Oregon Medical Board

BOARD ACTION REPORT

April 15, 2016

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between March 16, 2016, and April 15, 2016.

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 Agreements 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 the License Verification and Malpractice Report Request (http://www.oregon.gov/OMB/ombforms1/request-licensee-info-verification.pdf) found under the Forms 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.

***Ames, Stephen Keith, MD; MD25332; Ontario, OR**
On April 7, 2016, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's October 8, 2015, Corrective Action Agreement.

***Andrews, David Anker, MD; MD09145; Hillsboro, OR**
On April 7, 2016, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 3, 2014, Stipulated Order.

***Barnwell, Stanley Lamons, MD; MD17155; Portland, OR**
On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; and violation of the federal Controlled Substances Act. This Order retires Licensee's medical license while under investigation.

***Booher, Benjamin Wesley, DO; DO22832; Hermiston, OR**
On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross negligence or repeated negligence in the practice of medicine; willfully violating any provision of the Medical Practice Act or any rule adopted by the board, or failing to comply with a board request; and prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order surrenders Licensee's medical license while under investigation.

*__Buckler, Robert Earl, MD; MD13443; Woodburn, OR__
On April 7, 2016, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

*__Craigg, Gerald Bartholomew Roger, MD; MD22708; Walla Walla,__ WA
On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional conduct and disciplinary action by another state of a license to practice medicine. This Order requires that Licensee comply with all prescribing restrictions imposed by the state of Washington in the state of Oregon.

__Grucella, Christina Marie, MD; MD16083; Oregon City, OR__
On April 8, 2016, Applicant entered into a Consent Agreement with the Board. In this Agreement, Applicant agreed to obtain 76 hours of continuing medical education and obtain recertification from her specialty board.

*__Hsu, Monica, MD; MD155319; Tulsa, OK__
On April 7, 2016, the Board issued an Order Modifying Corrective Action Agreement. This Order modifies Licensee's April 3, 2016, Corrective Action Agreement.

*__Johnson, William Ellis, MD; MD20044; Portland, OR__
On April 7, 2016, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's June 24, 2010, Corrective Action Agreement.

*__Kemp, Judith Marie, MD; MD26365; Hillsboro, OR__
On April 13, 2016, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 11, 2013, Corrective Action Agreement.

*__Kort, Daniel Duane, MD; MD18043; Salem, OR__
On April 7, 2016, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 2, 2015, Stipulated Order.

*__Le, Christian Thanh, MD; MD153577; Portland , OR__
On April 6, 2016, Licensee entered into an Interim Stipulated Order to voluntarily cease the prescribing of all controlled substances pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

*__Marath, Aubyn, MD; MD21604; Sisters, OR__
On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course in documentation; to continue using the Prescription Drug Monitoring Program when prescribing controlled substances; and to consult with the primary care provider of any minor when authorizing a medical marijuana card.

*__Mian, Burhan Ahmed, MD; PG172422; Portland, OR__
On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; failure to report official action within 10 days; and failure to report a felony arrest. With this Order Licensee surrenders his medical license while under investigation.

*__Sarver, Patrick John, MD; MD25942; Medford, OR__
On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved documentation and prescribing courses; and open his practice to review by the Board of his charting and prescribing practices.

Sax, Barbara Friedman, MD; MD170885; Portland, OR
On April 7, 2016, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's September 21, 2015, Consent Agreement.

Simpson, Jennifer Dale, MD; MD17884; Portland, OR
On April 7, 2016, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's July 12, 2013, Consent Agreement.

*__Vance, Lee Wendell, MD; MD16746; Jacksonville, FL__
On April 7, 2016, the Board issued an Order Terminating Corrective Action Order. This Order terminates Licensee's October 14, 2004, Corrective Action Order.

*__Winder, Donald Edwin, Jr., PA; PA156714; Salem, OR__
On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on pain management; to write a paper on the contra-indications to spinal injections for the treatment of pain; to shadow a board-certified pain specialist for 16 hours; and to provide a copy of the Corrective Action Agreement to all supervising physicians.

*__Wong, Charles Men, MD; MD14849; Portland, OR__
On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses on pediatric urgent care and medical documentation.

*__Wymer, Todd Allan, LAc; AC165723; Portland, OR__
On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of a Board order or regulation. This Order reprimands Licensee; requires Licensee to provide a chaperone for all female patients over the age of 14; requires Board pre-approval of all practice sites; requires that Licensee complete a pre-approved course on professional boundaries; allows for no-notice site visits by the Board; restricts Licensee's use of social media with patients and former patients; and requires that Licensee chart every patient encounter.

*__Zielinski, Leann Alexandria, DO; DO157231; Portland, OR__
On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses on professional boundaries and professionalism.

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.

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
STEPHEN KEITH AMES, MD LICENSE NO. MD25332	)	ORDER TERMINATING CORRECTIVE ACTION AGREEMENT
	)	
	)	

1.

On October 8, 2015, Stephen Keith Ames, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On December 9, 2015, 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 October 8, 2015, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of DAVID ANKER ANDREWS, MD LICENSE NO. MD09145	)))))	 ORDER MODIFYING STIPULATED ORDER

1.

On April 3, 2014, David Anker Andrews, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On December 1, 2015, Licensee submitted a written request asking that the Board terminate this Order. Terms 5.1, 5.2, 5.3 and 5.4 of this Order read:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a civil penalty of $5,000, payable in full within 10 months from the signing of this Order by the Board Chair. Payment installments of $500 per month are due on the first of every month subsequent to the signing of the Order by the Board Chair.

5.3 Within six months from the signing of this Order by the Board Chair, Licensee must successfully complete a course on professional boundaries that is pre-approved by the Board's Medical Director.

5.4 Licensee is placed on probation for five years. Licensee will report in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a probationer interview unless ordered to do otherwise by the Board.

2.

Having fully considered Licensee's request and compliance with these terms, the Board terminates terms 5.1, 5.2, 5.3, and 5.4 of the April 3, 2014, Stipulated Order effective the date

///

///

///

this Order is signed by the Board Chair. All other terms of the April 3, 2014, Stipulated Order are unchanged and remain in full force and effect.

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of STANLEY LAMONS BARNWELL, MD LICENSE NO. MD17155	)	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. Stanley Lamons Barnwell, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On August 19, 2015, the Board opened an investigation after receiving credible information regarding Licensee's prescribing irregularities.

