

BEFORE THE
BOARD OF NATUROPATHIC EXAMINERS
STATE OF OREGON

In the Matter of the License of)	Case No. N07-12-17
)	
SHANDOR WEISS, N.D.,)	AMENDED NOTICE OF INTENT
Licensee)	TO DISCIPLINE AND RIGHT TO A HEARING

1.

The Board of Naturopathic Examiners (Board) is the state agency responsible for licensing, regulating and disciplining naturopathic physicians in the State of Oregon. Shandor Weiss, N.D., (Licensee) is a licensed naturopathic physician currently practicing in Ashland, Oregon, and is subject to the jurisdiction of the Board.

2.

The Board conducted an investigation based on a complaint received in regards to Licensee. Based on the results of the investigation and pursuant to ORS 685.110 and OAR 850-050-0010(1) and (2), the Board hereby proposes to revoke Licensee's license to practice naturopathic medicine, on the grounds described in the following paragraphs.

3.

Patient A. In September 2006 and from approximately October 27, 2007 to November 16, 2007, licensee consulted with and treated Patient A. Licensee was a long-time personal acquaintance of Patient A. Patient A did not live in Ashland at the time of her first phone consultation with Licensee. Licensee advised Patient A to move to Ashland for treatment rather than refer the patient to a local provider.

4.

Licensee is an N.D. and a licensed acupuncturist. Licensee does not have specialized training in the field of mental health. Patient A had a prior history of severe depression, and had been under psychiatric care before consulting with Licensee. On or about November 16, 2007, Patient A attempted suicide and was seriously injured in the attempt.

5.

Licensee advised Patient A in September 2006 that drug prescriptions were highly detrimental for use. Patient A discontinued use of Prozac 2 and stopped taking Lexapro. Licensee did not encourage Patient A to continue either medication. Licensee treated Patient A with non-drug therapy treatment without adequate time for withdrawal of drug therapy.

6.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. Licensee diagnosed Patient A using a "test" to conclude Patient A had suffered a brain injury in childhood. Licensee treated Patient A with the use of an Infratonic 8000 machine and neurofeedback. Licensee concluded during treatment that Patient A's threat to commit suicide was a "lie."

7.

Licensee did not contact Patient A's prior mental health providers or obtain copies of their records. Licensee did not appropriately refer Patient A to a mental health specialist during treatment in Ashland or upon Patient's A's return to Portland.

8.

Based on the facts alleged in the paragraphs above, Licensee violated ORS 685.110(6) by treating Patient A when he lacked the specialized training and education to provide all necessary care. Violation of ORS 685.110(6) is grounds for discipline.

9.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient A, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

10.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). In addition, failure to refer a patient when referral is appropriate is a violation of OAR 850-050-0010(1)(c)(D). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

11.

Licensee presented himself to Patient A or Patient A's family as a medical specialist in diagnosing and treating difficult cases and conditions, rather than a general practitioner. Licensee presented himself as having greater diagnostic skills than other providers. Representing that a licensee is a medical specialist or practices a medical specialty is a violation of ORS 685.110(22). Claiming to have greater skill than fellow physicians is a violation of OAR 850-050-0190(7). Violation of ORS 685.110(22) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

12.

During consultation or treatment, Licensee advised Patient A that he could cure her condition. Patient A suffered from depression. Representing to a patient that a manifestly incurable condition can be permanently cured is a violation of ORS 685.110(14), and the guarantee of any cure or results from treatment is a violation of OAR 850-050-0190(10). Violation of ORS 685.110(14) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

13.

Licensee's diagnosis and treatment of Patient A was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

14.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis, treatment plan, and communications with Patient A and Patient A's family constitute dishonorable or unprofessional conduct.

15.

Patient B From approximately February 22, 2008 through July 30, 2008, Patient B sought treatment from Licensee. Patient B resides in Hillsboro, Oregon. Chart notes from the initial office visit indicate that, Patient B, who was 48 years old, felt sick and had chronic fatigue since 1995. He had pneumonia and a high fever for two weeks when he was 15 years old. Chart notes for that visit list symptoms that include "nerves" and "can't sit still, thinks rest etc". Patient B was taking amoxicillin and fluconazole for a cyst that ruptured in his abdomen, Lorazepam for nerves, and had been taking Dextrostat for eight years for attention deficit disorder (ADD). Patient B indicated during his office visit that he took a test for Lyme disease with a doctor in Portland in early 2008 or late 2007 and it was negative showing no antibodies.

16.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. Licensee's chart notes indicate that on March 17, 2008, Licensee conducted "tests". Patient B was not in Licensee's office. Licensee's email to the patient on June 4, 2008 describes his services as including "distant testing". Licensee's March 17, 2008 chart notes then state

methicillin-resistant Staphylococcus aureus (MRSA) is a cause of Patient B's symptoms. Licensee also attributes attention deficit hyperactivity disorder (ADHD) to fevers Patient B had at age 15. Licensee filled out a US Department of Labor Family and Medical Leave Act form indicating Patient B has a "chronic lymes infection" since November 2007. There are no objective findings or medical records to support Licensee's findings.

17.

Licensee's March 17, 2008 chart notes conclude that Patient B's diagnosis is "CFS/IDS" and the overall diagnosis is a "Spirit disease". An email to Patient B states:

The main problem is what the Tibetans call a spirit, or demonic disease. The Reiki teacher transmitted this to you. This teacher was an incarnate demon. The original cause was in a past life, however, that is not important now. It is not like you did something bad; it is more like someone bad wanted you to keep from doing something good. In fact all your health problems and obstacles in this life can be seen in this context. * * *That is why you have these health problems. The "cure" is very simple; you need to get back on track. To do this you need 3 things:

- 1.) Me telling you to do it.
- 2.) You doing it.
- 3.) Neurofeedback and then medicine.

