OREGON BOARD OF NATUROPATHIC MEDICINE

OF THE STATE OF OREGON

In the Matter of the License to Practice as a Naturopathic Physician of: **ARIS CAMPBELL, ND**	) **FINAL ORDER**)) OAH Case No.: 901267) Agency Case Nos.: N09-02-04, N09-02-) 05, N09-02-06

The Oregon Board of Naturopathic Medicine hereby adopts and incorporates by reference the attached Amended Proposed Order, dated April 26, 2010. The proposed order is adopted in its entirety.

ORDER

(1) Licensee is placed on probation for a period of three years during which time Licensee must comply with the statutes, rules, and orders of the Board and the following conditions:

a) Complete additional continuing education hours that are pre-approved by the Board within six (6) months; specifically twelve (12) hours on patient record keeping/charting, and six (6) hours on conflict management; and

b) Submit to the Board for approval, within one (1) month of completing the required additional continuing education hours, a plan to correct Licensee's processes for patient charting and record keeping and improve conflict management skills.

(2) Licensee is assessed civil penalties of $4,000.00.

Dated this 23rd day of June 2010.

Signature on file

Glen Taylor, Chair
Oregon Board of Naturopathic Medicine

Date of Mailing: June 24, 2010

NOTICE OF OPPORTUNITY FOR JUDICIAL REVIEW (COURT OF APPEALS)

You are entitled to judicial review of this Order pursuant to ORS 183.482. Judicial Review may be initiated by filing a petition for review with the Oregon Court of Appeals within 60 days from the date this Order was mailed to you.

BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF OREGON
for the
BOARD OF NATUROPATHIC MEDICINE

IN THE MATTER OF:	) AMENDED **PROPOSED ORDER**
	)
ARIS CAMPBELL, ND	) OAH Case No.: 901267
	) Agency Case Nos.: N09-02-04, N09-02-05,
	) N09-02-06

HISTORY OF THE CASE

On June 10, 2009, the Board of Naturopathic Examiners[1] (Board) issued a Notice of Proposed Disciplinary Action and Opportunity for Hearing (Disciplinary Notice) to Aris Campbell, ND (Licensee). On June 24, 2009, Licensee, through counsel Kenneth Lee Baker, attorney at law, requested a hearing. On February 2, 2010, the Board issued an Amended Notice of Proposed Disciplinary Action and Opportunity for Hearing (Amended Notice) to Licensee.

On September 9, 2009, the Board of Naturopathic Medicine referred the hearing request to the Office of Administrative Hearings (OAH). Senior Administrative Law Judge (ALJ) Ken Betterton was assigned to preside at hearing. A prehearing conference was convened on October 15, 2009, ALJ Betterton presiding. Hearing dates and relevant deadlines were set. On November 23, 2009, the matter was re-assigned to Senior ALJ A. Bernadette House. A second pre-hearing conference was convened on December 14, 2009.

A hearing was held on February 2 and 3, 2010, in Portland, Oregon. Licensee appeared with counsel, Mr. Baker, and testified. Anne Walsh, executive director, appeared as the authorized representative of the Board, and testified. Assistant Attorney General Johanna Riemenschneider represented the Board. Robert Cowles, Jonathan Hansel, ND, DC, Carly Munster, and Jodynne Viernes testified on behalf of Licensee. In addition to Ms. Walsh, Patient A,[2] John Laws, investigator for the Board, and Rita Bettenburg, ND testified in person on behalf of the Board. Patients B and C also appearing for the Board by telephone.

The record remained through February 17, 2010 for the receipt of closing arguments. Following timely receipt of closing arguments, the record closed on February 17, 2010.

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[1] On January 1, 2010, the Board of Naturopathic Examiners became the Board of Naturopathic Medicine. Or Laws 2009 c.43

[2] Confidential Patient Key attached as Appendix I.

ISSUES

1. Whether Licensee failed to adequately chart patient records for, and communicated in an unprofessional manner with, Patients A, B, and C, and failed to provide medical records upon the requests of Patients A and B in violation of ORS 685.110(15) and OAR 850-050-0190(3).

2. Whether Licensee failed to meet the standard of care by not making a diagnosis for Patient B in violation of ORS 685.110(8) and (15) and OAR 850-050-0910(3).

3. Whether Licensee failed to meet the standard of care by failing to refer Patient A and Patient C [3] to a licensed practitioner in violation of OAR 850-050-0190(11).

4. If any of the violations are proved, whether the Board's proposed penalty of a civil penalty of $4000 and a probationary period of three years with conditions for continuing education as set out in the Disciplinary Notice is appropriate.

EVIDENTIARY RULING

Exhibits A1 through A7, A9, A11 and A12, offered by the Board of Naturopathic Medicine, were admitted into the record. Exhibits A8 and A10 were withdrawn by the Board. Exhibit R1, offered by Licensee, is a photocopy of a prescription record for Patient C from Fred Meyer Pharmacy produced during a break in the hearing and was objected to by the Board for lack of notice and foundation. The objection was overruled on the record and the Board's request for a standing objection was granted. Exhibit R1 was entered into the evidentiary record.

Dr. Bettenburg was offered and qualified, without objection, as an expert witness in the practice of naturopathic medicine.

Licensee objected to the appearance of Patients B and C by telephone, arguing it violated his due process rights and deprived him of ability to evaluate the credibility of a witness during testimony. OAR 137-003-0605[4] provides for the appearance of witnesses and parties by telephone. Holding a contested case hearing by telephone is not a violation of due process. *Babcock v. Employment Division,* 72 Or App 486 (1985). Licensee's objection was overruled on the record. The testimony of Patients B and C, provided by telephone, was admitted into the record.

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[3] The Amended Notice alleged that Licensee violated OAR 850-050-0190(11) for failure to refer Patient C to a licensed practitioner. In the Board's Closing Argument, the Board did not present argument regarding Licensee's alleged failure to refer Patient C to a licensed practitioner and conceded that the record did not support a violation. In the absence of evidence or argument to support the allegation as set out in the Amended Notice, the Board has failed to meet its burden of proof regarding that alleged violation and it is not addressed further in this Order.

[4] OAR 137-003-0605(1), regarding telephone hearings provides as follows:
Unless otherwise precluded by law, the administrative law judge may hold a hearing or a portion of a hearing by telephone and may permit a party or witness to appear at a hearing by telephone.

FINDINGS OF FACT

1. Licensee has practiced as a licensed doctor of naturopathic medicine (ND) in Oregon since 1987. He has previously held an Oregon license as a registered nurse (RN) but his RN license is not current. (Test. of Licensee.)

2. As part of his training to become an ND and an RN, Licensee was taught the importance of, and methods for, taking and maintaining accurate patient chart notes. (Test. of Licensee.)

3. Rita Bettenburg, ND, consults with the Board regarding the practice of naturopathic medicine and the expected standards of care for naturopathic physicians in Oregon. Dr. Bettenburg is currently Dean of the Naturopathic Program at the National College of Naturopathic Medicine (NCNM) in Portland. Prior to acting as dean, Dr. Bettenburg taught classes in clinical and physical diagnosis, including charting at NCNM. Dr. Bettenburg continued to teach clinical work until Fall 2009. Dr. Bettenburg continues to provide on-going training to the ND professional community. Dr. Bettenburg also performs private consulting services, including assessment of provider chart notes, submitted in support of insurance claims, for accuracy and sufficiency. (Test. of Bettenburg.)

4. Oregon ND's are held to standards of care similar to those stated in the publication entitled "The Standards of Care" published by the Southwest Naturopathic Medical Center (SWNMC). Although SWNMC standards have not been adopted by the Board in Oregon, the standard of care expected of naturopathic physicians in Oregon is consistent with those published by the SWNMC. SWNMC based its standards on materials taught by the NCNM at the time the standards were written. The SWNMC standards are consistent with those taught by Dr. Bettenburg and in the curriculum at NCNM. (Test. of Bettenburg; Ex. A9.)

5. Included in the SWNMC Standards is an expectation that providers will use the common charting system known as the SOAP (Subjective, Objective, Assessment and Plan) method. The SOAP method is not required but it is the industry standard, and best practice includes gathering and noting similar information for each visit in patient charts. (Test. of Bettenburg and Hansel; Ex. A9 at 5.)

6. Accurate chart notes include the following elements: a subjective component which includes what the patient said or indicated was the complaint or reason for the visit; an objective component which includes information observed by the provider or gathered during, or as a result of, the visit, such as test results; an assessment which includes the provider's conclusions based on what was seen and heard; and a plan which includes what the provider did to treat the symptoms or diagnosis or diagnoses as documented in the notes for that visit, such as a manipulation performed or a prescription given. The notes should include lab reports and any information brought in by the patient or provided to the patient or other contacts. Notes may be handwritten but must be legible and understandable to fulfill the purposes of charting. (Test. of Bettenburg; Ex. A9 at 5-9.)