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 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 he engaged in conduct that violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS 677.190(23) violation of the federal Controlled Substances Act. 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 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 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 06 day of January, ~~2015.~~ 2016

SIGNATURE REDACTED

STANLEY LAMONS BARNWELL, MD

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of BENJAMIN WESLEY BOOHER, DO LICENSE NO. DO22832	)))))	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. Benjamin Wesley Booher, DO (Licensee) is a licensed osteopathic physician in the State of Oregon.

2.

On September 16, 2014, the Board opened an investigation after receiving credible information regarding Licensee's prescribing practices and possible boundary violations. On October 7, 2015, Licensee entered into an Interim Stipulated Order with the Board in which Licensee agreed not to diagnose or treat any new patient, not begin treatment for chronic pain for any existing patient or increase the dosage or add any controlled substance medication for any existing chronic pain patient. Licensee also agreed to voluntarily withdraw from the practice of medicine in 90 days. Additional concerns were raised and on November 30, 2015, Licensee entered into an Interim Stipulated Order superseding the prior Order. In this Order Licensee agreed to immediately stop treating all patients except certain addiction patients until December 31, 2015, at noon, at which time Licensee would cease practice entirely and his license would be placed into an inactive status. Subsequent to that, additional investigations were opened regarding Licensee. One case involved the Licensee's arrest for Driving Under the Influence of Intoxicants and another for additional prescribing and boundary concerns.

///

3.

The Board's early investigation revealed information that resulted in the Board having serious concerns regarding the Licensee's practice of medicine. Concerns raised included issues related to Licensee's care and treatment of patients, boundaries, charting, ethics, prescribing, and willingness to be forthcoming about facts surrounding these issues. The investigations to date have not produced any information that would abate the Board's serious concerns regarding Licensee's practice.

4.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing 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)(b) and (c); ORS 677.190 (13) gross negligence or repeated negligence in the practice of medicine; ORS 677.190 (17) willfully violating any provision of the Medical Practice Act or any rule adopted by the board, or failing to comply with a board request pursuant to ORS 677.320; 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 DataBank and the Federation of State Medical Boards.

5.

Licensee and the Board agree that the Board will close these investigations and resolve this matter by entry of this Stipulated Order, subject to the following conditions:

5.1 Licensee surrenders his Oregon medical license while under investigation.

5.2 The Interim Stipulated Order of November 30, 2015, terminates effective the date the Board Chair signs this Order.

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

5.4 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).

6.

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

IT IS SO STIPULATED this 16 day of ~~April~~ March BB 2016.

SIGNATURE REDACTED

BENJAMIN WESLEY BOOHER, DO

IT IS SO ORDERED this 7th day of April 2016.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of ROBERT EARL BUCKLER, MD LICENSE NO. MD13443	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. Robert Earl Buckler, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to certain terms until the investigation is completed.

3.

In order to address the Board's concern, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and will remain in effect while this matter remains under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee must not practice inpatient geriatric psychiatry in any form, including the treatment of dementia or dementia related behaviors.

3.2 Licensee must not prescribe antipsychotics to patients 65 years of age and older.

3.3 Licensee must not prescribe antipsychotics for the treatment of dementia related behaviors in inpatient or outpatient settings.

3.4 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

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

4.

At the conclusion of the Board's investigation, the Board will decide whether to close the case or to proceed to some form of disciplinary action. If the Board determines, following that review, not to lift the requirements of this Order, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.410, which grants the Board the authority to attach conditions to the license of Licensee to practice medicine. These conditions will remain in effect while the Board conducts a complete investigation in order to fully inform itself with respect to the conduct of Licensee. 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 5th day of February, 2015.

SIGNATURE REDACTED

ROBERT EARL BUCKLER, MD

IT IS SO ORDERED THIS 5th day of February, 2015.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of GERALD BARTHOLOMEW ROGER CRAIGG, MD LICENSE NO. MD22708	)))))	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. Gerald Bartholomew Roger Craigg, MD (Licensee) is a licensed physician in the state of Oregon.

2.

2.1 Licensee is a board-certified internal medicine physician practicing in Walla Walla, Washington. Licensee reported to the Board that the Washington Medical Quality Assurance Commission (WMQAC) had taken action restricting his prescribing.

2.2 On August 6, 2015, WMQAC issued a Statement of Charges against Licensee. On August 11, 2015, WMQAC issued an Ex Parte Order of Summary Restriction which restricted Licensee's ability to prescribe Schedule II, III, and IV medications. Based upon this Order, the Board opened an investigation. On September 21, 2015, Licensee and the Board entered into an Interim Stipulated Order in which Licensee voluntarily agreed to cease the prescribing of all Xcheduled II, III, or IV controlled substances to Oregon patients. On October 30, 2015, WMQAC issued an Amended Statement of Charges against Licensee.

2.3 On November 5, 2015, WMQAC issued a Stipulated Findings of Fact, Conclusions of Law, and Agreed Order. This Order concludes that Licensee committed unprofessional conduct in that he violated Washington Administrative Codes addressing the treatment of chronic non-cancer pain.

///

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 nor denies, but the Board finds, that he engaged in conduct that violated ORS 677.190(1)(a), as defined by ORS 677.188(4)(a); and ORS 677.190(15) disciplinary action by another state of a license to practice medicine. 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 terms:

4.1 Licensee must comply with all terms and conditions of the November 5, 2015, Stipulated Findings of Fact, Conclusions of Law, and Agreed Order issued by WMQAC (Attachment A), as well as any modifications to the Agreed Order. These terms and conditions apply to any patients treated by Licensee in the state of Oregon.

4.2 Any modifications to the WMQAC Agreed Order must be reported to the Board, with a copy of the modification sent to the Board's Compliance Officer within ten business days of the effective date of the modification.

4.3 Licensee understands that should the WMQAC Agreed Order be held in abeyance, or if any terms of the Agreed Order are stayed, all terms of the Agreed Order must continue to be complied with in the state of Oregon.

4.4 Licensee must sign all necessary releases to allow full communication and exchange of documents and reports, to include any third party evaluations or reports, between the Board and the Physician Assessment and Clinical Education Program (PACE).

4.5 The Interim Stipulated Order of September 21, 2015, terminates effective the date the Board Chair signs this Order.

4.6 Upon termination of the WMQAC Stipulated Findings of Fact, Conclusions of Law, and Agreed Order, Licensee may submit a request to terminate this Order.

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

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

4.9 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 14 day of DECEMBER, 2015.