These 3 things will get you on the right track. Being on the right track is the "cure." Your immune system will recover simply by your life going in the right direction. * * *

18.

Licensee's March 17, 2008 chart notes further state that Patient B's ADHD can be cured with neurofeedback and that could be in two days with four sessions a day. An email to Patient B states, "The ADHD you have was caused by high fevers from past infections. Like the pneumonia you had and perhaps other times of illness. * * *This conditioning can be corrected with homeopathy and Neurofeedback. It would take about 8 sessions of Neurofeedback which you could do in a 2-3 day period here in Ashland."

19.

Licensee did not refer Patient B to a provider closer to Hillsboro for treatment.

20.

In an email dated July 24, 2008, Licensee told Patient B that he will have to take only the prescriptions Licensee recommends and only consult with Licensee or someone Licensee approves of. If he does not do so, Licensee will stop working with Patient B.

21.

In an email dated July 24, 2008, Licensee asks Patient B to prepay for a month's worth of work and states it is his office policy that long distance work must be prepaid. Licensee describes it as being "like a retainer or prepaid account." Licensee's office policy prohibits refunds of prepayments.

22.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care; he was negligent in the diagnosis and treatment of Patient B, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

23.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of Patient B in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). In addition, failure to refer a patient when referral is appropriate is a violation of OAR 850-050-0010(1)(c)(D). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

24.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee required pre-payment before

treatment, threatened to terminate the doctor/patient relationship if the patient saw another provider without his approval, and asserted the right to approve other providers and treatment. Licensee's diagnosis and treatment plan are also unprofessional or dishonorable conduct.

25.

Based on the foregoing paragraphs, Licensee violated ORS 685.110(14) by representing to Patient B that a manifestly incurable condition can be permanently cured is a violation of and violated OAR 850-050-0190(10) with the guarantee of any cure or results from treatment. Violation of ORS 685.110(14) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

26.

Licensee's diagnosis and treatment of Patient B was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

27.

Patient C. Licensee treated Patient C beginning on or about May 13, 2008 and continuing through at least August 27, 2008. Licensee's chart notes begin with notes from a phone call with Patient C dated July 1, 2008 as a follow up for migraines. Billing records for Patient C indicate Patient C was billed for an office visit on May 13, 2008, May 16, 2008, May 20, 2008, June 13, 2008, and June 26, 2008. Billing records also note Patient C was billed for "NF" visits on May 20, 2008, May 20, 2008, May 27, 2008, May 29, 2008, June 5, 2008, June 10, 2008, and on June 12, 2008. Licensee does not have chart notes for these visits.

28.

Licensee's chart notes dated July 11, 2008 show that he was managing methadone and clonazepam dosages for Patient C. These notes state that Patient C has a prescription refill appointment and further state that Patient C had 8 methadone left over. The notes state that Patient C was taking 2 in the morning and 2 more around 2 pm. The notes conclude, "maybe start to decrease next month." On

the same date Patient C says he was taking extra clonazepam in a “mania period”. There are no prescriptions for these medications by the doctor in the chart prior to August 12, 2008. Methadone is a Class II controlled substance. 21 CFR 1308.12(c). A written prescription is required for Class II prescriptions. 21 CFR 1300.01(35), 1306.05, 1306.06, 1306.11(a), (b).

29.

Patient C was hospitalized from August 2, 2008 through August 11, 2008 following a fall from a balcony that resulted in several broken bones. On August 10, 2008, a friend of Patient C advised Licensee by email that Patient C’s drug and alcohol addictions were “out of his control.” Despite having this knowledge, on August 12, 2008, Licensee wrote Patient C prescriptions for pain medications methadone, norco, and clonazepam. Licensee wrote these prescriptions after he had a phone call with Patient C, not an in-person visit.

30.

On August 12, 2008, Licensee prescribed Patient C a quantity of 48 methadone tabs of 60 mg. each with instructions to take one tab every 6 hours for pain. In November 2006, the federal Food and Drug Administration issued a Public Health Advisory regarding the use of methadone for pain control. The advisory states that physicians should “[a]void prescribing methadone 40 mg dispersible tablets for pain. This product is only FDA-approved for detoxification and maintenance treatment of narcotic addiction.”

31.

Licensee’s copy of Patient C’s hospital records is incomplete. The incomplete records indicate Patient C has been prescribed gabapentin 600 mg, #90 and oxycodone 5 mg, #200 for pain, but other medications may have been prescribed. Licensee’s notes from an August 14, 2008 house call state that Patient C told the doctor he was prescribed by the hospital “30 mg of methadone every day at first, then up to 60 mg twice a day plus some other pain meds”. Licensee did not verify this information.

32.

On August 12, 2008, Licensee changed the directions for Patient C's methadone prescription without conferring with the prescribing physician or the patient. Licensee's notes for an August 14, 2008 house call to Patient C state that after Patient C told him what the methadone dosing protocol at the hospital was (up to 60 mg twice a day), "I explained that I had calculated he needed 60 mg four times a day and that was now, not right after the injury, so it was no wonder that he did not get enough pain relief * * *."

33.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat Patient C or to calculate the proper dosage of methadone. Further, Licensee's August 12, 2008 chart notes state the following after the word "Test":

genetically insensitive to methadone
decreased sensitivity to methadone due to long use
liver function changing methadone activity

Each of the above phrases has the word "No" in front. The final note is "it is worse to get off oxycodone than methadone".

34.

