Oregon Medical Board

BOARD ACTION REPORT

December 15, 2015

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between November 16, 2015, and December 15, 2015.

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.

***Booher, Benjamin Wesley, DO; DO22832; Hermiston, OR**

On November 30, 2015, Licensee entered into an Interim Stipulated Order to voluntarily cease treating all patients except those currently being treated for addiction, and to not treat any friend or family member. Additionally, Licensee agreed to voluntarily withdraw from practice and place his license in inactive status effective December 31, 2015, pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

***Mcqueen, Robert Jerome, MD; MD14655; Sherwood, OR**

On November 23, 2015, the Board issued an Order of Emergency Suspension to immediately suspend Licensee's medical license due to the Board's concern for the safety and welfare of Licensee's current and future patients. This Order is in effect pending the completion of the Board's investigation.

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 BENJAMIN WESLEY BOOHER, DO LICENSE NO. DO22832	)))))	INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Benjamin Wesley Booher, DO (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. Licensee entered into an Interim Stipulated Order with the Board on October 7, 2015 and agreed to certain terms. The results of the Board's investigation to date have raised additional concerns to the extent that the Board believes it necessary that Licensee agree to further terms until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which supersedes the Interim Stipulated Order of October 7, 2015, and 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 must immediately stop treating all patients except those currently being treated by Licensee for addiction with Suboxone or buprenorphine.

3.2 Licensee must not prescribe any scheduled medication other than Suboxone or buprenorphine to anyone.

3.3 Licensee must not treat any current addiction patient for anything other than addiction.

3.4 Licensee must not initiate treatment for any patient that is not currently being treated by Licensee for addiction.

3.5 Licensee must not treat any friend, family member, or anyone with whom he has, or has had, a romantic or non-therapeutic relationship.

3.6 Licensee's medical license will be placed on Inactive status effective noon, on December 31, 2015, pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

3.7 Licensee must notify the Oregon Medical Board within 10 days as to how patients may access or obtain their medical records.

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

4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. Following that review, if the Board determines that Licensee shall not be permitted to return to the practice of medicine, Licensee may request a hearing to contest that decision.

5.

This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform 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. However, as a stipulation this Order is a public document and is reportable to the national Data Bank and the Federation of State Medical Boards.

///

6.

This Order becomes effective the date it is signed by the Licensee.

IT IS SO STIPULATED THIS 30 day of November, 2015.

SIGNATURE REDACTED

BENJAMIN WESLEY BOOHER, DO

IT IS SO ORDERED THIS 1st day of December, 2015.

State of Oregon
OREGON MEDICAL BOARD

SIGNATURE REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
ROBERT JEROME MCQUEEN, MD	)	ORDER OF EMERGENCY
LICENSE NO. MD14655	)	SUSPENSION
	)	

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 Jerome McQueen, MD (Licensee) holds an active license to practice medicine in the state of Oregon.

2.

The acts and conduct that support this Order for Emergency Suspension follow:

2.1 Licensee has a history of past orders and disciplinary action with the Board, to include a Corrective Action Order, dated June 4, 1998; a Stipulated Order on July 12, 2001, for having violated professional boundaries; and a Stipulated Order dated September 4, 2008, for having engaged in repeated acts of gross or repeated acts of negligence and failing to report the change of a practice location. The Board concluded in the 2008 Stipulated Order that Licensee had written false patient chart entries, such as notes regarding examinations and diagnoses before seeing his patients in a face to face clinical setting and falsely stating that he had conducted a complete examination. In addition, Licensee's chart notes were found to be often illegible, with records that he performed a complete examination without medical justification, and on occasion, failed to identify the dosage or duration of treatment with antibiotics. As a result, the Board reprimanded Licensee, placed him on probation for five years, and required him to take a

///

course on medical charting and a course on family medicine, and to successfully complete PEER (Physicians Evaluation Education and Renewal). Licensee completed PEER in 2011.

2.2 The Board opened a new investigation in 2014 after receiving a complaint in regard to the quality of care provided by Licensee to patients at Vibra Specialty Hospital in Portland. The Board's investigation included Licensee's delivery of care to patients at Vibra Hospital, as well as at the Newberg Urgent Care and Medical Center, where Licensee currently practices. During the investigation, the Board ordered Licensee to undergo an assessment of his medical knowledge and judgment at the Center for Personalized Education for Physicians (CPEP). The Board's investigation was also conducted with the benefit of third party medical consultants, who conducted a review of a sampling of medical charts from both Vibra Specialty Hospital and the Newberg Urgent Care and Medical Center. The Board received the consultant reports in October and November of 2015. The consultant reports revealed serious deficiencies in Licensee's delivery of care to multiple patients in both settings, as well as important gaps in his medical knowledge, clinical judgment, and documentation. Specific concerns were identified in his delivery of care at Vibra Hospital in regard to Patients A and B, as set forth below:

a. Patient A, a 64-year-old male, with a history of a severe left-sided middle cerebral artery cerebrovascular accident complicated by respiratory failure and sepsis secondary to an infected PICC line. Patient A had also developed pneumonia and peritonitis from a misplaced PEG tube. Patient A was readmitted to Vibra Hospital on October 4, 2013, for ventilator weaning and was followed by Licensee and a pulmonologist. Patient A developed an exacerbation of heart failure and was started on furosemide by a pulmonologist for persistent left pleural effusion prior to being seen by Licensee. On October 12, 2013, Licensee started Patient A on a T3 supplement, despite a normal TSH and a high free T4 level (which is an indicator of thyroid function). Licensee failed to address the risk that T3 may aggravate atrial fibrillation. Patient A's labs reflected a gradual rise in his blood urea nitrogen (BUN) and serum sodium level when his free water intake was decreased in his tube feedings. Licensee rounded on Patient A on October 26, 2013. Patient A's labs at that time reflected an elevated BUN (135) and a

serum sodium level of 156. Licensee charted that the diuretic should be decreased and to check the EKG, but did not address the hypernatremia (elevated sodium blood level). The labs were not repeated until October 29, 2013. Licensee's care for Patient A constituted gross or repeated acts of negligence and subjected Patient A to risk of harm.

