Oregon Medical Board

BOARD ACTION REPORT

July 15, 2014

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

Scanned copies of Interim Stipulated Orders, Orders of Emergency Suspension, Stipulated Orders, Final Orders, Termination Orders, Modification Orders, Corrective Action Agreements, 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.

***Blackburn, Roy Manell, III, MD; MD22132; Eugene, OR**

On July 11, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order reprimands Licensee; assesses a $5,000 fine; places Licensee on probation; requires Board approval of any practice site; prohibits Licensee from supervising a physician assistant; requires Licensee to complete a pre-approved course in professionalism; prohibits Licensee from prescribing Schedule II and III medications; limits Licensee's prescribing for chronic pain; and places the same prescribing restrictions on all employees of Licensee.

***Bost, Dawn Elizabeth, MD; MD16820; Salem, OR**

On July 10, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order reprimands Licensee and assesses a $5,000 civil penalty.

*__Denker, John Thomas, MD; MD12668; Portland, OR__
On July 10, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; and violation of the federal Controlled Substance Act. This Order reprimands Licensee; fines Licensee $5,000; places Licensee on probation; limits Licensee's ability to prescribe Schedule II and III medications; and imposes the same prescription limitations on any physician assistant supervised by Licensee.

*__Garibaldi, Abel Alejandro, MD; MD159594; Coos Bay, OR__
On July 10, 2014, Licensee entered into a Stipulated Order with the Board. This Order retires Licensee's medical license while under investigation.

*__Helman, Edward Allan, MD; MD09729; Medford, OR__
On July 10, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses in pain management and medical documentation, and complete 20 hours of Category I CME in pain management.

*__Jean-Baptiste, Firmine, MD; MD23105; Lake Oswego, OR__
On July 10, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete the individualized education program designed by the Center for Personalized Education for Physicians.

*__Johnson, Kevin Raymond, MD; MD16564; Portland, OR__
On July 10, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; impairment, and gross or repeated negligence. This Order reprimands Licensee; requires that Licensee practice in sites approved by the Board's medical director; requires that Licensee maintain treatment with a healthcare provider; and outlines Licensee's re-entry to active surgical practice.

*__Kleinert, Kathleen Marie, DO; DO153515; Springfield, OR__
On July 10, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; fraud or misrepresentation when applying for a license; gross or repeated negligence in the practice of medicine; disciplinary action in another state; violation of the federal Controlled Substance Act; prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substance without following accepted procedures for record keeping; and failure to report to the Board any adverse action taken against Licensee by another licensing jurisdiction or governmental agency. This Order permanently surrenders Licensee's medical license.

*__Lafemina, Paul, MD; MD28776; Hillsboro, OR__
On July 10, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. Under this Order, Licensee surrenders his medical license while under investigation.

__Lowy, Leasa Jean, MD; Applicant__
On July 15, 2014, Applicant entered into a Consent Agreement with the Board. In this Agreement, Applicant agreed to practice under the supervision of pre-approved mentors to include monthly meetings and the submission of quarterly reports to the Board by the mentors.

*__Meyerding, Elliott Eugene, MD; MD13954; Medford, OR__
On July 10, 2014, the Board issued an Order Terminating Corrective Action Order. This Order terminates Licensee's January 11, 2007, Corrective Action Order.

*__Murray, Scott Michael, MD; MD15084; Portland, OR__
On July 3, 2014, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from treating female patients pending the completion of the Board's investigation.

*__Redfern, Craig Calvin, DO; DO14108; Portland, OR__
On July 10, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated acts of negligence. This Order reprimands Licensee; assesses a $2,500 civil penalty; places Licensee on probation; requires Licensee to complete a pre-approved course on the prescribing of controlled substances; requires Licensee to complete 20 hours of CME regarding the treatment of pain management; prohibits Licensee from treating patients on opioid therapies greater than MED 120 and prescribing controlled substances in excess of MED 120; and allows for no notice chart audits by the Board.

*__Rivas, Henry Rainier, MD; MD14654; Portland, OR__
On July 11, 2014, Licensee entered into a Stipulated Order with the Board. This Order retires Licensee's medical license while under investigation.

*__Roberts, Charles Anthony, PA; PA00257; Veneta, OR__
On July 10, 2014, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's January 10, 2013, Stipulated Order.

*__Roddy, Timothy James, MD; MD14358; Vancouver, WA__
On July 10, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on professional ethics.

*__Sills, Shawn Michael, MD; MD25091; Medford, OR__
On July 10, 2014, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's July 12, 2012, Stipulated Order.

*__Stull, Carol Grammer, MD; MD21384; Portland, OR__
On July 10, 2014, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's October 11, 2012, Stipulated Order.

*__Thomas, Paul Norman, MD; MD15689; Portland , OR__
On July 10, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's January 10, 2013, Corrective Action Agreement.

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of ROY MANELL BLACKBURN, III, MD LICENSE NO. MD22132	)	STIPULATED ORDER

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. Roy Manell Blackburn, III, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On June 3, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action pursuant to ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.

Licensee is board certified in physical medicine and rehabilitation, practicing in Eugene, Oregon. Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 The Board conducted a review of Licensee's management and treatment of chronic pain patients (Patients A – E), which revealed a pattern of practice that breached the standard of care, to include the following: Licensee failed to set forth clinical findings to support

the treatment of his patients with escalating high dosages of opioid therapy; Licensee treated high-risk patients with dangerous combinations of opioids, such as Oxycontin (Schedule II), hydromorphone (Dilaudid, Schedule II) and morphine (Schedule II), with benzodiazepines (such as lorazepam (Ativan, Schedule IV) and alprazolam (Xanax, Schedule IV)), that was not medically indicated and without explanation to the patients about the specific risks associated with such a combination of medications; Licensee failed to conduct a risk assessment for his chronic pain patients before adding opioids or benzodiazepines to the medication regimen; Licensee failed to address the efficacy of the treatment provided during follow-up clinical visits (to include failing to assess patient function); after initiating high dose opioid therapy, Licensee failed to ensure that effective surveillance measures were in place, to included frequent urine drug screens (UDS) and more frequent clinic visits after aberrant behavior; Licensee failed to re-examine his patients when they returned to his clinic; and Licensee rarely or never took or recorded his patients' vital signs. Specific concerns follow:

a. Patient A, a 45-year-old adult female with an extensive medical history that included low back pain, physical abuse, and bilateral thigh pain, first presented to Licensee on March 23, 2010. Licensee documented her history and examined her. He also required Patient A to sign a new Material Risk Notification and Narcotic Pain Contract. She was currently taking oxymorphone (Opana, Schedule II), 10 mg, 4 a day. On April 21, 2010, Patient A presented to Licensee with the stated goal of avoiding methadone "due to concerns that she read about it." Licensee prescribed oxymorphone, 10 mg, 1 - 3 tablets every 3 hours and wrote that a daily maximum of 20 tablets was for a "bad day." By September 15, 2010, Licensee was prescribing oxymorphone, 10 mg, 1 - 3 tablets every 3 hours for breakthrough low back pain (616 prescribed). Licensee conducted a pill count this day, revealing that Patient A had 232 tablets, indicating that she was taking 20 tablets a day. On March 30, 2011, Patient A presented at Oregon Health Science University (OHSU) for a pain consultation at Licensee's request. On July 7, 2011, Licensee increased Patient A's dosage of oxymorphone to 10 mg, 1 - 8 tablets a day every 3 hours (1,560 tablets prescribed, daily maximum of 52 tablets "per bad day"). On September 14, 2011, Licensee prescribed 1,920 tablets (10 mg) of oxymorphone to Patient A.

When pharmacies were unable to fill this monthly amount because it exceeded the insurance coverage, Licensee began to substitute hydromorphone for oxymorphone, without documenting his medical rationale. On October 12, 2011, Licensee prescribed 1,050 tablets of oxymorphone, 10 mg, 1 - 9 tablets every 3 hours, and 360 tablets of hydromorphone (Dilaudid, Schedule II), ½ - 2 tablets every 4 hours, for unpredictable significant breakthrough low back pain to last one month. Licensee received information from a pharmacist that Patient A was also prescribed alprazolam (Xanax, Schedule IV) during this time period by a nurse practitioner. On November 2, 2011, Licensee added lorazepam (Ativan, Schedule IV), 1 mg, ½ - 1 tablet every 4 hours for new onset bilateral lower extremity leg spasms, with instructions not to use lorazepam and oxymorphone on the same day. On November 30, 2011, Licensee changed the dosage for oxymorphone to 10 mg, ½ - 3 tablets every 2 hours as needed for breakthrough pain, with a maximum daily dosage of 24 tablets, and discontinued hydromorphone due to complaints of side effects. Patient A reported decreased activity and that "I can't do this trip anymore." On January 16, 2012, Patient A's husband called to inform Licensee that Patient A told him that she "couldn't take the pain any more" and had jumped off a bridge to her death. Licensee prescribed escalating dosages of short-action medications (oxymorphone and hydromorphone) for chronic pain control and added a benzodiazepine (lorazepam) without clinical justification. Licensee conducted periodic pill counts, but failed to provide Patient A clear instructions on how much medication to take. Subsequent to the initial patient visit, Licensee's chart has no record that he ever examined Patient A and or took vital signs, thereby unnecessarily exposing Patient A to the risk of harm.

b. Patient B, a 28-year-old female initially presented to Licensee via referral on July 9, 2009, with a history of fibromyalgia, headaches and pelvic pain. Her previous provider had prescribed alprazolam (Xanax, Schedule IV). Licensee conducted a comprehensive physical examination and confirmed a diagnosis of fibromyalgia and initiated a Material Risk Notification and a Narcotic Pain Contract. Licensee prescribed oxycodone/acetaminophen (Percocet, Schedule II) 10/325 mg, ½ - 1 tablet every 3 hours. On September 14, 2009, Licensee added MS Contin/morphine sulfate 15 mg every 6 hours, which was discontinued one week later

because of side effects. On October 5, 2009, Licensee instructed Patient B to continue Percocet, and started her on methadone (Schedule II) 5 mg, 3 times a day. Patient B presented to Licensee on January 5, 2010, and disclosed that she had run out of Percocet the previous week but did not call for a refill. Licensee continued the prescription for Percocet and increased the methadone dosage to 5 mg 4 times a day, with one additional tablet each day for "anticipated activity significantly painful." On January 25, 2010, Patient B reported that she lost her bottle of methadone. Licensee authorized a refill of half a month's supply. When Patient B returned to the clinic on March 1, 2010, Licensee noted that Patient B has fallen down the stairs that caused her to go to the Emergency Room. Licensee maintained Patient B on the same medication regimen, while adding promethazine hydrochloride (Phenergan), 50 mg suppository, 2 times a day for vomiting. In April 2010, Patient B reported a citation for driving while intoxicated, but Licensee did not discuss this with her. Licensee noted that Patient B did not want to attempt to be weaned from narcotics. Licensee maintained Patient B on a regimen of Percocet, 10/325 mg, ½ - 1 tablet every 3 hours and methadone, 5 mg, 4 times a day with one additional tablet each day for "anticipated activity particularly painful." Patient B received an early refill of methadone on April 28, 2010. On July 27, 2010, Licensee increased the prescription for Percocet to ½ - 2 tablets every 3 hours as needed, did not change the methadone dosage, and added oxycodone (OxyContin HCl, Schedule II), 10 mg, 1 - 3 tablets every 6 hours. On August 30, 2010, Patient B's spouse reported that they had gotten into an argument about the medications she was taking and that she had flushed the OxyContin and methadone down the toilet. On August 31, 2010, Licensee refilled the Percocet, OxyContin and methadone. In the months that followed, Patient B missed appointments and had more incidents of losing prescriptions and falling down stairs, without Licensee taking action to address this. On October 4, 2011, License added a fentanyl patch (Schedule II), 25 mcg to Patient B's drug regimen. In November of 2010, Patient B had a syncopal episode at the clinic. In December of 2010, Licensee increased the prescription for methadone to 10 mg, 3 times a day, and started oxycodone, 30 mg, ½ - 2 tablets every 3 hours, while maintaining Patient B's prescription for Oxycontin, 10 mg, 1 - 3 tablets every 6 hours, and methadone, 10 mg, 3 times per day. Patient B

continued to miss appointments in the months that followed. Patient B was found dead in her home on April 18, 2011, the state Medical Examiner reported the cause of death as "Combined Drug Toxicity (Methadone, Oxycodone and Alprazolam)."

