

Oregon Medical Board  
**BOARD ACTION REPORT**  
**January 15, 2014**

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between December 16, 2013 and January 15, 2014.

Scanned copies of Interim Stipulated Orders, Orders of Emergency Suspension, Stipulated Orders, Final Orders, Termination Orders, Modification Orders and Voluntary Limitations are included at the end of this report in the order that they appear in the report. These orders are marked with an \* asterisk. **Scanned copies of Consent Agreement are not posted, as they are not disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report, as they are not final actions by the Board. Both Orders, however, are public and are available upon request.

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

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

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

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**\*Beckmann, Brooke Robert, DPM; DP00434; Salem, OR**

On January 9, 2014, the Board issued a Default Final Order for unprofessional or dishonorable conduct, impairment, and incapacity to practice medicine or podiatry. This Order revokes Licensee's podiatric license.

**\*Clark, Thomas Leonard, MD; MD15528; White City, OR**

On January 9, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's October 11, 2012, Corrective Action Agreement.

**\*Clinkingbeard, Cynthia Lou, MD; MD25344; Boise, ID**

On January 9, 2014, Licensee entered into a Stipulated Order with the Board for willfully violating any board rule, board order or board request. This Order surrenders Licensee's medical license while under investigation.

**\*Fairchild, Ralph Berry, MD; MD151165; Minneapolis, MN**

On January 9, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to practice only at Board-approved sites and engage in ongoing healthcare.

**\*Feinman, Jessica Ariel, MD; MD154687; Portland, OR**

On January 9, 2014, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's December 6, 2012, Consent Agreement.

**Fortune, Michael Arthur, MD; MD14008; Adair Village, OR**

On January 9, 2014, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to practice under a Board approved mentor and complete 23 hours of CME.

**\*Foster, David William, MD; MD12438; Stayton, OR**

On January 9, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's April 4, 2013, Corrective Action Agreement.

**\*Francis, Peter James, MD; MD126335; Albany, OR**

On January 9, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a Board-approved course on professional ethics.

**\*Harrie, Robert Raymond, MD; MD22886; Bradford, PA**

On January 9, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence. This Order reprimands Licensee, assesses a \$5,000 fine, requires Licensee to complete a medical ethics course, and requires Licensee to continue with a pre-approved healthcare provider.

**\*Hooper, Lawrence Hoskins, Jr., MD; Applicant; Portland, OR**

On January 9, 2014, the Board issued a Final Order for unprofessional or dishonorable conduct and fraud or misrepresentation in applying for a license. This Order denies Applicant's medical license application and assesses a \$10,000 fine and the costs of the contested case hearing.

**Melnick, Jeffrey Bruce, PA; PA00251; Hillsboro, OR**

On January 9, 2014, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to practice under the personal supervision of his supervising physician for 60 days and adhere to 100% chart review by his supervising physician for 60 days.

**\*Read, Robert Allen, MD; MD21063; Corvallis, OR**

On January 9, 2014, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's October 11, 2012, Stipulated Order.

**\*Tyler, Jeffrey Richard, MD; MD13966; Portland, OR**

On January 7, 2014, Licensee entered into an Interim Stipulated Order to voluntarily cease the prescribing of Schedule II, III, and IV controlled substances (with the exception of testosterone) pending the completion of the Board's investigation into his ability to safely and competently practice medicine. This limitation becomes effective on January 21, 2014.

**\*Welker, Kenneth Jay, MD; MD22731; Lake Oswego, OR**

On January 9, 2014, the Board issued an Order of Emergency Suspension to immediately suspend Licensee's medical license due to the Board's concern for the safety and welfare of Licensee's current and future patients. This Order is in effect pending the completion of the Board's investigation.

**White, Kris Ramdas; AC160155; Portland, OR**

On January 9, 2014, Applicant entered into a Consent Agreement with the Board. In this Agreement, Applicant agreed to complete a 20-hour mentorship with a Board-approved clinical supervisor.

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If you have any questions regarding this service, please call the Board at (971) 673-2700 or toll-free within Oregon at (877) 254-6263.



1 date, which consists of Licensee's file with the Board, as the record for purposes of proving a  
2 prima facie case, pursuant to ORS 183.417(4)

3 5.

4 NOW THEREFORE, after considering the Board's file relating to this matter, the Board  
5 enters the following Order.

6 FINDINGS OF FACT

7 5.1 Licensee is a podiatrist who practiced at various skilled nursing facilities and  
8 care homes in the Portland metro and mid-Willamette Valley areas. Licensee was granted an  
9 unrestricted license to practice podiatric medicine in Oregon on October 3, 2007. Licensee  
10 subsequently moved to Texas and his license was placed in inactive status. Licensee returned  
11 to Oregon in 2010, and applied to reactivate his license. Due to some behavioral issues,  
12 Licensee underwent a psychiatric evaluation in August of 2010. This evaluation did not result  
13 in a psychiatric diagnosis, but noted that Licensee has a history "of difficulty in maintaining  
14 effective interpersonal relationships in both his personal and professional life." The Board  
15 reactivated Licensee's podiatric license on September 3, 2010.

16 5.2 On June 19, 2013, Licensee submitted a written complaint to the Federal  
17 Communications Commission, FCC, which was posted on the FCC webpage. Licensee's  
18 complaint made a number of bizarre allegations, to include the following: "My complaint  
19 concerns people illegally tracking me and seems not to be of your office. It concerns the fact  
20 that there have been illegal ear implants placed into my ears without legal reason and without  
21 my permission...They utilize this system to be able to call my ear directly, the right one that  
22 is, also they seem to be utilizing this technology within the state of Oregon to track and record  
23 my statements almost to the point of my thoughts. I get criminally harassed and followed."

24 5.3 A Board Investigator contacted Licensee in July of 2013, and asked if he  
25 actually had filed the FCC complaint. He confirmed that he did, and then proceeded to make  
26 various allegations in regard to some family members. Licensee also asserted that he had  
27 electronic implants in his body that monitor him; that he is under constant surveillance; that

1 his conversations and thoughts are being monitored; and that different people have stolen his  
2 patent ideas.

3 5.4 Licensee was asked to undergo a psychiatric evaluation. Licensee met with a  
4 Board approved psychiatrist on July 25, 2013. During the session, Licensee adamantly  
5 insisted that he has transmission devices embedded in his second and eighth cranial nerves.  
6 The psychiatrist concluded in his evaluation that Licensee is paranoid and is acting within a  
7 complex delusional system. Licensee's insight was assessed to be "poor," and his judgment  
8 "fair." The psychiatrist identified several mental health conditions to be considered as a  
9 possible underlying diagnosis, and concluded that Licensee's paranoia could affect his  
10 judgment, and that "there is too great a risk to the general public for him to practice without  
11 further evaluation."

12 5.5 During a contested case hearing on August 22, 2013 before an Administrative  
13 Law Judge (ALJ), pursuant to an Order of Emergency Suspension, dated August 1, 2013,  
14 Licensee reiterated his belief that he has nonconsensual electronic implants in his body and  
15 that he is under surveillance. During this hearing, the psychiatrist that conducted a psychiatric  
16 evaluation of Licensee at the Board's request testified that Licensee is "paranoid, and he is  
17 operating within a complex delusional system." In his opinion, Licensee's judgment is  
18 impaired, and his impaired judgment could affect his ability to safely practice medicine.

19 5.6 In the Board's Final Order, dated October 3, 2013, the Board approved the  
20 findings of the ALJ in a Proposed Order, following a contested case hearing, which sustained  
21 the Order of Emergency Suspension that the Board issued on August 1, 2013.

22 5.7 Licensee has displayed poor judgment and substandard professional skills in  
23 the performance of his job by trimming a resident's toenails in a care center's dining facility  
24 just before mealtime, neglecting to knock before entering the room of various residents,  
25 causing various "nicks" resulting in superficial bleeding when attending the feet of various  
26 residents, and engaging in a verbal argument when a resident confronted him in a hallway.

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1 Right to Judicial Review

2 NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained  
3 by filing a petition for review with the Oregon Court of Appeals within 60 days after the final  
4 order is served upon you. See ORS 183.482. If this Order was personally delivered to you,  
5 the date of service is the day it was mailed, not the day you received it. If you do not file a  
6 petition for judicial review within the 60 day time period, you will lose your right to appeal.  
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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of: )  
CYNTHIA LOU CLINKINGBEARD, MD ) STIPULATED ORDER  
LICENSE NO. MD25344 )

1.  
1. The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Cynthia Lou Clinkingbeard, MD, is a licensed physician in the state of Oregon and holds an inactive medical license.