7. Chart notes are expected to reflect the events of the day the note is charted. Additional notes relating to earlier events should be added and dated as separate notes. Any addendums to chart notes should be noted as addendums and dated to reflect the date when added. It is also expected that chart notes contain relevant information only. Patient charts are expected to include any intake information provided by a patient. (Test. of Bettenburg.)

8. HCFA (Health Care Financing Administration) codes, used for insurance reimbursement, are not required to be used by the Board or in the community. However, use of HCFA codes for diagnoses or other billing information has become the standard of care by default because reimbursement by insurance companies requires use of the codes. (Test. of Bettenburg.)

9. A patient has the right to access and review his or her protected health information and to receive a copy upon request. A naturopathic physician is legally required to respond within 30 days of receiving a request. (Test. of Bettenburg.)

Patient A

10. Patient A saw Licensee after reading Licensee's advertisement in a local magazine. After Patient A's back "went out," he experienced lower back pain and, for a time, walked only with the aid of crutches. (Test. of Patient A.) On or about June 17, 2008, Patient A was treated by Licensee for back pain. (Test. of Patient A and Licensee.)

11. At the June 17, 2008 visit, Licensee reviewed Patient A's intake information, talked to Patient A about his past medical history and the reason for the visit. Among other things, Patient A told Licensee that his son was a chiropractor but that the son was "not very good at it." (Test. of Licensee; Ex. A1 at 18.)

12. Licensee referred Patient A for x-rays from a local chiropractic clinic. (Test. of Patient A and Licensee.) Patient A paid for the x-rays at the time they were taken and brought them with him for the office visit with Licensee later that same day, June 20, 2008. (Test. of Patient A; Ex. A2 at 5, 6.) Following review of x-rays during the visit, Patient A left them with Licensee. (Test. of Patient A and Licensee; Ex. A1 at 24.)

13. In addition to the above visits, Patient A saw Licensee for additional office visits on June 19, 21, 23, 24, 25, 26, 27, and 30, 2008. (Ex. A1 at 21-25.)

Conduct towards Patient A

14. Approximately six months after Patient A's last visit, Licensee prepared a summary of his treatment of Patient A in response to a verbal request for medical information from Licensee's attorney. (Test. of Licensee; Ex. A2.)

15. Patient A spoke about his son at length on each visit with Licensee. Licensee documented the discussions because they appeared to be important to Patient A. Licensee believed that listening to Patient A talk about the son was an important part of treating Patient A

and Licensee did not feel that a provider could get to Patient A's medical issues if the provider did not listen to Patient A. (Test. of Licensee; Ex. A1.)

16. On June 30, 2008, when Licensee last saw Patient A as a patient, Licensee referred Patient A to Jenny Kirkendall, RN, L.Ac., licensed acupuncturist. (Test. of Licensee and Patient A; Ex. A1 at 27.) Licensee told Patient A that he would contact Kirkendall to let her know that Patient A needed to be scheduled. Licensee attempted to reach Kirkendall during the visit on June 30, 2008 but was unable to get through. (Test. of Patient A.) Licensee was able to contact Kirkendall's office on or about July 1, 2008 regarding a referral for Patient A. Licensee was told Kirkendall was out on vacation but that she would get back to Licensee when she returned. (Ex. A1.)

17. After his June 30, 2008 visit with Licensee, Patient A continued to experience a high level of pain. Patient A made repeated attempts to reach Kirkendall on the telephone to schedule an appointment. Patient A spoke directly with Kirkendall during at least one of the telephone calls. (Test. of Patient A.)

18. When speaking with Kirkendall, Patient A asked if Licensee had spoken to her about him needing a visit. Kirkendall had not spoken to Licensee about Patient A at that time and she told Patient A that she had not. She told Patient A that she was leaving town on a scheduled vacation but would be able to see him on July 2, 2008 at 11:00 a.m. Patient A accepted the appointment time. (Test. of Patient A; Ex. A1 at 27.)

19. Patient A became frustrated because he was in pain, because he believed that Licensee had not followed through on his promise to contact Kirkendall for an appointment, and because Kirkendall would be unavailable to see Patient A as soon as Patient A wanted to be seen. (Test. of Patient A.)

20. Patient A continued to experience a high degree of pain and decided that he would not be able to wait to see Kirkendall. Patient A left a message when he was unable to talk to someone at Kirkendall's office and canceled the appointment. Patient A then made an appointment on or about July 2 or 3, 2008, for an MRI (magnetic imaging resonance) with another provider and paid for it himself because he was "desperate and hurting." (Test. of Patient A.)

21. On July 7, 2008, Kirkendall wrote to Licensee regarding Patient A. Kirkendall stated that Patient had repeatedly called her and seemed to be unable to understand that he could not be seen when he wanted. Kirkendall wrote that Patient A "raised his voice, and was most hostile, and rude . . .and [she] advised [Patient A] that [Patient A's] threatening manner would not secure [him] an appointment[.]" (Ex. A1 at 27.) Kirkendall also wrote that she had asked Patient A not to call her again, a step that she had never taken with any client or potential client in her years of practice. (*Id.*)

22. Sometime after July 7, 2008, Patient A called Licensee's office and requested return of the x-rays he brought to the initial visit at Licensee's office. Patient A told Licensee that he was going to get an MRI. At first, Licensee told Patient A that he could not have the x-rays.

Patient A asked for an explanation. After further discussion, Licensee told Patient A to come in and to pick up his x-rays. (Test. of Patient A.) Licensee was upset and understood Patient A to be firing him as a provider. (Test. of Licensee.) Patient A was not intending to fire Licensee at the time of the telephone call. Patient A believed that Licensee had been "indifferent" to him when Patient A called to ask for the x-rays. (Test. of Licensee.)

23. Patient A then came to Licensee's office to pick up the x-rays. Licensee had pulled the x-rays from the file to have them ready. (Test. of Licensee.) Patient A believed the office was vacant when he arrived. (Test. of Patient A.) After Patient A entered the office, Licensee came to the front of the office. Licensee's daughter, Carly Munster, who was Licensee's bookkeeper and receptionist at that time, was present in the back areas of the office, along with a patient or patients. (Test. of Licensee and Munster.)

24. In the ensuing verbal exchange, Licensee told Patient A that he had received the letter from Dr. Kirkendall. Patient A attempted to continue a discussion with Licensee in a manner Licensee perceived had been argumentative and forceful in the past. Licensee did not want further discussion with Patient A or for other patients to overhear the discussion. (Test. of Licensee.) When Patient A tried to talk to Licensee further about the attempt to see Kirkendall, Licensee told Patient A in a stern and deliberate manner "Out! Out!" (Test. of Licensee and Patient A; Ex. A3 at 5.) Licensee believed that Patient A no longer wanted Licensee to provide medical treatment. Licensee said that Patient A had "embarrassed" Licensee by Patient A's treatment of his colleague. He pointed to the counter where Patient A's x-rays were located. At that time, Patient A was feeling poorly physically, he was still having difficulty walking without crutches, and he understood very clearly that Licensee no longer wanted to see him as a patient. Patient A took the x-rays and left. (Test. of Patient A.)

25. Licensee stood in the doorway to the back area while Patient A left the office. (Test. of Licensee and Munster.) Licensee's voice, while speaking to Patient A, had been loud enough that Carly Munster, who was in the back area of the office, was able to hear his voice, which she characterized as "stern" although she could not overhear what was said. (Test. of Munster.)

26. Licensee did not refer Patient A to another acupuncturist when the referral to Kirkendall was unsuccessful. Licensee did not ask for, or obtain, a signed release from Patient A for the x-rays that Patient A took with him at the time of the last visit. (Test. of Patient A and Licensee.)

27. In the opinion of Dr. Bettenburg, Licensee was not obligated to provide a referral to another provider upon termination of the relationship with Patient A. Patient A was already seeing at least one other provider at the time the patient/doctor relationship with Licensee was severed. (Test. of Bettenburg.) Considering the deterioration of the relationship at that time, Licensee believed that most likely a referral to another provider from Licensee would not have been considered by Patient A. (Test. of Licensee.)

28. Patient A received medical attention at Kaiser sometime after he last visited Licensee. At the time of the Kaiser appointment, Patient A's blood pressure was very high. The provider who saw Patient A was very concerned and wanted Patient A admitted for a one-day

observation period. Patient A told the provider about being treated at Licensee's office and that he had received a shot but was unsure what he had been given in the shot. The provider called Licensee's office to find out what medications had been given to Patient A but was unsuccessful in getting that information. (Test. of Patient A.)