SIGNATURE REDACTED

GERALD BARTHOLOMEW ROGER CRAIGG, MD

IT IS SO ORDERED THIS 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **GERALD B. CRAIGG, MD** License No. MD00044814 Respondent.	**No. M2015-1** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through Suzanne L. Mager, Commission Staff Attorney, and Respondent, represented by counsel, stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On August 6, 2015, the Commission issued a Statement of Charges against Respondent. On October 30, 2015, the Commission issued an Amended Statement of Charges against Respondent to include allegations concerning additional patients, Patients E through J.

1.2 In the Amended Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180 (4) and (7) and WAC 246-919-853 through -855, -857, -858, and -862.

1.3 The Commission is prepared to proceed to a hearing on the allegations in the Amended Statement of Charges.

1.4 Respondent has the right to defend against the allegations in the Amended Statement of Charges by presenting evidence at a hearing.

1.5 The Commission has the authority to impose sanctions pursuant to RCW 18.130.160 if the allegations are proven at a hearing.

1.6 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.7 Respondent waives the opportunity for a hearing on the Amended Statement of Charges if the Commission accepts this Agreed Order.

1.8 This Agreed Order is not binding unless it is accepted and signed by the Commission.

1.9 If the Commission accepts this Agreed Order, it will be reported to the National Practitioner Data Bank (45 CFR Part 60), the Federation of State Medical Boards' Physician Data Center and elsewhere as required by law.

1.10 This Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2. FINDINGS OF FACT

Respondent acknowledges that the evidence is sufficient to justify the following findings, and the Commission makes the following findings of facts:

2.1 On March 31, 2005, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

2.2 Respondent is board certified in internal medicine and has a solo practice in Walla Walla, Washington.

Patient A

2.3 Patient A died on February 23, 2014 from methadone intoxication. At the time of his death, Patient A was a 39-year-old man living in an assisted living facility and receiving physical rehabilitation services. Patient A suffered from the following medical conditions: Diabetes mellitus, obesity, sleep apnea (for which he had nightly C-pap treatments), hypertension, depression and bipolar I disorder, obsessive compulsive disorder, schizoaffective disorder, alcohol abuse, GERD, and pain both from diabetic Charcot joint of foot and from two surgeries on his left shoulder after recurrent dislocations. The staff at the assisted living facility administered all of Patient A's medications.

2.4 Respondent saw Patient A five times over approximately a six-week period prior to his death, with the first visit occurring on December 12, 2013. Patient A's mother or sister accompanied him to most of his visits to Respondent's office. Respondent last

saw Patient A during an office visit on February 20, 2014, three days before Patient A's death due to methadone toxicity.

2.5 Prior to seeing Respondent for the first time, Patient A had periodically been prescribed pain medications for his shoulder and foot pain. Patient A's Prescription Monitoring Program records document that he was prescribed intermittent, low-dose oxycodone or hydrocodone over the previous two years.

2.6 During the time that the Respondent prescribed for Patient A, he issued similarly low-dose oxycodone until Patient A's last office visit: in mid-December 2013, Respondent prescribed oxycodone-acetaminophen 5-325mg, one tablet every three hours as needed (up to three tablets per day, MED of 22.5 mg). In late December 2013, January 15 and 21, and February 3, 2014, he prescribed oxycodone 5mg, one to two tablets every four hours as needed for pain (up to 12 tablets per day, MED of 90mg). On February 6, 2014, Respondent discontinued the routine doses of oxycodone every four hours.

2.7 On February 20, 2014, approximately two weeks after discontinuing Patient A's routine doses of oxycodone, Respondent initiated a prescription of 30mg of methadone daily (10mg of methadone, three times per day). The instructions did not direct the facility to provide the doses at eight-hour intervals. Respondent's records contain no explanation for the switch from low-dose oxycodone (90 mg MED daily) to methadone. Respondent instructed Patient A to return in a month for a follow-up visit.

2.8 Patient A died of methodone intoxication three days later, on February 23, 2014.

2.9 Prior to prescribing 30mg of methadone three times per day to Patient A, Respondent failed to:

2.9.1 provide adequate education about methadone risks, including symptoms associated with methadone toxicity;

2.9.2 obtain informed consent concerning the risks of methadone;

2.9.3 obtain an EKG; or

2.9.4 titrate the dosage of methadone.

2.10 During the time Respondent treated Patient A, he failed to document a treatment plan, in violation of WAC 246-919-854.

2.11 Respondent failed to adequately and appropriately monitor Patient A while initiating treatment with methadone.

2.12 Respondent failed to consider the contraindications for prescribing methadone to Patient A, including taking into account his other medications such as amitriptyline. He further failed to prescribe methadone to Patient A in appropriate amounts and at appropriate dosing schedules. In his treatment of Patient A, the Respondent created an unreasonable risk of harm and/or death.

Patient B

2.13 At the time she initiated treatment, Patient B was a 31-year-old woman residing in Clarkston, Washington, approximately 194 miles roundtrip from Respondent's office. She had a history of treatment for chronic non-cancer pain, including pain associated with knee surgeries and multiple four-wheeler crashes.

2.14 Patient B first saw Respondent on April 14, 2014. She identified her previous physician and claimed she was being prescribed 80-120mg of methadone daily, 50mg of hydrocodone-acetaminophen10/325mg daily (five tablets of hydrocodone-acetaminophen10/325mg), and 3mg of Xanax, a benzodiazepine, daily (three tablets of Xanax 1mg). Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient B 50mg of hydrocodone-acetaminophen 10/325mg daily (five tablets of hydrocodone-acetaminophen 10/325mg), 80-120mg of methadone daily (four tablets, two to three times daily of methadone 10mg), and 3mg of Xanax (three tablets of Xanax 1mg), all the amounts she self-reported. Respondent's records do not contain adequate justification to support his methadone, hydrocodone, or Xanax prescriptions. Respondent's records also do not document that he provided adequate education about medication treatment risks, including symptoms associated with methadone toxicity.

2.15 Throughout the time Respondent prescribed for Patient B, he failed to document an adequate treatment plan or to taper the controlled substances prescribed.

2.16 Also during the time Respondent treated Patient B, she failed to comply with her pain contracts but he continued to prescribe pain medications. Patient B reported that her methadone, Xanax, and hydrocodone were stolen from her car, but without any sign of a break in. Respondent wrote her another 30-day supply for each medication. He also

continued to write opioid prescriptions after Patient B failed to consult with a pain specialist or attend physical therapy.

Patient C

2.17 At the time she initiated treatment, Patient C was a 51-year-old woman residing in Clarkston, Washington, approximately 194 miles roundtrip from Respondent's office.