2.  
Licensee entered into a Stipulated Order with the Board in July 2004, which placed specific restrictions on her medical license and practice setting.

Term 5.4 of the 2004 Order required Licensee to immediately notify the Board's Compliance Officer of any change in her condition that would indicate she has suffered a relapse or any other condition that could adversely affect her ability to safely practice medicine.

Term 5.5 of the 2004 Order required Licensee to obey all federal and Oregon State laws and regulations pertaining to the practice of medicine.

3.  
In September 2013, the Board learned that Licensee had been arrested for aggravated assault with a firearm, a felony crime, in March 2012 in Boise, Idaho. Licensee subsequently pled guilty to a felony violation of Aggravated Assault and was sentenced to five (5) years probation.

Licensee failed to report this felony arrest and conviction to the Board as required by ORS 677.415 as defined in OAR 847-010-0073.

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4.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order.

Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183); Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee stipulates that she engaged in the conduct described in paragraph 3 and that this conduct violated ORS 677.190(17) willfully violating any board rule, board order or board request.

5.

Licensee and the Board agree that the Board will close the investigation and resolve this matter by entry of this Stipulated Order, and that Licensee agrees to fully comply with the following terms and conditions:

5.1 Licensee immediately surrenders her Oregon medical license while under investigation and agrees to never reapply for a medical license in Oregon.

5.2 Licensee's Stipulated Order of July 9, 2004, is terminated upon approval of this Order by the Board.

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

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

5.7 Licensee understands that this Order is a public record and is a disciplinary action and that is reportable to the national Data Bank and the Federation of State Medical Boards.

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6.

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

IT IS SO STIPULATED this 25 day of October, 2013.

SIGNATURE REDACTED

CYNTHIA LOU CLINKINGBEARD, MD

SIGNATURE REDACTED

SUSAN BARKIS  
COURT APPOINTED CONSERVATOR

IT IS SO ORDERED this 9th day of January, 2014.

SIGNATURE REDACTED

ROGER M. MCKIMMY, MD  
Board Chair







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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
DAVID WILLIAM FOSTER, MD ) ORDER TERMINATING  
LICENSE NO. MD12438 ) CORRECTIVE ACTION AGREEMENT  
 )

1.

On April 4, 2013, David William Foster, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On August 21, 2013, Licensee submitted documentation that he has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the April 4, 2013, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 9<sup>th</sup> day of January, 2014.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURES REDACTED**

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ROGER M. MCKIMMY, MD  
Board Chair

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
)  
PETER JAMES FRANCIS, MD ) CORRECTIVE ACTION AGREEMENT  
LICENSE NO. MD126335 )  
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Peter James Francis, MD (Licensee) holds an active license to practice medicine in the state of Oregon.

2.

On August 5, 2013, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, pursuant to ORS 677.205 against Licensee for violating the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a).

3.

In regard to the above-referenced matter, Licensee and the Board desire to settle this matter by entry of this Agreement. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Agreement in the Board's records. The Board agrees to close the current investigation and does not make a finding in regard to any violation of the Medical Practice Act. This Agreement is a public document; however, it is not a disciplinary action and

1 is not reportable to the National Data Bank, but will be reported to the Federation of State  
2 Medical Boards.

3 4.

4 In order to address the concerns of the Board and for purposes of resolving this  
5 investigation, Licensee and the Board agree to the following terms:

6 4.1 Within six months from the signing of this Agreement by the Board Chair,  
7 Licensee must successfully complete a course on professional ethics that is pre-approved by the  
8 Board's Medical Director.

9 4.2 Licensee must obey all federal and Oregon State laws and regulations pertaining  
10 to the practice of medicine.

11 4.3 Licensee agrees that any violation of the terms of this Agreement constitutes  
12 grounds to take disciplinary action under ORS 677.190(17).

13  
14 IT IS SO AGREED THIS 3 day of DECEMBER, 2013.

15 SIGNATURE REDACTED

16 \_\_\_\_\_  
17 PETER JAMES FRANCIS, MD

18 IT IS SO AGREED THIS 9<sup>th</sup> day of JANUARY, 2014

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20 OREGON MEDICAL BOARD  
21 State of Oregon

22 SIGNATURE REDACTED

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24 ROGER MCKIMMY, MD  
25 BOARD CHAIR





1 finally waives the right to a contested case hearing and any appeal therefrom by the signing of  
2 and entry of this Order in the Board's records. Licensee admits that he engaged in conduct  
3 that violated The Medical Practice Act as described in the Complaint & Notice of Disciplinary  
4 Action. Licensee understands that this Order is a public record and is a disciplinary action  
5 that is reportable to the National Data Bank and the Federation of State Medical Boards.

6 5.

7 In order to address the concerns of the Board and for purposes of resolving this  
8 investigation, Licensee and the Board agree to the following terms:

9 5.1 Licensee is reprimanded.

10 5.2 Licensee must pay a civil penalty of \$5,000 within 30 days from the signing of  
11 this Order by the Board Chair.

12 5.3 Within six months from the signing of this Agreement by the Board Chair,  
13 Licensee must successfully complete a course on medical ethics that is pre-approved by the  
14 Board's Medical Director. Licensee has already completed work on anger management.

15 5.4 Licensee must remain under the continuing care of a treating healthcare  
16 provider that is pre-approved by the Board's Medical Director. This provider will submit  
17 quarterly reports to the Board.

18 5.5 Licensee must obey all federal and Oregon State laws and regulations  
19 pertaining to the practice of medicine.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

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IN THE MATTER OF: )  
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LAWRENCE HOSKINS HOOPER, JR., MD ) FINAL ORDER  
APPLICANT )  
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**HISTORY OF THE CASE**

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On November 6, 2012, the Oregon Medical Board (OMB or Board) issued a Notice of Intent to Deny License Application (Notice) to Lawrence H. Hooper, Jr., M.D. (Applicant or Dr. Hooper). On or about December 3, 2012, Applicant requested a hearing.

On January 2, 2013, the Board referred the hearing request to the Office of Administrative Hearings (OAH). The OAH assigned Senior Administrative Law Judge (ALJ) Joe L. Allen to preside at hearing. A prehearing conference was convened on February 4, 2013 with ALJ Allen presiding. Warren Foote, Senior Assistant Attorney General (AAG), appeared on behalf of the Board. Applicant appeared without counsel. The purpose of the prehearing conference was to identify the issues for hearing, establish a schedule for filing prehearing motions and exchange of exhibits and witness lists, as well as determining the date, time, and location for hearing.

On June 7, 2013, OMB issued an Amended Notice of Intent to Deny License Application (Amended Notice). On June 10, 2013, Applicant filed a request for hearing and amended answer.

An in-person hearing was held on October 8, 2013, in Portland, Oregon.<sup>1</sup> Applicant appeared with counsel, Dale M. Roller, and testified on his own behalf. Katharine Lozano, Senior AAG represented OMB. Testifying on behalf of OMB were Eric Brown, Chief Investigator for the Board, and Joseph Thaler, M.D., Medical Director for the Board. The parties requested written closing arguments. The ALJ received the transcripts on or about October 21, 2013. The record closed upon receipt of those arguments on October 29, 2013.

The ALJ issued a Proposed Order on November 29, 2013. Dr. Hooper filed no exceptions to the Proposed Order.

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<sup>1</sup> This matter was originally scheduled for hearing on October 8 and 9, 2013, from 9:00 am until 5:00 p.m. each day. At the hearing, Applicant amended his original witness list to eliminate all witnesses other than himself. As a result, this matter concluded after approximately three hours of in-person hearing.

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## ISSUES

1. Whether Applicant engaged in fraud or misrepresentation in applying for a medical license. ORS 677.188(1).

2. Whether Applicant engaged in unprofessional or dishonorable conduct. ORS 677.188(4).

3. Whether the Board may deny Applicant's application for licensure, assess a civil penalty of \$10,000, and assess costs associated with this proceeding against him. ORS 677.265(2).

## EVIDENTIARY RULINGS

The Board offered Exhibits A1 through A22 which were admitted into the record. Applicant's objections to Exhibits A1, A2, A4 through A6, A8, A9, A12, and A14 were overruled. Applicant offered Exhibits R1 through R10.<sup>2</sup> Exhibits R1-A, B, and D, R2, R4, and R6 through R9 were excluded by the ALJ as irrelevant. Exhibits R1-C and E, R3, R5, and R10 were admitted into the record.