The notes from an August 14, 2008 house call to Patient C state:

~~I did also point out that [Patient C] had broken his agreements in the Pain Medicine Agreement form, in that he accepted a pain med Rx from another doctor other than in an emergency setting. In a follow up letter I requested that he return the methadone, if the Rx was filled, to the pharmacy or to me, to keep for him for possible future use, or to dispense to other patients by prescription."~~

There is no Pain Medicine Agreement form in the file for Patient C.

35.

In a letter to Patient C on or about August 15, 2008, Licensee asks Patient C, his mother or his friend to bring the methadone pills to him if the pharmacy won't accept a return. Licensee says he will

hold them in case Patient C needs them or he will give them to a needy patient. Licensee's proposal to re-distribute a Class II controlled substance is unlawful. *See* 21 USC § 828. The procedure for disposing of controlled substances is set forth in 21 CFR § 1307.21.

36.

In the August 15, 2008 letter to Patient C, Licensee recommends the purchase of an infra-red healing mat and a mattress. Licensee states that the mattress costs \$2700 with \$200 for shipping. However, Licensee alleges that he "got a special deal on this particular mattress" and "would be willing to sell it for \$1700 without any additional shipping fees." Licensee notes that if Patient C does not buy it, Licensee will have to move it to a different location in his office. Licensee further states, "I know this is a lot of money, and a twin is not that big. However, high quality conventional mattresses are almost this expensive, and I strongly recommend against them. The inner spring coil mattresses create an emf [electro-magnetic field] problem, and the memory foam ones are toxic." Licensee recommends the purchase of other items, and then advises "whoever is paying for these things, the costs can be deducted as a medical expense since I am prescribing them. * * *This might not matter for [Patient C], but it might for his father who may be paying for it."

37.

When Patient C responded on August 16, 2008 and said buying the mat is not a realistic possibility, Licensee responded by email, which includes the statement:

If I recommend a medicine supplement program and if you get the medicines and we charge your father's credit card, that seems to me to be consistent with his agreement to "pay for whatever it takes." If we purchase an infra red healing mat the same way, it's no different except in degree (cost). On a more immediate issue, are you saying that you don't want to get the medicines I recommended because of cost? That is illogical because your father is paying for it. Or is there some other reason? I am not accustomed to being employed to create a treatment plan, and then being told that the patient and his mother and friend are going to ignore it, and create their own program. Am I misunderstanding something, or is that actually what is happening?

If that is the case, that you are creating your own treatment plan instead of using mine, then I have a big problem with that. In general I would have a problem with any patient

doing that, because if someone is my patient then their results are an indication of my work. * * * So I generally don't work with patients under such conditions, unless we have a mutual agreement that they will select their own medicines, but they have to pass my approval through testing or evaluation.

In an email dated August 17, 2008 to Patient C and a friend, Licensee states:

In terms of the recommendations for a bed, pillow and healing mat, I do not require that patients purchase expensive items that I prescribe, when they may not be able to afford them. It is not a perfect world and we can't all afford whatever is best for us. I do ask that when I recommend these kinds of things, that they be considered as of the highest priority. I know your financial situation and I am not recommending things unless they are very important. * * * In your case, for example, it may be that your father already has and/or would pay for such items. The issue might not be money, but the willingness to ask for or receive assistance. * * * [I]f you don't get what you need now, and then if you don't recovery fully, you will be partially (physically) disabled the rest of your life and this will cost much more in the long run, in both actual expenses and lost income. Every dollar spent now could save one hundred dollars over the span of your life.

38.

Licensee's chart for Patient C includes a page dated August 20, 2008 that is titled, "How [Patient C] manipulates."

39.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care; he was negligent in the treatment (including his prescribing practices) of Patient C, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

40.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of Patient C in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

41.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's communications with and about Patient C and others related to his case are unprofessional, Licensee threatened to terminate the doctor/patient relationship if the patient did not follow treatment plan, including purchasing items that could be to the financial benefit of Licensee, and Licensee asserted the right to approve other providers and treatment.

42.

Licensee's diagnosis and treatment of Patient C was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

43.

Patient D. Licensee treated Patient D from approximately July 28, 2008 through at least August 29, 2008. Patient D was seen with his wife.

44.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. Licensee's chart notes from July 28, 2008 use the word "Test" followed by a diagnosis of vascular dementia due to lead toxicity. The notes state "plaques in artery walls, replaces calcium, immune reactions." Licensee's chart notes for July 30, 2008 state Patient D's weight loss is due to lead, leading to lowered testosterone, and leading to lowered anabolic. Patient D's wife advised as early as August 7, 2008 that they obtained a lead test kit and it was negative. On August 25, 2008, Licensee's chart notes state that the lead was from past exposure and out with bone loss due to andropause. There are no objective findings or medical records to support Licensee's findings.

45.

After Patient D had a choking incident and his wife reported he was having trouble taking the pills prescribed by Licensee, Licensee advised Patient D's wife that he was acting as though she was his mother. Chart notes dated August 25, 2008 state "Test," followed by "causes of not taking pills." The causes listed are bad taste, fear, and passive/aggressive attitude toward Patient D's wife. The third cause is explained as Patient D's feelings about his wife after infidelity. Licensee concludes that if Patient D's wife forgives Patient D, he will take medicines and do the treatment. There are no objective findings or medical records to support Licensee's findings.

46.

One page of Licensee's chart notes for Patient D dated August 25, 2008 contains chart notes for Patient D's wife.

47.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care; he was negligent in the diagnosis and treatment of Patient D, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

48.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

49.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's communications about Patient D, his diagnosis and treatment, and failure to protect patient confidentiality by including chart notes for

two individuals in one chart are unprofessional or dishonorable conduct.