29. Patient A also called Licensee and requested his medical records from Licensee, including records detailing what Patient characterized as "a shot" on July 17, 2008. Licensee did not send the records as requested. (Test. of Patient A.) Licensee provided a billing summary of service dates and charges that did not include progress notes or other information from Patient A's charts. (Test. of Licensee.)

30. On September 16, 2008, Patient A signed a permission to release medical records, requesting from Licensee's office, chart notes, "billing receipts, diagnoses given, and medicine or other," and "drugs administered," to Good News Community Health Center. (Test. of Patient A.) A copy of the release was produced as part of Licensee's records for Patient A in preparation for the current contested case matter. The copy of the September 16, 2008 request for medical records was received by Licensee's office on October 10, 2008, the date of fax transmission at the top of the page. (Ex. A1 at 14.)

31. Licensee did not send a copy of Patient A's records in response to the request for medical records received October 10, 2008. He does not remember getting the request. Licensee remembers getting a telephone call from someone with a "very thick Indian accent" who asked for Patient A's records. Licensee told the caller that he needed a written release to send medical records. Licensee does not recall getting a written release for Patient A's medical records prior to receiving a later letter from Patient A's attorney. (Test. of Licensee.)

32. On October 17, 2008, Stefan Feurherdt, Attorney at Law, sent a letter to Licensee requesting medical records on behalf of his client Patient A. (Ex. A2 at 13.) The letter included a copy of Patient A's medical records request to Licensee for Good News Community Health Center and requested Licensee to have the records within fourteen days of the date of the letter. (*Id.*) Licensee's file for Patient A provided to the Board during investigation of Patient A's care did not include a copy of the attorney's October 17, 2008 letter. (Ex. A1.)

33. Licensee recalls that he spoke to Patient A's attorney on the telephone and explained that Patient A's chart notes were not typed and that it would be quicker and easier to follow if he provided a written summary. (Test. of Licensee; Ex. A1 at 2.) Licensee did not document the telephone conversation with Patient A's attorney in Patient A's file. (Test. of Licensee.)

34. Licensee provided the attorney with a narrative summary of Patient A's treatment. The narrative did not include copies of chart notes for Patient A. (Ex. A1 at 2.) The narrative included a statement indicating that "[Patient A] likely never took the [V]alium and even though I explained the advantage of working on him before he spasmed his back by walking he only came in one time before 11:00 a.m. [M]ost of our visits started out with the same talk about his poor inept son and how good his treatment was here." (*Id.*) Licensee did not document Patient A's failure to take the Valium or that Licensee had advised Patient A to come in prior to 11:00 a.m. for appointments. (Ex. A1.)

35. Patient A had taken the Valium and had not discussed it with Licensee. (Test. of Patient A.)

36. Naturopathic physicians are held to a standard of professional ethics. The ethical standards applicable to Oregon naturopathic physicians are consistent with those set out and adopted by the American Association of Naturopathic Physicians (AANP) and the Oregon professional naturopathic associations. The AANP standards are aspirational and have not been adopted by the Board in Oregon. (Test. of Bettenburg; Ex. A11.)

37. Pursuant to the standards of professional ethics, the naturopathic doctor is expected to maintain a calm and collected demeanor and to listen without reactivity to patients. The naturopathic physician, among other things "shall endeavor to first, do no harm * * * [and] shall acknowledge the worth and dignity of every person[.]" The standard remains applicable to communications with patients regardless of the termination of the patient/provider relationship. (Test. of Bettenburg; Ex. A11.)

38. Licensee's statements in the narrative to Patient A's attorney appear to be unrelated to his treatment of Patient A. They were also, in part, inaccurate, and were negative in nature without apparent reason. As such, the statements were unprofessional and did not meet the standards expected for a naturopathic physician. (Ex. A1 at 2; test. of Bettenburg.)

39. Patient A's attorney sent a second letter to Licensee on December 3, 2008, to inform Licensee that the summary of information provided was not adequate and stated that copies of all Patient A's records were required. (Exs. A1 at 29, A2 at 15.)

40. On December 15, 2008, Licensee provided to the attorney copies of Patient A's billing statements, and copies of Patient A's chart notes, including copies of chart notes where Licensee had made additional notations after the date of the original notes. Licensee also sent information that had not originally been included in Patient A's chart at the time Licensee was seeing Patient A. The new information included a product information sheet for the supplement, Pro-Trauma, with a list of ingredients and recommended dosage. (Test. of Licensee; Ex. A2 17-26.)

41. John Laws works as a part-time investigator for the Board. Laws also works part-time as a crime analyst and has a history of over 25 years as a police officer. In his job for the Board, Laws investigates complaints filed by citizens regarding the practice of naturopathic physicians in Oregon. It is his practice to draft questions, as prompts, prior to interviewing individuals during a complaint investigation and to handwrite notes documenting responses given during the interview. Laws interviewed Patients A, B, and C, Licensee and other relevant individuals during the investigation in the current matter and kept notes of the interviews. (Test. of Laws; Exs. A3, A5, and A7.)

42. During the investigation regarding Patient A, Licensee told the Board's investigator on February 24, 2009 that Patient A was "just an old man that is a menace," that Patient A never showed up on time for his appointments, that Patient A wanted his own way, and that Patient A

should not be driving anymore. (Test. of Laws; Ex. A3 at 1.) Licensee also told Laws, among other things, that "the old fool is crazy" and that Patient A was on "a vendetta." (Test. of Laws; Ex. A3 at 2.)

43. Laws also scheduled an interview with Licensee at Licensee's office. During the visit, Laws observed that Licensee's records were untidy and disjointed. When requested to produce one particular file, Licensee was unable to locate it. Licensee searched in loose files out in the office and in files which were stacked in boxes, and in the data base on Licensee's computer. The file in question was located only after a telephone call to Licensee's daughter, who was on leave at the time, for assistance. (Test. of Laws.)

44. Until approximately a year ago, Licensee's practice was to handwrite his chart notes. Licensee began typing his chart notes because he was having problems with insurance reimbursement requests. (Test. of Licensee.)

45. Licensee was also transferring his files to a computer data base and beginning to maintain typed chart notes in response to a June 14, 2007 letter from the Board. (Test. of Licensee; Ex. A12.) The Board stated in the letter that a prior complaint against Licensee had been dismissed, no violation having been found, but the Board was concerned about matters had been revealed during the complaint investigation. The Board reminded Licensee, among other things, that it was his responsibility to keep legible patient records (OAR 850-050-0010(a)(B)) and to make the records available upon request. The Board warned that, should the Board be made aware of other complaints against Licensee, the complaint referred to in the letter might be considered an aggravating circumstance. (Ex. A12.)

46. Licensee told Laws that his files were in the process of being converted from handwritten notes to a computer and that he was changing to a new computer data base. Licensee explained that his current computer database required entries for chart notes into an Excel data-sheet for the date of the patient's appointments, and that accessing the notes required referencing a separate record of patient appointments. The data-base had no search function and did not contain continuous notes for patient records. (Test. of Laws and Licensee.)

Licensee's charting of Patient A

47. Dr. Bettenburg reviewed the copies of Licensee's chart notes and file for Patient A which were provided in response to the Board's request. Licensee's summary of care prepared for Patient A in response to the request from Patient A's attorney did not conform to the standard of care expected for charting patient visits for a provider of naturopathic medicine. A summary of care may be provided to another provider but is expected to be a distillation of daily progress notes. Reviewing the entire records provided by Licensee for Patient A, Dr. Bettenburg opined that she would not have sufficient information upon which to treat a patient who presented as a referral from Licensee with the charts produced for Patient A. (Test. of Bettenburg.)

48. The summary of care provided to Patient A's attorney is legible because it is typed. However, a medical practitioner receiving the summary from Licensee would not have a complete and accurate history for Patient A. The summary is undated and unsigned. There are

no notes as to what Licensee observed about the patient on each visit, what procedures or medicines were administered on each visit, or what Patient A's diagnosis was. (Test. of Dr. Bettenburg.) In the summary, Licensee stated that Patient A was provided a prescription for 5 milligrams of Valium. (Ex. A1 at 2.) Chart notes for Patient A did not document a prescription for Valium. The date the prescription was provided is unknown. (Test. of Bettenburg.)

