent with a recent traumatic episode. She was placed on routine cardiac
15 monitoring. An Electrocardiogram (EKG) monitoring strip reading indicated she had an atrial
16 fibrillation with a reasonable ventricular rate, but this was not well-indicated in the record.

17 2.7 Licensee did not find a medical basis per admission criteria to admit Patient A to
18 the hospital. He ordered her discharge and authorized a medical transport service to take her to
19 her residence. Licensee urged Patient A to contact a family member or caregiver and her
20 primary physician. Patient A expressed her desire that her family members and caregiver not be
21 contacted about her situation.

22 2.8 Licensee noted on Patient A's medical record that he ordered x-rays and
23 examined her knee and hip, however, there was no recorded attempt to ascertain the reason for
24 her falling out of the bed. Licensee noted that there was degenerative joint disease and evidence
25 of bursitis of the right hip. Noted also, were lab tests including a complete blood count (CBC).
26 The white cell count was noted to be high at 20,200.

27 ///

1 2.9 Licensee's notation did not reflect any assessment and diagnosis in regard of the
2 high white blood cell count or the chest x-ray ordered that day. In spite of the patient being
3 elderly, her having a high white blood cell count, and the ambulance attendant telling him that
4 there was a strong smell of urine on the patient, Licensee did not have Patient A submit a urine
5 sample. The cardiac rhythm abnormality was not addressed in the records.

6 2.10 Patient A was given a prescription ordered by Licensee for 600 mg of ibuprofen
7 (Motrin) to take with her hydrocodone bitartrate and acetaminophen (Vicodin).

8 2.11 Patient A was returned in the late afternoon to her residence by the emergency
9 medical service and was made comfortable in her home. The emergency medical service staff
10 assisting Patient A noted concern that she would be unable to fully care for herself at home
11 without assistance, and sent notice to Licensee and the hospital ED of the situation. Patient A
12 was told to contact 911 if she needed any further emergency assistance.

13 2.12 On February 13, 2008, after Patient A was returned to her home, her daughter
14 called and then came to visit her. The daughter took Patient A to the Kadlec Hospital ED in
15 Richland, Washington, where she was admitted and evaluated by a different ED physician. The
16 medical record at this visit did not indicate the presence of sepsis. She was discharged later in
17 the evening to the care of her daughter.

18 2.13 On February 15, 2008, Patient A was taken again by her daughter to the Kadlec
19 Hospital ED where she was admitted to the hospital's coronary care unit. Further testing,
20 evaluation and care ensued.

21 2.14 On February 17, 2008, Patient A died. The final diagnosis indicated severe sepsis
22 and septic shock. She had Methicillin-Resistant Staphylococcus Aureus (MRSA) associated
23 with endocarditis, bacteremia, and pyelonephritis. She was experiencing acute respiratory failure
24 and the computed axial tomography (CT) scan revealed an intracerebral hemorrhage.

25 2.15 In light of how Patient A initially presented at the Othello hospital ED, her history
26 of what happened to require a call to 911, and what was noted of her condition by the ED nursing
27 staff, it was reasonable to see that she was not going to be able to care for herself after her

1 discharge. In spite of Patient A's request not to bother family, Licensee could have made an
2 effort to contact a family member to transport and assist Patient A at her home. Although
3 identified, contact was also not made with Patient A's primary care provider to inform him of his
4 patient's condition.

5 3.

6 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
7 Licensee understands that he has the right to a contested case hearing under the Administrative
8 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
9 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
10 Order in the Board's records. Licensee admits that he violated the Medical Practice Act as
11 alleged in paragraph 2 by violating ORS 677.190(1)(a), unprofessional or dishonorable conduct,
12 as defined in ORS 677.188(4)(a), and ORS 677.190(15) disciplinary action by another state of a
13 license to practice based upon acts by Licensee similar to acts described in the Medical Practice
14 Act.

15 4.

16 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order.

17 Licensee is placed on probation and is subject to the following terms:

18 4.1 Licensee must fully comply with the terms of the Washington Agreed Order,
19 which was approved by MQAC on June 3, 2010. (See attachment.)