50.

Licensee's diagnosis and treatment of Patient D was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

51.

Patient E. Licensee treated Patient E from approximately January 22, 2008 through at least February 25, 2008. Among other things, Patient E sought treatment for hypertension. Licensee's chart notes from January 22, 2008 and January 25, 2008 contain objective evidence of high blood pressure in Patient E.

52.

Licensee's chart notes from January 22, 2008 and January 25, 2008 include a diagnosis that Patient E's high blood pressure is due to "emf" (electro-magnetic fields). The notes further specify that this is not due to "dental metal emf but [due to] transformer +/- or power poles outside window." In addition, the notes state that if Patient E has no emf exposure, his blood pressure will be normal in 3 to 4 weeks. Licensee's chart notes from January 29, 2008 use the word "Test" followed by notes that state that if Patient E moves to another bedroom, his emf and high blood pressure will decrease by 75-80 percent. The January 29, 2008 treatment plan is for Licensee to visit Patient E's home and check how to deflect emf and/or paint emf block base paint and check attic.

53.

There is no objective scientific evidence of a link between high blood pressure and electro-magnetic fields. Licensee did not address Patient E's diet or other behaviors as a means to control high blood pressure. Licensee did not use conventional, scientific or otherwise established methods to

diagnose or treat the patient's condition.

54.

Patient E visited the emergency room (ER) at Ashland Community Hospital on February 1, 2008 for high blood pressure. The ER report, which was sent to Licensee, states, "The patient will need his blood pressure managed somewhat urgently and I have instructed him to make a primary care appointment within the next 2 or 3 days to further discuss which agent might be best for him." Licensee's February 5, 2008 notes from a phone call with Patient E indicate the patient saw a Dr. Morningstar, who did not provide a prescription for high blood pressure, said he was not in danger except one time, and would do a full physical in two weeks.

55.

Licensee's prescription plan for high blood pressure on January 25, 2008 was for 2 caps of StressX every 3-4 hours and 1 tab of Clonazepam .5 mg up to three times a day if the StressX did not help. Licensee's chart notes indicate Clonazepam .5 mg was prescribed on January 25, 2008 (20 tabs), January 29, 2008 (20 tabs), February 5, 2008 (20 tabs), and February 22, 2008 (40 tabs). Clonazepam is a Class IV controlled substance for treatment of panic disorders and seizures. 21 CFR 1308.14(c). Patient E did not sign a Pharmaceutical Prescription Agreement until February 22, 2008.

56.

On February 8, 2008, chart notes state a plan to lower the dose of Clonazepam to balance blood pressure and mental function. On February 19, 2008, Patient E reported the prescription was "pushing him down" and he had a decrease in driving skills and peripheral vision. Licensee's chart notes for the same date use the word "Test" and the notes state 90 percent of sadness is due to suppressed feelings to avoid high blood pressure. They further state the prescription dose is correct, not excessive, and StressX will decrease negative feelings. Chart notes also imply that Patient E's soul or spirit is the source of his frustration.

57.

At Patient E's last appointment on February 25, 2008, Patient E said he did not like the way Licensee talked to him in the lobby about emf. Licensee charts that he discussed Patient E's need to become savvy regarding emf and issues with grounding.

58.

Licensee's emails to Patient E and clinic staff indicate Licensee researched "the most cost effective and important items for emf protection" and "tested" locations in Ashland to see if it would be safe for Patient E to live there. A January 29, 2008 email from Licensee to a staff employee that is in Patient E's chart states:

Please talk to [Patient E] and tell him I did this work for him, because after our phone call I realized he needed extra help. Tell him I chose the most cost effective and important items for emf protection. I spent over an hour selecting these items for [Patient E]. But I did not tell him I was going to do it, plus some of the time is just because I am not familiar enough with the items because we have not been routinely ordering or using them. However, it's also part of my work for [Patient E], and some of these will save him a lot of money, instead of paying an electrician to do it all. Anyway, I'd like to charge for 40 minutes for the case analysis/management.

Explain to Patient E that protecting him in one room of the house is not enough, he has to be protected wherever he goes since he is now emf hypersensitive. Throughout the house, and outside the home, in the car, etc.

When you and Patient E have put an order together, figure out how much profit we will earn. Then add extra items to the order, so we use our profit to have some of the items in stock to sell to patients. Spread it around if you can. Obviously the less expensive things are easier to get, such as wrist ground straps and grounding cords. I could sell these till the cows come home! Or the deer. Grounding pads also, and emf hats, car seats... all of it! But just get what we can pay for with these profits...you could go over up to \$25 but not more. Also wait to place the order until Patient E's card charges have been deposited. You can decide what to get but if you need advice ask me. Also consider these are some of the same items I think we could sell online very well.

59.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient E, in violation of ORS 685.110(8)

and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

60.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

61.

During consultation or treatment, Licensee advised that the elimination of emf would cure his condition. The guarantee of any cure or results from treatment is a violation of OAR 850-050-0190(10). Violation of ORS 685.110(14) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

62.

Licensee's diagnosis and treatment of Patient A was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

63.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's treatment plan, prescription practices, and communication and billing practices with Patient E are unprofessional and dishonorable conduct.

64.

Patient F. Patient F was a patient of Licensee from approximately November 16, 2007 through at least July 24, 2008. Patient F sought treatment for an enlarged prostate. Patient F reported a history

of viral pneumonia.

65.