2.18 Patient C first saw Respondent on June 20, 2014. She had a history of treatment for chronic non-cancer pain and had diagnoses that included degenerative disc disease, arthritis, fracture of lower spine, neuropathy in leg, obesity, spinal stenosis, fibromyalgia, depression, lupus, compression fracture, irritable bowel syndrome, ulcer, pancreatitis, Hiatal hernia, and carpel tunnel syndrome. Patient C listed no former health care provider on her intake form, but listed with specificity the thirteen prescription drugs she reported taking, including methadone, hydrocodone, clonazepam, trazodone, Fioricet, tizanadine, and zolpidem. Patient C also reported two recent falls, one caused for no stated reason and one of which caused her to be taken to the hospital by ambulance.

2.19 Respondent did not obtain Patient C's prior medical records until approximately five months after he began treatment, and only obtained records from 2009 through 2010.

2.20 Patient C reported to Respondent that she had been prescribed 160mg of methadone per day (four times per day of 40mg methadone) by her former health care provider. The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had prescribed 40mg *total* of methadone per day. Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 160mg of methadone per day, the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his methadone prescriptions. Respondent's records also do not document that he provided adequate education about methadone risks, including symptoms associated with methadone toxicity.

2.21 Patient C also reported to Respondent that she had been prescribed 80mg of hydrocodone per day (eight tablets of hydrocodone 10mg, 80 MED). The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had

prescribed *two* tablets of hydrocodone-acetaminophen10/325mg per day (20 MED). Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 80mg of hydrocodone per day (eight tablets of hydrocodone 10mg, 80 MED), the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his hydrocodone prescriptions.

2.22 Patient C also reported to Respondent that she had been prescribed 16mg of clonazepam, a benzodiazepine, per day (eight tablets of clonazepam 2mg). The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had prescribed *four* tabs of clonazepam 2mg per day, or 8mg per day. Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 16mg of clonazepam per day (eight tablets of clonazepam 2mg), the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his clonazepam prescriptions.

2.23 Patient C also reported to Respondent that she had been prescribed 2,800mg of Soma, a muscle relaxant, per day (eight tablets of carisoprodol 350mg). The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had infrequently prescribed *two* tabs of carisoprodol 350mg per day. Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 2,800mg of carisoprodol per day (eight tablets of carisoprodol 350mg), the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his carisoprodol prescriptions.

2.24 While prescribing methadone, hydrocodone, clonazepam, and carisoprodol to Patient C, Respondent also prescribed zolpidem, a sleep aid, to be taken nightly.

2.25 Respondent saw Patient C from June 2014 until at least November 11, 2014, at which time she reported spilling her methadone and hydrocodone medications and needed an early refill, which Respondent provided.

2.26 Throughout the time Respondent prescribed for Patient C, he failed to document an adequate treatment plan or to taper the controlled substances prescribed.

2.27 Respondent failed to enforce the pain contracts signed by Patient C. He did not obtain urine drug screens to confirm Patient C was taking the medications as prescribed. Respondent referred Patient C to a pain specialist and a physical therapist

when he first saw her on June 20, 2014, but failed to enforce her compliance with the pain specialist consultation requirement.

Patient D

2.28 At the time he initiated treatment, Patient D was a 33-year-old man residing in Clarkston, Washington, approximately 194 miles roundtrip from Respondent's office. Patient D first saw Respondent on July 11, 2013, to establish care and treatment of chronic, non-cancer pain. Patient D's diagnoses included a history of skull fracture and chronic bilateral heel and ankle pain resulting from injury and surgeries after jumping off a three-and-a-half story building in a suicide attempt. Respondent obtained some of Patient D's recent prior medical records and reviewed them on July 14, 2013. These prior medical records document Patient D's recurrent pattern of drug-seeking behavior, doctor shopping, dishonesty, and non-compliance with pain contracts.

2.29 The records Respondent obtained revealed that Patient D had been treated for his chronic non-cancer pain by another physician who had tapered Patient D's methadone down from "an astronomical amount." After he was discharged from that physician's practice for dishonesty and non-compliance with his pain contract, Patient D saw a podiatric physician to obtain pain medications on May 3, 2013. At his second visit, on May 30, 2013, the podiatrist noted that Patient D had missed two appointments with his new primary care provider and confirmed he would not refill the methadone prescription for the eight days prior to his appointment with the new primary care provider. Patient D did not return to the podiatrist nor did he follow through with his new primary care provider. About one week later, on June 5, 2013, Patient D sought treatment from yet another physician. After this new physician obtained information regarding Patient D's behavior with prior physicians, he refused to accept Patient D as a patient because Patient D had "been less than honest with" him. This physician questioned "whether any of the neuropathic pain medications ... have ever been trialed on [Patient D] in the past as these are avenues that could be considered." He further noted: "I think, however, until [Patient D] is honest with his providers and shows a willingness to stick to the plan that is prescribed he is not a good candidate for long-term opioid therapy. If this is ever pursued in the future [Patient D] would need to be watched closely with frequent urine drug

screens, goals would need to be obtained based upon his utilization of medication, and any deviation would be reason for dismissal."

2.30 Patient D first saw Respondent on July 11, 2013. Patient D reported that he had been prescribed 6mg of clonazepam per day (three times per day of 2mg clonazepam) and 120mg of methadone per day (three times per day of 40mg methadone) by his former health care providers.

The Prescription Monitoring Program profile for Patient D indicated that Patient D had been prescribed *4mg* of clonazepam, not 6mg as he reported, with the last filled prescription occurring in October of 2012. The profile also indicated that Patient D's previous physicians had generally prescribed him *30mg* of methadone per day, not 120mg as he reported. Without confirming his prior prescriptions, Respondent prescribed Patient D 6mg of clonazepam per day (three times per day of 2mg clonazepam) and 120mg of methadone per day (three times per day of 40mg methadone), the amounts Patient D self-reported. Respondent's records do not contain adequate justification to support his methadone or clonazepam prescriptions. Respondent's records also do not document that he provided adequate education about methadone risks, including symptoms associated with methadone toxicity. Respondent referred Patient D to a pain specialist and physical therapist.

2.31 On July 22, 2013, less than two weeks after his first visit, Patient D returned to Respondent and reported that all his medications got wet and were ruined. Despite having obtained Patient D's prior medical records that detailed numerous accounts of his drug-seeking behavior, doctor shopping, dishonesty, and non-compliance with pain contracts, Respondent refilled his prescriptions, including for methadone.

