Oregon Medical Board
Report

Volume 125, No. 1 Winter 2013 www.oregon.gov/OMB

The mission of the Oregon Medical Board is to protect the health, safety and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

The Pendulum of Chronic Opioid Therapy

Doctors I speak to about chronic pain management sometimes express confusion or irritation about what they perceive to be a reversal of expectations regarding the prescribing of opioids for chronic non-cancer pain. Indeed, following state laws permitting this practice in the 1990s and the promotion of pain as a "fifth vital sign," physicians met perceived expectations by patients and regulators by learning new skills to safely prescribe these medications. Now many doctors perceive a reversal of expectations by state regulators and struggle to explain a change in prescribing behavior to patients.

Why the reversal?

Long-term opioid use for non-cancer pain seems not to be as "safe and effective" as we had hoped, and there was no way of knowing that when we undertook this path since studies of opioids for chronic non-cancer pain were generally of six months duration or less. Regarding safety, patients receiving more than 100 mg/day morphine (or bioequivalent) have a nine time risk of overdose (1.8% annually) compared to those receiving 20 mg/day or less.[1] Twelve percent of these are fatal. In addition, patients can expect about a 30% reduction in their pain score,[2] far less than they hope for.

Dose limitations

One approach to mitigate risk is to limit the daily amount prescribed. Data is not yet available to measure the impact of the State of Washington 2010 law requiring consultation for patients receiving more than 120 mg-equivalents of morphine daily. While an arbitrary threshold, Canada specifies 200 mg as the "watchful dose." Some patients will benefit from a higher dose, and prescribing more is justifiable if function can be documented to improve and there is no aberrant behavior.

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Statement of Purpose:

The OMB report is published to help promote medical excellence by providing current information about laws and issues affecting medical licensure and practice in Oregon.

The Pendulum of Chronic Opioid Therapy

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Populations at risk

Two groups of patients at risk for a poor outcome from chronic opioids are those with a history of substance abuse and those with mental illness. It is common sense to recommend abstinence from substances to which our patients have been addicted. Yet the very drugs we prescribe for pain place the patient at risk for relapse by stimulating the reward center that promotes addiction. Because aberrancy occurs in 50% of these patients,[3] I recommend prescribing opioids to them only when they are enrolled in an active treatment program (i.e. AA or NA). Patients with inadequately treated depression may be tempted to overdose; patients with anxiety may be tempted to overuse to treat psychological discomfort.

Benzodiazepines and Marijuana

For different reasons, I advise against concurrent chronic opioids and either benzodiazepines or marijuana. Benzodiazepines and alcohol markedly increase the risk of overdose. The proliferation of state laws permitting medical and recreational use of marijuana make some physicians uncomfortable saying "No" to marijuana. Patients who request marijuana generally do so for "mood modulation." It doesn't make sense to me to add a drug to a pain regimen that has the analgesic properties of 50 mg of codeine[4] when it already includes much more potent opioids. Patients should choose between marijuana and opioids, and I'm always surprised how many opt for the former.

Detection of aberrancy

In that regard, urine drug screening becomes important, though the evidence supporting the effectiveness of urine drug screening overall is weak.[5] Detection of aberrant drug use is challenging and beyond the scope of this article, but lost prescriptions are an early red flag.

The Pendulum of Chronic Opioid Therapy

Having the conversation

Maintaining a therapeutic alliance while enforcing limits can be difficult. Being clear and consistent about boundaries is harder for some doctors than others, especially those who feel that saying "No" is choosing to let the patient suffer. Teasing out the personal challenges can be a rewarding experience and often bears fruit in general relationships beyond medicine. Building interviewing skills is much more challenging than learning facts and takes time – I'm still working on it.

Here are some suggestions about challenging moments:

I am changing the rules after years of having done it differently. I regularly update my knowledge, and given recent data, I feel it is in my patients' best interest to change my approach. (After all, you do the same for heart failure!)

You're covering for someone who prescribes differently. I can't address how Dr. X practices; I can only do what I think is in my patient's best interest.