## FINDINGS OF FACT

1. Applicant, Lawrence H. Hooper, Jr., M.D., is a board certified pediatrician previously licensed to practice medicine in the states of Texas and Utah. Applicant was first licensed in both states in 1981. (Ex. A16 at 2.)

2. In 1990, while practicing medicine in El Paso, Texas, Applicant was charged with two counts of indecency with a child. As a result of these charges, Applicant was placed on temporary probation by the Texas Board of Medical Examiners (Texas Board). Applicant agreed to a voluntary restriction of his clinical privileges to see female patients without a chaperone. On or about March 9, 1992, Applicant was found not guilty after trial by jury. Thereafter, the Texas Board lifted Applicant's probation. (Exs. A16 at 3, A20, and R3-A through C.)

3. In 1994, Applicant was again charged with indecency with a child in El Paso, Texas. These charges were unassociated to the 1990 complaints and brought by a different complainant. Applicant again agreed to a voluntary restriction of his clinical privileges to see female patients without a chaperone. Those charges were dismissed prior to trial. (Exs. A16 at 3, A20, and A22 at 3.)

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<sup>2</sup> Applicant's Exhibit List identifies Exhibits using the designation assigned by the ALJ. Applicant's exhibit list further identifies sub-exhibits designated A through E, in the case of Exhibits R1 and R4, and A through C, in the case of Exhibits R3, R7 and R9, as well as A and B for Exhibit R2. Applicant offered exhibits separated by tabs bearing handwritten exhibits numbers on each. However, none of the exhibits was individually marked or otherwise identifiable as corresponding to the sub-exhibit designations listed on the exhibit list. Applicant's exhibits have been marked in the lower right hand corner to provide clarity in the record and identification of those pages, subject to objection.

1  
2 4. In 1996, Applicant relocated to Windsor, Missouri, when he entered active duty  
3 with the United States Air Force (USAF). Applicant was assigned to the 509<sup>th</sup> Medical Group at  
4 Whiteman Air Force Base (AFB). (Ex. A17 at 1; *also see*, Exs. A1 through A7 generally.)  
5

6 5. Between January 24 and 26, 2000, Applicant participated in a Command Directed  
7 Evaluation as part of a security clearance evaluation. This evaluation resulted in a diagnosis of  
8 Pedophilia, Sexually Attracted to Females, Nonexclusive. (Exs. A1 at 1 and A5 at 1.)  
9 Thereafter, Applicant was directed to participate in further mental health examinations during  
10 April and May, 2000. (Ex. A2 at 1.) On May 15, 2000, Applicant arrived at Lackland AFB,  
11 Texas for further mental health evaluation. That evaluation also returned a diagnosis of  
12 pedophilia. (Ex. A5 at 1 through 3.)  
13

14 6. Sometime prior to April 2000, Applicant's commanding officers learned he was  
15 providing medical treatment to members of the civilian population of Windsor, Missouri.  
16 Applicant's commanding officer instructed him to cease such practices as he did not possess a  
17 license to practice medicine in the State of Missouri. (Exs. A3 at 1 and 2, A7.)  
18

19 7. In June 2000, the Credentialing Committee for the USAF 509<sup>th</sup> Medical Group  
20 voted to revoke Applicant's clinical privileges to practice medicine based on improper clinical  
21 judgment, unprofessional conduct, and mental impairment. These determinations stemmed from  
22 Applicant's diagnosis of pedophilia and his unauthorized practice of medicine in the State of  
23 Missouri. (Ex. A1 at 2.)  
24

25 8. In January 2001, the commander for the 509<sup>th</sup> Medical Group issued a formal  
26 Letter of Reprimand to Applicant for providing medical treatment to non-military civilians in the  
27 area of Windsor, Missouri. (Ex. A7.)  
28

29 9. On January 10, 2001, Applicant was arrested at his home in Windsor, Missouri,  
30 on a felony warrant alleging the unlawful practice of medicine. (Ex. A9.) Thereafter, the  
31 prosecutor for Henry County, Missouri, filed a criminal complaint against Applicant alleging  
32 nine separate felony counts for the unlawful practice of medicine in violation of Missouri  
33 Revised Statute 334.010. (Ex. A8.)  
34

35 10. On or about January 13, 2001, a hearing committee for the USAF entered findings  
36 and recommendations substantiating earlier findings that Applicant had engaged in the  
37 unlicensed practice of medicine in Missouri and supporting restriction of his clinical privileges to  
38 treat pediatric patients (under 15 years of age). (Ex. A10.) Thereafter, on April 9 and May 22,  
39 2001, Applicant's commander upheld prior decisions to revoke Applicant's clinical privileges  
40 within the USAF 509<sup>th</sup> Medical Group. (Exs. A11 and A12.)  
41

42 11. On May 14, 2001, the prosecutor for Henry County, Missouri, filed a *nolle*  
43 *prosequi* declaration dismissing the felony complaint against Applicant. (Ex. R1-E.)  
44

45 12. On or about June 13, 2001, after lengthy appeal, the Brigadier General for  
46 MAJCOM Langley AFB, Virginia determined Applicant's clinical privileges to see pediatric

1 patients should be permanently revoked, but restored his clinical privileges to treat adult patients.  
2 This determination had no effect on the Letter of Reprimand issued in January 2001. (Ex. A13.)  
3

4 13. After revocation of his pediatric privileges, Applicant remained on active duty but  
5 did not see patients. Rather, he worked on other projects until his term of service expired in  
6 September 2001. (Tr. at 99: 6 through 21.) On or about September 30, 2001, Applicant  
7 separated from active duty with the USAF. Applicant remained in the USAF Reserves until  
8 November 16, 2006. (Ex. A15 at 1 and 2.) Upon separation from active duty, Applicant went to  
9 work in various non-clinical positions because his wife was pregnant and he did not want to  
10 stress her physically with a change to their living situation. (Ex. A16 at 2 through 4.)  
11

12 14. On or about December 2010, Applicant filed an application for licensure with the  
13 Oregon Medical Board. Through the application, Applicant sought an unrestricted license to  
14 practice medicine within the State of Oregon. (Ex A16; Tr. at 54: 7 through 20.)  
15

16 15. Question 7 of the application asks:

17 Have you ever been arrested, convicted of, or pled guilty or "nolo contendere"  
18 to ANY offense in any state in the United States or any foreign country, other  
19 than minor traffic violations?  
20

21  
22 (Ex. A 16 at 3, emphasis in the original.) In response, Applicant reported the 1990 and 1994  
23 arrests in El Paso, Texas. Applicant did not report the arrest for the unlicensed practice of  
24 medicine in the State of Missouri. (*Id.*)  
25

26 16. Question 14 of the application asks, in relevant part:

27  
28 Have you ever had privileges \* \* \*reduced, restricted, suspended, revoked,  
29 terminated or have you been placed on probation, been subject to staff  
30 disciplinary action \* \* \*.  
31

32 (Ex. A16 at 4.) Applicant responded in the affirmative but qualified the response by indicating,  
33 "No other instances not addressed above. None of the above ever resulted in a permanent  
34 restriction or privileges \* \* \*." (*Id.*) Applicant did not report the 2001 arrest, the Letter of  
35 Reprimand also from that year, or the suspension and revocation of clinical privileges while in  
36 the military anywhere on his application. (A16.)  
37

38 17. Upon receipt of Applicant's application, the Board initiated a routine background  
39 investigation. This investigation revealed the USAF investigations as well as the civilian arrest  
40 in Missouri from January 2001. (Ex. A22; Tr. at 59:1 through 13 and 60:5 through 61:12.)  
41 During the investigation, the Board made attempts to obtain records of the criminal proceedings  
42 related to the Missouri arrest. The custodian of records for the State of Missouri informed the  
43 Board's investigator that all records related to the court proceedings were unavailable,  
44 purportedly due to an expungement order. Nonetheless, the State of Missouri maintained records  
45 of the original arrest and provided those records to the Board. (Ex. A22 at 3.)  
46

///

1  
2 18. After learning of the Board's receipt of previously undisclosed information,  
3 Applicant provided the Board with a written addendum to his application. In this addendum,  
4 Applicant indicated, "I did not think to include [the Missouri arrest] on my original medical  
5 license application because \* \* \* I had been told at the time that the incident was eligible and  
6 would be scheduled to be expunged." (Ex. A17 at 1.) Applicant went on to explain, "When this  
7 incident came to mind a month or two ago, I called the Clerk of [the] Court at the Henry County,  
8 MO courthouse who informed me that the case had never been scheduled in court for  
9 expungement[.]" (*Id.*)

## 10 11 CONCLUSIONS OF LAW

- 12 1. Applicant engaged in fraud or misrepresentation in applying for a medical license.
- 13 2. Applicant engaged in unprofessional or dishonorable conduct.
- 14 3. The Oregon Medical Board denies Applicant's application for licensure, assesses a  
15 civil penalty of \$10,000, and assesses costs associated with this proceeding against  
16 him.