2.32 On August 13, 2013, Respondent added a prescription for Hydrocodone 5/325 mg every six hours as needed, in addition to continuing to prescribe methadone 120 mg per day, without adequate justification. Also at this visit, Patient D called the Respondent requesting an early refill of his methadone prescription because he had used up the prior month's methadone prescription early and had then used his mother's methadone. Despite being warned not to borrow from others or take it upon himself to find other means of obtaining methadone, later that same day, he attempted to fill his

methadone prescription early at an unapproved pharmacy, in clear violation of his pain contract.

2.33 The next appointment, September 30, 2013, Respondent increased the strength of the hydrocodone prescription to 10/325mg and increased the frequency to every four hours. Over the following year, Respondent increased Patient D's methadone dose to 160mg per day and added hydromorphone with doses up to 12mg per day, all without documenting adequate justification for the prescriptions.

2.34 Respondent routinely failed to provide accurate documentation of each visit due to importing outdated and incorrect information from prior visits into the electronic health record. Respondent's records do, however, document Patient D's pattern of pain contract violations and generally dishonest, drug-seeking behaviors:

2.34.1 On October 9, 2013, Patient D reported being pushed down the stairs and requested an increase in his pain medications.

2.34.2 On December 10, 2013, Patient D reported being in a car crash and stated that was going to increase his methadone dose to four times a day. Respondent noted this violated Patient D's pain contract.

2.34.3 When Respondent saw Patient D the next day, he learned that the car crash incident also involved Patient D's children who were in the vehicle with him when it "rolled 5 times fifty feet down mountain." The children were taken by ambulance to the hospital.

2.34.4 On December 31, 2013, Respondent reviewed a police report in which an acquaintance stated that Patient D invited him to his home on December 25, 2013, to buy some of Patient D's methadone pills. Patient D reported to the police that that the acquaintance had stolen the 480 tabs of methadone. Respondent later issued Patient D a refill for the methadone.

2.34.5 On March 4, 2014, Patient B (Patient D's wife) called and requested more pain medication for Patient D due to his having had teeth pulled.

2.34.6 On April 14, 2014, Patient D reported that he had been involved in another four-wheeler crash in which he "flew off [and] rolled on

road" with loss of consciousness, and that he wanted to be back on monthly methadone.

2.34.7 On May 7, 2014, Patient D reported he had used up his Dilaudid (hydromorphone) prescription early and needed a refill.

2.34.8 Patient D again requested early refills of his opioid prescriptions on June 9, 2014.

2.34.9 The next month, on July 7, 2014, a pharmacist informed Respondent that Patient D had tried to obtain an early refill of hydromorphone.

2.35 During the time Respondent treated and prescribed for Patient D, he consistently failed to follow through with appointments for physical therapy and pain management.

2.35.1 When Patient D finally obtained an evaluation by a physical therapist on May 28, 2014, ten months after the initial referral, he was discharged from the practice within a month for failing to return; cancelling or failing to show each time.

2.35.2 Respondent noted for nine months that Patient D failed to see the referred pain specialist. Once Patient D finally saw the pain specialist in April 2014, the physician noted that "Patient has pain everywhere. Per notes wants to be on methadone. ... I don't manage methadone. Recommend a true pain clinic." On June 30, 2014, Respondent referred Patient D to another specialist, starting the cycle again and noting at each visit that Patient D had not gone to see the pain specialist.

2.36 Instead of discharging Patient D due to his repeated non-compliance, Respondent explained to the Commission that Patient D's "inconsistency with keeping appointments ... complicated his treatment."

2.37 During the time Respondent treated Patient D, he failed to document an adequate treatment plan.

2.38 Patients B, C and D listed themselves in Respondent's records as family members. Patient B is listed as Patient D's wife. Patient C is Patient D's mother. All three patients traveled from the Clarkston-Lewiston area to see Respondent, a trip of approximately 194 miles roundtrip. The Respondent did not document any suspicion or

other inquiry into the reason these three family members would travel 194 miles to obtain prescriptions for high levels of opioid pain medications for chronic, non-cancer pain.

2.39 While treating Patients A through D with high levels of methadone, Respondent had inadequate training in pain management with long-acting opioids, and did not discharge Patients B, C, or D for their failures to comply with the pain contracts.

Patients E Through J

1.40 For the following patients Respondent violated the applicable standard of care by initiating high-dose methadone without titration or observation, or by greatly increasing methadone doses without titration or observation: Patients E, F, G, I, and J.

1.41 For the following patients Respondent violated the applicable standard of care by failing to provide adequate education about methadone risks, and failing to obtain informed consent concerning the risks of methadone: Patients E through J.

1.42 Respondent violated the applicable standard of care for Patients G and J by abruptly discontinuing their high-dose methadone, without taper schedules.

1.43 Respondent violated the applicable standard of care for Patient H by maintaining him on an extremely high-dose of methadone, without a taper schedule or justification for the high dose.

1.44 For the following patients Respondent violated the applicable standard of care by failing to provide documentation of his reasoning and/or justification for his prescribing practices and by failing to develop a meaningful treatment plan: Patients E through J.

1.45 For the following patients Respondent violated the applicable standard of care by increasing without justification the patients' lifetime risks of opioid tolerance and hyperalgesia as a result of his prescribing practices: Patients E through J.

1.46 For the following patients Respondent violated the applicable standard of care by failing to require that they consult with a pain specialist: Patients E through J.

1.47 For the following patients Respondent violated the applicable standard of care by failing to perform urine drug screens: Patients E, G, and I.

//

//

3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (4) and (7) and WAC 246-919-853 through -855, -857, -858, -860, and -862.

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order.

4.1 **Practice Restriction**. Respondent is not permitted to prescribe Schedule II and III narcotics or Schedule IV controlled substances unless this Agreed Order is modified as provided by Paragraph 4.5 or terminated.

4.2 **Term of Commission Oversight**. Respondent's license to practice as a physician and surgeon in the state of Washington is subject to this Agreed Order for a period of at least five years from the Agreed Order's effective date, subject to the modification provision in Paragraph 4.5. During the term of the Agreed Order, Respondent must comply with all of the terms and conditions of the Agreed Order and Respondent's treatment of his patients must meet the standard of care.

4.3 **Clinical Competency Assessment**. Within 90 days of the effective date of this Agreed Order, Respondent must complete a Competency Assessment at the Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego School of Medicine.