49. During the June 17th visit, Licensee performed a manipulation on Patient A, and administered a vitamin solution by an intravenous line, referred to by Licensee as an "IV push." Patient A paid $183.00 for the initial visit, including a manipulation and a supplement called "Pro-Trauma." (Test. of Licensee; Ex. A1 at 15.) Pro-Trauma is a brand-name supplement which was provided to Patient A at the first visit to Licensee. At the time of the visit, Licensee billed Patient A for the supplement but did not document the dosage or list of ingredients in Patient A's chart. Licensee did not chart what was included in the "IV-push." (Ex. A1 at 19, 20, 22; test. of Licensee.)

50. On June 18, 2008, the second office visit, Patient A was given another IV push, and a manipulation. Patient A was billed $380.00 for services which included another IV push, a manipulation, and the consultation. (Ex. A1 at 23.)

51. In addition, Licensee's chart notes for Patient A did not meet the standard of care for the following reasons:

- Visit of June 17, 2008: the note does not included an assessment and it is unclear what the patient was complaining of; part of the note is not legible; it is difficult to understand what is documented in the note and why because it is written in a "stream of consciousness" style; the note does not include an objective portion and is missing data normally noted in patient charts, including blood pressure or other vital signs or the patient's height and weight; the notes did not document the dosage or ingredients for the Pro-Trauma supplement or the IV "push" given to the patient; and it is unclear why Licensee felt it necessary to document the patient's comments about the patient's son. (Test. of Bettenburg; Ex. A1 at 22.)

- Visit of June 18, 2008: there is no assessment of the patient; the handwriting is difficult or impossible to read; as in the June 17th note, the patient's vital signs are not noted; there is a note that a manipulation was done but there was no description of what manipulation was performed; and magnesium was given but no specifics as to the form and dosage of the magnesium.[5] (Test. of Bettenburg; Ex. A1 at 23.)

- Visit of June 19, 2008: the first note dated June 19 is unclear as to whether patient was seen in the office for a visit; if so, among other missing information is any assessment as to how the patient indicated he was feeling, any record of patient's vital signs, or whether any medications or other procedures were performed. (*Id.*)

[5] Notes at the bottom of A1 at 23 define the dose amount and form of magnesium given to Patient A on June 17, 2008 but the notes were not made contemporaneously to the chart notes for the visit. The notes at the bottom were added after Patient A requested copies of the records, specifically to include medication and dosages administered by Licensee to Patient A. (Test. of Licensee.)

- Visit of June 19, 2008: the second note dated June 19 is also unclear; there is no assessment; there is a reference to the patient being complimentary to Licensee but no note as to why Licensee believed this information was important or how it related to patient care; no patient vital signs are noted; there is a note regarding hip rotation but it is unclear what Licensee meant in the note; notations, in the bottom margin of the page, regarding magnesium were added after the date of the visits, and it is not clear to which, if any, of the visits, the notes added to the bottom of the page relate. (*Id.*)

- Visits of June 21 and 23, 2008: portions of the notes are illegible and there is no assessment of the patient. (Test. of Bettenburg; Ex. A1 at 24.)

- Visit of June 24, 2008: portions of the notes are illegible, making it difficult to understand what happened at the visit; the note references a shot given by Licensee to the patient at a trigger point but there is no documentation that the shot or its contents were discussed with the patient; it is unclear as to why Licensee believed the shot was necessary; and the note at the bottom of page references a shot, including the contents of the shot, but it is difficult to understand when that shot was given. (Test. of Bettenburg; Ex. A1 at 25.)

- Visit of June 27, 2008: Blood pressure is noted but there is no other assessment of Patient A for that visit; it is unclear if the patient is improving, or getting worse; and much of the standard information which would be included in a SOAP format is missing. (Test. of Bettenburg; Ex. A1 at 21.)

- Notes added after the chart note dated July 1, 2008: additional notes reference a letter dated July 7, 2008 and a phone call between Licensee and Patient A that occurred on a different date. (Test. of Bettenburg; Ex. A1 at 21.)

- A telephone call from Patient A to Licensee regarding the patient's x-rays and continuation of care and Patient A's visit to pick up his x-rays were not documented in Patient A's chart. Accurate and complete charts are expected to include notes on all interactions and matters related to a patient. The treatment summary provided to Patient A's attorney did not document the telephone call but did document the visit regarding the x-rays. Licensee's charting was incomplete and misleading as a result of these omissions or errors. (Test. of Bettenburg.)

52. When charting, if additional information is added to a chart note at a later date, it is standard practice and expectation that the additional information is added only if relevant and necessary, such as in the case of something that occurred or was noted during the visit but was inadvertently forgotten in the original note. It is the expectation that any addendums or additional notes are clearly marked as such and dated as of the date the addendum is made. (Test. of Bettenburg.)

53. Licensee added information to Patient A's chart notes after the original notes but without clearly marking or dating the information as additional. The additional notes did not

meet the standard of care for charting expected of naturopathic medical providers. (Test. of Bettenburg.)

Patient B

Licensee's charting for Patient B

54. Patient B saw Licensee six times between November 24, 2007 and January 12, 2008. (Test. of Licensee and Patient B; Ex. A4 at 4.) Patient B's chart at Licensee's office included the following: an intake form completed by Patient B with notations to Patient B's answers, added by Licensee at the time of the patient's first visit; billing statements including billing codes and amounts for each office visit; billing codes and amounts for IV therapies and medications, where appropriate; and brief handwritten progress notes taken at the time of each patient visit. (Test. of Licensee; Ex. A4 at 3-14.)

55. In response to the Board's request for information, Licensee produced a typed page of progress notes. At the time he generated the information provided to the Board, Licensee summarized the progress notes from his handwritten notes about Patient B, and added patient billing codes and the SOAP format to the original notes. Licensee added Patient B's visit notes to the computer on the associated appointment page. In order to create the summary, each text for the associated note was cut and pasted into a single document to create the summary. Licensee did not include the handwritten notes for Patient B in the copies of Patient B's chart provided to the Board. (Test. of Licensee; Ex. A4.)

56. Licensee's chart notes for Patient B were incomplete and did not meet the standard of care expected for providers of naturopathic medicine based upon the following:

- Visit of November 24, 2007: information relied upon by Licensee was information included in notes made on Patient B's intake form; subsequent providers would have difficulty differentiating between the patient's input and Licensee's assessment; under "objective," Licensee included statements made by the patient, which should have been placed under the "subjective" portion of the notes; Licensee noted what the patient believed was wrong with her but did not include Licensee's assessment of the patient; there is no evidence of a physical exam or record of the patient's vital signs; and no details of Patient B's history were included.

- Visits of December 1, 12, 8, 22, 2007 and January 5 and 12, 2008: no vital signs are charted for any visit; no physical examination is charted as being performed; the notes summarize office visit without sufficient detail; the substance of Licensee's findings; assessment and plan elements are not charted; the notes are insufficient to discern what substances were given to the patient and in what amounts; and billing codes noted in the chart are not accompanied by information sufficient to identify what the codes are or where to find that information.

(Test. of Bettenburg.)

57. No handwritten notes were included in the charts produced for Patient B in response to the Board's request during the investigation. (Test. of Laws.) The one page summary of notes provided to the Board for Patient B is not dated and the entry under each date is not signed. (Ex. A4 at 2.) Patient B's chart does not document any contacts between Patient B and Licensee. (Ex. A4 at 1-14.)

58. Licensee dispensed thyroid medication to Patient B on January 12, 2008, charging $30.00 for the medication. (Test. of Patient B; Ex. A4 at 14.) Patient B's chart does not note an assessment, plan, or prescription for Patient B for thyroid problems nor is there a record of the amount or dosage of the thyroid medication dispensed on January 12th. (Test. of Bettenburg; Ex. A4 at 1-8.) The summary of chart notes does not document any assessment or plan regarding a thyroid issue nor is there a record of a prescription for thyroid medication for Patient B. (Test. of Bettenburg; Ex. A4 at 2.)

59. Licensee noted that Patient B had documented a thyroid condition on her intake forms. Licensee did not initially treat Patient B for thyroid because he was seeing her for "sleep disruptions." He intended his notes of "biochemical issues" to reflect Patient B's thyroid condition. (Test. of Licensee.) Licensee's Answer filed in response to the Notice admitted that he dispensed a sample thyroid medication to Patient B on Patient B's last visit "which was Licensee's normal procedure." (P2 at 6.)[6] On Patient B's intake form, under "Current Medications or Supplements, " Patient B' wrote "thyroid medication" but provided no further information. (Ex. A4 at 7.)

60. Licensee's charting of Patient B's thyroid issue was inadequate. If Patient B had a prior diagnosis and prescription for thyroid medication, the information should have been documented clearly in the patient's chart but it was not. On-going treatment of a thyroid condition should be documented, as well as any samples of medications provided to a patient. Patient B's chart notes do not show adequate documentation regarding the patient's thyroid condition over time or samples of medication, if any, given. (Test. of Bettenburg.)