A patient comes to you on high dose opioids and has run out. Make it a practice not to prescribe on the first visit. Consider posting signs or having your scheduler inform all patients when they call for a first appointment. You have to get records to know what you're dealing with. The patient's poor planning is his problem, not yours.

Here are some suggestions about the therapeutic stance:

- Be non-judgmental. Every person has equal value as a human being. Your patient may have made some bad choices in life, but he or she is in your office for help and is suffering on some level.
- There's no reason to get angry. There are two reasons I commonly see anger in physicians. First, they want a better outcome for the patient, but the patient makes bad choices, thus limiting the physician's ability to help. I remind myself that the patient's behavior is about him or her, and I have no control over that. The other is that doctors feel manipulated or taken advantage of. I remind myself that I am in complete control of my choices.

Conclusion: Prescribing opioids safely and effectively presents a challenge similar to treating other complex medical problems like obesity and tobacco abuse. The discussions we have with patients about opioid pain medications need to be as careful as those involving sexuality and screening for domestic violence. ✚

Written by Barry Egener, MD, Medical Director, The Foundation for Medical Excellence

Please read the full *Report* for all the Board's news and ways to improve your practice. Previous issues of the *Report* can be found at **www.oregon.gov/OMB/newsltr.shtml.**

[1]*Dunn, K.M. et al. Opioid prescriptions for chronic pain and overdose. Ann Intern Med. 2010; 152:85-92.*

[2]*Kalso, E. et al. Opioids in chronic non-cancer pain: systematic review of efficacy and safety. Pain. 2004;112:372-380.*

[3]*Dunbar, S.A. and Katz, N.P. Chronic opioid therapy for nonmalignant pain in patients with a history of substance abuse: report of 20 cases. J Pain Symptom Manage. 1996:11:163-171.*

[4]*Campbell, F. A. et al. Are cannabinoids an effective and safe treatment option in the management of pain? A qualitative systematic review. BMJ. 2001;323:1-6.*

[5]*Starrels, J.L. Systematic review: treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. Ann Intern Med. 2010;152:712-720.*

Statement of Philosophy: Pain Management

The OMB urges the skillful use of effective pain control for all patients. It is important for providers to be well-informed on relevant pain management techniques and hone their skills for the optimal treatment of their patients, taking into account the etiology of the pain. Types of pain include, but are not limited to, acute post-operative or traumatic pain, chronic non-cancer pain, chronic pain caused by malignancies and pain associated with terminal illness. Providers are encouraged to treat pain within the scope of their practice and refer patients to the appropriate specialists when indicated.

Acute Pain

Effective treatment of acute pain promotes recovery and return to normal function. The potential for addiction is low when short courses of opioids are used to treat acute pain and discontinued as the patient recovers. Inadequately managed acute pain may result in chronic pain. Patients who are not recovering as expected must be carefully assessed. Skillful pain management techniques including oral, parenteral and, when available, regional pain management techniques, can achieve maximum patient comfort and may reduce the need for opioids.

Chronic Pain

Patients with chronic pain require complex care and treatment decisions for multi-faceted problems. Providers have a responsibility to diagnose and manage chronic pain while maximizing the benefits and minimizing the potential adverse effects of treatment. Opioids are not always required or effective for the treatment of chronic pain, and they should be discontinued if the patient's pain control or function does not improve with their use. Pain management treatment must be evidence-based and individualized to the patient. Oregon statute protects providers from disciplinary action by the Board when prescribing or administering controlled substances as part of a treatment plan for pain with the goal of controlling the patient's pain for the duration of the pain. However, prescribing controlled substances without a legitimate medical purpose is prohibited.

Patient safety should be a key factor in determining a treatment plan for pain management. When the provider prescribes opioids as part of the treatment plan, the provider must consider drug safety, efficacy and treatment goals for the patient. Safe opioid prescribing requires knowledge of the pharmacology of various opioid classes, and of potential drug interactions. Opioids are most likely to be successful in reducing pain and restoring function when they are combined with other pain management approaches such as physical therapy and psychological techniques.