4.3.1 Respondent must contract with PACE to conduct a complete and thorough competency assessment. The assessment must include screening examinations, including at a minimum history and physical, cognitive, and psychological screening. The assessment must also include reviews of Respondent's:

- actions which resulted in this case;
- responses to his patients' negative outcomes;

- reasoning and decision making;
- knowledge and understanding of controlled substances, especially methadone and other narcotics, including his knowledge of the appropriate use of controlled substances, their risks alone and in combination, and how to document decision making when prescribing controlled substances;
- ability to create meaningful and appropriate medical records and evaluate the medical records of his patients' other health care providers;
- ability to identify his knowledge gaps and implement appropriate responses to any such areas of deficiency.

4.3.2 Respondent must provide PACE with any release for information that is requested, and must unconditionally cooperate with PACE during the evaluation. Respondent must sign a waiver of confidentiality and a release to permit PACE and the Commission to share information. The Commission will provide PACE with records from the Commission's files that the Commission deems appropriate.

4.3.3 Respondent must authorize PACE to provide a comprehensive written report, including any third-party evaluation reports, to the Commission. Respondent must ensure that PACE provides its report to the Commission.

4.3.4 Respondent must follow all recommendations in PACE's evaluation report, including recommendations for educational and other remediation, medical or other treatment, the use of a preceptor, additional evaluations indicated by the assessment's screening examinations, and re-assessment after completion of remediation or if Respondent leaves the clinical practice of medicine and seeks to return to treating patients. Respondent agrees that the recommendations will be incorporated into a modified Commission Order.

4.4 Fine. Respondent must pay a fine to the Commission in the amount of $5,000, which may be paid in installments, to be paid at least annually in installments of at least $1,000 each. The first installment must be paid by July 1, 2016. The fine must be paid by certified or cashier's check or money order, made payable to the Medical Quality Assurance Commission and mailed to the Department of Health, P.O. Box 1099, Olympia, Washington 98507-1099.

4.5 **Modification**. Following the Commission's receipt of the PACE report and the reports from any other evaluations recommended by PACE, the Commission may modify this Agreed Order based on the assessments and recommendations of the evaluator(s). The modification may include the addition or removal of sanctions, conditions, restrictions, and/or extend the length of Commission oversight. The modified order will include a termination clause. The Commission will give Respondent notice and

the opportunity to be heard regarding modification of this Agreed Order, if he objects to the modification's proposed terms.

4.6 **Notification of Change in Practice.** Respondent will notify the Commission within 30 calendar days if he stops treating patients.

4.7 **Obey all laws.** Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.8 **Compliance Costs.** Respondent is responsible for all costs of complying with this Agreed Order.

4.9 **Violation of Order.** If Respondent violates any provision of this Agreed Order in any respect, the Commission may initiate further action against Respondent's license.

4.10 **Change of Address.** Respondent shall inform the Commission and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

4.11 **Address for Communications.** All reports required by this Stipulation, as well as any other communications related to it, must be sent to: Compliance Officer, Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504-7866.

4.12 **Effective Date of Order.** The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Tier C of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices result in severe patient harm or death. Respondent's care of Patient A caused severe harm, and Respondent created the risk of severe harm or death for Patients B through J due to Respondent's unsafe prescribing practices.

5.2 Tier C requires the imposition of sanctions ranging from three years of restrictions and/or conditions to permanent restrictions and/or conditions, or revocation.

Under WAC 246-16-800(3)(d), the starting point for the duration of the sanctions is the middle of the range, but there is no middle of the range for Tier C. The Commission uses aggravating and mitigating factors, listed below to move toward the maximum or minimum ends of the range. The mitigating and aggravating factors in this case, listed below, justify moving away from the minimum end of the range, and in the judgment of the Commission the aggravating factors greatly outweigh the mitigating factors and justify the terms. The terms of this Agreed Order include oversight for at least five years, a restriction from prescribing Schedule II and III narcotics and Schedule IV controlled substances, a clinical competency assessment conducted by PACE, other evaluations as directed by PACE, modification of this Agreed Order to incorporate the assessment report's recommendations, and a $5,000 fine.

5.3 The following are aggravating factors:

5.3.1 The gravity of Respondent's unprofessional conduct;

5.3.2 The injury caused by Respondent's unprofessional conduct;

5.3.3 The potential for injury by Respondent's unprofessional conduct;

5.3.4 Respondent's unprofessional conduct involved multiple patients.

5.4 The following are mitigating factors:

5.4.1 Respondent has not been the subject of discipline in the past;

5.4.2 Respondent cooperated with the Commission's investigation by promptly providing requested medical records;

5.4.3 After the Statement of Charges was issued, Respondent attended continuing medical education to improve his understanding of narcotics prescribing.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the

Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. RESPONDENT'S ACCEPTANCE

I, GERALD B.R. CRAIGG, Respondent, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.

GERALD B. R. CRAIGG, MD
RESPONDENT

DATE 11/03/2015

JOEL R. COMFORT, WSBA# 31477
ATTORNEY FOR RESPONDENT

DATE 11/3/2015

ORIGINAL

8. COMMISSION'S ACCEPTANCE AND ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED: 5 Nov, 2015.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

WE Gotthold MD
PANEL CHAIR

PRESENTED BY:

SUZANNE L. MAGER, WSBA#19284
COMMISSION STAFF ATTORNEY

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of MONICA HSU, MD LICENSE NO. MD155319	))) ORDER MODIFYING CORRECTIVE) ACTION AGREEMENT)

1.

On April 3, 2014, Monica Hsu, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's medical license. On January 28, 2016, Licensee submitted a written request asking the Board to modify Term 4.3 of this Agreement, which reads:

> *4.3 Licensee must become board certified in obstetrics and gynecology within 24 months of the effective date of this Agreement.*

2.

Having fully considered Licensee's request, the Board modifies Term 4.3 of the April 3, 2014, Corrective Action Agreement as follows:

4.3 Licensee must become board certified in obstetrics and gynecology within 36 months of the effective date of this Agreement.

This modification becomes effective the date this Order is signed by the Board Chair. All other terms of the April 3, 2014, Corrective Action Agreement are unchanged and remain in full force and effect.

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of WILLIAM ELLIS JOHNSON, MD LICENSE NO. MD20044	)))))	 ORDER TERMINATING CORRECTIVE ACTION AGREEMENT

1.

On June 24, 2010, William Ellis Johnson, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On December 14, 2015, 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 June 24, 2010, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
JUDITH MARIE KEMP, MD LICENSE NO. MD26365	)	ORDER TERMINATING CORRECTIVE ACTION AGREEMENT
	)	

1.