20 4.2 Licensee will be subject to periodic compliance reviews for the purpose of
21 reviewing his medical records pertaining to any care that he delivers in Oregon to ensure that
22 effective comprehensive ER examinations and appropriate ER treatment is maintained.

23 4.3 Licensee must notify the Board if MQAC finds that he is out of compliance with
24 the Washington Agreed Order, or modifies the Agreed Order in any way.

25 4.4 Licensee must forward directly to the Board a copy of the certificates for any
26 continuous medical education (CME) completed in relationship to the MQAC order and a copy
27 of any monitoring reports generated for MQAC.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

ORIGINAL

In the Matter of the License to Practice
as a Physician and Surgeon of

KENNETH F. WENBERG, MD
License No. MD00025365

No. M2008-118474

STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW, AND
AGREED ORDER

Respondent.

The Medical Quality Assurance Commission (Commission), through Mike Bahn, Commission Staff Attorney, and Kenneth F. Wenberg, MD, (Respondent), as represented by counsel, Douglas K. Yoshida, Esq., stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On or about June 19, 2009, the Commission issued a Statement of Charges against Respondent.

1.2 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(4).

1.3 Respondent understands that the Commission is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent understands that if the allegations are proven at a hearing, the Commission has the authority to impose sanctions pursuant to RCW 18.130.160.

1.5 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing. Respondent would present other facts that would support his position on the matter.

1.6 Respondent waives the opportunity for a hearing on the Statement of Charges, provided that the Commission accepts this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.7 The parties agree to resolve this matter by means of this Agreed Order.

1.8 Respondent understands that this Agreed Order is not binding until it is signed and accepted by the Commission.

1.9 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Data Bank (HIPDB) (45 CFR Part 61), and elsewhere as required by law. The HIPDB may report this Agreed Order to the National Practitioner Data Bank (45 CFR Part 60).

1.10 This Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's e-listserv, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at a hearing of any Commission members who heard the presentation of this Agreed Order.

2. FINDINGS OF FACT

Respondent and the Commission acknowledge that the evidence is sufficient to justify the following findings.

2.1 On March 28, 1988, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent has practiced in emergency departments (ED) since 1981.

2.2 Patient A, an 86 year old female, saw Respondent at the Othello Community Hospital emergency department on February 13, 2008.

2.3 In the morning on February 13, 2008, Patient A fell or slid out of her bed at her residence and became wedged between her bed and her desk. She was unable to dislodge herself from this predicament for approximately five hours. Ultimately she freed herself and managed to call 911 for medical assistance.

2.4 Patient A was found by the emergency responders and was transported to the hospital ED.

2.5 At the ED, Patient A complained of right hip and knee pain and pain in her lower back.

2.6 Respondent performed a full physical examination of Patient A and treated her for her complaint of pain.

2.7 Patient A was in the ED for approximately two and a half hours, during which time she vomited twice, had x-rays taken of her hip, chest, and spine. She also had a comprehensive metabolic profile done and her blood count tested. Her white blood cell count was elevated and consistent with a recent traumatic episode. She was placed on routine cardiac monitoring. An EKG monitoring strip reading indicated she had an atrial fibrillation with a reasonable ventricular rate, but this was not well indicated in the record.

2.8 Respondent did not find a medical basis per admission criteria to admit Patient A to the hospital. He ordered her discharge and authorized a medical transport service take her to her residence. Respondent urged Patient A to contact a family member or caregiver and her primary physician. Patient A expressed her desire that her family members and caregiver not be contacted about her situation.

2.9 Respondent noted on Patient A's medical record that he ordered x-rays and examined her knee and hip, however there was no recorded attempt to ascertain the reason for her falling out of the bed. Respondent noted that there was degenerative joint disease and evidence of bursitis of the right hip. Noted also were lab tests including a CBC. The white cell count was noted as high at 20,200.

2.10 Respondent's notation did not reflect any assessment and diagnosis in regard of the high white blood cell count or the chest x-ray ordered that day. In spite of the patient being elderly, her having a high white blood cell count, and the ambulance attendant telling him that there was a strong smell of urine on the patient, Respondent did not have Patient A submit a urine sample. The cardiac rhythm abnormality was not addressed in the records.