c. Patient C, a 34-year-old adult female presented to Licensee on December 16, 2009 with a history of a motor vehicle accident in 1994 and complaints of chronic headaches and neck pain. Licensee ordered X-rays and conducted a physical examination, without checking her pulse and blood pressure. During the initial visit, Licensee provided a Material Risk Notification to Patient C as well as a Narcotic Pain contract. Licensee also made adjustments to her medication regimen for chronic pain, to include diazepam (Valium), 5 mg, 1 - 2 tablets at bedtime for 2 weeks, then discontinue; increase oxycodone to 30 mg, 1 - 2 tablets in morning, one additional tablet every 4 hours as needed (maximum of 6); prescribed methadone, 10 mg, 4 tablets 3 times a day, with an additional 1 - 2 tablets every 6 hours; and increased the prescription for gabapentin (Neurontin) to 600 mg, ½ tablet 3 times a day with a scheduled increase in dosage to 1 tablet 3 times a day beginning the following week. Licensee maintained Patient C on the medication regimen of oxycodone, methadone and Neurontin over the course of the next several years. Licensee did not use pain assessment tools, chart a UDS, or refer Patient C to a chronic pain specialist. In February of 2011, Patient C told Licensee that she had run out of methadone about a week early, and oxycodone five days early. Licensee advised Patient C to consult with her pediatrician in regard to checking her breast milk to determine the level of methadone and oxycodone. After giving birth, Patient C made the decision not to breast feed her baby, which subjected the baby to withdrawal symptoms. Subsequently, Licensee did ask the pharmacist to conduct a pill count, and restricted the dosage of methadone and oxycodone dispensed to Patient C to a one month supply. Licensee reduced the prescription of methadone to 10 mg, 2 tablets 4 times a day (56 tablets), and oxycodone, 30 mg, 2 tablets in the morning, and may repeat 1 - 3 tablets every 6 hours for breakthrough pain. On March 22, 2011, Licensee increased the methadone dosage to 10 mg, 4 tablets 4 times per day (#480). On December 6, 2011, Licensee added alprazolam (Xanax, Schedule IV) 1 mg ½ - 2 tablets every 4 hours, maximum of 4 a day, to the medication regimen for relief of neck tension. On February 29,

2012, Patient C reported that her right arm numbness was getting worse, and that "I drop things more often." Licensee did not conduct a neurological examination, but changed the medication regimen by increasing the oxycodone dosage to taking up to 4 tablets at once with a daily maximum dosage of 15 tablets (#379 prescribed). Licensee also reduced the methadone dosage to 10 mg, 4 tablets 3 times a day, and reduced the Xanax dosage ("needs half what was previously issued.") Throughout this time, Patient C missed a number of appointments and reported running out of medications or losing her medications on multiple occasions. The patient visit on April 3, 2012 is notable in that this is one time that Licensee recorded Patient C's blood pressure and pulse (150/101 & 140/97 10 minutes later; pulse of 110). The medication regimen at this time included methadone, 10 mg, 2 tablets 4 times a day (#240); oxycodone, 30 mg, 1 - 2 tablets in the morning, 1 - 3 tablets every 6 hours thereafter (#439); and Xanax, 1 mg, ½ - 2 tablets every 4 hours (#30). Licensee failed to monitor and advise Patient C on her use of controlled substances during and after her pregnancy, added Xanax to the medication regimen without explaining his medical rationale in the chart or specifically informing Patient C of the risks when combined with high dose opioids, and progressively increased doses of a short acting opioid (oxycodone) while inadequately monitoring Patient C's compliance with the medication regimen.

d. Patient D, a 34-year-old male (and husband of Patient C), initially presented to Licensee on March 17, 2009, with a history of chronic neck pain as well as traffic violations, to include speeding and driving under the influence of intoxicants. Licensee decreased Patient D's prescription of methadone to 10 mg, 4 tablets, 3 times a day (#180). Licensee started Patient D on OxyContin HCl, 80 mg, 1 tablet every morning (#15), OxyContin HCl 40 mg, 1 tablet every 6 hours (#30), oxycodone 30 mg, ½ - 1 tablet every 6 hours (#30) (only to take up to 2 "per bad day"), started Patient D on baclofen (Lioresal) 10 mg, ½ tablet 3 times a day (#90) and Neurontin, 100 mg, (#100) (with instructions for an escalating dosage). On March 24, 2009, Licensee established a medication regimen of methadone, 40 mg, 4 times per day, oxycodone, 30 mg, 4 times per day, baclofen 10 mg, 3 times per day, and Neurontin, 100 mg, 3 times per day. The record is replete with Patient D missing his scheduled medical appointments. The

medication regimen on January 31, 2011, included methadone, 10 mg, 4 tablets 4 times per day (#240) and oxycodone, 30 mg, 4 times per day and an additional 1 tablet for anticipated painful activity (#146). On February 2, 2011, Licensee noted that Patient D had not come in for a scheduled appointment since November 29, 2010, but he continued to authorize prescription refills. On August 29, 2011, Licensee revised the medication regimen by increasing the dosage of oxycodone to 30 mg, 4 times per day and additional 1 - 2 tablets each day.(#332) while continuing methadone 10 mg 4 tablets, 4 times per day (#480). Patient D refused to attempt a trial weaning from the narcotics and reported that "...the extras you gave me for work help. Haven't thrown up this month due to the pain." Licensee received an anonymous letter dated January 23, 2012, stating that Patient C and D were diverting their medications by selling all their oxycodone and half the methadone that Licensee prescribed for them. The writer urged Licensee to have both Patient C and D come in for UDS and pill counts. Licensee took no action based on this letter. On February 13, 2012, Licensee adjusted the medication regimen as follows: methadone, 10 mg, 4 tablets 4 times per day, (#480), and oxycodone, 30 mg, 4 times per day, 1 - 2 additional tablets every 4 hours for anticipated painful activity (#360). In March of 2012, Licensee called Patient D requesting that both Patients C and D take a polygraph test "to test the veracity of your reports to me that you are using your medicines as prescribed." In June of 2012, Licensee charted that Patient D's UDS showed positive for methadone and oxycodone, as well as two benzodiazepines (temazepam and oxazepam) "from another provider." On the last patient visit in July of 2012, Licensee changed the dosage to methadone, 10 mg, 2 tablets 4 times per day (#240), and additional oxycodone, 30 mg, 1 tablet 4 times per day, and an additional 1 - 3 tablets every 4 hours for anticipated painful activity (#475).