Licensee's chart notes from December 4, 2007 state "test" and indicate a fungal infection, not viral pneumonia. Licensee did not take cultures, exams, or x-rays. Licensee's chart notes further concluded Patient F had mercury toxicity of a "3" due to silver amalgams. He concludes Patient F's liver function is normal and he can "detox ok naturally [and with] Body Mind." Patient F reported trauma to his urethra with bleeding for about one week. Licensee's chart notes for January 2, 2008 state "Test" and then state that the urethra is healing normally. Licensee prescribed Thymus and Resveratrol. In an email on February 4, 2008, Patient F asked Licensee to use his "pendulum" as he sees fit to determine if hormones are an appropriate treatment for Patient F.

66.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. There are no objective findings or medical records to support Licensee's findings.

67.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient F, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

68.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

69.

Licensee's diagnosis and treatment of Patient F was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

70.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis methods and treatment plan with Patient F are unprofessional and dishonorable conduct.

71.

Patient G. Patient G was a patient of Licensee from approximately July 2006 through at least August 7, 2008. Patient G resides in California. In an email dated June 17, 2008, Patient G asked Licensee to diagnose her. Licensee's email response advised Patient G that she has PTSD, Fibromyalgia, and pre-menstrual syndrome. Licensee made this diagnosis without seeing Patient G or conducting any tests or exams. There are no objective findings or medical records to support Licensee's findings.

72.

In emails dated October 25, 2007, January 8, 2008, and June 17, 2008, Patient G asked Licensee for "any reads" or "consult testing" on an individual with whom she had a relationship and regarding her employment. Licensee responded to these requests by email with advice on personal matters, including comments such as November 7, 2007 email that states in part, "testing indicates a lot of potential" with someone Patient G dated.

73.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient G, in violation of ORS 685.110(8)

and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

74.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

75.

Licensee's diagnosis and treatment of Patient G was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

76.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis methods and communications with Patient G are unprofessional and dishonorable conduct.

77.

Patient H. Patient H was a patient of Licensee from approximately March 20, 2008 through at least July 11, 2008. Patient H was 69 years old at the time. Licensee's chart includes medical records from her previous doctors dated May 9, 2007 through April 2, 2008. These charts do not list porphyria or lead toxicity as prior diagnoses.

78.

In a May 12, 2008 email to Patient H, Licensee refers her to webpages on treatment of lead toxicity and porphyria. Licensee's chart does not contain evidence of any exam or testing to support a diagnosis of these conditions.

79.

On or about June 6, 2008, Patient H was taking Levothyroxine, which was prescribed by another doctor for her thyroid goiter and cysts. Licensee's chart notes for June 6, 2008 state "test", followed by a conclusion Patient H dreams of her mother because her ghost is still there, and Patient H needs to take Adderall to block her mother. Licensee also concludes that Patient H should stop taking Levothyroxine. There is no evidence Licensee consulted with Patient H's prescribing physician or obtained any objective findings to support these conclusions.

80.

Patient H's medical history indicates she is diagnosed with and taking medication for bipolar disorder. Patient H reported to Licensee that she gets four hours of sleep. Licensee's June 20, 2008 chart notes use the word "test" and state "sleep: [due to] hypervigilant [due to] PTSD." There is no evidence Licensee evaluated or referred Patient H for evaluation of manic symptoms. There are no objective findings or medical records to support Licensee's findings.

81.

Licensee's May 12, 2008 email to Patient H states in part:

I will focus on porphyria in the next visit. However, there is no way to treat it without treating the whole person, comprehensively. I will do my best to limit what is comprehensive, to what is needed to treat the porphyria, and to try to stay within what you can afford. At the same time, I will ask you to be able or willing to afford, what is needed to treat this health issue, which may be bigger than you had realized. I'm sure we can work together to find agreement on how much to do.

On May 23, 2008, Patient H prepaid \$2,500 to Licensee for future services.

82.

In a June 4, 2008 email to Patient H, Licensee states, in part,

* * *It is absolutely essential that you use citrus pectin or grapefruit itself. Your resistance to purchase due to cost is not my problem. Many drugs cost more than that, and patients buy them anyway because they are essential. Do not be misled just because it is a "powder" from food sources. I spent a lot of time finding that product for you. * *

* * *If you want more explanation about a particular instruction or prescription, that is OK, but then you should engage me in an email consult, phone consult or office visit to do so. Even then, you should follow the instructions without delay, and then get more information as and when you can, if you want to pay the extra expense for more education.* * *.

Unless, of course, you feel that you need to be punished. If you do, then please punish yourself in some other way, than by not following directions, doing stupid things and suffering from illness. For example, you could give yourself a “time out”, or spank yourself, or write on a pad of paper 100 times, “I will be a good girl from now on”.

83.

Based on the facts alleged in the paragraphs above, Licensee’s conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient H, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

84.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

85.

Licensee’s diagnosis and treatment of Patient H was gross or repeated malpractice in violation of ORS 685.110(13). Licensee’s conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee’s license.

86.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee’s diagnosis methods and

communications with Patient H are unprofessional and dishonorable conduct.

87.

Patient I. Patient I was a patient of Licensee from approximately June 4, 2008 through at least August 7, 2008.

88.

On July 4, 2008, Licensee's chart notes report a phone call with Patient I, who indicated feeling sick and has a sinus headache. Legible notes that follow indicate "one time per year", "always with smoke in air" and "head pounds, [nausea] < bending over." Licensee's chart notes indicate he prescribed without an office visit 500 mg of Cephalexin with one refill. The next contact with Patient I in the chart is a July 7, 2008 email in which Licensee indicates an office visit would be a good idea, but if Patient I can't come in, he could schedule a phone consult.

89.