## 17 18 19 20 21 OPINION

22 Pursuant to ORS 677.190, the Board may deny an application for a license to practice  
23 medicine for a variety of reasons. The Board alleges Applicant's application for licensure should  
24 be denied based on fraud or misrepresentation and unprofessional or dishonorable conduct. As  
25 the proponent of this position, the Board must prove its allegations by a preponderance of the  
26 evidence. ORS 183.450(2) and (5); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule  
27 regarding allocation of burden of proof is that the burden is on the proponent of the fact or  
28 position); *Cook v. Employment Div.*, 47 Or App 437 (1980) (in absence of legislation adopting a  
29 different standard, the standard in administrative hearings is preponderance of the evidence).  
30 Proof by a preponderance of the evidence means that the fact finder is convinced that the facts  
31 asserted are more likely true than false. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or  
32 390 (1987).

### 33 34 35 1. *Violations alleged.*

36 The Board alleges Applicant engaged in fraud or misrepresentation in applying for a  
37 license to practice medicine in Oregon as well as unprofessional or dishonorable conduct by  
38 failing to disclose certain facts in the application. Specifically, the Board asserts Applicant  
39 intentionally failed to disclose that, in 2001, he was arrested on a felony warrant in the State of  
40 Missouri on charges of practicing medicine without a license. The Board also alleges Applicant  
41 deliberately withheld information, on his initial application, pertaining to disciplinary action  
42 taken against his medical practice privileges by the United States Air Force while he served on  
43 active duty in 2001.

44  
45  
46 ORS 677.190 provides, in part:

1  
2 The Oregon Medical Board may refuse to grant, or may suspend or revoke a  
3 license to practice for any of the following reasons:

4  
5 (1)(a) Unprofessional or dishonorable conduct.

6  
7 \* \* \* \* \*

8  
9 (8) Fraud or misrepresentation in applying for or procuring a license to practice in  
10 this state, or in connection with applying for or procuring registration.

11  
12 ORS 677.188 provides definitions for ORS 677.190 and provides, in relevant part:

13  
14 (1) "Fraud or misrepresentation" means the intentional misrepresentation or  
15 misstatement of a material fact, concealment of or failure to make known any  
16 material fact, or any other means by which misinformation or a false impression  
17 knowingly is given.

18  
19 \* \* \* \* \*

20  
21 (4) "Unprofessional or dishonorable conduct" means conduct unbecoming a  
22 person licensed to practice medicine or podiatry, or detrimental to the best  
23 interests of the public, and includes:

24  
25 (a) Any conduct or practice contrary to recognized standards of ethics of the  
26 medical or podiatric profession or any conduct or practice which does or might  
27 constitute a danger to the health or safety of a patient or the public or any conduct,  
28 practice or condition which does or might adversely affect a physician's or  
29 podiatric physician and surgeon's ability safely and skillfully to practice medicine  
30 or podiatry.

31  
32  
33 *i. Failure to disclose prior arrest.*

34  
35 The Board provided evidence showing Applicant was arrested on a felony warrant on  
36 January 10, 2001, for the alleged unlawful practice of medicine within the State of Missouri.  
37 Also in January 2001, subsequent to the arrest, Applicant was charged in the Circuit Court of  
38 Henry County, Missouri with nine felony counts of practicing medicine without a license in  
39 violation of Missouri Revised Statutes (RSMo) section 334.010. On or about May 14, 2001, the  
40 charges were dismissed pursuant to the prosecutor's *nolle prosequi* declaration. The evidence  
41 indicates that, based on the dismissal, the Circuit Court of Henry County made the criminal  
42 complaint and records of subsequent proceedings unavailable. The record of the January 10,  
43 2001 arrest remained intact.

44  
45 What is unclear from the evidence is the mechanism that effectuated the unavailability of  
46 the records pertaining to Applicant's criminal proceedings in Missouri. Throughout the

1 investigation and hearing, Applicant provided inconsistent statements regarding a purported  
2 expungement of such records. Most persuasive is the statement, provided by Applicant in his  
3 addendum to the original license application, indicating that he was informed by the clerk of the  
4 court in Henry County, Missouri, that the case records were never actually placed on the court  
5 docket for expungement. Unfortunately, statements made to the Board's investigator, by the  
6 Missouri Highway Patrol, indicated the records of the criminal proceeding were expunged and  
7 therefore unavailable. This matter is further complicated by the manner in which the prosecutor  
8 in Henry County dismissed the complaint. For these reasons, it is impossible to ascertain  
9 whether the court ever issued an order expunging any portion of Applicant's criminal records or  
10 if the records were simply made unavailable pursuant to the dismissal via the *nolle prosequi*  
11 declaration.

12  
13 At the hearing and in his closing brief, Applicant argued that the arrest record should  
14 have logically been included in the purported order of expungement<sup>3</sup> and that for this tribunal to  
15 consider such records violates Article IV section 1 of the United States Constitution (the full  
16 faith and credit clause). [Applicant's] Closing Arguments at 2 through 3. Applicant cited RSMo  
17 610.122 (erroneously cited as MRC) for the proposition that Applicant's arrest record should  
18 have been destroyed upon entry of the order granting expungement. Applicant then argued that  
19 expunged convictions, arrests, or other proceedings are considered not to have occurred and he  
20 was justified in not disclosing "the now nonexistent arrest." *Id* at 3.

21  
22 Assuming, arguendo, an order for expungement was entered by the Henry County Circuit  
23 Court, Applicant's arguments still fail for several reasons. First, Applicant's assumption that any  
24 order of expungement included the arrest is not supported by Missouri's statutory framework.  
25 Under Missouri law, a petition for expungement of most arrest records is governed by RSMo  
26 610.122.<sup>4</sup> Certain other records, including certain pleadings, trial records, or records of  
27 conviction are governed by RSMo 610.140. The logical conclusion drawn from examination of  
28 the statutory framework is that an order granting expungement of criminal proceedings does not  
29 include arrest records by default. If Applicant's assumption was accepted, the procedures set  
30 forth in RSMo 610.122 would be superfluous. At hearing, Applicant provided no evidence,  
31 other than a vague belief, to indicate a petition for expungement was ever filed by him or on his  
32 behalf. To the contrary, in his addendum to his application with OMB, Applicant indicated he  
33 "had been told at the time that the incident was eligible for and would be scheduled to be  
34 expunged." Ex. A17 at 1. Applicant goes on to recount how his contact with the court clerk in  
35 Henry County revealed to him that "the case had never been scheduled in court for expungement  
36 but assured [him] that because of the way the case was dismissed, that no information would  
37 show up on routine background checks." *Ibid*. Accordingly, it is impossible to ascertain which  
38 records, if any, the court in Missouri ordered expunged. Further, Applicant's assumptions are  
39 not supported by his own evidence.

40  
41 <sup>3</sup> Applicant asserted that, because there was no conviction, the only logical record left to be expunged is the arrest  
42 record. However, a review of Missouri statutes reveals that the processes available for expunging arrests may be  
43 separate from pleas, trial records, or convictions. *See*, RSMo 610.122 and 610.140. Nothing in the record  
44 establishes Applicant actually petitioned the court for an order expunging the arrest.

45 <sup>4</sup> The State of Missouri utilizes a central repository, maintained by the State Highway Patrol, for arrest records.  
46 Records of most misdemeanor and felony arrests are required to be submitted to the Highway Patrol for the purposes  
of maintaining complete and accurate criminal history information. *See* RSMo 43.503 generally. RSMo 610.122  
identifies the circumstances under which arrests, recorded pursuant to RSMo 43.503, may be expunged.