e. Patient E, a 42-year-old male, presented as a new patient in Licensee's clinic on March 4, 2009, with a history that included spinal injury from a motocross accident in 2003, previous failed medical interventions to address his injury and associated pain, and suicide attempts. Licensee identified thoracic back pain. Licensee prescribed oxycodone HCl (OxyContin, Schedule II), 10 mg, 1 tablet 2 times per day, with 1 additional tablet for anticipated painful activity (#90); hydromorphone HCl (Dilaudid, Schedule II), 4 mg, ½ - 1 tablet for

breakthrough pain (#60); baclofen (Lioresal) 10 mg, ½ tablet 3 times per day (#90); and promethazine hydrochloride (Phenergan) 25 mg, 1 - 2 tablets 4 times per day (#240). On May 19, 2010, Licensee modified the prescription for Dilaudid as follows: Injectable, 1mg/ml, inject 4 ml each day as needed (10 vials), and tablets, 4 mg, 1 tablet every 4 hours as needed (#82). On September 18, 2012, Licensee prescribed injectable Dilaudid, 10 mg/ml vial (13 vials). On September 19, Licensee prescribed Dilaudid, 8 mg, 2 tablets every morning and an additional ½ - 2 tablets every 4 to 6 hours (#150), and attempted to start buprenorphine transdermal patch (Butrans, Schedule III), 10 mcg, (4 patches), which may have triggered withdrawal symptoms, but this medication was denied by insurance. Patient E's wife called Licensee about her husband's need to wean off narcotics. Patient E was followed by a psychiatrist, and Patient E considered in-patient treatment for opioid dependency and pain. On January 7, 2013, Licensee prescribed hydromorphone HCI (Dilaudid, Schedule II), 8 mg, 2 tablets every morning and an additional ½ - 2 tablets every 4 to 6 hours (#165), and injectable Dilaudid, 10 mg vials, (12 vials, inject 6 mg per day). On January 14, 2013, Licensee was notified by Patient E's therapist that Patient E presented at an appointment heavily sedated, that he was half asleep, slurred his speech, was tangential, and appeared to be over-medicated. Licensee received this report without comment, and on the next patient visit on February 4, 2013, increased the medication regimen to Dilaudid, 8 mg, 2 tablets every morning and an additional ½ - 2 tablets every 4 to 6 hours (#360), and injectable Dilaudid, 10 mg vials (28 vials). Licensee did not see Patient E after February 2013, but refills were given through April 2013. On September 2, 2013, Patient E went to a local emergency room, "pleading" for more narcotics or benzodiazepines for his headaches. Patient E was given Toradol and Phenergan in the ER.

3.2 In 2011, Licensee sent a video clip to the Oregon Board of Pharmacy depicting an adult male stripped of his clothes, secured to a post by uniformed authorities in an overseas location, and lashed repeatedly on his buttocks with a whip, causing profuse bleeding and visible lacerations. Licensee explained that he sent this video to illustrate what he thinks should happen to any person who illegally obtains and sells pain pills for profit. Licensee's action in sending

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this video clip displayed poor judgment, had the potential of causing emotional distress to anyone viewing this video clip, and constitutes unprofessional or dishonorable conduct.

4.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. 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 Order in the Board's records. Licensee admits that he engaged in the conduct described in paragraph 3 that violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following sanctions and terms:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a civil penalty of $5,000, payable in full within 12 months from the effective date of this Order.

5.3 Licensee is placed on probation for a minimum period of five years and shall report in person to the Board at each of its quarterly meetings at the scheduled times for a probation interview, unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.

5.4 Licensee must not prescribe Schedule II or III medications.

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5.5 Licensee must not prescribe more than 30 days of medications for chronic pain to any one patient over a period of one year. Chronic pain is defined as pain that persists or progresses for more than thirty (30) days.

5.6 Any medical provider's working under Licensee employ must abide by the same prescribing limits as Licensee as described in terms 5.4 and 5.5.

5.7 Licensee may only practice medicine in settings that are pre-approved by the Board's Medical Director.

5.8 Within 12 months from the signing of this Order by the Board Chair, Licensee must complete a course in professionalism pre-approved by the Board's Medical Director.

5.9 Licensee may not act as a supervising physician to a physician assistant, or become a member of a Supervising Physician Organization.

5.10 The Interim Stipulated Order of November 7, 2013, terminates upon approval of this Order by the Board.

5.11 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

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

5.13 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).

IT IS SO STIPULATED THIS 2ND day of July, 2014.

SIGNATURE REDACTED

ROY MANELL BLACKBURN, III, MD

IT IS SO ORDERED THIS 11th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
DAWN ELIZABETH BOST, MD	)	STIPULATED ORDER
LICENSE NO. MD16820	)	
	)	

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. Dawn Elizabeth Bost, MD (Licensee) holds an active license to practice medicine in the state of Oregon.

2.

On April 3, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action pursuant to ORS 677.205(2), to include the revocation of license, a $10,000 fine, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a).

3.

Licensee is board-certified in internal medicine. Licensee entered into a Stipulated Order with the Board on October 11, 2012, to address her multi-year lapse from the practice of medicine. This Stipulated Order was terminated when Licensee and the Board entered into a Corrective Action Agreement on October 3, 2013, which is a non-disciplinary action.

3.1 Licensee's acts and conduct that violated the Medical Practice Act are described in the Complaint and Notice of Proposed Disciplinary Action issued April 3, 2014. In brief, Licensee left a recording device known as a "Livescribe Pen" in the Board's

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Boardroom while Board members met in executive session, thereby recording confidential information that was statutorily protected.

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), 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 Order in the Board's records. Licensee acknowledges that she was negligent in leaving her recording pen behind in the Boardroom on October 3, 2013, and that it was inappropriate to have done so. Licensee agrees that to inadvertently record any portion of the Board's discussion in Executive Session compromised the confidentiality of matters under discussion, and constitutes unprofessional or dishonorable conduct. The Board finds that Licensee violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following sanctions and terms:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a civil penalty of $5,000, payable in full within 60 days from the date the Board Chair signs this Order.

5.3 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

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

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5.5 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).

IT IS SO STIPULATED THIS 18 day of June, 2014.