2.11 Patient A was given a prescription ordered by Respondent for 600 mg of Motrin to take with her Vicodin.

2.12 Patient A was returned in the late afternoon to her residence by the emergency medical service and was made comfortable in her home. The emergency medical service staff assisting Patient A noted concern that she would be unable to fully care for herself at home without assistance, and sent notice to Respondent and the hospital ED of the situation. Patient A was told to contact 911 if she needed any further emergency assistance.

2.13 On February 13, 2008, after Patient A was returned to her home, her daughter called and then came to visit her. The daughter took Patient A to the Kadlec Hospital ED in Richland, Washington, where she was admitted and evaluated by a different ED physician. The medical record at this visit did not indicate the presence of sepsis. She was discharged later in the evening to the care of her daughter.

2.14 On February 15, 2008, Patient A was taken again by her daughter to the Kadlec Hospital ED where she was admitted to the hospital's coronary care unit. Further testing, evaluation, and care ensued.

2.15 On February 17, 2008, Patient A died. The final diagnosis made indicated severe sepsis and septic shock. She had Methicillin-Resistant Staphylococcus Aureus (MRSA) associated with endocarditis, bacteremia, and pyelonephritis. She was experiencing acute respiratory failure, and the CT scan revealed an intracerebral hemorrhage.

2.16 In light of how Patient A initially presented at the Othello hospital ED, her history of what happened to require a call to 911, and what was noted of her condition by the ED nursing staff, it was reasonable to see that she was not going to be able to care for herself after her discharge. In spite of Patient A's request not to bother family, Respondent could have made an effort to contact a family member to transport and assist Patient A at her home. Although identified, contact was not also made with Patient A's primary care provider to inform him of his patient's condition.

3. CONCLUSIONS OF LAW

The Commission and Respondent acknowledge that the findings are sufficient to justify the following conclusions.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4).

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order.

Probation Period:

4.1 Respondent's license will be subject to a compliance monitoring period of two years.

Fine:

4.2 Respondent is fined \$1000. Respondent will remit the fine within three months from the effective date of this Agreed Order. The fine is to be paid by certified or cashier's check or money order, made payable to the Department of Health, and mailed to the Department of Health, Medical Quality Assurance Commission, PO Box 1099, Olympia, WA 98504-1099.

Continuing Medical Education (CME):

4.3 Respondent agrees to enroll in and successfully complete at least two of the following courses and medical education programs:

4.3.1 Oregon Health and Science University – the 21st Annual NW States Trauma Medicine Conference, (April 21-23, 2010).

4.3.2 The 14th Annual National Emergency Medical Board Review Course, (July 19-22 or August 30-September 2).

4.3.3 University of California San Francisco – Advances in Internal Medicine, (May, 2010).

4.3.4 University of California San Francisco – High Risk Internal ER Medicine, (May 2010).

4.4 Prior to taking this CME course work, or if there is reasonable difficulty in securing admittance in these courses, Respondent must obtain the Commission's approval, via the Commission's staff medical consultant, of this particular course work or of other suitable courses. Once completed, Respondent must submit documentation verifying that he has taken the courses/programs.

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4.12 The Commission will review the petition and, if it is determined that Respondent has successfully completed all the terms and conditions of this Agreed Order, the Commission's Compliance Officer will send a letter to Respondent indicating the Commission's decision to release Respondent and to terminate this Agreed Order. Respondent will not have to appear before the Commission panel.

General terms and conditions:

4.13 Respondent shall obey all the federal, state, local laws, and the administrative rules that govern the practice of the profession in Washington.

4.14 Respondent is responsible for all costs of his compliance with this Agreed Order.

4.15 If Respondent violates any provision of this Agreed Order in any respect, the Commission may take further action against Respondent's license, and/or may modify this Agreed Order by extending the oversight period.

4.16 Respondent shall inform the Commission and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within 30 days of the change.

