

Oregon Medical Board
BOARD ACTION REPORT
November 15, 2011

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between October 16, 2011 and November 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 and Consent Agreements are not included, as they are not a disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report, as they are not final actions by the Board. Both Orders, however, are public and are available upon request.

Printed copies of the Board Orders not provided with this report are available to the public. To obtain a printed copy of a Board Order not provided in this report, please complete a Service Request Form (<http://egov.oregon.gov/BME/PDFforms/VerDispMalFillin.pdf>) found under the Licensee Information Request Form link on the Board's web site, submit it with the \$10.00 fee *per licensee* and mail to:

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

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

***Campbell, Robert Perry, MD; MD10884; Oregon City, OR**

On November 3, 2011, the Oregon Medical Board issued an Order Terminating Board Orders. This Order replaces the October 6, 2011 Order Terminating Board Orders which contained a scrivener's error. This Order terminates Licensee's April 12, 2006 Stipulated Order, his October 7, 2010 Stipulated Order, and his February 17, 2011 Interim Stipulated Order.

***Lhundup, Karma Jampa, LAc AC00845; Portland, OR**

On November 3, 2011, the Board issued an Order Terminating Order of License Suspension. This Order terminates Licensee's May 5, 2011, Order of License Suspension.

***O'Gara, Michael Thomas, DO; DO08605; Gold Beach, OR**

On November 1, 2011, Licensee entered into an Amended Interim Stipulated Order to voluntarily withdraw from the practice of obstetrics, with the exception of emergent situations during emergency room shifts, pending the completion of the Board's investigation into his ability to safely and competently practice in this specialty.

Shergill, Preet Kanwal, MD; MD27755; Vancouver, WA

On November 3, 2011, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to submit a re-entry plan to the Board which is to include weekly meetings with a mentor, and complete 100 hours of CME.

***Staggenborg, Richard Kelly, MD; MD20053; Roseburg, OR**

On November 3, 2011, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of any provision of the Medical Practice Act or any rule adopted by the Board. This Order stipulates that Licensee will surrender his Oregon medical license while under investigation and that Licensee may not reapply for licensure in Oregon for two years.

***Weiner, Marcus Ira, DO; DO29163; Portland, OR**

On November 3, 2011, Licensee entered into a Stipulated Order with the Board. This Order stipulates that Licensee will surrender his Oregon medical license while under investigation.

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)
)
ROBERT PERRY CAMPBELL, MD) *CORRECTED ORDER*
LICENSE NO. MD10884) *TERMINATING BOARD ORDERS*
)

1.

On April 12, 2006, Robert Perry Campbell, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). On October 7, 2010, Licensee entered into a second Stipulated Order with the Board. On February 17, 2011, Licensee entered into an Interim Stipulated Order with the Board. These Orders placed conditions on Licensee's Oregon medical license.

2.

At its meeting on September 1, 2011, The Board voted to enter into a Stipulated Order with Licensee in which Licensee surrendered his license under investigation. The Board therefore terminates the April 12, 2006 Stipulated Order, the October 7, 2010 Stipulated Order and the February 17, 2011 Interim Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 3rd day of November 2011.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

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

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
KARMA JAMPA LHUNDUP, LAc) ORDER TERMINATING ORDER
LICENSE NO. AC00845) OF LICENSE SUSPENSION

1.

On May 5, 2011, the Oregon Medical Board (Board) issued an Order of License Suspension regarding Karma Jampa Lundup, LAc (Licensee). This Order was issued pursuant to ORS 25.750, and Licensee's failure to pay child support. On August 18, 2011, the Board received notification from the Multnomah County District Attorney's office 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 terminate the May 5, 2011 Order of License Suspension, effective the date this Order is signed by the Board Chair and orders that Licensee's license be returned to active status.

IT IS SO ORDERED this 3rd day of November, 2011.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURES REDACTED

RALPH A. YATES, DO
Board Chair

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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 unrestricted 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 and reportable to both the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 1 day of Nov., 2011.

SIGNATURES REDACTED

MICHAEL THOMAS O'GARA, DO

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IT IS SO ORDERED THIS 1st day of November, 2011.

State of Oregon
OREGON MEDICAL BOARD

SIGNATURES REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
RICHARD KELLY STAGGENBORG, MD) STIPULATED ORDER
LICENSE NO. MD20053)

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. Richard Kelly Staggenborg, MD (Licensee) holds an active license to practice medicine in the state of Oregon.

2.

On August 3, 2011, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willfully violate any provision of the Medical Practice Act or any rule adopted by the Board.

3.