SIGNATURE REDACTED

DAWN ELIZABETH BOST, MD

MD

IT IS SO ORDERED THIS 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of JOHN THOMAS DENKER, MD LICENSE NO. MD12668	)))))	STIPULATED ORDER

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. John Thomas Denker, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On March 19, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action pursuant to ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee is a general practitioner in Portland, Oregon. On October 17, 2002, Licensee and the Board entered into a Corrective Action Order in which the Board agreed to close its investigation in regard to Licensee's treatment of chronic pain patients and Licensee agreed to successfully complete the Oregon Medical Association's PEER (Physicians Education Evaluation and Renewal) program. Licensee satisfied the terms of this agreement and the Board terminated the agreement on April 15, 2005. The Board received a complaint in January of 2013 and opened an investigation in regard to Licensee's treatment of patients for chronic pain. On March 6, 2013, the Board informed Licensee that it had opened an investigation in regard to his prescribing practices, medication management, and chronic pain treatments that he provided to

certain identified patients. Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 The Board conducted a review of Licensee's management and treatment of chronic pain patients (Patients A – G), which revealed a pattern of practice that breached the standard of care, to include the following: Licensee failed to set forth clinical findings to support the treatment of his patients with escalating high dosages of opioid therapy; Licensee treated high risk patients with dangerous combinations of opioids, and dangerous combinations of benzodiazepines; Licensee failed to conduct a risk assessment for his chronic pain patients before initiating high dose opioid therapy; Licensee failed to address the efficacy of the treatment and medications provided during follow-up clinical visits (to include failing to assess patient function and pain status); after initiating high dose opioid therapy, Licensee failed to ensure that effective compliance measures were in place, to include random urine drug screens (UDS), pill counts and more frequent clinic visits after aberrant behavior; Licensee's charts failed to address evidence of some patients' aberrant behavior, to include inconsistent UDS reports and the concurrent use of tetrahydrocannabinol (THC); and after assuming care of certain chronic pain patients, Licensee allowed several months to pass before requesting an updated pain contract with these patients and providing them with current material risk notifications.

3.2 Specific concerns in regard to the care that Licensee provided to Patients A – G follows:

a. Patient A, a 48-year-old obese adult female with a complex medical history who was on a medication regimen for chronic abdominal and lower back pain associated with fibromyalgia and pancreatitis, initially presented to Licensee on December 3, 2012. Licensee continued prescriptions for oxycodone, 30 mg, three times a day, and prednisone, 10 mg, use as directed, while Patient A continued to receive prescriptions from another provider for clonazepam (Klonopin, Schedule II), 1 mg three times a day. On March 11, 2013, Licensee added methadone HCL, 10 mg, twice daily, to the regimen that included oxycodone, 30 mg, 3 tablets per day, Klonopin, 1 mg, 3 a day, and prednisone, 10 mg. On that same date, Licensee also updated Patient A's pain contract and provided material risk notification.

b. Patient B, a 30-year-old male college student with a history of a knee injury (sprain of a cruciate ligament) from a motor vehicle accident, received care from Licensee for many years. A review of the chart reveals that on March 8, 2012, Licensee was prescribing oxycodone HCL, 5 mg, 1 – 2 tablets every 4 – 6 hours, as well as methylphenidate (Ritalin, Schedule II) 10 mg, twice a day, for Attention Deficit Hyperactivity Disorder (ADHD), without establishing a diagnosis for ADHD in the chart. The regimen continued until October 16, 2012, when Licensee added alprazolam (Xanax, Schedule IV), 0.5 mg, 3 times a day, to the medication regimen for "panic attacks." The chart does not reveal a material risk notification, pain contract or UDS for this time period. Licensee signed an attending physician's statement to authorize medical marijuana for Patient B for severe pain and muscle spasms on December 26, 2012, again without a chart note for medical efficacy or material risk notification. The Board's review reveals that on March 26, 2013, Licensee continued to prescribe the same regimen, and noted Patient B's knee pain "is bearable" and that he was doing well in college (with a GPA of 4.0). Patient B felt that Ritalin "helped considerably at school." Licensee also noted that he reviewed the chart on this date and could not find a controlled medication contract, although he recalled having done one.

c. Patient C, a 56-year-old adult female with complaints of lumbar disc disease and Meniere's disease, came under Licensee's care in 2005, and entered into a pain contract with Licensee at that time. Licensee placed Patient C on a medication regimen for chronic pain that included lorazepam (Ativan, Schedule IV), 4 mg daily; methadone, 60 mg daily, hydromorphone (Dilaudid, Schedule II), 32 mg daily, and diazepam (Valium, Schedule IV), 10 - 15 mg daily. Over the course of the next several years, Licensee did not use pain assessment tools, chart a UDS, or refer Patient C to a pain specialist. On February 5, 2013, Licensee was prescribing diazepam, 5 mg, use as directed; hydromorphone, 8 mg, every 4 hours, lorazepam, 1 mg, 1 every 4 – 6 hours; and carisprodol (Soma, Schedule IV), 350 mg, 4 tablets day. Licensee did not chart his medical reasoning for prescribing two benzodiazepines (lorazepam and diazepam) in addition to Soma and an opiate, and failed to provide Patient C with material risk notification.

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d. Patient D, a 44-year-old male, initially presented to Licensee on December 12, 2012, with a history that included insulin-dependent diabetes, severe anxiety, as well as chronic back and knee pain from degenerative arthritis. Patient D's previous provider had treated him with Klonopin for anxiety and methadone for chronic pain. Licensee noted that Patient D appeared to be "quite anxious and upset." Licensee prescribed Klonopin, 0.5 mg, 3 times a day, and methadone HCL, 10 mg, 1 tablet every 4 – 6 hours. On March 28, 2013, Licensee noted that Patient D "appears pathetic" and "is anxious and tremulous. He appears in pain." On that day, Licensee ordered refills for methadone (Schedule II), 10 mg, 1 tablet every 4 – 6 hours, and Klonopin, 0.5 mg, 3 times a day. Licensee noted that a UDS was not done "due to cost" but executed a pain contract. Licensee did not conduct a pain assessment, confer with a pain specialist, or employ a UDS schedule. Licensee also failed to provide material risk notification and unnecessarily delayed establishing a pain contract.

e. Licensee managed the care of Patient E, a 68-year-old male, with a history that included hypertension, gout, restless leg syndrome, and osteoarthritis. On November 14, 2012, Patient E presented to Licensee for a medication check. Licensee noted "osteoarthrosis, localized, primary, left leg," without any clinical findings. At this time, Licensee's medication regimen for Patient E included allopurinol; Klonopin, 1 mg, 1 – 2 tablets at night; and codeine with acetaminophen (Schedule III), 3/25 mg, 1 – 2 tablets every 4 – 6 hours. A review of the chart for March 13, 2013, reveals that Licensee maintained Patient E on the same medication regimen, without a pain contract, material risk notification, or UDS.