When prescribing opioids for chronic pain, Oregon law requires practitioners to provide careful assessment and documentation of the medical condition causing pain as well as co-morbid medical and mental health conditions.

Statement of Philosophy: Pain Management

Goals for treatment should be established with the patient before prescribing opioids. The provider's assessment, diagnosis and discussion must be documented in the patient record. The diagnosis, drugs used, goals, alternatives, and side effects must be included in a signed document demonstrating consent and understanding of the treatment plan and its risks. A sample document may be found at **www.oregon.gov/OMB/pdfforms/materialrisknotice.pdf**. In addition to the signed informed consent document, a written patient-provider agreement is recommended for patients requiring opioids for chronic pain. In all cases of pain management, practitioners should maintain records to track prescriptions and coordinate care with other treating practitioners.

The OMB recommends enrollment and participation in the Oregon Prescription Drug Monitoring Program (PDMP), a division of the Oregon Health Authority, to help guide treatment plans. The PDMP is a database that allows prescribers of controlled substances to access a patient's name, the controlled substance prescribed, the dosage, and the name and contact information of the prescriber.

Terminal Illness

The OMB believes that physicians should make every effort to relieve the pain and suffering of their terminally ill patients. Patients nearing the end of their lives should receive sufficient opioid dosages to produce comfort. The physician should acknowledge that the natural dying process usually involves declining blood pressures, decreasing respirations and altered levels of consciousness. Opioids should not be withheld on the basis of physiologic parameters when patients continue to experience pain. Some physicians express concerns that the use of opioids in these patients may hasten death through pneumonia or respiratory depression. For these reasons, at times physicians may have limited the use of opioids in dying patients out of fear that they may be investigated for inappropriate prescribing or allegations of euthanasia.

The OMB is concerned that such fear on the part of physicians may result in inadequate pain control and unnecessary suffering in terminally ill patients. The OMB encourages physicians to employ skillful and compassionate pain control for patients near the end of life and believes that relief from suffering remains the physician's primary obligation to these patients. ✚

Amended January 2013

Committee Opening

The Board's **Emergency Medical Services (EMS) Advisory Committee** is seeking a physician member and a public member.

The Committee develops the scope of practice for EMS providers in Oregon. It is composed of three EMS providers, two physicians and one public member. The term of office is three years. Committee meetings occur quarterly, with additional meetings or conference calls if necessary.

Applicants must submit a curriculum vitae and letter of intent. Interested parties may contact the Board at 971-673-2700 or log on to **www.oregon.gov/OMB/pages/ccmvacancies.aspx**. ✚

Board Actions

October 13, 2012, to January 11, 2013

Many licensees have similar names. When reviewing Board Action details, please review the record carefully to ensure that it is the intended licensee.

Interim Stipulated Orders

*These actions are not disciplinary because they are not yet final orders, but are reportable to the national data banks.**

LEE, Anthony H., MD; MD15438
Beaverton, OR

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

Disciplinary Actions

*These actions are reportable to the national data banks.**

BALOG, Carl C., MD; MD19519
Portland, OR

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

FIELD, Frederick G., MD; MD26105
The Dalles, OR

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

FORSYTH, Ashley W., DO; DO14953
Newport, OR

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

GAGE, Arden J., Jr., PA; PA01226
Klamath Falls, OR

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

GOERING, Edward K., DO; DO19450
Portland, OR

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

HATLESTAD, Christopher L., MD; MD24066
Portland, OR

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

LINDBERG, John F., MD; MD12005
Lebanon, OR

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

ROBERTS, Charles A., PA; PA00257
Veneta, OR

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

YANKEE, Joseph E., DO; DO19458
Milwaukie, OR

On October 25, 2012, the Board issued a Default Final Order for unprofessional or dishonorable conduct, gross or repeated acts of negligence, willfully violating any rule adopted by the Board or any Board Order or any Board request and prescribing controlled substances without a legitimate medical purpose, or prescribing without following

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accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order revokes Licensee's license to practice medicine in Oregon, assesses a civil penalty of $10,000, and assesses the costs of the contested case hearing.