Licensee is a Board certified psychiatrist who has practiced in Oregon since June 1996. After leaving his employment as a psychiatrist with the U.S. Department of Veteran Affairs (VA) in March, 2010, Licensee began to practice family medicine in Roseburg, Oregon, with a practice that included the management of patients with chronic pain. The Board subsequently opened an investigation after receiving complaints regarding Licensee's practice of medicine. The acts and conduct that violated the Medical Practice Act follow:

3.1 The Board conducted a review of medical records for Patients A – F. This review revealed a pattern of substandard care in regard to patients managed by Licensee (after he left the

1 VA) that reportedly suffer from chronic pain. Specific concerns include the following: (1)
2 Licensee lacks adequate training and medical knowledge to manage the care and treatment of
3 chronic pain patients; (2) Licensee failed to document an adequate history or physical
4 examination and his chart notes lack objective findings; (2) Licensee failed to document his
5 medical decision-making and failed to address the efficacy of the treatment provided and in
6 follow up clinical visits; (3) Licensee failed to require patients receiving chronic pain
7 medications to undergo periodic urine monitoring tests and failed to conduct periodic pill counts
8 to monitor appropriate medication use; (4) Licensee failed to provide written notice (as required
9 by OAR 847-015-0030) to his patients disclosing material risks associated with controlled
10 substances for the treatment of intractable pain or to obtain their informed consent; (5) Licensee
11 failed to maintain an up to date medication list, as a result, it is difficult to discern how much
12 medication a patient was taking at any given point in time; (6) Licensee wrote overlapping
13 prescriptions of scheduled medications without addressing the risk of over-medication and the
14 possibility of diversion; and (7) Licensee failed to address possible co-morbidities between the
15 Oxycodone he was prescribing and patient concomitant use of medical marijuana as well as
16 prescribed opioids or benzodiazepines.

17 3.2 Specific examples of substandard care include the following:

18 a. Licensee wrote prescriptions for Oxycodone 30 mgs (Schedule II) for Patient A, a
19 58 year old female, on July 19, 2010 for 240 tablets; on July 28th 180 tablets, and on July 30,
20 2010 for 120 tablets, as well as a prescription for 60 tablets of Hydromorphone 4 mgs (Dilaudid,
21 Schedule II) on July 30, 2010. On August 3, 2010, Patient A filled another prescription written
22 by Licensee for 120 tablets of Oxycodone 30 mgs and 60 tablets of Dilaudid 8 mgs after Patient
23 A claimed that her medications had been stolen from her vehicle. In a letter to Licensee dated
24 August 10, 2010, Patient A referred to the recent theft of medications from her vehicle and
25 enclosed a corresponding police report. The police report reflects that Patient A informed the
26 Roseburg police on August 3, 2010, that her car had been broken into while parked at the
27 Roseburg Hospital on August 1, and that four prescription bottles of medications had been
28 stolen. There was no damage to her vehicle and there was no evidence of a break in. A review

1 of the patient record reveals that between August 2, 2010 and September 29, 2010, Licensee
2 prescribed 1,170 tablets of Oxycodone 30 mgs for Patient A. Between November 5, 2010 and
3 November 16, 2010, Licensee prescribed 180 tablets of Oxycodone 30 mgs and 120 tablets of
4 Dilaudid 8 mgs for Patient A. These prescriptions were excessive and exposed Patient A to the
5 risk of harm.

6 b. Patient B, a 25 year old male, presented to Licensee on June 29, 2010 with
7 complaints that included severe lower back pain. Licensee prescribed 180 tablets of Oxycodone
8 30 mgs, two tablets, tid (three times a day). Licensee's chart for this patient includes a pain
9 management flow sheet that has one entry: "oxycodone 30 mg three x's daily". Nevertheless,
10 on July 14, 2010, Licensee increased the prescription to 300 tablets of Oxycodone 30 mg, two
11 tablets, qid (four times a day), and one to two tablets per day for breakthrough pain. Moreover,
12 on August 17, 2010, Licensee increased the prescription to 360 tablets of Oxycodone 30 mgs,
13 two tablets, five times a day, and one or two tablets per day for breakthrough pain. Licensee
14 increased the dosage without documented medical justification. The excessive dosage exposed
15 Patient B to the risk of harm.

16 c. Patient C, a 41 year old male, presented to Licensee with complaints of chronic
17 bilateral knee pain and mild to moderate lower back pain. Licensee's chart note for July 30,
18 2010 reflects that he prescribed Oxycodone 30 mg, two tablets, tid and Methadone (Schedule II)
19 10 mgs bid (twice a day) for breakthrough pain. On August 4, 2010, Licensee prescribed 240
20 tablets of Oxycodone 30 mgs, two tablets qid (four times a day). On August 10, 2010, Licensee
21 prescribed 240 tablets of Oxycodone 30 mgs, two tablets, qid, and Methadone 10 mgs bid. This
22 was followed by successive prescriptions on August 23, September 21, and October 19, 2010 for
23 240 tablets of Oxycodone 30 mgs two tablets, qid and 90 tablets of Methadone 10 mgs tid.
24 These prescriptions were excessive, lacked monitoring and patient follow up, were not supported
25 by Licensee's chart notes, and exposed Patient C to the risk of harm.

26 d. On August 31, 2010, Patient D, an adult male, came to a pharmacy in Eugene,
27 Oregon, with a prescription for 180 tablets of Oxycodone, 30 mg, two tablets, tid that had been
28 signed by Licensee. After verifying the prescription, the pharmacist filled the prescription.