1  
2 In addition, Applicant's reliance on RSMo 610.122 to support expungement of the arrest  
3 record subsequent to dismissal of the charges is not supported by the evidence. The indictment  
4 at issue was dismissed pursuant to a *nolle prosequi* declaration filed by the prosecutor. Such  
5 declarations are commonly used by the charging official in a jurisdiction when the prosecuting  
6 body is no longer interested in pursuing a cause of action. These declarations can be used either  
7 before or during trial and may indicate charges cannot be proved or the prosecutor doubts the  
8 veracity of the allegations. However, *nolle prosequi* can also be used to dismiss a state action  
9 where charges are likely to be brought in another jurisdiction, such as federal court. As such, the  
10 filing of such a declaration is not indicative of the truth or falsity of the information upon which  
11 an arrest is based. RSMo 610.122 permits expungement of the record of an arrest based on false  
12 information. Nothing in the record supports a finding that the information pertaining to the  
13 allegations of unlicensed practice of medicine within the State of Missouri was false. Rather, the  
14 evidence demonstrates, as discussed more fully below, that disciplinary proceedings were also  
15 being pursued by the United States Air Force for these and other allegations. Accordingly, the  
16 more likely inference is that the Henry County prosecutor elected to allow the USAF to handle  
17 discipline and prosecution of one of its own active duty service members. Again, the Board,  
18 keeping with the ALJ, is disinclined to adopt Applicant's assumption that any order of  
19 expungement was made pursuant to RSMo 610.122 and therefore included the arrest record.  
20

21 Finally, the Board obtained the record of Applicant's arrest from the Missouri Highway  
22 Patrol. At the time the Board's investigator contacted the State of Missouri to obtain records of  
23 the criminal proceedings at issue, the custodian of records informed the Board that the court  
24 documents were expunged but that the state still retained the arrest record. The logical inference,  
25 in light of Missouri's statutory framework, is that any court order of expungement did not  
26 include the arrest record.  
27

28 At the hearing, Applicant argued first that he forgot about the arrest and then that he  
29 believed the arrest was expunged and consequently did not exist. Therefore, Applicant asserted  
30 he did not knowingly or intentionally fail to disclose this information because he either did not  
31 recall the information, and therefore lacked intent to conceal the information, or he believed the  
32 arrest record was obliterated through the expungement process and therefore he was not required  
33 to disclose it. Applicant's testimony is neither consistent nor persuasive.  
34

35 During the application process, Applicant disclosed detailed information pertaining to  
36 two prior instances in which he was charged with sexual assault of a child. These charges were  
37 brought in 1990 and 1994 while Applicant was practicing in El Paso, Texas and involved  
38 different alleged victims. The 1990 charges resulted in acquittal in 1992, while the 1994 charges  
39 were dismissed prior to trial. In his application, Applicant provided information pertaining to the  
40 investigation(s), allegations, accusing party, ultimate disposition, and his voluntary restriction of  
41 his clinical privileges pending the outcome. In addition, in response to a question related to  
42 whether Applicant had ever interrupted the practice of his profession or one year or more, he  
43 indicated that, when he left active military service in 2001 while in Missouri, he went into a non-  
44 clinical position until after his wife gave birth and he was able to relocate to another state.  
45 Nonetheless, Applicant failed to explain why recounting his separation from the USAF did not  
46 bring to mind the arrest and charges brought against him in Henry County.

1  
2 It strains credulity to believe that Applicant was unable to recall events involving an  
3 arrest and indictment for nine felony counts, occurring approximately nine years prior to  
4 application and continued for approximately five months during that year, yet was able to recall  
5 those instances, occurring approximately 20 years prior, where he was cleared of all wrongdoing.  
6 Applicant's selective recollection is self-serving at best. This point is underscored by the  
7 subsequent disciplinary proceedings, instituted by the USAF, which resulted in a disciplinary  
8 reprimand for the allegations underlying the felony complaint as well as a suspension and  
9 ultimate revocation of his clinical privileges, discussed more fully below. The idea that  
10 Applicant simply forgot the arrest is implausible and inconsistent with his demonstrated  
11 recollection of past events.  
12

13 Likewise, Applicant's testimony that he believed he was not required to disclose the  
14 arrest because it was expunged is not supported by the totality of the evidence. While the Board  
15 was able to confirm the records of the complaint and court proceedings were ordered expunged,  
16 Applicant provided no evidence to indicate the arrest was subject to the court's order. To the  
17 contrary, the State of Missouri still maintained the arrest record as of 2012. While Applicant  
18 appears to be a fastidious record keeper with regard to every other document that tends to prove  
19 his innocence, including those dating back more than 20 years, he was unable to locate or obtain  
20 a copy of the order of expungement which purportedly served as the basis for his belief that he  
21 was not required to disclose the arrest. Applicant was able to produce the original charging  
22 document and the declaration from the Henry County prosecutor dismissing the action against  
23 him. Nonetheless, he alleges he simply based his determination that every record pertaining to  
24 the arrest and criminal charges brought against him in Missouri were destroyed on a verbal  
25 representation by a former attorney. Moreover, the connection of this arrest to the disciplinary  
26 action by the USAF, which Applicant also failed to disclose, cannot be overlooked. Disclosure  
27 of either was likely to lead to inquiries by the Board that would ultimately reveal the other.  
28

29 A preponderance of the evidence supports the conclusion that Applicant intentionally  
30 withheld information pertaining to the 2001 arrest for practicing medicine without a license. An  
31 arrest for such allegations is clearly material to the Board's determination of Applicant's fitness  
32 to practice medicine in Oregon. More likely than not, Applicant withheld this information in  
33 order to give the false impression that the only arrests or charges brought against him were those  
34 that occurred in Texas in 1990 and 1994.  
35

36 *ii. Failure to disclose disciplinary action and revocation of privileges by the USAF.*  
37

38 Next, the Board asserts Applicant intentionally failed to disclose disciplinary action, in  
39 the form of a letter of reprimand and suspension/revocation of his clinical privileges, in 2001  
40 while Applicant served as a Lieutenant Colonel in the USAF.  
41

42 On or about January 3, 2001, Applicant was issued a Letter of Reprimand by the  
43 commander of the 509<sup>th</sup> Medical Group of the USAF after investigation into allegations that he  
44 provided medical care, without a license, to civilian citizens of Windsor, Missouri in violation of  
45 USAF regulations, prior instructions of his commanding officer, and Missouri law. In this  
46 reprimand, Applicant was rebuked for engaging in the alleged misconduct, for an extended

1 period of time, demonstrating “blatant disregard for the laws of the state of Missouri.” Ex. A7.  
2 The reprimand further asserted Applicant had called into question his suitability for service as a  
3 physician by “failing to strictly adhere to the rules governing credentialed Air Force medical  
4 providers.” *Id.* In his application, Applicant failed to disclose this Letter of Reprimand in  
5 response to question number 14 which asked, inter alia, whether he had ever been subject to staff  
6 disciplinary action.

7  
8 At the hearing, Applicant initially testified the Letter of Reprimand was not an action  
9 from the “military medical board” or a member of the credentialing board. As such, he asserted  
10 he did not believe the action was responsive to the question. When confronted with the full text  
11 of the question on cross-examination, Applicant stated that it simply did not occur to him that he  
12 should disclose the reprimand because he had forgotten about the document until the Board  
13 produced it as part of its investigation. *See*, Transcript at 99:25 through 100:21 and 102:22  
14 through 103:17. Again, Applicant’s selective recollection appears self-serving, implausible, and  
15 internally inconsistent.

16  
17 It is, once again, difficult to accept Applicant’s assertions that he recalled, with clarity,  
18 proceedings occurring at least 20 years before completion of the application but was unable to  
19 recall a Letter of Reprimand, issued approximately nine years before application, which triggered  
20 events that culminated in the revocation of his pediatric clinical privileges and ultimately led to  
21 his separation from active duty service with the USAF. Also of note is the fact that, while Henry  
22 County dismissed the criminal complaint against Applicant, the USAF found that the underlying  
23 allegations of practicing medicine without a license were substantiated. While Applicant made  
24 much at hearing about the *nolle prosequi* declaration dismissing charges against him, he was  
25 nearly silent on the substantiated findings of the Air Force.

26  
27 Additionally, question 14 of the application asked Applicant if he had ever had privileges  
28 “denied, reduced, restricted, suspended, revoked, [or] terminated \* \* \*.” Ex. A16 at 4. In  
29 response, Applicant indicated there were no such instances not already disclosed within his  
30 earlier responses. Further, Applicant indicated no such actions ever resulted in permanent  
31 restriction of privileges. Both statements were patently false. First, while serving in the military,  
32 in 2001, Applicant’s pediatric clinical privileges were permanently revoked subsequent to a  
33 command directed psychological evaluation that rendered a diagnosis of pedophilia. Moreover,  
34 during the pendency of the 2001 investigation of criminal allegations discussed above,  
35 Applicant’s clinical privileges to see adult patients were suspended for a period of several  
36 months.