61. Dr. Hansel opined, when asked if Licensee's dispensing of thyroid medication for Patient B was appropriate, that he would first review the patient's chart for lab reports, diagnosis, and a prescription. Dr. Hansel stated that a dosage is usually noted in the chart with the prescription. When asked if he would be comfortable treating a patient for thyroid, who presented with the copy of Licensee's records for Patient B, Dr. Hansel said that a patient would normally bring their medications in with them and he would be able to refer to the bottle for treatment. (Test. of Hansel.)

Licensee's conduct towards Patient B

[6] Licensee testified at hearing that he refilled Patient B's to prevent her from crashing, and after he had seen her original prescription bottle with the dosage and amount. To the extent that Licensee's testimony at hearing was neither corroborated by Licensee's chart notes nor any other evidentiary source, and it is in the form of an additional defense to those raised in Licensee's Response to the Notice, pursuant to OAR 850-050-0015, it will not be considered.

62. Licensee provided billing statements to Patient B when she requested documentation to submit to her insurance for reimbursement. The billing statements included the CPT billing codes associated with Patient B's visits. (Test. of Licensee and Patient B; Ex. A4 at 9-14.) When Patient B's insurance denied her claim for insufficient documentation, Patient B requested additional information, including copies of chart notes, from Licensee. Licensee provided handwritten notes to Patient B for submission to her insurance company. The notes were not legible and the insurance company again refused to reimburse Patient B based on insufficient documentation of the care provided by Licensee. (Test. of Patient B.)

63. Patient B repeatedly informed Licensee of the denial of her claims and asked for additional information. Each time Patient B received an explanation of benefits (EOB) from her insurance company denying her claim for visits to Licensee, Patient B called the company and was told the documentation was insufficient. Patient B called Licensee multiple times, attempting to get sufficient documentation. (Test. of Patient B.)

64. Approximately one year after the first request, Licensee provided a typed summary of Patient B's progress notes. Patient B submitted the summary to the insurance company but it was also rejected because of insufficient documentation. (Test. of Patient B; Ex. A4 at 1.) Patient B's claims were not paid because the documentation provided by Licensee was determined to be incomplete and, after over a year, her attempts to complete the claim submissions were denied by the insurance company as being submitted untimely. Patient B "gave up" because of the time and effort expended in attempting to get adequate information from Licensee for insurance reimbursement. Patient B never received reimbursement for the out-of-pocket amount of $573.00 paid to Licensee. (Test. of Patient B.)

65. Patient B's health insurance provided benefits for treatment from alternative medical providers, including naturopathic physicians. (Test. of Patient B and Licensee.) Health insurance providers differ as to what services are covered for naturopathic physicians. If a provider is following HCFA guidelines with proper chart notes, reimbursement for the visit to naturopath's office should not be a problem. Payment for supplements may be denied if the policy does not provide coverage for supplements. (Test. of Bettenburg.)

66. Insurance companies may accept a summary of billing like that provided by Licensee but if such a summary is refused due to lack of sufficient information, the provider is expected to provide additional detailed information. If copies of chart notes are requested for reimbursement of charges from an insurance company, a summary of billing is not adequate for reimbursement and the physician is required to provide sufficient documentation of a patient visit to allow evaluation of the visit for reimbursement. Naturopathic physicians are expected to respond within 30 days to a request for medical records. The copies of billing statements and the summary of progress notes provided by Licensee to Patient B, in light of the insurance company's request for additional information, did not meet the standard of care for practice of naturopathic medicine in Oregon. (Test. of Bettenburg.)

Patient C

Licensee's charting for Patient C

67. Patient C saw Licensee for multiple visits between May 14, 2007 and November 4, 2008. (Test. of Patient C; Ex. A6 at 1-79.) Patient C was referred to Licensee by her acupuncturist for treatment of multiple issues, including a diagnosis of multiple sclerosis (MS) by a neurologist. (Test. of Patient C; Ex. A6 at 1.)

68. Dr. Bettenburg reviewed the chart notes for Patient C that Licensee provided to the Board during its investigation. In Dr. Bettenburg's opinion, the notes did not meet the standard of care for the following reasons:

- Patient C is considered a complicated or complex patient because of the patient's numerous medical conditions. Complex patients require more detailed chart notes to ensure accurate patient care from the provider and to ensure an accurate history of treatment should the patient receive additional or subsequent medical care by a different provider. Licensee's notes for a majority of visits do not contain the basic information required to document the subjective, objective, assessment, and plan for the patient on each visit.

- Licensee documented a series of administrations of a "glut push" but did not chart patient vital signs on those visits. When a patient is a return patient for similar treatments, minimal notation may be acceptable. In the case of Patient C, Licensee noted in some instances what the patient's perception of the effect of the treatment was but failed to document Licensee's assessment of the patient's condition or his long-term plans for treatment.

- Licensee used abbreviations in some notes that are non-standard for charting purposes and which would not be understood easily, if at all, by another provider.

- Licensee's notes consistently lack a treatment plan rationale.

- Licensee's notes indicate that he made objective observations of Patient C and used his clinical judgment to treat the patient but his chart notes do not reflect those elements.

- Chart notes for visits dated November 4, 2008 and February 2, 2009 include information added at a later date but the additional information is not clearly marked, separated or dated in order to indicate when and why it was added.

- Licensee prescribed Xanax .25 mg to be taken one-half pill, two times daily for Patient C on July 10, 2007. (Ex. A6 at 3.) On November 4, 2008, Licensee noted a refill for a prescription for Xanax for the patient but did not document the dosage. (*Id.* at 11.) It is standard practice to document dosages for refills of prior prescriptions. Proper documentation records the current dosage and prevents errors if the refill prescription is separated from the chart notes or is otherwise unable to be located.

(Test. of Bettenburg; Ex. A6 at 1-81.)

69. On or about October 21, 2008, Patient C asked Licensee if she might have Lyme's disease. Licensee wrote in his chart note that Patient C was comparing her self to other MS patient's in the clinic and was asking for a diagnosis of Lyme's because the treatment for the those patients seemed to help their symptoms improve. (Ex. A6 at 11.) During Law's investigation interview, Patient C told Laws that Licensee responded to her inquiry about having Lyme's by telling her that she was trying to self-diagnose and was mimicking the symptoms of other patients. Patient C believed Licensee was rude and egotistical in his treatment of her. (Test. of Laws; Ex. A 7 at 1, 2.)

70. Patient C asked Licensee for a referral to get a second opinion regarding the possibility that she had Lyme's. Licensee told Patient C that he would think about it. He did not provide the referral. (Test. of Patient C.)

71. During an office visit of November 4, 208, Patient C told Licensee she was seeking another opinion from a provider in New Mexico. (Test. of Patient C; Ex. A6 at 11) She did not tell Licensee who the provider was prior to seeing the provider. Patient C then sought a second opinion from a Sir Carl E. Haese in New Mexico. Patient C had been told about "Sir Carl" by other patients. Patient C was evaluated and treated for Lyme's by Sir Carl. Patient C later found out that Sir Carl was not a licensed medical provider and that he had pled guilty to practicing without a license. (Test. of Patient C.)

72. Patient C called Licensee while in New Mexico and told Licensee that she had been diagnosed with Lyme's. (Test. of Patient C and Licensee.)

73. Licensee's chart notes for the November 4, 2008 visit state that Patient C "is going to New Mexico, to see a Sir Carl E. Haese, for a work up. For her lymmes (*sic*) disease." (Ex. A6 at 11.) Licensee added to the chart notes for Patient C's visit of November 4, 2008 stating that Patient C had subsequently called from New Mexico, told Licensee about the diagnosis, and asked for a refund. Licensee wrote that Patient C "made it clear she was not going to see me anymore" and that her doctor in New Mexico would send her to an appropriate doctor for follow-up. Licensee also wrote, among other things, that he found out later that Patient C had called other patients of his and had told them Licensee did not know what he was doing. (Ex. A6 at 11; test. of Licensee.)

74. In a chart note dated February 2, 2009, Licensee wrote that Patient C had called him and requested a write up, stating that she had MS so that she could get disability benefits. He then wrote "[s]he hung up mad when I would not do a write up on her. I likely would have helped her but she had clearly fired me and now wanted me to fix the damage done by an unlicensed provider. I have followed up on several of the people who went to him and they were very toxic from the chemicals he gave." (Ex. A6 at 11, 12.)