f. Patient F, a 38-year-old female with lower back pain, presented as a new patient in Licensee's clinic on January 13, 2010, with a history of being dismissed as a patient at three other clinics for issues with chronic pain treatments and drug seeking behavior. In 2010 and 2011, Licensee executed pain contracts and provided a material risk notification. On June 23, 2010, Licensee managed Patient F with a prescription regimen that included hydrocodone & acetaminophen (Schedule III), 7.5/325 mg, 1 – 2 tablets every 6 hours, gabapentin (Neurontin), and metformin HCL, 500 mg, 3 times a day. Starting in January of 2013, Licensee subsequently transitioned Patient F to methadone (Schedule II), 10 mg, 1 tablet every 4 – 6 hours, and

oxycodone HCL (OxyContin, Schedule II), 15 mg, 1 tablet every 3 hours. Licensee did not risk stratify this patient, make a pain referral, or increase the compliance measures in response to aberrant behavior (such as lost medications), to include more UDS, pill counts, or more frequent clinic visits.

g. Patient G, a 62-year-old male, received care from Licensee from 2009 into 2013. Patient G presented with a history of osteoarthritis of the right knee and frequent complaints of tension headaches. Licensee prescribed hydrocodone & acetaminophen (Vicodin, Schedule III) 5/500 mg, to address Patient G's complaint of acute pain in both knees and his shoulder. Licensee noted that Patient G asked for early refills of Vicodin, but did not address this issue or establish why the patient was making this request. When Patient G complained of tension headaches, Licensee prescribed acetaminophen & butalbital & caffeine (Fioricet), 1 – 2 tablets every 4 – 6 hours. Licensee failed to note whether he tried to determine the cause of the tension headaches or to develop a treatment plan for this condition.

4.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. 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 Order in the Board's records. Licensee neither admits nor denies, but the Board finds that he engaged in the conduct described in paragraph 3 that violated ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(13); and ORS 677.190(23). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following sanctions and terms:

5.1 Licensee is reprimanded.

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5.2 Licensee must pay a civil penalty of $5,000, payable in full within 60 days from the effective date of this Order.

5.3 Licensee is placed on probation for a minimum period of five years and shall report in person to the Board at each of its quarterly meetings at the scheduled times for a probation interview, unless otherwise directed by the Board's Compliance Officer or its Investigative Committee. After two years of compliance with the terms of this Order, Licensee may submit a written request to the Board to modify or terminate the terms of probation.

5.4 Licensee must not prescribe more than 30 days of Schedule II or III medications to any one patient over a six-month period, except for patients seen in long-term care facilities where Licensee serves as Medical Director.

5.5 For patients seen in long-term care facilities where Licensee serves as Medical Director, Licensee must not prescribe in excess of a daily morphine equivalent dose (MED) of 80 mg. To prescribe in excess of 80 MED for any patient in a long-term care facility where Licensee serves as Medical Director, Licensee must first obtain a second opinion from a specialist in the patient's area of pain (i.e. oncologist for cancer related pain; a board certified rheumatologist for pain associated with arthritis; or a board certified pain specialist) and must include that written second opinion endorsing the treatment plan in the patient chart. Licensee must not prescribe sedatives for more than 30 days to patients on chronic opioids without obtaining a second opinion and including that second opinion in the patient chart.

5.6 Any physician assistant supervised by Licensee must abide by the same prescribing limits as Licensee as described in terms 5.4 and 5.5.

5.7 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

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

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5.9 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).

IT IS SO STIPULATED THIS 10th day of June, 2014.

SIGNATURE REDACTED

JOHN THOMAS DENKER, MD

IT IS SO ORDERED THIS 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of ABEL ALEJANDRO GARIBALDI, MD LICENSE NO. MD159594	)))))	STIPULATED ORDER

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. Abel Alejandro Garibaldi, MD (Licensee) is a licensed physician in the State of Oregon.

2.

Licensee is a board-certified thoracic surgeon. On August 8, 2013, the Board opened an investigation after receiving information regarding Licensee's laparoscopic surgical skills.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to retire his license while under investigation, consistent with the terms of this Order and to close this matter. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and 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 understands that this document is a public record and is reportable to the National Databank and the Federation of State Medical Boards.

4.

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

4.1 Licensee permanently retires his license to practice medicine while under investigation concerning his laparoscopic surgical skills.. This retirement of license becomes effective the date the Board Chair signs this Order.

4.2 Licensee may not apply for any license status with the Oregon Medical Board.

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

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

IT IS SO STIPULATED this 16th day of June, 2014.

SIGNATURE REDACTED

ABEL ALEJANDRO GARIBALDI, MD.

IT IS SO ORDERED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
EDWARD ALLAN HELMAN, MD LICENSE NO. MD09729	)	CORRECTIVE ACTION AGREEMENT
	)	

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. Edward Allan Helman, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The April 30, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed to take disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

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. This document is reportable to the National Data Bank and the Federation of State Medical Boards.

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BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of FIRMINE JEAN BAPTISTE, MD LICENSE NO. MD23105	CORRECTIVE ACTION AGREEMENT

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. Firmine Jean-Baptiste, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On April 3, 2014, the Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit ORS 677.190(1)(a) unprofessional or dishonorable conduct as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated negligence.

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 she 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. This document is reportable to the National Data Bank and the Federation of State Medical Boards.

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4.

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

4.1 Licensee completed an assessment by the Center for Personalized Education for Physicians (CPEP) on March 27-29, 2013, and on May 30, 2013, CPEP issued an Assessment Report with educational recommendations.

4.2 Licensee, at her own expense, must participate in a structured, individualized education program designed and managed by CPEP to address all identified areas of need set forth in the CPEP Assessment Report. Licensee must fully cooperate with and successfully complete this CPEP education remediation plan within 24 months from the date of the signing of this Agreement by the Board Chair. CPEP will provide written evaluation and progress reports directly to the Board. Licensee must sign all necessary consent forms to allow full communication between CPEP and Board staff.

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

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

IT IS SO AGREED this 05 day of June, 2014.

SIGNATURE REDACTED

FIRMINE JEAN-BAPTISTE, MD

IT IS SO AGREED this 10th day of July, 2014.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

4.

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

4.1 Within six months from the signing of this Agreement by the Board Chair, Licensee must successfully complete a course on pain management and a course on medical documentation that are pre-approved by the Board's Medical Director.

4.2 After completing the above specified coursework, Licensee must successfully complete a minimum of 20 hours of Category I continuing medical education on pain management, pre-approved by the Board's Medical Director, within the next 18 months.

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

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

IT IS SO AGREED this 30th day of April, 2014.