Prior Orders Modified or Terminated

COLLINS, Elbert C., MD; MD14732
Grants Pass, OR

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

DURAN, Michael G., MD; MD27904
Kingman, AZ

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

FRITTS, Julia A., LAc; AC151342
Corvallis, OR

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

HOFFMAN, Gregory R., MD; MD22890
Sandy, UT

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

KAST, John M., MD; MD23327
Portland, OR

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

MANN, Thomas W., MD; MD06385
Eugene, OR

On October 29, 2012, the Board issued an Order Terminating Order of License Suspension. This Order terminates Licensee's July 31, 2012, Order of License Suspension.

MARJANOVIC, Danijela M., MD; MD12634
Roseburg, OR

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

MASLONA, Andrew R., MD; MD28259
Coos Bay, OR

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

McCLUSKEY, Edward A., MD; MD18356
Gresham, OR

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

REDWINE, David B., MD; MD09578
Bend, OR

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

SKOTTE, Daniel M., DO; DO13485
Sunriver, OR

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

STRAUMFJORD, Marianne, MD; MD07575
Bend, OR

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

Non-Disciplinary Board Actions

October 13, 2012, to January 11, 2013

Corrective Action Agreements

*These agreements are **not disciplinary** Orders and are not reportable to the national data banks* unless related to the delivery of health care services or contain a negative finding of fact or conclusion of law. These are public agreements with the goal of remediating problems in the licensees' individual practice.*

GAEKWAD, Satyajeet Y., MD; MD26995
Albany, OR

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

HARSANY, Robert M., MD; MD10669
Portland, OR

On January 10, 2013, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, he agreed to complete a course on urogynecology.

THOMAS, Paul N., MD; MD15689
Portland, OR

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

Consent Agreements

*These actions are not disciplinary and are not reportable to the national data banks.**

FEINMAN, Jessica A., MD; MD154687
Wilsonville, OR

On December 6, 2012, Licensee entered into a Consent Agreement with the Board. In this Agreement, she agreed to complete 26 hours of CME and submit a re-entry to practice plan to include a mentor.

HAHN, Suzanna S., MD; MD156788
Portland, OR

On December 6, 2012, Licensee entered into a Consent Agreement with the Board. In this Agreement, she agreed to practice in accordance with the submitted re-entry plan, maintain treatment with her healthcare provider and have her employer submit a report to the Board detailing her professional development after one year.

Current and past public Board Orders are available on the OMB website:
www.oregon.gov/OMB/Pages/bdactions.aspx ✚

**Data Bank (National Practitioner and Healthcare Integrity & Protection), and Federation of State Medical Boards (FSMB).*

Oregon Administrative Rules

Rules proposed and adopted by the Oregon Medical Board.

The Oregon Medical Board and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be amended in response to evolving standards and circumstances. OARs are written and amended within the agency's statutory authority granted by the Legislature.

Rules go through a First and Final Review before being permanently adopted. Temporary rules are effective after First Review, but they expire in 180 days unless permanently adopted after a Final Review. The full text of the OARs under review and the procedure for submitting comments can be found in the Secretary of State Bulletin, available at: **http://arcweb.sos.state.or.us/banners/rules.htm.**

Proposed Rules

First Review

All Licensees

847-008-0068: State and Nationwide Criminal Records Checks, Fitness Determinations – Moves (renumbers) the rule on criminal records checks from Division 020 to Division 008 to accurately show that it applies to all Board applicants and licensees and clarifies that the submitted fingerprints must be legible.

847-012-0000: Patient's Access to Medical Records – Clarifies that electronic information is also "health information" for the purpose of these rules and corrects statutory references due to amendments and renumbering of the implemented Oregon Revised Statutes.

Physicians (MD/DO/DPM)

847-015-0025: Dispensing Physicians and Podiatric Physicians – Establishes documentation standards for drugs dispensed, distributed or administered; clarifies that distribution, as defined by the Board of Pharmacy, is distinct from dispensing; and clarifies that a physician supervising a physician assistant with drug dispensing authority without first registering as a dispensing physician is a violation of the rule.