75. Patient C reviewed the copies of the chart notes prior to testifying at hearing. She found the notes to be inaccurate in part, as follows: she did not request a refund of fees when she called from New Mexico; she did not tell Licensee who she was going to see prior to leaving for New Mexico; she did not call other patients and talk poorly about Licensee; and she did not hang up "mad" when she spoke with Licensee over the telephone. (Test. of Patient C.)

76. The Board requested a copy of Patient C's chart. In response to the Board's request, Licensee created a summary of progress notes by accessing each appointment date with the associated computer notes and creating a compilation of notes from those entries. The material provided to the Board for Patient C included the summary created by Licensee. (Test. of Licensee; Ex. A6.) The events recorded under the chart note for November 4, 2008 did not all occur on November 4, 2008. Licensee added events that occurred on at least two later days to the notes for November 4, 2008. The additional material was not separated and marked as an addendum nor dated at the time it was added the original chart note for November 4, 2008 for Patient B. (Test. of Licensee; Ex. A6 at 11.)

77. It is Licensee's practice to write prescriptions on a pad that creates a carbon copy of each prescription written. Licensee or staff later files the carbon copy of the prescription in each patient file. If the prescription is called in to a pharmacy, Licensee writes a duplicate handwritten copy of the prescription to be placed in the patient's chart. Not all copies of prescriptions were accurately filed with each patient record. (Test. of Licensee.)

78. Licensee's progress note for Patient C's visit of January 21, 2008 reads "Vega treatment. Is feeling sick tested for mold aspergillis TX with electromagnetic energy." (Ex. A6 at 6.) Patient C's file also included a copy for a prescription, dated January 1, 2008, for "Lyme 1GG & 1GM, DX weakness chronic fatigue, 780.71. (*Id.* at 37.) No reference to the prescription is recorded in the progress note of the same day. (Test. of Bettenburg; Ex. A6 at 6.)

79. A November 4, 2008 chart note indicates that Licensee, at Patient C's request, refilled Patient C's prescription for Xanax. In the chart notes provided to the Board for Patient C, there was no copy of a refill for Xanax for Patient C on or about November 4, 2008. (Test. of Licensee; Ex. A6.)

80. On or about December 17, 2008, Licensee authorized a prescription for Licensee over the telephone. The prescription was for Xanax .25 mg, 1/2 tablet by mouth, 1 to 2 times during the day and 1 tablet at bedtime, quantity of 10 tablets, with one refill allowed, that was filled at a Fred Meyer pharmacy. (Ex. R1.) No carbon copy of the prescription was included in the records provided to the Board's request for Patient C's files. (Test. of Bettenburg; Ex. A6.)

81. Prior to purchasing a new computerized system, it was Licensee's practice to copy progress notes from his computer, filed by appointment date, and to cut and paste those notes to create a progress summary, and to provide copies of prescriptions from the file. Licensee found that creating a copy of a chart for a longtime patient required a lengthy, complex process and that "it was a mess." Copies of patient records were not always complete. For example, the copy of the refill for Patient C's last prescription refill for Xanax should have been provided to the Board but it was inadvertently left out of Patient C's file. (Test. of Licensee.)

Conduct towards Patient C

82. In Winter or early Spring 2009 when she was no longer seeing Licensee, Patient C called him and asked for copies of her medical records. She also asked Licensee to complete a

disability report. Licensee responded abruptly to Patient C that she had fired him and that he had not seen her in six to eight months. Licensee did not tell Patient C that he would complete the report as requested. At the conclusion of the call, Patient C believed that Licensee was refusing to complete the report. Patient C was disappointed and sad at the end of the telephone call, due in part to her lengthy doctor/patient relationship with Licensee and the nature of his response. Patient C perceived Licensee as "very rude" in his response to her request for the disability form. (Test. of Patient C.)

CONCLUSIONS OF LAW

1. Licensee failed to adequately chart patient records for, and communicated in an unprofessional manner with, Patients A, B, and C, and failed to provide medical records upon the requests of Patients A and B, in violation of ORS 685.110(15) and OAR 850-050-0190(3).

2. Licensee failed to meet the standard of care by not making a diagnosis for Patient B in violation of ORS 685.110(8) and (15) and OAR 850-050-0910(3).

3. Licensee did not fail to meet the standard of care for Patients A and C regarding the obligation to refer patients to a licensed practitioner, and did not violate OAR 850-050-0190(11).

4. The Board's proposed penalty of a civil penalty of $4000 and a probationary period of three years with conditions for continuing education as set out in the Disciplinary Notice is within the Board's discretion to impose and is appropriate.

OPINION

The Board proposes to assess Licensee a civil penalty and impose a probationary period upon Licensee with conditions for multiple violations of the laws and rules governing Licensee as a naturopathic physician. Specifically, the Board alleged that Licensee's charting, for Patients A, B, and C was inadequate, that Licensee's communication, including his conduct towards those patients, was unprofessional, and that Licensee failed to provide medical records upon request of Patients A and B, in violation of ORS 685.110(15) and OAR 850-050-0190(3). The Board also alleged that Licensee failed to meet the standard of care by failing to make a diagnosis for Patient B in violation of ORS 685.110(8) and (15), and OAR 850-050-0190(3) and that he failed to refer Patient A to a licensed practitioner in violation of OAR 805-050-0190(11).

Licensee argued that his charting in all instances met the required standards and was adequate, that his conduct had been professional, that he provided medical records timely when requested, and that he was not obligated to refer Patient A to a licensed practitioner when Patient A sought other care and ended the patient/doctor relationship.

Burden of proof

In a contested case, the proponent of a fact or position has the burden of producing evidence to support that fact or position. ORS 183.450(2). In this case, the Board has the burden of proving Licensee engaged in the conduct as alleged, that, if proven, the conduct violated

Board statutes or rules, and that the Board's proposed sanction is within its discretion to impose. Proof must be by a preponderance of the evidence. *Gallant v. Board of Medical Examiners*, 159 Or App 175, 180 (1999).

Authority of the Board

The Board is authorized to govern the licensure and practice of naturopathic medicine in Oregon and to promulgate rules to carry out its responsibilities. ORS 685.160. The Board may impose disciplinary action upon licensees pursuant to ORS 685.110. *Former* ORS 685.110(2003), *amended by* Or Laws 2009 c.43, was in effect at the time the alleged conduct occurred and at the time the Notice was issued. *Former* ORS 685.110 provided, in relevant parts:

> **685.110 Grounds for discipline; penalties.** The Oregon Board of Naturopathic Examiners may refuse to grant a license, may suspend or revoke a license, may limit a license, may impose probation, may issue a letter of reprimand and may impose a civil penalty not to exceed $1,000 for each offense for any of the following reasons:
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> * * * * *
>
> (8) Negligence related to the practice of naturopathic medicine.
>
> * * * * *
>
> (15) Any conduct or practice contrary to a recognized standard of ethics of the profession or any conduct or practice that does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition that does or might adversely affect a physician's ability safely and skillfully to practice naturopathic medicine.
>
> * * * * *
>
> (25) Violation of any provision of this chapter or rules adopted by the board.

The Board has promulgated rules to carry out its responsibilities. OAR 850-050-0190 governs the discipline or denial of a license to practice Naturopathic medicine. In relevant parts, OAR 850-050-0190 provides:

> Discipline or Denial of License
> The Board may refuse to grant a license to practice Naturopathic medicine in the State of Oregon, or may discipline a licensee, for any of the following reasons:
>
> * * * * *
>
> (3) Unprofessional or dishonorable conduct which includes but is not limited to:
>
> (a) Any conduct or practice contrary to recognized standards of ethics of the naturopathic profession; or
>
> * * * * *
>
> (11) Failure to refer the patient to an appropriate care provider upon termination of treatment where referral is called for, unless termination was the decision of the patient and the licensee had no opportunity to refer the patient.
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> * * * * *

In addition, the Board may also exercise its discretion, and may consider aggravating and/or mitigating factors, in imposing sanctions for violations as set out in OAR 850-050-0010,[7]

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[7] OAR 850-050-0010, provides in relevant parts, as follows:
Sanctions for Violations
The following lists the Board's disciplinary practices with respect to most common violations of law. Other less common violations may also result in discipline. The Board will determine the severity of each violation and decide the discipline to impose accordingly.

(1) General violations.
(a) The Board will attempt to resolve by non-disciplinary means, allegations of the following kinds of violations, in the absence of aggravating circumstances and if the licensee has not been the subject of a final order which finds the licensee committed a violation of a similar nature:

* * *

(B) Inadequate charting;

* * *

(F) Failure to refer upon termination.