37  
38 At the hearing, Applicant attempted to justify the failure to disclose the suspension and  
39 revocation of clinical privileges by asserting that he was thinking only of state medical boards  
40 and not credentialing boards when he responded. However, the application makes no distinction  
41 between state medical boards, credentialing boards, or medical institutions. In fact, the  
42 application is silent as to the agency, institution, or employer taking such action. As such,  
43 Applicant’s internal qualifiers are of little benefit here. Rather, such testimony simply follows  
44 Applicant’s pattern of self-serving recollections and interpretations.

45 ///  
46

1 A preponderance of the evidence shows Applicant intentionally withheld information  
2 pertaining to disciplinary action taken, and the suspension and revocation of his clinical  
3 privileges while serving in the USAF in order to give the false impression that the only actions  
4 restricting his medical privileges were voluntary and related to charges that were ultimately  
5 dismissed. This was simply not true.  
6

7 The facts misrepresented and concealed by Applicant are material. All prior physician  
8 discipline, suspension and revocation of privileges, and gaps in length of time an applicant has  
9 been seeing patients or practicing his specialty are crucial pieces of information in determining  
10 whether and what type of license a medical applicant should be granted or, in the alternative,  
11 what additional measures that applicant would need to take to be reasonably entrusted with such  
12 license. Moreover, determinations of basic trustworthiness and honesty are also critical for  
13 licensing a physician. If an individual cannot be trusted to be honest on an application that can be  
14 verified by a staff and board members, that calls into question the physician's professionalism.  
15

16 Further, a preponderance of the evidence shows Applicant violated ORS 677.190(1)(a),  
17 committing unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), which  
18 includes, any conduct contrary to recognized standards of ethics of the medical profession.  
19 Applicant was intentionally untruthful on his application for medical licensure in Oregon and  
20 intentionally omitted material facts from that same application. Such conduct is "contrary to  
21 recognized standards of [medical] ethics." As succinctly explained by the Board's Medical  
22 Director, medical expert and a clinical practitioner of medicine for over 30 years, making full,  
23 complete, and truthful applications for medical licensure is required by physicians' code of  
24 ethics. *See*, Transcript at 89:4 through 90:2. Dr. Thaler explained that such conduct is included in  
25 the physicians' code of ethics because:  
26

27 [a] licensing board is responsible for saying that someone who has a license is fully  
28 qualified to do what – to be a medical practitioner in Oregon. And if there have been gaps  
29 in our knowledge about what took place previously in a licensee's or an applicant's  
30 history, we cannot judge truthfully whether someone is qualified. \* \* \* we could then  
31 decide based on that information what additional qualifications someone would need to  
32 become a fully licensed physician in Oregon, but if there are gaps in that, we cannot  
33 adequately assess their ability to practice. *See*, Transcript at 89:15 through 90:2.  
34

35 Some of the very information Applicant concealed that the Board uses to assess his  
36 abilities to practice with full medical licensure. As Chief Investigator Eric Brown testified, a  
37 medical doctor's license in Oregon – the license for which Applicant applied – allows the  
38 licensee to engage in, "[t]he unfettered practice of medicine within the state. It's a position of  
39 trust \* \* \* they deal with all segments of society and not everybody is necessarily a very good  
40 advocate for themselves, and – and there is a natural higher level of trust given to physicians.  
41 Transcript at 54, 67, 68. An expectation of honor and professionalism through basic honesty and  
42 forthrightness on a professional license application, in exchange for the trust and discretion given  
43 to a licensed physician, is a minimal standard, but one breached by Applicant.  
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**ORDER**

The Oregon Medical Board issues the following Order:

Applicant engaged in misrepresentation in his application for licensure and engaged in dishonorable or unprofessional conduct. Accordingly, Applicant's application for licensure is DENIED. In addition, Applicant shall pay a civil penalty in the amount of \$10,000 as well as the costs associated with these proceedings. The civil penalty is due and payable within 90 days from the effective date of this Order. Costs are due within 90 days from the date the Board issues the Addendum to Final Order - Bill of Costs.

DATED this 9<sup>th</sup> day of January, 2014.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURE REDACTED

ROGER M. MCKIMMY, MD  
Board Chair

**APPEAL OF FINAL ORDER**

You have the right to appeal this Final Order to the Oregon Court of Appeals, pursuant to ORS 183.482. To appeal, you must file a petition for review with the Oregon Court of Appeals within 60 days from the day the Final Order is served upon you. If the Final Order is personally delivered to you, the date of service is the date you receive the Final Order. If the Final Order is mailed to you, the date of service is the date it is *mailed*, not the date you receive it. If you do not file a petition for judicial review within the 60-day time period, you will lose your right to appeal.

1 BEFORE THE  
2 OREGON MEDICAL BOARD  
3 STATE OF OREGON

4 In the Matter of )  
5 )  
6 ROBERT ALLEN READ, MD ) ORDER MODIFYING  
7 LICENSE NO. MD21063 ) STIPULATED ORDER

8 1.

9 On October 11, 2012, Robert Allen Read, MD (Licensee) entered into a Stipulated Order  
10 with the Oregon Medical Board (Board). This Order placed certain conditions on Licensee's  
11 medical license. On September 6, 2013, Licensee submitted a written request asking the Board  
12 to terminate Term 4.7 of this Order, which reads:

13 4.7 Licensee must complete a health assessment at a medical facility that is pre-  
14 approved by the Board's Medical Director within one year from the signing  
15 of this Order by the Board Chair. Licensee must sign any releases to allow  
16 full communication between the evaluators and the Board. Licensee must  
cover all expenses associated with the assessment, to include travel,  
lodging, and testing.

17 2.

18 Having fully considered Licensee's request and compliance with this term, the Board  
19 terminates Term 4.7 of the October 11, 2012, Stipulated Order effective the date this Order is  
20 signed by the Board Chair. All other terms of the October 11, 2012, Stipulated Order are  
21 unchanged and remain in full force and effect.

22  
23 IT IS SO ORDERED this 9th day of January, 2014.

24 OREGON MEDICAL BOARD  
25 State of Oregon

26 SIGNATURE REDACTED

27 DONALD E. GIRARD, MD  
Board Vice Chair





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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
KENNETH JAY WELKER, MD ) ORDER OF EMERGENCY SUSPENSION  
LICENSE NO. MD 22731 )

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Kenneth Jay Welker, MD (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is a board certified surgeon, but has ceased practicing as a surgeon, and now practices medicine at a clinic called Optimal Health, in Eugene, Oregon. Licensee states that he is a Diplomate of the American Academy of Anti-Aging Regeneration and Functional Medicine. This organization is not recognized by the American Board of Medical Specialties or the American Osteopathic Association. The acts and conduct that support this Order for Emergency Suspension follow:

2.1 Patient A, a 56-year-old female, presented to Licensee on November 19, 2010, with complaints of a non-healing ulcer on her left calf. Patient A was morbidly obese with underlying insulin dependent adult onset diabetes with renal insufficiency and a history of congestive heart failure, and chronic obstructive pulmonary disease. Licensee estimated her weight to be between 350 and 400 pounds. Licensee noted that Patient A was interested in hydrogen peroxide intravenous (IV) therapy and that she did not want her conventional medicine providers to know that she was receiving other forms of therapy. Licensee initiated a course of IV hydrogen peroxide therapy that was to be done twice a week while she continued with ongoing conventional medical treatment from her primary care provider (PCP). Licensee failed to explain (or document that he explained) the risks, alternatives and

1 side effects associated with this type of treatment, and whether the patient had any questions  
2 regarding the treatment. Patient A experienced dizziness and nausea during the initial IV  
3 hydrogen peroxide therapy. Patient A returned to the clinic on November 22, 2010 for a  
4 repeat treatment, and received hydrogen peroxide IV therapy from another provider.