847-017-0000 through 847-017-0040: Office-Based Surgery – Classifies levels of office-based surgeries and sets forth the corresponding requirements; reorganizes and adds new definitions; establishes a standard of practice for licensees performing office-based surgery; sets forth requirements for office-based surgery facilities; clarifies the assessment and informed consent procedures prior to the performance of an office-based surgery; clarifies the requirements for patient medical records; expands the emergency care and transfer protocol requirements; requires reporting of specified office-based surgical adverse events; and contains general grammar and language housekeeping changes.

847-020-0100 through 847-020-0200: Rules for Licensure to Practice Medicine in Oregon – Reorganizes the rules in Division 020 to be more concise and updates the rules to reflect a simplified application process that has evolved with advancements in technology and availability of electronic documents; streamlines the definitions; clarifies the requirements for a license after the first post-graduate year; removes the requirement for licensing staff to verify the accreditation of each medical school clerkship for international graduates; removes contradictory language about postgraduate training requirements for international graduates; removes the discussion of the Limited License

Visiting Professor in favor of its primary location in OAR Chapter 847, Division 010; requires documents in a foreign language to be submitted with an official translation; removes references to a paper application form; revises the requirements for a photograph so that it may be submitted digitally; updates the name of the Practitioner Self-Query for the data banks; includes fingerprints within the rule on documents to be submitted for licensure; clarifies that the Board may ask for additional documents regarding information received during the processing of the application; clarifies that a Verification of Medical Education form must include dates of attendance; includes the ECFMG certificate among the documents that must be sent to the Board from the source; clarifies that license verifications are required from international licensing boards in addition to licensing boards within the United States; reorganizes the list of examinations that may be used to apply for licensure; adds an "extenuating circumstances" waiver for the requirement that USMLE or NBOME must be passed within seven years; adds a "board certification" waiver for the requirement that the FLEX examination must be passed within four attempts; incorporates licensing examinations administered by other state boards among the examinations accepted by the Board for licensure based upon reciprocity and repeals the independent rule addressing the issue; and simplifies the discussion of the Limited License SPEX by referring to the rule describing this license status in OAR Chapter 847, Division 010.

Emergency Medical Service Providers (EMS)

847-035-0011: EMS Advisory Committee – Adds a position for a public member to the EMS Advisory Committee.

847-035-0030: Scope of Practice – Adds "intramuscular injection" of epinephrine to the scope of practice for an EMT; removes the subsection related to the release of chemical warfare agents from the Umatilla Army Depot; and requires that all Emergency Medical Responders (formerly First Responders) have standing orders from an approved supervising physician (agency medical director). The category of Emergency Medical Responders without standing orders will be eliminated by this proposed rule amendment; there will be no scope of practice that an Emergency Medical Responder can perform without standing orders. The former scope of practice for these Emergency Medical Responders will now be included within the scope of practice for Emergency Medical Responders with standing orders.

Temporary Rules

First Review, Temporarily Adopted

All Licensees

847-008-0040: Process of Registration – Reflects the Board's online registration renewal process and the Board's provision of certificates of registration electronically rather than by mail and reorganizes the subsections, streamlines the language, and contains general grammar and housekeeping changes.

Adopted Rules

Final Review

All Licensees

847-008-0065: Use of Name – Clarifies the definition and proof of legal name for the purposes of licensing.

847-008-0010: Initial Registration – Adds a fine for violating ORS 677.190(8), providing false, misleading or deceptive information on an application for licensure.

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Oregon Administrative Rules

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Physician Assistants (PA)

847-050-0027: Approval of Supervising Physician – Adds a fine for failure to apply and be approved as a supervising physician by the Board prior to using the services of a physician assistant under a practice agreement.

847-050-0041 and 847-050-0065: Prescribing and Dispensing Privileges; Duties of the Committee – Implements 2012 Senate Bill 1565 related to physician assistant dispensing, corrects the reference to oral issuance of Schedule II drugs, and contains general language and grammar housekeeping.