On July 11, 2013, Judith Marie Kemp, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On December 29, 2015, Licensee submitted documentation that she 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 July 11, 2013, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 13th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted on Copies

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of DANIEL DUANE KORT, MD LICENSE NO. MD18043	))) ORDER MODIFYING) STIPULATED ORDER)

1.

On April 2, 2015, Daniel Duane Kort, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On January 29, 2016, Licensee submitted a written request asking the Board to modify or terminate this Order. Terms 4.1 and 4.3 of the Order read:

4.1 Licensee is reprimanded.

4.3 Licensee is placed on probation for five years. Licensee will report in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a probationer interview unless ordered to do otherwise by the Board.

2.

Having fully considered Licensee's request, the Board terminates Term 4.1 and Term 4.3 of the April 2, 2015, Stipulated Order effective the date this Order is signed by the Board Chair. All other terms of the April 2, 2015, Stipulated Order are unchanged and remain in full force and effect.

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of CHRISTIAN THANH LE, MD LICENSE NO. MD153577	)))))	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. Christian Thanh Le, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. On October 13, 2015, the Board issued an Interim Stipulated Order in which Licensee agreed to cease signing Oregon Medical Marijuana Program related Attending Physician's Statements for patients under the age of eighteen (18). The Board's investigation to date has raised concerns to the extent that the Board believes it necessary that Licensee agree to additional terms until the investigation is completed.

3.

In order to address the Board's concerns, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and will remain in effect while this matter remains under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee must not prescribe any controlled substances to any patient. This restriction does not preclude Licensee from signing Oregon Medical Marijuana Program related Attending Physician's Statements for patients aged 18 and over.

///

3.2 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17).

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

4.

At the conclusion of the Board's investigation, the Board will decide how the investigation will be closed. If the Board determines, following that review, not to lift the requirements of this Order, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.410, which grants the Board the authority to attach conditions to the license of Licensee to practice medicine. These conditions will remain in effect while the Board conducts a complete investigation in order to fully inform itself with respect to the conduct of Licensee and determines how to resolve the investigation. 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 6th day of April, 2016.

SIGNATURE REDACTED

CHRISTIAN THANH LE, MD

IT IS SO ORDERED THIS 6th day of April, 2016.

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 AUBYN MARATH, MD LICENSE NO. MD21604	)))))	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. Aubyn Marath, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board opened investigations after receiving a report regarding his care and documentation in relation to medical marijuana card authorizations.

3.

In regard to the above-referenced matters, Licensee and the Board desire to settle this matter by entry of this agreement. Licensee makes no admissions of any wrongdoing and 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 investigations 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. The Agreement is reportable to the National Practitioner Data Bank and the Federation of State Medical Boards.

4.

In order to address the concerns of the Board and for purposes of resolving these investigations, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

4.1 Within six months from the signing of the Agreement by the Board Chair, Licensee agrees to complete a course on documentation that is pre-approved by the Board's Medical Director.

4.2 Licensee agrees to continue to use the Prescription Drug Monitoring Program when prescribing controlled substances.

4.3 Licensee agrees to consult with the primary care provider of any minor when authorizing a medical marijuana card, and to document that consultation in the patient chart.

4.3 Licensee shall 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 shall be grounds for disciplinary action under ORS 677.190(17).

IT IS SO AGREED this 18th day of February, 2016.

SIGNATURE REDACTED

AUBYN MARATH, MD

IT IS SO AGREED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of BURHAN AHMED MIAN, MD LICENSE NO. PG172322	)	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. Burhan Ahmed Mian, MD (Licensee) has a Postgraduate License in the State of Oregon that is currently expired.

2.

On October 26, 2015, the Board opened an investigation after receiving information from Oregon Health and Science University (OHSU) that the Licensee's employment was terminated. The Licensee was granted a leave of absence in August, 2015. In September, 2015, upon returning to the United States, he was detained in Michigan for felony warrants. Licensee failed to report either event to the Board.

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 ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), ORS 677.415(4) failure to report official action

within 10 days, and ORS 676.150(3) failure to report a felony arrest. Licensee understands that 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 surrenders his Oregon medical license while under investigation. This surrender of license becomes effective the date the Board Chair signs this Order.

4.2 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 29 day of January, 2016 BAM

SIGNATURE REDACTED

Burhan Ahmed Mian, MD

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of BURHAN AHMED MIAN, MD LICENSE NO. PG172422	))) ADDENDUM TO STIPULATED ORDER))

1.

Document entitled "Stipulated Order" contained a Scrivener's error. License No. reads as "PG172322," when, in fact, it should read "PG172422."

DATED this 14th day of April, 2016.

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: PATRICK JOHN SARVER, MD LICENSE NO. MD25942	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. Patrick John Sarver, MD (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is a family practice physician who previously practiced in a clinic in Cottage Grove, Oregon. The Board opened an investigation in 2014 after receiving credible information from Providence Health Plan regarding Licensee's status with the health plan. On November 15, 2015, Licensee entered into an Interim Stipulated Order with the Board which placed restrictions on Licensee's prescribing for the treatment of chronic pain. On January 27, 2016, the Board issued a Complaint and Notice of Proposed Disciplinary Action citing possible violations of the Medical Practice Act.

3.

Licensee and the Board now 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.

4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

4.1 Within six months from the signing of this Agreement by the Board Chair, Licensee agrees to successfully complete a documentation course and a prescribing course which have been pre-approved by the Board's Medical Director.

4.2 Licensee agrees that the Board may conduct occasional retrospective review of Licensee's prescribing practices and charting.

4.3 Once Licensee completes term 4.1 of this Agreement, he may submit documentation of completion to the Board's Medical Director. Upon review and approval by the Medical Director, the Interim Stipulated Order of November 15, 2015, will be terminated.

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

///

///

///

///

///

///

///

///

///

4.5 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 STIPULATED THIS 21st day of March, 2016.

SIGNATURE REDACTED

PATRICK JOHN SARVER, MD

IT IS SO ORDERED THIS 7th day of April, 2016.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of LEE WENDELL VANCE, MD LICENSE NO. MD16746	)))))	ORDER TERMINATING CORRECTIVE ACTION ORDER

1.

On October 14, 2004, Lee Wendell Vance, MD (Licensee) entered into a Corrective Action Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's medical license. On November 18, 2015, 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 October 14, 2004, Corrective Action Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of: DONALD EDWIN WINDER, Jr., PA LICENSE NO. PA156714	)))))	CORRECTIVE ACTION AGREEMENT

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating, educating, and disciplining certain health care providers, including physician assistants, in the State of Oregon. Donald Edwin Winder, PA (Licensee) is a licensed physician assistant in the state of Oregon.