5       2.2 Patient B, a 77-year-old male, presented to Licensee on November 30, 2011,  
6 with complaints of fatigue, joint pain, sleep deprivation, and benign prostate hypertrophy.  
7 Licensee examined Patient B, noted an elevated blood pressure of 163/91 and ordered both  
8 conventional and unorthodox laboratory studies, but did not conduct a digital rectal  
9 examination or check Patient B's prostate-specific antigen (PSA), which was last checked in  
10 2005, when Patient B's PSA level was 10, which is elevated. Licensee diagnosed Patient B  
11 with hypercholesterolemia, hypertension, and fatigue due to "heavy metal burden chronic  
12 toxicity." Licensee's chart note for this initial visit lists thirty eight (38) distinct diagnoses.  
13 Licensee started Patient B on a course of medications and supplements, to include  
14 clonazepam (Schedule IV), Pregnenolone, hydrochlorothiazide, and ultimately 29 dietary  
15 supplements. Patient B underwent a test infusion of disodium ethylene diamine tetra-acetic  
16 acid (EDTA) on December 2, 2011 as well as heavy metal testing and other studies. Patient  
17 B's testosterone level was 396 (within the normal range) and his thyroid stimulating hormone  
18 (TSH) level was 2.99 (also within the normal range). On December 19, 2011, Licensee  
19 reviewed the recent lab studies with Patient B and decided to treat Patient B with 10 sessions  
20 of IV chelation, and prescribed an additional one half grain of thyroid and began treating  
21 Patient B with injections of 0.5 mL of testosterone per week along with anastrozole  
22 (Armindex) (a medication normally used for breast cancer prophylaxis for women) 1 mg per  
23 week. Licensee told Patient B that his testosterone level should be in an optimal range of 850  
24 to 950. Licensee did not check Patient B's PSA level or conduct a digital rectal examination  
25 (DRE). Licensee did not advise Patient B of the risks and possible side effects associated  
26 with the regimen of medications and supplements that he was taking. On January 13, 2012,  
27 Patient B came in for chelation treatment, and complained that his arthritic right knee had

1 caused him to stop playing basketball. Licensee injected his right knee with “1 mm” (sic)  
2 aqueous testosterone and 6 mL of prolotherapy. Patient B returned for repeated treatments of  
3 aqueous testosterone and prolotherapy. Although Patient B had a history of hypertension,  
4 Licensee did not record a blood pressure reading at the January 13<sup>th</sup> visit. On February 24,  
5 2012, Patient B’s blood pressure was noted to be 178/101, and on February 29<sup>th</sup>, Patient B  
6 collapsed at his chiropractor’s office. Later that day, his blood pressure readings at  
7 Licensee’s office were 196/109 and 178/126. Licensee failed to address the issue of  
8 hypertension in his progress notes. On March 4, 2012, Patient B was seen at the Sacred Heart  
9 Emergency Department (ED), with a blood pressure of 168/108. Patient B was discharged  
10 from the ED with a diagnosis of Transient Ischemic Attack (TIA). On March 12, 2012,  
11 Patient B informed Licensee that he had an MRI that documented multiple small strokes in  
12 the left basal area and right frontal lobe, and that he had been placed on a statin drug and  
13 clopidogrel (Plavix), which reduces the risk of strokes by reducing platelet aggregation in the  
14 blood. On March 13, 2012, Patient B was again seen at Sacred Heart Emergency Department  
15 and diagnosed with a TIA. Licensee spoke by phone with Patient B while he was being seen  
16 at Sacred Heart and prescribed losartan 25 mg BID without coordination with the emergency  
17 department physicians. Patient B returned on March 19 for EDTA chelation, and informed  
18 Licensee that he had been hospitalized for two days the previous week due to a small stroke,  
19 and was having trouble with his peripheral vision and understanding the radio. On April 6,  
20 2012, Patient B’s testosterone level was 717, blood sugar of 124, A1C of 5.8, and  
21 cholesterol/HDL ratio of 6.2. Patient B presented to Licensee on April 9, 2012, for EDTA  
22 chelation (#12) treatment. He complained of being irritable and had a large ecchymosis on  
23 his left buttocks. Licensee informed Patient B that his ecchymosis may be a hemorrhage at  
24 his testosterone injection site caused by his Plavix. Licensee told Patient B to stop taking  
25 Plavix. Licensee did not consult with Patient B’s PCP, and did not advise Patient B of the  
26 risks associated with discontinuing this medication, particularly in the context of his recent  
27 history of cerebrovascular disease. Licensee charted that he thought Patient B was “well

1 covered to reduce his risk of stroke particularly on EDTA chelation.” During this time,  
2 Patient B experienced difficulty urinating and asked Licensee if his symptoms could be  
3 attributed to the medications and supplements that Licensee had prescribed or recommended.  
4 Licensee rejected the idea, but on April 20, 2012, did prescribe tamsulosin (Flomax) 0.4 mg  
5 30 tablets. On April 23, 2012, Patient B’s PCP noted that Patient B did not understand the  
6 importance of taking Plavix as well as his statin medication and recommended that Patient B  
7 and the Licensee not alter any of his allopathic medications. Patient B continued to  
8 experience urination problems, and on May 23, 2012, presented to his PCP with complaints of  
9 incomplete voiding. Patient B received a consultation with Oregon Urology Institute, where  
10 he presented on May 30, 2012, with complaints associated with urine retention. Patient B was  
11 found to have a PSA of 17.6 (elevated) and an enlarged prostate. Patient B declined a  
12 transurethral resection of the prostate and elected to discontinue testosterone and to continue  
13 taking Flomax. Patient B’s symptoms gradually resolved. Licensee failed to inform Patient B  
14 of the health risks associated with his treatment plan, recommended unnecessary treatments to  
15 address his health condition, to include treatment with thyroid and testosterone, jeopardized  
16 Patient B’s health by recommending that he discontinue Plavix without medical justification,  
17 did not inform the PCP of his intervention into the treatment plan, which included the  
18 prescribing of Plavix, and failed to effectively address Patient B’s cerebrovascular disease  
19 while providing misleading information that chelation therapy is an effective treatment for  
20 cerebrovascular disease.

21       2.3     A review of the charts for Patients C – F revealed an ongoing pattern of  
22 conduct in which Licensee breached the standard of care by prescribing testosterone for men  
23 over the age of 60 that was not medically indicated and without checking their PSA or  
24 conducting a digital rectal exam (DRE). Patients C - F ranged in ages from 61 to 65, and  
25 presented to Licensee with various complaints of fatigue. Licensee tested the patients’  
26 testosterone level, informed these patients that their testosterone was low (although their test  
27 results were in the normal range), recommended that they take various supplements and began

1 treating them with testosterone. Licensee put Patients C – F on a course of Arimidex (1 mg, 1  
2 tablet twice a week) and intra muscular injections of testosterone (200mg/mL at 0.5 mL) that  
3 was not medically indicated. In addition, during the course of treatment, Licensee did not  
4 monitor PSA levels and did not conduct a DRE prior to initiating testosterone therapy and  
5 three to six months after initiating therapy.

6 2.4 Licensee treated Patients G – H with hydrogen peroxide therapy without  
7 documenting in the patients' charts that he explained the potential side effects, alternatives,  
8 risks, or answered his patients' questions.

9 2.5 Patient I, a 44-year-old adult male, presented to Licensee on October 13, 2009  
10 with a history of chronic fatigue, fibromyalgia, insomnia, and complained about numbness  
11 and tingling in the hands, with progressive clumsiness and weakness. Licensee examined  
12 Patient I and noted for the cardiovascular examination: "RRR [regular rate rhythm], No  
13 murmur." Licensee tested for heavy metals and initiated therapy with tramadol (Ultram). On  
14 October 26<sup>th</sup>, Patient I called Licensee to report that he was experiencing "a worsening in his  
15 irregular heartbeat and chest discomfort" as well as nausea, headaches and feeling of  
16 weakness. Patient I presented to Licensee on October 29, 2009, and reported an increase in  
17 his irregular heartbeats with an addition of racing heart and chest discomfort. Patient I  
18 attributed his symptoms of diarrhea, nausea, headaches and faintness to his rapid titrated  
19 increase of ProtoClear (a nutritional supplement). Licensee's assessment and plan follows:  
20 "Due to slight loss in lean body mass, will increase calorie intake to 1600 calories. Begin use  
21 of Chasteberry Plus to assist with symptoms of racing heart and thermo regulation." Licensee  
22 did not document that he conducted a cardiovascular examination, did not record Patient I's  
23 heart rate or blood pressure, did not order an EKG, check enzyme levels, obtain a consult with  
24 a cardiologist or contact Patient I's PCP. Licensee failed to document whether he recognized  
25 the significance of Patient I's potentially life threatening symptoms, and failed to follow up by  
26 examination, laboratory work or referral. By so doing, Licensee unnecessarily exposed  
27 Patient I to risk of harm.