*For more information on OARs, visit the Oregon Medical Board website at **www.oregon.gov/OMB**, or call 971-673-2700.* ✚

Apply to Become a Member of the Oregon Board of Medical Imaging

The OBMI needs official members who are:

Licensed Physicians
Licensed Medical Imaging Professionals
Members of the Public

"Promoting public health through the safe and effective practice of medical imaging"

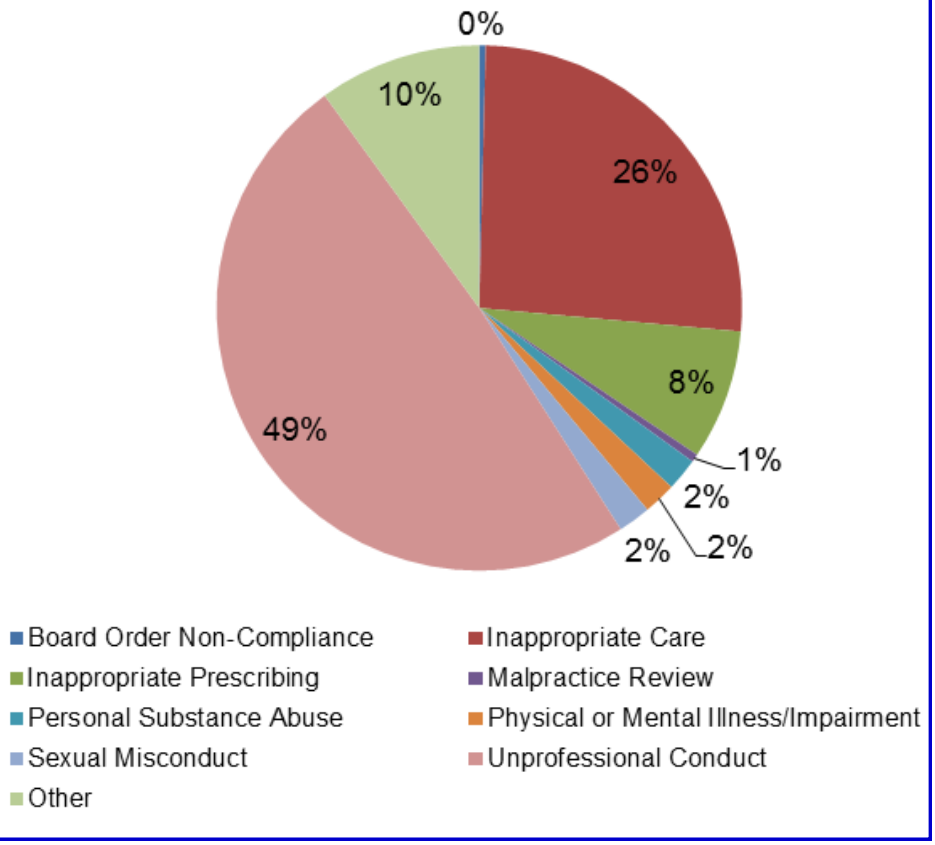
Apply through the Governor's Office at:
www.oregon.gov/gov/pages/boards.aspx

Contact the OBMI if you have questions!
971-673-0216 or **ed.conlow@state.or.us**
OBMI Website: **www.oregon.gov/obmi**

Annual Statistics

OMB staff is continually preparing for and wrapping up Board and Committee meetings. For example, the Investigative Committee met eleven times last year, each meeting spanning ten hours. One contested case hearings were held, each taking two to three days after months of preparation. Investigations staff and the state Attorney General's Office prepared for an additional five hearings that settled before the scheduled date. Each Board meeting requires Board members to read, and staff to compile, over 8,000 pages of material. The following statistical report is a snapshot of the resulting work.