Licensee's chart notes dated June 17, 2008 use the word "test" and note that the shaking Patient I reported after taking a prescription was from increased stomach acid with isocort. Licensee further notes that the shaking and increased stomach acid are due to a "panic reaction" regarding carbon dioxide. The chart notes further state that PTSD leads to a pattern of needing increased carbon dioxide to negate stomach acid. Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. There are no objective findings or medical records to support Licensee's findings.

90.

Patient I's chart indicates a history of being beaten by her mother with objects under the age of 5, and her mother was verbally and physically abusive. In an email dated July 7, 2008, Licensee responded to Patient I's email indicating her mother will be visiting. Licensee's response is:

I specialize in treating patients with difficult mothers. Is yours a narcissist? If so, I often recommend watching the movie, "Now, Voyager", with Bette Davis. It's an old classic movie. Did I recommend it already? It's probably the movie I prescribe the most often.

* * *The main point is to pay attention to the scene in which the mother dies, and what happens after that.

91.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient I, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

92.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

93.

Licensee presented himself to Patient I as a medical specialist in treating patients with difficult mothers. Representing that a licensee is a medical specialist or practices a medical specialty is a violation of ORS 685.110(22). Claiming to have greater skill than fellow physicians is a violation of OAR 850-050-0190(7). Violation of ORS 685.110(22) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

94.

Licensee's diagnosis and treatment of Patient A was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

95.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis methods, prescription practices and communications with Patient I are unprofessional and dishonorable conduct.

96.

Patient J. Patient J was a patient of Licensee from approximately September 6, 2007 through at least December 26, 2007. Patient J was 73 years old and living in California. Patient J sought treatment for feeling weak at times of stress, depression and stomach problems with acidic foods. Patient J reporting have hepatitis A in 1978.

97.

Licensee's chart notes for Patient J for September 6, 2007 state "test". This page states the cause of Patient J's fatigue is from adrenal deficiency and that the adrenals are less than 5% functional. It also says Patient J's hepatitis A led to an autoimmune reaction and that he is positive for a H. Pylori infection. H. Pylori is a bacteria associated with causing stomach ulcers. Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. There is no evidence that Licensee ordered diagnostic tests for H. Pylori infection.

98.

On September 6, 2007, Licensee prescribed Hydrocortisone cream as an "adrenal hormone" for Patient J. It is a prescription to be rubbed on skin "anywhere he feels stiff or sore." Refills are not addressed. There is nothing in the chart notes for September 6, 2007 that discussed skin conditions. Chart notes after this date do not mention the Hydrocortisone prescription or Patient J's response. Licensee's chart for Patient J does not mention adrenal deficiency except as a "test" result.

99.

Licensee's chart notes for September 28, 2007 state "Test", followed by notes that Patient J's stomach is "> 90% better", he is "gluten intolerant" and that's a "7". Licensee did not use conventional,

scientific or otherwise established methods to diagnose or treat patient's condition.

100.

On November 9, 2007, Patient J reports having black stools every day, "a lot of gas" and "still has tired spells." Licensee's plan is for Patient J to "cut out Liver for 1 week to see if dark stool stops and get occult blood test." Black stools can signify bleeding in the intestinal system. In the emails from Licensee or his staff to Patient J that follow this visit, Licensee does not follow up on the occult stool test, mention the significance of the test, or mention obtaining other tests to determine if there is any blood loss.

101.

In an email dated September 26, 2007, Patient J's wife states, "Leigha told us we need to write to you for the next phase of our consulting with you for [Patient J's] medical situation. This seems a little strange to us but we will try to communicate what she has requested."

102.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care and he was negligent in the diagnosis and treatment of Patient J, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

103.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

104.

Licensee's diagnosis and treatment of Patient J was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing

harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

105.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis methods, prescription practices, and communications with Patient J are unprofessional and dishonorable conduct.

106.

Patient K. Patient K was a patient of Licensee from approximately September 25, 2007 through at least October 16, 2007. During this period, Patient K saw Licensee for three office visits. For the three office visits, Licensee accepted payment of \$1183. Patient K is a veteran of the war in Vietnam. Patient K sought treatment for Parkinson's Disease, PTSD, high blood pressure, back pain, and cholesterol. During his first office visit, Patient K related a traumatic event while serving in Vietnam and indicated he had left Vietnam right afterward.

107.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. Licensee's September 25, 2007 chart notes state that the cause of Patient K's PTSD is "guilt for leaving others behind when left job" and because he "quit job that [day] of event." Licensee finds the cause of Patient K's shaking is mind/body because "if [his wife] left, [Patient K] could not be loyal to her [leading to] a short circuit". Licensee makes these determinations without tests or other information.

108.

Licensee's chart notes for October 16, 2007 state "Test" followed by notes that say the number one cause of excess weight is that "T3 receptors blocked by food lectin". T3 is a thyroid hormone. Licensee's treatment plan is for Patient K to avoid pork, and to quit prescriptions from the Veterans' Administration "except for shake, trol, st., B.B." Licensee did not use conventional, scientific or

otherwise established methods to diagnose or treat patient's condition. There is no evidence Licensee used other means to determine the cause of weight gain.

109.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care; he was negligent in the diagnosis and treatment of Patient K, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

110.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of Patient K in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

111.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis and treatment of Patient K and his billing practices are unprofessional or dishonorable conduct.

112.

Licensee's diagnosis and treatment of Patient K was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

113.

Patient L. Patient L's billing records indicate she was a patient of Licensee from approximately November 2006 through at least July 28, 2008. Licensee's file for Patient L contains two pages of chart notes for two office visits on April 16, 2008 and May 9, 2008, and one page noting prescriptions on May 9, 2008.

114.