(b) Instead of discipline in the violations listed in (1)(a), the Board may issue a letter of caution or a letter of warning. If Licensee disregards the Board's recommendation in the letter of caution or the letter of warning, the Board may initiate disciplinary action.
(c) The Board generally will take formal disciplinary action for allegations of the following kinds of violations, in the absence of major mitigating circumstances:

* * *

(C) Conduct contrary to the standard of ethics;
(D) Failure to refer when referral is appropriate[.]

* * *

(d) Discipline for violations listed in (1)(c) may include a letter of reprimand, a civil penalty, probation, license suspension, license limitations, and license revocation.
(e) For violations which are not listed in subsections (1)(a) and (b) of this rule, the Board will determine the appropriate discipline.
(f) If a violation is listed in subsection (1)(a) of this rule and the licensee has already received a letter of caution or a letter of warning for a violation of a similar nature, the Board may proceed with formal discipline.

(2) Aggravating and Mitigating Factors or Circumstances. Discipline proposed by the Board may increase in severity, possibly up to license revocation, if there are aggravating circumstances. Discipline may decrease in severity if there are mitigating circumstances.
(a) Aggravating circumstances include, but are not limited to, the following:
(A) The same or similar violation has occurred more than once;
(B) The violation occurred or was repeated over a significant length of time;
(C) The licensee has previously been disciplined by the Board or in another jurisdiction[.]

* * *

(b) Mitigating circumstances include, but are not limited to, the following:
(A) The licensee accepted responsibility for the violation;
(B) The licensee practiced a significant period of time without complaints or disciplinary action taken by the Board or any other jurisdiction.

including inadequate charting and failure to refer upon termination. OAR 850-050-0010(1)(a)(B) and (F).

Expert Testimony

The testimony offered by each party's expert witness differed as to whether Licensee's charting for Patients A, B, and C met the standards expected for naturopathic physicians in Oregon. Because more weight is given to an expert opinion that is well reasoned and based on complete information, it is necessary to evaluate the reasoning and basis for each expert's opinion. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Dr. Bettenburg, expert witness for the Board, has been licensed as a practitioner of naturopathic medicine for over 21 years. She has taught classes in clinical and physical diagnosis including patient charting for NCNM. Dr. Bettenburg is currently Dean of NCNM and acts as a consultant to the Board on the practice of naturopathic medicine. Dr. Bettenburg's demeanor and manner when testifying was unequivocal and straightforward.

Licensee's expert witness, Dr. Jonathan Hansel, has been licensed as a naturopathic physician in Oregon since 1998. Dr. Hansel and Licensee have referred patients to each other in the past. Dr. Hansel is not certified to perform IV therapy and was unable to offer an opinion as to the appropriateness of Licensee's actions regarding any IV treatments. But for a short, unspecified period of time when Dr. Hansel was on staff at NCNM, he maintains his medical practice but does not otherwise hold an academic position. Dr. Hansel is currently on probation with the Board under a consent order and may not prescribe or administer controlled substances, due to habitual or excessive use of controlled substances. Dr. Hansel also disciplined in 2002 by the Board for violating ORS 685.110(15). When asked his opinion regarding Licensee's charting practices, Dr. Hansel's answers were equivocal. In multiple instances, Dr. Hansel did not offer opinions based on the facts at issue. His opinions were frequently based on facts he added when formulating his answers, rendering his ambiguous.

Weighing the testimony of each expert, in view of the record as a whole, and in view of each expert's familiarity and experience with the application of Oregon licensure rules for naturopathic physicians and practical experience applying those rules as applied to any particular factual situation, I give greater weight to the testimony of the Board's expert witness.

Licensee also offered testimony at hearing that was in conflict with the facts according to other witnesses and with Dr. Bettenburg's opinion on the standards of practices for naturopathic physicians. A formulation of the standards for evaluating credibility of a witness was made in *Tew v. DMV*, 179 Or App 443, 449 (2002):

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(3) Probation. Probation may be added where the circumstances indicate that future monitoring, training, or other follow-up is necessary or appropriate[.]

* * *

(5) Education. Education may be required when the circumstances indicate that further education is merited to prevent a recurrence of the violation.

> A determination of a witness' credibility can be based on a number of factors other than the manner of testifying, including the inherent probability of the evidence, internal inconsistencies, whether or not the evidence is corroborated, and whether human experience demonstrates that the evidence is logically incredible.

Considering the factors in *Tew*, Licensee's testimony was inconsistent, both internally and externally, regarding details of various events at issue. Specifically, regarding Patient B's thyroid medication refill, Licensee's testimony varied at hearing and was inconsistent with that stated in the Request for Hearing and Response filed to the Notice in this matter, and with the notes, or lack thereof, in Patient B's files. Licensee added notes to patient charts after the date of the original notes, bringing into question the accuracy of Licensee's patient files. Summaries of progress notes created after the fact were undated in the case of Patients A and B. Considering these and other inconsistencies, I find Licensee's testimony of questionable reliability.

Alleged inadequate charting for Patients A, B, and C

The Board alleged multiple instances of inadequate charting by Licensee in regards to Patients A, B, and C. The findings of fact support the Board's argument. Licensee's arguments to the contrary are not persuasive and are not supported by the record. As stated by Dr. Bettenburg, failure to adequately chart patient care affects not only the treating physician's ability to accurately, effectively, and safely treat the patient but also the ability of a subsequent medical provider to ascertain the history and treatment of the patient in order to provide safe and effective treatment. Proper charting is also necessary to allow a patient to obtain insurance coverage to which he or she is entitled.

Licensee failed to include subjective and objective data for each patient visit, his assessment of the patient during the visit, and his plan of treatment in multiple chart notes for the patients at issue. Licensee failed to note all contacts with each patient or matters related to each patient. Licensee added notes to charts after the fact without clearing delineating and dating the additions. Licensee failed to ensure copies of all prescriptions were maintained in each patient's chart. Licensee's handwritten chart notes were, in many instances, not legible, and the charts maintained on the computer data base were not easily and accurately accessible when needed. Licensee's multiple failures to adequately chart records for Patients A, B, and C were contrary to the standards expected of a naturopathic physician, in violation of ORS 685.110(15).

Alleged unprofessional communications with Patients A, B, and C

The Board alleged that Licensee engaged in unprofessional communications with Patients A, B, and C. Licensee disputed the allegations. As testified to by Dr. Bettenburg, a licensed provider must maintain a professional manner and remain non-reactive and open to patient communication, even if the patient or doctor severs the doctor/patient relationship. The record at hearing supports the Board's allegation that Licensee failed to meet the standard of professional conduct in his communications with Patients A and C.

Licensee's conduct towards Patient A when Patient visited the office to retrieve his x-rays was unprofessional. Although Licensee believed Patient A had fired him prior to coming for the visit, Licensee would still be held to the standard of professionalism and ethics expected of licensed naturopathic physicians in Oregon when Patient A came to the office. Licensee's feelings regarding Patient A and the situation with his colleague Dr. Kirkendall were irrelevant to Licensee's duty to behave professionally towards Patient A. Interrupting Patient A and ordering him to leave the office, in a loud voice, rather than calmly discussing the patient's concerns or, if Licensee had other obligations at that time, requesting that Patient A schedule a time to return, was unprofessional.

Although Licensee failed to fulfill his professional obligations to Patient B regarding production of records upon request, the record does not support a finding that Licensee's communications with Patient B were unprofessional.

However, as alleged, Licensee's communications with Patient C also failed to meet professional standards. As stated by Dr. Bettenburg, Licensee's obligation to meet professional standards existed at the time Patient C contacted Licensee regarding disability paperwork. The obligation towards Patient C, stemming from the previous patient/provider relationship, required Licensee to respond in a positive, professional manner and to complete the patient's request. Licensee's response, telling Patient C that she had fired him and failing to make clear to Patient C that he would complete the requested paperwork, was unprofessional. Licensee's comments added to Patient C's chart notes, including among other things, his conclusions about Patient C's conduct while away from his office, were irrelevant to Patient C's care and were stated in such a way as to convey a negative connotation about Patient C. Such comments were unprofessional. The record supports the Board's allegations that Licensee's communications and conduct towards Patients A, B, and C were unprofessional.

Licensee's comments to the investigator regarding Patients A and C were unprofessional. Even if they were made in the nature of a confidential investigation, as argued by counsel, the nature of the comments was unnecessarily negative. Licensee's choice of language corroborated the negative and unprofessional nature of his interactions with Patients A and C as alleged by the Board.