Categories of Complaints (Investigations)



Annual Investigative Statistics

Investigations totals as of December 31, 2012

Inquiries Received	2010	2011	2012
Preliminary Phone Calls	2,446	2427	2127
Preliminary E-mails	149	187	149
Written Complaints*	712	799	757

**Only written complaints may result in an investigation.*

Source of Investigations	2010	2011	2012
Oregon Medical Board	52	50	52
Board or HPSP Non-Compliance	20	2	0
Hospital or Other Health Care Institution	19	37	30
Insurance Company	4	3	8
Malpractice Review	20	19	27
Other	36	85	75
Other Boards	6	10	5
Other Health Care Providers	37	56	65
Patient or Patient Associate	165	442	448
Pharmacy	11	6	7
Self-Reported	14	26	21

Final Dispositions of Investigations		2010	2011	2012
No Violations	No Apparent Violation	80	327	383
	No Violation/Preliminary Investigation	N/A	133	105
	No Violation/Prior to Committee Appearance	107	78	69
	No Violation/Post Committee Appearance	11	10	11
	Letter of Concern	60	80	107
	No Violation/App Withdrawal w/Report to Federation	5	7	2
	Temporarily Closed	2	12	1
Public Orders	Corrective Action Agreement	7	10	17
	Stipulated Order **	29	41	39
	Voluntary Limitation **	4	3	2
	Consent Agreement	N/A	2	8
	Final Order (includes Default Final Orders)**	9	13	7
Total	Investigations Opened	378	744	757
	Investigations Closed	314	709	761
	Contested Case Hearings	3	3	1
	Investigative Committee Interviews	76	65	74
	Investigations Closed with Public Orders	49	69	73
	**Reportable Orders (National Databases)	42	57	48

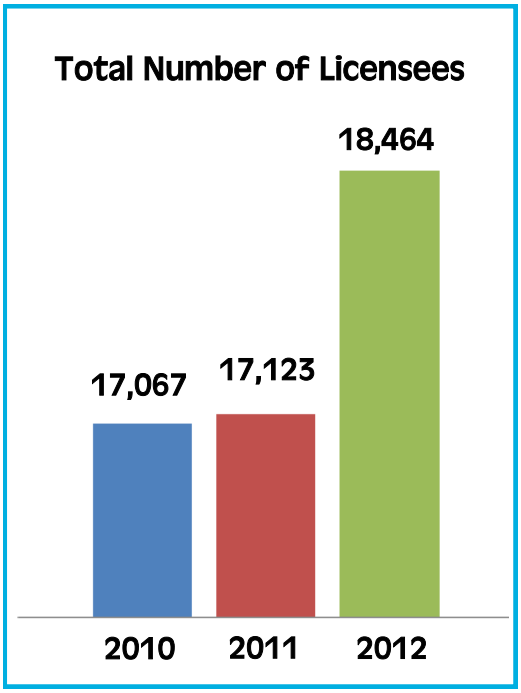
Annual Licensing Statistics

Number of Licensees as of December 31, 2012

Doctors of Medicine (MD)	2010	2011	2012
Active	10,546	10,389	11,203
Inactive	1,659	1,322	1,485
Emeritus	491	448	396
Locum Tenens	369	331	349
Limited (all types)	683	752	1,160
Total	**13,748**	**13,242**	**14,593**

Doctors of Osteopathy (DO)	2010	2011	2012
Active	706	734	850
Inactive	112	93	102
Emeritus	8	9	8
Locum Tenens	32	28	35
Limited (all types)	80	94	134
Total	**932**	**958**	**1,129**

Podiatric Physicians (DPM)	2010	2011	2012
Active	161	154	166
Inactive	18	17	18
Emeritus	0	0	0
Locum Tenens	1	1	0
Limited (all types)	9	9	11
Total	**189**	**181**	**195**



Physician Assistants (PA)	2010	2011	2012
Active	1,010	1,046	1,238
Inactive	74	53	47
Emeritus		2	0
Locum Tenens	0	0	3
Limited (all types)	2	1	1
Total	**1,086**	**1,100**	**1,289**

Acupuncturists (LAc)	2010	2011	2012
Active	1,032	1,140	1,173
Inactive	64	66	65
Emeritus	0	1	6
Locum Tenens	10	13	12
Limited (all types)	0	0	2
Total	**1,106**	**1,119**	**1,258**