On April 16, 2008, Patient L reports using Armour and Pure Thyro for a thyroid imbalance, but had taken nothing for a couple of months. Patient L sought a prescription and dose. Patient L reported weight gain, hair falling, dry skin, heart palpitations and increase anxiety. Licensee's chart notes do not state why Patient L stopped taking medication or identify the original prescriber.

115.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. Licensee's chart notes for April 16, 2008 state "Test" followed by "+ needs Thyro but can't tolerate due to [adrenal deficiency]?" Further notes state that Patient L's adrenal function is 5-10% of normal due to pain and is stimulated by mental emotional stress. Licensee then notes "Near Addison's [disease]" next to a note that Patient L is never sick but this winter was sick four times.

116.

Licensee's treatment plan for Patient L on April 16, 2008 was for her to use caffeine "for now" and to follow-up to treat her pain, adrenals, and thyroid. Licensee's chart does not indicate he provided Patient L with any prescriptions. However, on May 9, 2008, Patient L reports she "feels sliding [leading to] anxiety, in a fog, etc. Felt real good for awhile on adrenal and thyroid." Licensee notes on May 9, 2008, that the patient has no "Thyr." for 4-6 months, with increased weight and blood pressure.

117.

Licensee prescribed Patient L 1 grain per day (65 mg) Armour thyroid medicine and pure adrenal 400 supplement on May 9, 2008. There is no indication Licensee ordered a thyroid test. It is common practice to order a test at least once a year in order to determine the best thyroid dose. There is no notation of how much Licensee prescribed, or the number of refills.

118.

Licensee's chart notes for May 9, 2008 state "Test" followed by notes that Patient L's musculo-skeletal pain is greater than 80% of the cause for her adrenal deficiency and that greater than 90% is

from her neck, the left facet joint C2-C3. Patient L reported during this visit that her “neck bothers a lot”, her low back is “out”, and her “hip hurts”. She reported she fell off a horse and suffered a blow to her head when she was 13 or 14 years old. Licensee’s notes do not contain objective findings or other common diagnostic examinations to determine the source of neck pain.

119.

Based on the facts alleged in the paragraphs above, Licensee’s conduct was below the standard of care; he was negligent in the diagnosis and treatment of Patient L, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

120.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of Patient L in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

121.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee’s diagnostic and treatment practices are unprofessional or dishonorable conduct.

122.

Licensee’s diagnosis and treatment of Patient L was gross or repeated malpractice in violation of ORS 685.110(13). Licensee’s conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee’s license.

123.

Patient M. Licensee has billing records for Patient M from approximately December 12, 2005 through at least August 27, 2008. Licensee's chart for Patient M contains records dated between August 16, 2007 and July 30, 2008. Chart notes do not contain any record of Patient M's age, her health history or her health concerns.

124.

Licensee's chart notes dated September 13, 2007 note a phone call was received from Patient M during which the patient described an infection in an ear lobe that may have lasted over one month. Patient M reported the onset was around the time of some dental work that removed a metal cap. Licensee's notes of the phone call conclude, without an exam of the patient or other objective information, that the cause is Patient M's new phone. On this same phone call, Licensee prescribed a mix of ibuprofen and olive oil to be mixed and rubbed on the earlobe.

125.

Patient M sent a July 30, 2008 email to Licensee that indicates feelings of depression, anxiety and crying episodes since March 2008. Patient M reports taking Lexapro which she reports reduced crying episodes but increased her anxiety. In an email reply dated July 31, 2008, Licensee responds by stating in part, "Unfortunately, the current treatment options in conventional medicine are following a fad in which all problems that look like depression or anxiety are treated with the same kind of drugs."

126.

Licensee did not use any established methods to diagnose or treat patient's condition. In his email dated July 31, 2008, Licensee advises that the medicinal solution for Patient M's symptoms is progesterone, 12 tablets for three times a day, with extra for "breakthrough" episodes. Licensee's email says that for use more than one month or two, Patient M should have an office visit.

127.

Licensee's July 31, 2008 email to Patient M further states, "it is possible to find out more about your daughter and why she is the way she is, and what, if anything can be done for her." To do this, he advises it would require an office visit for Patient M.

128.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care; he was negligent in the diagnosis and treatment of Patient M, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

129.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of Patient M in violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

130.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis and treatment methods and Licensee's communications with Patient M are unprofessional and dishonorable conduct.

131.

Licensee's diagnosis and treatment of Patient M was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

132.

Patient N. Patient N was a patient of Licensee from at least March 14, 2008 through May 29, 2008. Patient N is 53 years old. Patient N's chief complaint on March 14, 2008 was memory loss, decreased energy, digestion problems, joint pains, and athlete's foot.

133.

Licensee's chart notes for March 14, 2008 use the word "Test" followed by a conclusion that Patient N's "biological age" is 64, and this is the primary cause of her symptoms. Licensee states in his notes that Patient N has an infection that is a "4" from 1 species GI candida, inflammation and foods due to "auto-intoxication", due to "drunk" with alcohol, not low blood sugar. A second cause is listed in the chart notes as deficient stomach acid due to food lectins. Licensee's notes further state Patient N's brain memory is more than 90 percent due to lectin reactions and decreased energy is due to lectin reactions with dopamine receptors. Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition.

134.

In other chart notes, Licensee discusses issues of wealth and family with Patient N. Chart notes from May 29, 2008 use the word "test" and state that Patient N's increased stress equals affliction, more than 90 percent from Dad. Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition.

135.

Based on the facts alleged in the paragraphs above, Licensee's conduct was below the standard of care; he was negligent in the diagnosis and treatment of Patient N, in violation of ORS 685.110(8) and OAR 850-050-0010(1)(c)(B). Violation of ORS 685.110(8) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

136.