SIGNATURE REDACTED

EDWARD ALLAN HELMAN, MD

IT IS SO AGREED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of: KEVIN RAYMOND JOHNSON, MD LICENSE NO. MD16564	STIPULATED ORDER

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. Kevin Raymond Johnson, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

Licensee is a board-certified general surgeon. The Board received credible information regarding Licensee that resulted in the Board initiating an investigation on September 8, 2011. A second investigation was opened on July 25, 2012, upon receipt by the Board of a malpractice claim report. On July 11, 2013, the Board issued a Complaint & Notice of Proposed Disciplinary Action, alleging violations of the Medical Practice Act. On December 4, 2013, Licensee's medical license was changed to inactive status by operation of Board rule. On March 5, 2014, Licensee and the Board entered into an Interim Stipulated Order allowing Licensee to hold an active license limiting his practice of medicine to taking patient histories and performing examinations.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and 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 neither admits nor denies the allegations as set forth in the Complaint and Notice of Proposed Disciplinary Action of July 11, 2013, but the Board finds that Licensee engaged in the conduct as described in the Notice, and that his conduct violated the Medical Practice Act, as alleged in the Notice.

4.

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

4.1 Licensee is reprimanded.

4.2 Licensee may only practice medicine in a setting that has been pre-approved in writing by the Board's Medical Director.

4.3 Licensee must maintain ongoing treatment with his current healthcare provider, or another provider approved by the Board's Medical Director.

4.4 Licensee may only re-enter the active practice of surgery in one of two ways (or a combination of both): (1) For a minimum of six months, to enter into a surgical retraining program that has been pre-approved by the Board's Medical Director, which includes monthly reports to the Board and personal supervision for all surgical procedures by currently board certified surgeons who are pre-approved by the Board's Medical Director; or (2) for a minimum of six months, Licensee must only perform surgeries with a currently board-certified general surgeon(s) acting as the supervising surgical assistant. The surgeon(s) must be pre-approved by the Board's Medical Director and must submit monthly reports to the Board.

4.5 After completing six months of surgical practice fully compliant with term 4.4 (above) and with the written endorsement of his supervising surgeons and treating physician, Licensee may submit a written request to the Board to modify or terminate the terms of this Order.

4.6 Licensee's Interim Stipulated Order of March 5, 2014, is terminated upon approval of this Order by the Board.

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

4.8 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).

4.9 Licensee understands that this Order is a public record and is a disciplinary action and that is reportable to the National Databank and the Federation of State Medical Boards.

5.

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

IT IS SO STIPULATED this 5th day of May, 2014.

SIGNATURE REDACTED

KEVIN RAYMOND JOHNSON, MD

IT IS SO ORDERED this 10th day of July, 2014.

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of KATHLEEN MARIE KLEINERT, DO LICENSE NO. DO153515	STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including osteopathic physicians, in the State of Oregon. Kathleen Marie Kleinert, DO (Licensee) is a licensed osteopathic physician in the State of Oregon.

2.

Licensee is an osteopathic physician working in Springfield, Oregon. On February 29, 2012 the Board opened an investigation upon receipt of credible information regarding Licensee. On March 5, 2013 Licensee signed an Interim Stipulated Order in which she voluntarily agreed to refrain from providing obstetrical care and from prescribing or dispensing any controlled substances.

3.

On August 8, 2013, the Board issued a Complaint and Notice of Proposed Disciplinary Action to take 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 civil penalty, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and (b); ORS 677.190(8) fraud or misrepresentation when applying for a license; ORS 677.190(13) gross or repeated negligence in the practice of medicine; ORS 677.190(15) disciplinary action in another state; ORS 677.190(23) violation of the federal

Controlled Substance Act; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substance without following accepted procedures for record keeping; and ORS 677.190(25) failure to report to the Board any adverse action taken against Licensee by another licensing jurisdiction or governmental agency.

4.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to surrender her license while under investigation, consistent with the terms of this Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and 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 neither admits nor denies she engaged in the conduct described in paragraph 3 above, but the Board concludes that Licensee violated the Medical Practice Act as described in paragraph 3 above and detailed in the Complaint and Notice of Proposed Disciplinary Action issued August 8, 2013. Licensee understands that this document is a public record and is reportable to the National Data Bank, and the Federation of State Medical Boards.

5.

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

5.1 Licensee permanently surrenders her license to practice medicine while under investigation. Licensee further agrees that she will never apply for a license to practice medicine in the state of Oregon. This surrender of license becomes effective the date the Board Chair signs this Order.

5.2 This Order terminates the Interim Stipulated Order of March 5, 2013, effective the date the Board chair signs this Order.

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

IT IS SO STIPULATED this 25th day of June, 2014.

SIGNATURE REDACTED

KATHLEEN MARIE KLEINERT, DO

IT IS SO ORDERED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of:	)	
	)	
PAUL LAFEMINA, MD LICENSE NO. MD28776	)	STIPULATED ORDER
	)	
	)	

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. Paul Lafemina, MD (Licensee) is a licensed physician in the state of Oregon and holds an inactive medical license.

2.

Licensee is a board-certified anesthesiologist. The Board received credible information regarding Licensee that resulted in the Board initiating an investigation on November 26, 2013. On November 27, 2013, Licensee and the Board entered into an Interim Stipulated Order in which Licensee agreed to voluntarily withdraw from the practice of medicine.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to surrender his license while under investigation, consistent with the terms of this Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and 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 neither admits nor denies but the Board finds that Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a).

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4.

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 his Oregon medical license while under investigation.

5.2 Licensee's Interim Stipulated Order of November 27, 2013, is terminated upon approval of this Order by the Board.

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

5.5 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).

5.6 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.

5.

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

IT IS SO STIPULATED this 21st day of April, 2014.

SIGNATURE REDACTED

PAUL LAFEMINA, MD

IT IS SO ORDERED this 10th day of July, 2014.

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
ELLIOTT EUGENE MEYERDING, MD LICENSE NO. MD13954	)	ORDER TERMINATING CORRECTIVE ACTION ORDER
	)	

1.

On January 11, 2007, Elliott Eugene Meyerding, MD (Licensee) entered into a Corrective Action Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On April 29, 2014, Licensee submitted documentation that he has successfully completed all terms of this Order and requested that this Order 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 Order. The Board terminates the January 11, 2007, Corrective Action Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of SCOTT MICHAEL MURRAY, MD LICENSE NO. MD15084	))))))	INTERIM STIPULATED ORDER

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. Scott Michael Murray, MD (Licensee) is a licensed physician in the state of Oregon and holds an active license.

2.

Licensee is a board-certified psychiatrist practicing in Portland, Oregon. The Board has opened an investigation of Licensee.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

3.1 Licensee may not treat any female patients.

3.2 Licensee understands that violating any term of this Order may be grounds for disciplinary action under ORS 677.190(17), willfully violating Board order.