1 Patient D was subsequently observed to leave the pharmacy, enter the passenger side of a parked
2 car in the parking lot, and transfer some tablets of Oxycodone to a person sitting on the driver's
3 side. This person was observed to crush the tablets and snort the powder into his nostrils via a
4 straw. Licensee subsequently received a phone call from the pharmacist, who reported his
5 observations and expressed concern that this patient was diverting controlled substances.
6 Licensee responded by directing repeated invective insults to the pharmacist. During the phone
7 phone call, Licensee's behavior displayed a cavalier disregard to the information provided by the
8 pharmacist and the potential hazard this patient's behavior posed to both the patient and the
9 public. The Board's review has not found a chart note that addresses this call.

10 e. Patient E, a 25 year old female with complaints of migraine headaches, lower
11 back pain and anxiety, presented to Licensee on May 4, 2010. Licensee conducted an
12 examination and prescribed 270 tablets of Oxycodone 15 mgs three tablets, tid and 60 tablets of
13 Diazepam 5 mgs (Valium, Schedule IV). On July 18, 2010, Licensee began prescribing
14 methylphenidate (Ritalin, Schedule II) 10 mgs, two tablets, tid to Patient E. A review of the
15 chart reveals that Patient E requested a new prescription due to incarceration, an alleged theft of
16 a prescription, and requested early refills. Despite these "red flags," Licensee continued to
17 prescribe increasing dosages of controlled substances without medical justification, monitoring,
18 or adequate follow-up. From June – October 2010, Licensee prescribed more than 3,000 tablets
19 of Oxycodone (15 – 30 mgs). On October 12, 2010, Licensee drove from Roseburg, Oregon to
20 the Costco pharmacy in Salem, Oregon, and wrote a "counter prescription" for 360 tablets of
21 Oxycodone, 30 mgs, two tablets, six times a day. Licensee stated that the patient would come by
22 later that day to pick up the medication. Patient E came by later that day (about 6:20 p.m.), but
23 the pharmacist did not fill the prescription. Licensee was observed to be with Patient E in the
24 Costco parking lot after Patient E left the pharmacy. Licensee's conduct displayed poor
25 judgment and exposed this patient to the risk of harm.

26 f. Licensee displayed poor judgment by meeting with Patient F (an adult female
27 residing in Roseburg) in Eugene, where he wrote a "counter prescription" for Oxycodone on or
28 about October 15, 2010. Licensee could not provide verification of his medical license, so the

1 pharmacist refused to fill the prescription. Licensee was subsequently observed to meet with
2 Patient F outside of the pharmacy and walk with her next door to Safeway.

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 neither admits nor denies, but the Board finds that he engaged in the
9 conduct described in paragraph 3, and that this conduct violated ORS 677.188(4)(a); ORS
10 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willfully violate any
11 provision of the Medical Practice Act or any rule adopted by the Board. Licensee understands
12 that this Order is a public record and is a disciplinary action that is reportable to the National
13 Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and the Federation of
14 State Medical Boards.

15 5.

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

18 5.1 Licensee surrenders his license to practice medicine while under investigation.

19 5.2 Licensee may not apply for a license to practice medicine with this Board until
20 two years have elapsed from the date this Order is signed by the Board Chair.

21 5.3 This Order terminates Licensee's Voluntary Limitation of July 25, 1996, and
22 Licensee's Interim Stipulated Order of October 21, 2010, effective the date this Order is signed
23 by the Board Chair.

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

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
MARCUS IRA WEINER, DO) STIPULATED ORDER
LICENSE NO. DO29163)

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. Marcus Ira Weiner (Licensee) is a licensed physician (suspended) in the State of Oregon.

2.

On April 22, 2011, the Board opened an investigation after receiving notification that Licensee had been terminated from employment at a health care clinic in Washington State. The Board investigation determined that there was credible evidence which raised concerns about Licensee's ability to safely practice medicine, due to impairment.

3.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of this Order in the Board's records. Licensee desires that his license be surrendered while under investigation relating to alleged violations of ORS 677.190(7) Impairment as defined in ORS 676.303. Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

1 4.

2 Licensee and the Board agree that the Board will close this investigation and resolve this
3 matter by entry of this Stipulated Order, subject to the following conditions:

4 4.1 Licensee will surrender his Oregon medical license and cease from practicing any
5 form of medicine, effective the date the Board Chair signs this Order. Licensee will not practice
6 any form of medicine, whether paid or volunteer, including writing prescriptions for patients
7 and/or relatives and conducting examinations or chart reviews for administrative agencies.

8 4.2 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(18).

10 5.

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

12
13 IT IS SO STIPULATED this 10 day of 3/11 2011.

14
15 SIGNATURE REDACTED

16 MARCUS IRA WEINER, DO

17 IT IS SO ORDERED this 3rd day of November 2011.

18 BOARD OF MEDICAL BOARD

19 SIGNATURES REDACTED

20 RALPH A. YATES, DO
21 Board Chair