Based on the facts alleged in the paragraphs above, Licensee engaged in conduct contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of Patient N in

violation of ORS 685.110(15), OAR 850-050-0190(3)(a), and OAR 850-050-0010(1)(c)(C). Violation of ORS 685.110(15) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

137.

Based on the facts alleged in the paragraphs above, Licensee engaged in unprofessional or dishonorable conduct in violation of OAR 850-050-0190(3). Licensee's diagnosis methods and communications with Patient N are unprofessional and dishonorable conduct.

138.

Licensee's diagnosis and treatment of Patient N was gross or repeated malpractice in violation of ORS 685.110(13). Licensee's conduct was grossly negligent and created a significant danger of causing harm to the patient or the public. Pursuant to OAR 850-050-0010(2), the above findings also constitute aggravating circumstances for the foregoing violations and are grounds for revoking Licensee's license.

139.

General violations.

The Arura Clinic of Natural Medicine is an assumed business name of Licensee. The website, www.aruraclinic.com, contains, or contained at the time Licensee treated the above-identified patients, statements that Licensee is a medical specialist. On or about April 9, 2008, the "Arura Clinic" posted the following comment to an online article about Lyme's Disease, located on the webpage, http://www.prohealth.com/library/showarticle.cfm?id=8775&t=cfid_fm :

If you or someone you know has Lyme's Disease, or any symptoms or condition that has not yet been diagnosed properly, please see Dr. Shandor Weiss for help. Although Dr. Weiss has a general practice of natural medicine, he is an expert in the diagnosis, treatment and cure of Lyme's Disease.

140.

Representing that a licensee is a medical specialist or practices a medical specialty is a violation of ORS 685.110(22). Claiming to have greater skill than fellow physicians is a violation of OAR 850-050-0190(7). Violation of ORS 685.110(22) or an administrative rule of the Board is grounds for discipline. ORS 685.110(25).

141.

Licensee's chart notes for the above-described patients do not follow the SOAP format (subjective/objective/analysis/plan). Licensee does not have notes in the above-described patient charts for all dates noted on billing records for patients. Licensee's charting for Patients B, C, H, J, L, M, N, is incomplete.

142.

Licensee's charting practices constitute conduct that is contrary to a recognized standard of ethics of the profession or conduct that does or might constitute a danger to health or safety of a patient or the public, in violation of ORS 685.110(15) and OAR 850-050-0190(3).

NOTICE OF RIGHT TO HEARING

143.

Licensee has the right, if Licensee requests, to a hearing as provided by the Administrative procedures Act (ORS Chapter 183) to contest the matters set out above. At the hearing, Licensee may be represented by an attorney, and may respond to and present evidence and argument. A request for hearing must be made in writing to the Board and sent to the Board at 800 NE Oregon Street, Suite 407, Portland, OR 97232. The request for a hearing must be received by the Board within 21 days from the date of mailing of this notice, and must be accompanied by a written answer to the charges contained in this Notice. If the Board receives a request for hearing, the Board will notify Licensee of the time and place of the hearing. If Licensee requests a hearing, Licensee will be given information on the procedures, right of representation, and other rights of parties relating to the conduct of the hearing as required by ORS 183.413(2). Failure to request a hearing means Licensee waives the right to hearing.

144.

The answer shall be made in writing to the Board and shall include an admission or denial of each factual matter alleged in this Notice, and a short plain statement of each relevant affirmative defense Licensee may have. Except for good cause, factual matters alleged in this notice and not denied in the answer shall be presumed admitted; failure to raise a particular defense in the answer will be

considered a waiver of such defense; and new matters alleged in the answer (affirmative defenses) shall be presumed to be denied by the agency and evidence shall not be taken on any issue not raised in the Notice and answer.

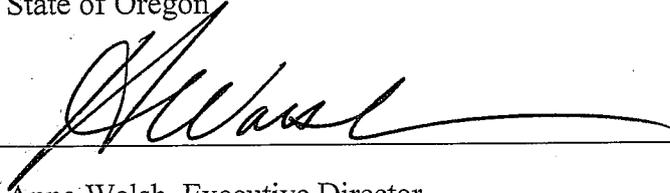
145.

If Licensee fails to request a hearing within 21 days, withdraws a request for a hearing, or fails to appear as scheduled at the hearing, the Board may issue a final order by default and impose the above sanctions against Licensee. Upon default order of the Board or failure to appear, the contents of the Board's file automatically becomes part of the evidentiary record of this disciplinary action for the purpose of proving a prima facie case. ORS 183.415(6).

DATED this 16th day of January, 2009.

BOARD OF NATUROPATHIC EXAMINERS

State of Oregon

A handwritten signature in black ink, appearing to read "Anne Walsh", is written over a horizontal line. The signature is cursive and extends to the right of the line.

Anne Walsh, Executive Director

CERTIFICATE OF SERVICE

I, Britt Duba, certify that on January 16, 2009 I served the foregoing AMENDED NOTICE OF PROPOSED DISCIPLINE AND RIGHT TO A HEARING upon the party hereto by mailing, certified mail, and regular mail, postage prepaid a true, exact and full copy thereof to:

SHANDOR WEISS ND
ARURA CLINIC OF NATURAL MEDICINE
233 FOURTH ST
ASHLAND OR 97520

COPY TO:
THOMAS E. COONEY, ATTORNEY
COONEY & CREW, LLP
494 MEADOWS ROAD, SUITE 460
LAKE OSWEGO, OR 97035



Britt Duba, Administrative Assistant
Oregon Board of Naturopathic Examiners

Certified Mail no: 7005 0390 0006 4011 4062