2.

Licensee works as a physician assistant in Salem, Oregon. The Board opened an investigation in 2015 after receiving complaints in about the care Licensee provided to elderly patients for chronic pain.

3.

Licensee and the Board now 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.

///

4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

4.1 Within six months from the signing of this Agreement by the Board Chair, Licensee agrees to successfully complete a course on pain management that is pre-approved by the Board's Medical Director.

4.2 Within six months from the successful completion of term 4.1 of this Agreement, Licensee agrees to write a paper of 500 to 1000 words on contraindications to spinal injections for the treatment of pain. Licensee will submit this paper to the Board for review by the Medical Director.

4.3 Licensee must shadow a board certified pain specialist other than his current supervisor for 16 hours within six months of signing this Order. This pain specialist must by pre-approved by the Board's Medical Director.

4.4 Licensee must immediately provide a copy of this Corrective Action Agreement to any supervising physician(s) he currently has, as well as to any future supervising physicians.

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

///

///

///

///

///

///

///

4.6 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 STIPULATED THIS 22 day of MARCH, 2016.

SIGNATURE REDACTED

DONALD EDWIN WINDER, PA

IT IS SO ORDERED THIS 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of CHARLES MEN WONG, MD LICENSE NO MD 14849	)))))	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. Charles Men Wong, MD (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is board certified in internal medicine. The Board has opened an investigation into Licensee's case in regard to the delivery of health care in an Urgent Care setting for adult and pediatric patients.

3.

Licensee and the Board now 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.

///

///

///

4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

4.1 Within 6 months from the signing of this Agreement by the Board Chair, Licensee must successfully complete a course on pediatric urgent care that is pre-approved by the Board's Medical Director. The Board acknowledges that Licensee has completed a course on pediatric advanced life support in December 2015.

4.2 Within 6 months from the signing of this Agreement by the Board Chair, Licensee must successfully complete a course on medical documentation that is pre-approved by the Board's Medical Director

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 STIPULATED THIS 7 day of March, 2016.

SIGNATURE REDACTED

CHARLES MEN WONG, MD

IT IS SO ORDERED THIS 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
TODD ALLAN WYMER, LAc	)	STIPULATED ORDER
LICENSE NO. AC165723	)	

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including acupuncturists, in the state of Oregon. Todd Allan Wymer, LAc (Licensee) holds a license to practice acupuncture in the state of Oregon. Licensee signed an Interim Stipulated Order that went into effect on April 29, 2015, in which Licensee agreed that all of his clinical practice sites or training sites must be approved by the Board's Medical Director.

2.

On October 15, 2015, 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 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(17) willfully violating a Board order or regulation.

3.

The ethical code published by the Oregon Association of Acupuncture and Oriental Medicine has published a Code of Ethics, which provides that: "A practitioner shall not enter into romantic or sexual relations of any type with a patient or patient's significant other, caregiver, or immediate family member while the practitioner-patient relationship continues or

for a period of six months following the conclusion of the practitioner-patient relationship." OAR 847-010-0073(3)(G) defines sexual misconduct as: "...behavior that exploits the licensee-patient relationship in a sexual way." OAR 847-070-0030(2) and (3) provide that the Board may revoke the authority of an acupuncturist to engage in the practice of acupuncture if the Board finds that the acupuncturist has performed any act in violation of any applicable law or rules regulating the practice of acupuncture or that the acupuncturist had engaged in conduct constituting gross negligence in the practice of acupuncture. Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 In 2014 and early 2015, Licensee practiced acupuncture as a contract acupuncture provider at a health care office in Portland. Between April 28, 2014, until December 29, 2014, Licensee provided a series of acupuncture treatments to Patient A, an adult female. Licensee violated professional boundaries with Patient A through the exchange of personal and sexual text messages, photographs, and by engaging in sexual encounters with Patient A. Licensee breached professional boundaries for an acupuncturist by having sexual encounters with an active patient as well as within six months from the termination of the practitioner – patient relationship.

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 conduct that violated ORS 677.190(1)(a), as defined by ORS 677.188(4)(a); ORS 677.190(13); and ORS 677.190(17). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the National Certification Commission for Acupuncture and Oriental Medicine.

///

///

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 provide a chaperone for all female patients over the age of 14, the presence of whom must be immediately charted by Licensee and signed by the chaperone.

5.3 Licensee may only practice acupuncture and any form of Oriental medicine in a clinical setting that is pre-approved by the Board's Medical Director. Licensee must not provide any form of treatment to a patient in either his home, or the home of a patient.

5.4 Within 180 days from the signing of this Order by the Board Chair, Licensee must successfully complete a course on professional boundaries that is pre-approved by the Board's Medical Director. It is noted that Licensee has completed such a course.

5.5 Licensee's practice site and chart notes are subject to no notice site visits and audits by the Board's designees.

5.6 Licensee must avoid all social media contacts (to include Facebook and Twitter) with his patients, prospective patients, and former patients (within six months of their last clinical visit).

5.7 Licensee must chart every patient encounter.

5.8 This Order terminates the Interim Stipulated Order of May 5, 2015.

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

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

///

///

///

///

5.11 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 10 day of March, 2016.

SIGNATURE REDACTED

TODD ALLAN WYMER, LAc

IT IS SO ORDERED THIS 7th day of April, 2016.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of LEANN ALEXANDRIA ZIELINSKI, DO LICENSE NO. DO157231	)	CORRECTIVE ACTION AGREEMENT

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. Leann Alexandria Zielinski, DO (Licensee) holds an active license to practice medicine in the state of Oregon.

2.

Licensee is a board certified family physician practicing in Milwaukie, Oregon. The Board opened an investigation after receiving a report that Licensee was arrested in late 2014 for driving under the influence of an intoxicant (DUII). Licensee pled guilty to DUII in Clackamas County Circuit Court in January of 2015. Licensee has successfully completed the diversion and is awaiting final dismissal from the Court.

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 and is not reportable to the National Databank but is reportable to the Federation of State Medical Boards.

///

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 professional boundaries and a course on professionalism that are pre-approved by the Board's Medical Director. These courses may not be used to satisfy Licensee's continuing education requirements for licensure or renewal.

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 STIPULATED THIS 18 day of Feb, 2016.

SIGNATURE REDACTED

LEANN ALEXANDRIA ZIELINSKI, DO

IT IS SO ORDERED THIS 7th day of April, 2016.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

SHIRIN SUKUMAR, MD
BOARD CHAIR