Annual Licensing Statistics

Licensees by County as of December 31, 2012

County (Seat)	MDs	DOs	DPMs	PAs	LAcs	Total	Population
Baker **(Baker City)**	83	7	1	9	1	**101**	**16,210**
Benton **(Corvallis)**	399	54	4	56	29	**542**	**86,785**
Clackamas **(Oregon City)**	1,195	118	20	85	94	**1,512**	**381,680**
Clatsop **(Astoria)**	171	8	2	17	6	**204**	**37,190**
Columbia **(St. Helens)**	38	2	0	17	8	**65**	**49,680**
Coos **(Coquille)**	219	16	6	11	8	**260**	**62,890**
Crook **(Prineville)**	29	5	1	8	2	**45**	**20,650**
Curry **(Gold Beach)**	57	8	1	6	2	**74**	**22,295**
Deschutes **(Bend)**	631	47	10	118	60	**866**	**160,140**
Douglas **(Roseburg)**	328	49	7	30	7	**421**	**108,195**
Gilliam **(Condon)**	6	0	0	3	0	**9**	**1,900**
Grant **(Canyon City)**	18	0	0	1	2	**21**	**7,450**
Harney **(Burns)**	35	0	0	2	0	**37**	**7,315**
Hood River **(Hood River)**	118	8	4	13	19	**162**	**22,875**
Jackson **(Medford)**	761	76	13	72	62	**984**	**204,630**
Jefferson **(Madras)**	38	1	2	4	2	**47**	**21,940**
Josephine **(Grants Pass)**	215	30	4	27	17	**293**	**82,775**
Klamath **(Klamath Falls)**	262	19	3	18	6	**308**	**66,740**
Lake **(Lakeview)**	22	2	0	2	0	**26**	**7,920**
Lane **(Eugene)**	1,339	75	17	115	76	**1,622**	**354,200**
Lincoln **(Newport)**	137	21	3	18	10	**189**	**46,295**
Linn **(Albany)**	261	30	3	23	7	**324**	**118,035**
Malheur **(Vale)**	119	20	5	41	0	**185**	**31,395**
Marion **(Salem)**	1,084	70	16	119	44	**1,333**	**320,495**
Morrow **(Heppner)**	15	0	0	9	0	**24**	**11,300**
Multnomah **(Portland)**	6,193	332	44	436	730	**7,735**	**748,445**
Polk **(Dallas)**	120	29	3	20	5	**177**	**76,625**
Sherman **(Moro)**	5	0	0	0	0	**5**	**1,765**
Tillamook **(Tillamook)**	94	3	1	8	4	**110**	**25,305**
Umatilla **(Pendleton)**	245	28	5	18	1	**297**	**77,120**
Union **(La Grande)**	122	9	0	1	3	**135**	**26,175**
Wallowa **(Enterprise)**	28	0	0	1	3	**32**	**7,015**
Wasco **(The Dalles)**	148	15	0	17	7	**187**	**25,485**
Washington **(Hillsboro)**	1,887	92	30	222	145	**2,376**	**542,845**
Wheeler **(Fossil)**	9	0	0	6	0	**15**	**1,425**
Yamhill **(McMinnville)**	274	17	7	19	14	**331**	**100,550**
None/Not Applicable	268	17	1	8	13	**307**	**0**

Some licensees have more than one practice location. Every practice location registered with the Board is included in the county totals above.

Oregon Medical Board
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OFFICE CLOSURES

The OMB Offices will be closed and unavailable to provide licensee support on the below dates.

2013 State Agency Furloughs

Friday, April 19

Friday, May 24

2013 Holidays

Memorial Day
Monday, May 27

Independence Day
Thursday, July 4

Labor Day
Monday, September 2

Veteran's Day
Monday, November 11

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CALENDAR OF MEETINGS

March 7, 7:30 a.m.
Investigative Committee

March 7, 5 p.m.
Legislative Advisory Committee

March 13, 5 p.m.
Administrative Affairs Committee

March 14, 9:30 a.m.
Physician Assistant Committee

April 4 - 5, 8 a.m.
Board Meeting

May 2, 7:30 a.m.
Investigative Committee

May 3, 9 a.m.
EMS Advisory Committee

June 6, 7:30 a.m.
Investigative Committee