Alleged failure to provide medical records upon request for Patients A and B

Access to protected health information (PHI) is governed by federal and state law. ORS 192.518, entitled "Policy for protected health information," provides as follows:

> (1) It is the policy of the State of Oregon that an individual has:
> (a) The right to have protected health information of the individual safeguarded from unlawful use or disclosure; and
> (b) The right to access and review protected health information of the individual.
>
> (2) In addition to the rights and obligations expressed in ORS 192.518 to 192.529, the federal Health Insurance Portability and Accountability Act privacy

regulations, 45 C.F.R. parts 160 and 164, establish additional rights and obligations regarding the use and disclosure of protected health information and the rights of individuals regarding the protected health information of the individual.

Federal rules promulgated by the United States Department of Health and Human Services pertaining to the disclosure of PHI are set out in 45 CFR §§164.524 which provides in relevant parts:

> (a) *Standard: Access to protected health information*—
> (1) *Right of access.* Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set[.]
>
> * * * * *
>
> (b) *Implementation specifications: requests for access and timely action*—
> (1) *Individual's request for access.* The covered entity must permit an individual to request access to inspect or to obtain a copy of the protected health information about the individual that is maintained in a designated record set. The covered entity may require individuals to make requests for access in writing, provided that it informs individuals of such a requirement.
> (2) *Timely action by the covered entity.* (i) Except as provided in paragraph (b)(2)(ii) of this section, the covered entity must act on a request for access no later than 30 days after receipt of the request [.]

(Emphasis in original.)

The Board alleged Licensee failed to provide medical records as required upon the request of Patients A and B. Licensee argued that he had provided records timely when requested. The Board met its burden of proof regarding its allegations as to both Patients A and B.

Licensee argued that he had responded timely and appropriately to Patient A's request for records. Patient A testified credibly at hearing that he had requested his records from Licensee, by oral requests beginning in July 2008, followed by written requests beginning in September 2008. Patient A did not receive the requested records until mid-December when they were sent to Patient A's attorney.

Licensee disputed receiving requests prior to the written request included with the letter from Patient A's attorney. Licensee admitted that Patient A asked for his x-rays, and that, eventually, he provided them during an office visit. Licensee denied receiving a signed authorization for a release of records until one was sent by Patient A's attorney and that he responded timely. The record does not support Licensee's testimony.

The copy of Patient A's written release, *provided by Licensee* to the Board shows that Licensee received the release and request for records by fax from "Bob B" on October 10, 2008. (Ex. A1 at 14.) The first letter to Licensee from Patient A's attorney, which enclosed a copy of the same authorization, was dated October 17, 2008. (Ex. A2 at 13.) Although the October 17, 2008 letter was not in the copy of Patient A's file that Licensee sent to the Board and Licensee also testified at first that he had not received the October 17, 2008 letter, the evidence was that Licensee responded to the October 17, 2008 request by providing a summary of treatment to Patient A's attorney. (Exs. A1 at 2; A2 at 14.) It is reasonable to infer that Licensee had received the October 17, 208 letter because he responded to it with the written summary.

The written summary was undated and incomplete, and did not include all of the documentation requested by Patient A. On December 3, 2008, Patient A's attorney sent a second letter to Licensee stating that Patient A had reviewed the summary of treatment, that Patient A found it incomplete, and Patient A was demanding a copy of his complete file, including a list of specific documents which Patient A demanded to be included in response. Licensee's testimony that he had spoken with Patient A's attorney after the first letter was sent and had been told that a summary of treatment would be acceptable was not corroborated, by chart notes or otherwise, in Licensee's documentary evidence. Patient A's testimony that he requested a copy of his records and not a summary was corroborated by the tone and the specific language of the December 3, 2008 letter from Patient A's attorney. On December 15, 2008, Licensee responded to the December 3, 2008 letter by sending copies of Patient A's files by fax to the attorney. Licensee's failure to timely provide Patient A with access to and copies of Patient A's PHI, when requested failed to meet the standard of care expected for medical practitioner's mandated by federal and state rules for such disclosure.

Likewise, the findings of fact support the Board's allegation that Licensee failed to provide copies of Patient B's PHI when requested. Patient B informed Licensee reimbursement from her insurance policy, which provided coverage for alternative medical providers including naturopathic physicians, had been denied because the billing statements he had provided as documentation were inadequate. Patient B was diligent and followed up each denial by calling her insurance company, and then requesting additional documentation, including chart notes, from Licensee. Licensee continued to send only billing statements until approximately one year after Patient B's first request. Licensee then created a set of typed progress notes for Patient B, based upon the handwritten notes in Patient B's file. The typed progress notes were also deemed insufficient and coverage was denied. Licensee's failure to provide copies of Patient B's PHI, including copies of his handwritten notes, for approximately one year failed to meet the applicable standard of care.

Alleged failure to properly record a diagnosis for Patient B

The Board alleged that Licensee saw Patient B and provided treatment, including dispensing thyroid medication, without properly documenting and recording a diagnosis regarding Patient B's thyroid condition, in violation of ORS 658.110(8) and (15) and OAR 850-050-0910(3). The record supports the Board's allegations, both as to negligence related to the practice of naturopathic medicine under ORS 658.110(8), and as to conduct contrary to a recognized standard of ethics or conduct that might constitute a danger to the health or safety of

a patient under ORS 658.110(15). Licensee's documentation provided no support for his having evaluated Patient B for a thyroid condition or having documentation regarding a prior provider's prescription for thyroid medication. Licensee did not document the type, amount or dosage of thyroid medication that he did dispense to Patient B. Licensee's speculation at hearing that he would have looked at a previous medication bottle before dispensing medication was inconsistent with his prior admissions and was not corroborated by any documentation made at the time the medicine was dispensed. The Board met its burden to prove Licensee violated ORS 658.110(8) and (15) when he failed to document a diagnosis prior to dispensing medication to Patient B.

Alleged failure to refer Patient A to a licensed practitioner

The Board's Amended Notice alleged that Licensee violated OAR 850-050-0190(1) by failing to refer Patients A and C to a licensed practitioner. In closing argument, the Board conceded that the record did not support the alleged violation with regard to Patient C. In review of the record, I find that the record does not support a finding that Licensee violated the rule with regard to Patient A.

Patient A testified at hearing that he had immediately sought other medical care on his own, after the failed referral to Dr. Kirkendall, but prior to contacting Licensee because he did not want to wait. During the first conversation after the failed referral, it became clear to both Patient A and Licensee that the patient/provider relationship had been severed, regardless of which party initiated the separation. In Dr. Bettenburg's opinion, a referral from Licensee for Patient A at that time was not required as Patient A had already secured an alternative provider and would not be abandoned by Licensee. Licensee's conclusion that the relationship had deteriorated such that Patient A most likely would not have accepted a referral from him was supported by the testimony of Patient A. Thus, the Board did not show that Licensee failed to refer Patient A to another provider upon termination of treatment under the requirements of the rule.

Proposed Penalty

The Board is authorized to exercise its discretion regarding the imposition of civil penalties and other disciplinary actions for violations of the laws and rules governing licensees. ORS 685.110; OAR 850-050-0010; OAR 850-050-0190. The record supports a finding of at least four violations, for inadequate charting alone, much less for the remaining violations for unprofessional communications and conduct, failure to record a diagnosis, and failure to produce PHI when requested. The Board may assess $1000.00 for each violation. The proposed penalty of $4,000.00 is within the Board's discretion.

In addition, the Board may place Licensee on probation as proposed. The record supports the Board's exercise of its discretion to do so, especially in light of the Board's prior letter of caution regarding inadequate charting and considering the number of violations proved at hearing. The terms of the probation are also within the Board's discretion to impose and are supported by the record in this matter.

ORDER

I propose the Board of Naturopathic Medicine issue the following order:

(1) Licensee is placed on probation for a period of three years during which time Licensee must comply with the statutes, rules, and orders of the Board and the following conditions:

a) Complete additional continuing education hours that are pre-approved by the Board within six (6) months; specifically twelve (12) hours on patient record keeping/charting, and six (6) hours on conflict management; and
b) Submit to the Board for approval, within one (1) month of completing the required additional continuing education hours, a plan to correct Licensee's processes for patient charting and record keeping and improve conflict management skills.

(2) Licensee is assessed civil penalties of $4000.00

A. Bernadette House
Sr. Administrative Law Judge
Office of Administrative Hearings

EXCEPTIONS

Exceptions in writing may be filed with the Board no later than 20 days after a Proposed Order is issued. Oral argument on the written exceptions may be requested when written exceptions are filed with the Board. The Board may grant or deny a request for oral arguments on the written exceptions. Exceptions must be delivered or mailed to:

Anne Walsh, Executive Officer
Board of Naturopathic Medicine
800 NE Oregon Street, Ste. 407
Portland OR 97232-2162