1           2.6     Patient J, a 62-year-old female, initially presented to Licensee on January 28,  
2 2013 with complaints of dizziness, ataxia, and a body mass index of 20. She had previously  
3 been diagnosed with multiple sclerosis, and a chiropractor had documented a finding of “lead  
4 heavy metal toxicity issues” after an April 2012 post provocative urine test. A November  
5 2011 blood test reported normal lead and copper levels. Licensee discussed with Patient J  
6 the possibility of “fat transfer with respect to getting cells fat for the purposes of her first  
7 rating (sic) her neurological growth.” Licensee noted a plan to “pursue a detox case of lead<sup>22</sup>  
8 via EDTA chelation”. Patient J subsequently underwent a series of 20 IV calcium EDTA  
9 chelation treatments at Licensee’s clinic. On May 14, 2013, Patient J signed an informed  
10 consent form to undergo a “Fat Transfer.” This form states that this procedure is not FDA  
11 approved, is usually not covered by health insurance, and that there are “inherent risks.” On  
12 that same day, Licensee performed a “stem cell transfer” procedure on Patient J, by removing  
13 80 mL of fluid and fat from the patient’s abdomen through liposuction as well as 120 mL of  
14 blood, and processing it. Licensee subsequently injected 8 mLs of the processed solution into  
15 the patient’s spinal fluid by lumbar puncture, while the remainder was injected intravenously  
16 into Patient J. Within 5 minutes, Patient J complained of tingling in her body and both legs.  
17 Licensee noted that she had a high respiratory rate and elevated blood pressure with a lot of  
18 perspiration that lasted about 45 minutes. Licensee was surprised by this reaction and could  
19 not offer an explanation for the adverse reaction. He did not report this reaction to the drug  
20 company that made the stem cell transfer material or the FDA. Patient J was not seen again at  
21 the clinic until two days later. Licensee’s clinic records for this patient included two (2)  
22 different versions of her Vital Signs log for the period of 1/28/2013 through 6/11/2013. The  
23 first version has three (3) log entries for vital signs taken during the May 14, 2013, stem cell  
24 therapy, the second version of this log does not include any vital signs recorded for that date.  
25 Licensee subjected Patient J to a series of EDTA chelation treatments that were not medically  
26 indicated and “stem cell transfer” that were not medically indicated and subjected her to an  
27 ///

1 unnecessary risk of harm. When the patient experienced an adverse reaction, Licensee did not  
2 report the incident or provide proper follow-up.

3           2.7     Patient K, a 60-year-old female, presented to Licensee on March 27, 2013 with  
4 complaints of rheumatoid arthritis and postherpetic neuralgia. Licensee started her on DHEA  
5 (dehydroepiandrosterone) 25 mg a day, with a plan to increase this to 50 mg a day, in order to  
6 “help modulate her immune system.” On July 30, 2013, Patient K signed a “Fat Transfer”  
7 informed consent form and underwent localized stem cell infusion into both knees, breasts,  
8 and shoulders, as well as IV infusion. On August 27, 2013, Licensee attempted to draw blood  
9 from Patient K in order to provide her with Platelet Rich Plasma (PRP) therapy. Licensee’s  
10 chart note reflects he made “Multiple attempts to obtain blood from L wrist R wrist R femoral  
11 a/v L femoral L & R carotid and ext jugular were unsuccessful.” Patient K finally told  
12 Licensee to discontinue and that she wanted to go home. After being informed of the Board’s  
13 concern about the multiple documented attempts to access this patient’s arteries to obtain  
14 blood for his proposed therapy, Licensee now asserts that his chart note is not accurate.  
15 Licensee now claims that “at no time was any effort made to gain access in an arterial vessel  
16 (neither carotid nor femoral).” Licensee’s “stem cell transfer” procedure was not medically  
17 indicated, and subjected Patient K to significant and unwarranted risk of harm. Furthermore,  
18 either Licensee is responsible for an erroneous detailed dictation, or he attempted to draw  
19 blood from the femoral and carotid artery, thereby subjecting Patient K to an unnecessary risk  
20 of harm.

21           2.8     The Board also reviewed other cases where Licensee provided stem cell IV  
22 infusion treatments in 2013, pertaining to Patient L – N. Patient L was a 39-year-old female  
23 with a history of rheumatoid arthritis who first saw Licensee in July of 2010. Patient L  
24 returned to Licensee’s clinic on July 15, 2013, after an absence of over one year. On July 22,  
25 2013, Licensee administered injections of autologous processed fat and blood into the right  
26 knee, left and right wrist, right hip and right shoulder of Patient L. Excess fat was processed  
27 and injected into each breast for this patient. On January 10, 2013, Patient M, a 71-year-old

1 male and former marathon runner, presented with complaints of knee pain and left medial  
2 knee arthropathy. This patient was seeking an alternative to knee replacement surgery. On  
3 January 22, 2013, Licensee performed a “mini liposculpture and venipuncture for his platelet  
4 rich plasma.” Licensee processed the extracted fat and blood and injected it into Patient M’s  
5 left knee. Licensee wrapped Patient M’s abdomen, prescribed him 20 tablets of Oxycodone  
6 (Schedule II) and discharged him. Licensee also started Patient M on DHEA, 50 mg. Patient  
7 N, a 39-year-old male, initially presented to Licensee complaining of a tear in his left patellar  
8 ligament that he sustained from playing basketball. Licensee referred him to an orthopedic  
9 surgeon. After receiving surgery, Patient N returned to Licensee, and on January 29, 2013,  
10 Licensee performed a mini liposculpture, processed the extracted fat and blood, and injected it  
11 into Patient N’s left knee in the patellar tendon and into the right knee. On February 28, 2013,  
12 Licensee injected platelet rich plasma into Patient N’s left knee. These procedures were not  
13 medically indicated and subjected these patients to an unnecessary risk of harm.

14 3.

15 The Board has determined from the evidence available at this time that Licensee’s  
16 continued practice of medicine would pose an immediate danger to the public and to his  
17 patients. Based upon the information available to the Board at this time, Licensee’s pattern  
18 of treating patients with forms of treatment that are not medically indicated and unnecessarily  
19 exposed his patients to the risk of harm leads the Board to conclude that it is necessary to  
20 immediately suspend his license to practice medicine. To do otherwise would subject  
21 Licensee’s patients to the risk of harm while this case remains under investigation.

22 4.

23 Licensee is entitled to a hearing as provided by the Administrative Procedures Act  
24 (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a  
25 hearing. If Licensee desires a hearing, the Board must receive Licensee’s written request for  
26 hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant

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1 to ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of  
2 the time and place of the hearing and will hold a hearing as soon as practical.

3 5.

4 The Board orders that pursuant to ORS 677.205(3), the license of Kenneth Jay Welker,  
5 MD, be suspended on an emergency basis and that Licensee immediately cease the practice of  
6 medicine until otherwise ordered by the Board.

7 6.

8 **NOTICE TO ACTIVE DUTY SERVICEMEMBERS:** Active duty  
9 servicemembers have a right to stay these proceedings under the federal Servicemembers  
10 Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the  
11 Oregon Military Department at 800-452-7500 or the nearest United States Armed Forces  
12 Legal Assistance Office through <http://legalassistance.law.af.mil>.

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IT IS SO ORDERED THIS 9<sup>th</sup> day of January, 2014.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD  
BOARD VICE CHAIR

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**CERTIFICATE OF MAILING**

On, January 9, 2014, I mailed the foregoing Order of Emergency Suspension regarding Kenneth Jay Welker, MD to the following parties:

**By: First Class Certified/Return Receipt U.S. Mail**  
**Certified Mail Receipt # 7013 1090 0001 2845 4382**

Kenneth Jay Welker, MD  
1200 Executive parkway, Suite 360  
Eugene, OR 97401

**By: First Class Certified/Return Receipt U.S. Mail**  
**Certified Mail Receipt # 7013 1090 0001 2845 4399**

Eli D. Stutsman  
Attorney at Law  
621 SW Morrison, 13<sup>th</sup> Floor  
Portland, OR 97205

**By: UPS GROUND**

Warren Foote  
Department of Justice  
1162 Court St NE  
Salem OR 97301

Beverly Loder  
Beverly Loder  
Investigations Secretary  
Oregon Medical Board