b. Patient B, a 40-year-old female, was admitted to Vibra hospital with a history of narcotic intoxication with sepsis, urinary tract infection, rhabdomyolysis, renal failure, and osteomyelitis. She was readmitted on October 16, 2013, for respiratory failure associated with tracheal stenosis. Licensee cared for Patient B for most of her inpatient care. By October 28, 2013, Patient B's BUN was 108 (elevated), with a creatinine of 2.7 (elevated) and a potassium level of 6.6 (hyperkalemia). Licensee's chart note states that the BMP (basic metabolic panel) was "almost certainly anomalous." This statement was not grounded in sound medical science. A repeat BMP was done 6 hours later that showed a potassium level of 6.7. An EKG revealed new elevation in T waves. Patient B was subsequently treated with calcium, Kayexalate, insulin, and D50, and the patient's diuretic and Lisinopril were discontinued, but she was started on an IV diuretic bumetanide by Licensee in the setting of renal failure. In the late evening of October 29, 2013, another hospitalist rounded on Patient and recognized the elevated potassium and BUN levels and arranged for Patient B's transfer to an acute care facility for hemodialysis. Licensee's care for Patient B constituted gross or repeated acts of negligence and subjected her to risk of harm.

2.3 The Board's review of Licensee's care for Patients C – M at the Newberg Urgent Care and Medical Center revealed that Licensee breached the standard of care on multiple occasions. Specifically, many of Licensee's diagnoses were not supported by the history and examination; Licensee provided many months of inappropriate opioid prescribing for patients with chronic pain in an urgent care setting; Licensee made serial errors in calculating the correct antibiotic dose and advised duration for pediatric patients; Licensee engaged in inappropriate antibiotic prescribing without supporting diagnoses, and provided PRN refills of antibiotics for worsening reported symptoms without seeing the patients; Licensee frequently documented an

incomplete medical history and failed to enter a diagnosis; Licensee prescribed unsafe dosages of topical ophthalmic corticosteroids for both pediatric and adult patients without ophthalmological consult; failed to follow widely accepted guidelines for the management of common medical problems such as otitis media and asthma with incomplete history taking and treatment plans; failed to mention or test for the possibility of pregnancy related diagnoses for a female patient of child bearing age with abdominal cramping who had recently discontinued oral contraceptives; failed to refer a patient with a soft tissue mass for 5 months when the chart shows no change after repeated treatments of various antibiotics and the diagnosis did not fit the patient's complaint; prescribing varenicline with no documentation that he informed the patient of the potential lethal adverse effects listed in the black box warnings for this medication; and refilling anti-hypertensives that require periodic laboratory monitoring in a patient where the chart does not document when the last laboratory monitoring was performed and accepted the patient's request to check in a couple of years. Licensee's manner of practice as revealed in the above stated review constituted gross or repeated acts of negligence and subjected the identified patients to the risk of serious harm.

2.4 Licensee's assessment at CPEP on January 14 – 15, 2015 concluded that Licensee "demonstrated a fund of medical knowledge that was appropriate, with scattered gaps, some of which were significant." Licensee's "most significant weaknesses were in the areas of cardiology, asthma, controlled substance prescribing, and pediatrics. His clinical judgment and reasoning were appropriate except in regards to index of suspicion for abuse of controlled substances and alcohol." His documentation in charts was "adequate" for his actual patient charts and marginal, with room for improvement, for simulated patient encounters. His communication skills were "poor" with simulated patients. CPEP recommended Licensee participate in a structured education intervention to address the identified areas of need. The Board directed inquiries to Licensee on multiple occasions regarding his willingness to enter into an agreement to address the deficiencies identified by CPEP. Licensee did not provide a direct answer. Instead, Licensee criticized the CPEP assessment process and denied any practice or

knowledge deficiencies. Licensee has demonstrated his inability to assimilate or consider external review and his very limited insight into his current level of practice.

3.

The Board has determined from the evidence available at this time that Licensee's continued practice of medicine would pose an immediate danger to the public and to his patients. Licensee was offered the opportunity to voluntarily withdraw from practice, but he has declined. In order to adequately protect the public, the Board concludes that is it necessary to immediately suspend his license to practice medicine. To do otherwise would subject Licensee's patients to the risk of harm while this case remains under investigation.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant to ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practical.

5.

The Board orders that pursuant to ORS 677.205(3), the license of Robert Jerome McQueen, MD, be suspended on an emergency basis and that Licensee immediately cease the practice of medicine until otherwise ordered by the Board. This suspension is effective upon a majority vote of the members of the Oregon Medical Board. This vote occurred at a special meeting of the Board on November 23, 2015.

///

///

///

///

///

6.

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

IT IS SO ORDERED THIS 24th day of November, 2015.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

MICHAEL MASTRANGELO, JR., MD
BOARD CHAIR