3.3 Licensee understands this Order becomes effective the date he signs it.

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4.

At the conclusion of the Board's investigation, the limitation placed on Licensee will be reviewed in an expeditious manner. If the Board determines, following that review, that these limitations shall not be lifted, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.265 while the Board conducts its investigation for the purpose of fully informing itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document, and is reportable to the National Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 3rd day of July, 2014.

SIGNATURE REDACTED

SCOTT MICHAEL MURRAY, MD

IT IS SO ORDERED THIS 8th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of CRAIG CALVIN REDFERN, DO LICENSE NO. DO14108	))))))	STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including osteopathic physicians, in the state of Oregon. Craig Calvin Redfern, DO (Licensee) is a licensed osteopathic physician in the state of Oregon.

2.

On April 3, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board set forth detailed factual allegations and proposed taking disciplinary action pursuant to ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. 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 Order in the Board's records. Licensee neither admits or denies, but the Board finds that he engaged in the conduct described in the Complaint and Notice of Proposed Disciplinary Action of April 3, 2014, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), and ORS 677.190(13) gross or repeated

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

4.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following sanctions and terms:

4.1 Licensee is reprimanded.

4.2 Licensee must pay a civil penalty of $2,500, payable in full within 60 days from the effective date of this order.

4.3 Licensee is placed on probation for five years. Licensee must report in person to the Board at each of its quarterly meetings at the scheduled times for a probation interview, unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.

4.4 Within 180 days from the signing of this Order by the Board's Chair, Licensee must complete a course on the prescribing of controlled substances that is pre-approved by the Board's Medical Director.

4.5 Within one year of completing the course described in term 4.4, Licensee must complete 20 hours of continuing medical education (CME) related to the treatment of chronic pain that has been pre-approved by the Board's Medical Director.

4.6 CME hours accumulated as part of complying with terms 4.4 and 4.5 may not be considered toward the fulfillment of the CME hours necessary to meet the requirements of license renewal.

4.7 Licensee must not accept any new patients on opioid therapies greater than a morphine equivalent daily dose (MED) of 120.

4.8 License must refer any existing patient on opioid therapy greater than MED 120 to a pain specialist for continuing therapy of their pain.

4.9 Licensee must not prescribe controlled substances for chronic pain in excess of MED 120.

4.10 Licensee's medical practice is subject to random, no notice chart audits by the Board's designees.

4.11 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

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

4.13 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).

IT IS SO STIPULATED THIS 12 day of June, 2014.

SIGNATURE REDACTED

CRAIG CALVIN REDFERN, DO

IT IS SO ORDERED THIS 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of HENRY RAINIER RIVAS, MD LICENSE NO. MD14654	)	STIPULATED ORDER

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. Henry Rainier Rivas, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On May 6, 2013, the Board opened an investigation regarding Licensee's medical practice. On April 3, 2014, the Board issued a Complaint & Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action pursuant to ORS 677.205(2), against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) as defined by ORS 677.188(4)(a), and ORS 677.190(13).

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to retire his license while under investigation, consistent with the terms of this Order. Licensee enters this Stipulated Order of his own volition, without any coercion or duress. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and 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. By entering into this Order, the Licensee understands that although the Board makes no finding at this time as to whether his conduct

violated the Medical Practice Act, this document is a public record and is reportable to the National Data Bank and the Federation of State Medical Boards.

4.

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

4.1 Licensee retires his license to practice medicine while under investigation. This retirement of license becomes effective the date the Board Chair signs this Order.

4.2 Throughout the time that the medical license of Licensee remains in a retired status, Licensee is prohibited from practicing any form of medicine.

4.3 In the event Licensee should submit an application for reactivation of his medical license, Licensee understands that the Board will reopen this investigation.

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

IT IS SO STIPULATED this 1 day of July, 2014.

SIGNATURE REDACTED

HENRY RAINIER RIVAS, MD

IT IS SO ORDERED this 11th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of CHARLES ANTHONY ROBERTS, PA LICENSE NO. PA00257	)))))	 ORDER TERMINATING STIPULATED ORDER

1.

On January 10, 2013, Charles Anthony Roberts, PA (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon physician assistant license. On April 16, 2014, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the January 10, 2013, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 11th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of TIMOTHY JAMES RODDY, MD LICENSE NO. MD14358	)))))	CORRECTIVE ACTION AGREEMENT

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. Timothy James Roddy, MD (Licensee) holds an active license to practice medicine in the state of Oregon

2.

On October 15, 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) as defined by ORS 677.188(4)(a) and ORS 677.190(11).

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. This

agreement is reportable to the Federation of State Medical Boards, but is not reportable to the National Data Bank.

4.

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

4.1 Within six months from the signing of this Agreement by the Board Chair, Licensee must successfully complete a course or courses on professional ethics or other topics that are pre-approved by the Board's Medical Director.

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

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

IT IS SO AGREED THIS 8 day of May, 2014.

SIGNATURE REDACTED

TIMOTHY JAMES RODDY, MD

IT IS SO AGREED THIS 10th day of July, 2014.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

DONALD G. GIRARD, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of SHAWN MICHAEL SILLS, MD LICENSE NO. MD25091	))) ORDER MODIFYING) STIPULATED ORDER)

1.

On July 12, 2012, Shawn Michael Sills, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On March 26, 2014, Licensee submitted a written request asking the Board to modify certain terms of this Order. Term 5.2 reads:

> *5.2 The license of Licensee to practice medicine is revoked, but the revocation is stayed.*

2.

Having fully considered Licensee's request, the Board terminates Term 5.2 of the July 12, 2012, Stipulated Order effective the date this Order is signed by the Board Chair. All other terms of the July 12, 2012, Stipulated Order are unchanged and remain in full force and effect.

IT IS SO ORDERED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of CAROL GRAMMER STULL, MD LICENSE NO. MD21384	)))))	ORDER TERMINATING STIPULATED ORDER

1.

On October 11, 2012, Carol Grammer Stull, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On May 14, 2014, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and her successful compliance with the terms of this Order, the Board terminates the October 11, 2012, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
PAUL NORMAN THOMAS LICENSE NO. MD15689	)	ORDER TERMINATING CORRECTIVE ACTION AGREEMENT
	)	
	)	

1.

On January 10, 2013, Paul Norman Thomas, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon medical license. On February 28, 2014, 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 January 10, 2013, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of July, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
Board Chair