4.17 The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fines or compliance documents until after the effective date of this Agreed Order.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies WAC 246-16-800, *et seq.*, to establish a compliance program in this Agreed Order. WAC 246-16-800(2) and (3) require the Commission to apply sanctions (terms and conditions) based on the appropriate sanction schedule(s).

5.2 The Commission determined that the stipulated conduct falls within "Tier B" of the "Practice Below Standard Of Care" sanction schedule set forth in WAC 246-16-810 on the grounds that Patient A was exposed to the risk of moderate to severe harm by her either not being admitted to the hospital or her not being discharged in the care of a family member. Patient A ultimately died, but her death was not caused by Respondent's care.

4.5 Regardless of Respondent's reporting cycle, Respondent will submit to the Commission a list of whatever CME that he has accomplished in the two years prior to the effective date of this Agreed Order. The list is to be submitted within 30 days of the effective date of this Agreed Order. Proper verification of his achievement of the CME course works must be provided with this list.

Compliance monitoring:

4.6 Respondent will be subject to periodic compliance reviews for the purpose of reviewing his medical records to ensure that effective comprehensive ER examinations and appropriate ER treatment is maintained.

4.7 The first compliance review will be performed at 12 months from the effective date of this Agreed Order.

4.8 Subsequent compliance reviews will be imposed at the discretion of the Commission, or its designee, as needed during the two-year compliance monitoring period. Given the nature of Respondent's locum tenens practice compliance reviews will be coordinated with Respondent so that they may be accomplished efficiently.

Modification of the Agreed Order:

4.9 Respondent may file a written petition for modification of this Agreed Order; however a petition for modification may not be submitted any sooner than one year from the effective date of this Agreed Order.

4.10 The Commission will review the petition for modification and make a decision. If it is determined that Respondent is in compliance at the time of the petition's review, and that the requested modification does not impair the effectiveness of this Agreed Order, the Commission will accept the modification by issuing to Respondent an amended agreed order. Respondent may be required to appear before the Commission to present evidence that a modification is necessary.

Release from the Agreed Order:

4.11 Respondent will file a written petition for release from this Agreed Order at the end of the two-year compliance monitoring period with the Adjudicative Clerk Office and the Commission. The petition for release will attest to his successful completion of all the terms and conditions of this Agreed Order.

5.3 Tier B's compliance monitoring period ranges from 2 to 5 years. The Commission starts its determination of the sanction schedule's compliance monitoring range in the middle of the range. It then considers the weight and number of mitigating and aggravating factors which can move the duration of time of the range toward one end or the other.

5.4 Considering the following mitigating and aggravating factors the duration of the compliance monitoring period as determined by the Commission is placed at two years.

5.5 Mitigating factor:

5.5.1 Respondent fully and freely disclosed the requested information during the investigation and cooperated accordingly.

5.5.2 Respondent is willing to partake of extensive CME for addressing the concerns of the Commission.

5.6 Aggravating factors:

5.6.1 Patient A was a vulnerable senior and susceptible to problematic medical outcomes.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the credential after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show good cause why his license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

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7. RESPONDENT'S ACCEPTANCE

I, Kenneth F. Wenberg, MD, Respondent, have read, understand, and agree to this Agreed Order. My counsel of record, Douglas K. Yoshida, has fully explained the legal significance and consequence of it. I understand that this Agreed Order may be presented to the Commission without my appearance, and that I will receive a signed copy if the Commission accepts this Agreed Order.

Kenneth F. Wenberg MD
KENNETH F. WENBERG, MD
RESPONDENT

9-21-2010
DATE

DK
DOUGLAS K. YOSHIDA, WSB# 17365
ATTORNEY FOR RESPONDENT

09-21-2010
DATE

ORIGINAL by
e-mailed 'pdf' and
received 9/21/10
(initials)

ORIGINAL

8. COMMISSION'S ACCEPTANCE AND ORDER

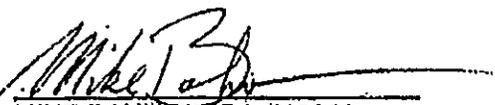
The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order.

DATED: 3 June, 2010.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION


PANEL CHAIR

Prepared and presented by:


MIKE BAHN, WSBA #16009
STAFF ATTORNEY