

Oregon Medical Board
BOARD ACTION REPORT
October 15, 2014

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

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

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

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

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

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

On October 2, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2013 Corrective Action Agreement.

***Cross, Lorne Max, MD; MD27400; Portland, OR**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; impairment; gross or repeated acts of negligence; and violation of federal Controlled Substances Act. This Order reprimands Licensee; places Licensee on probation for ten years; requires practice site approval by the Board's Medical Director; prohibits Licensee from prescribing Schedule II and III medications in excess of 15 days; and requires Licensee to remain under the care of a provider pre-approved by the Board's Medical Director.

Daniel, Sarah Florence, PA; PA162761; Salem, OR

On September 30, 2014, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to specific requirements regarding chart review from her supervising physician, and that her supervising physician would submit reports to the Board regarding her progress in her return to the practice of medicine.

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

On October 2, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2014 Corrective Action Agreement.

***Gaekwad, Satyajeet Yashwantrao, MD; MD26995; Albany, OR**

On October 2, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2013 Corrective Action Agreement.

***Gallant, James David, MD; MD12529; Corvallis, OR**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated acts of negligence. This Order suspends Licensee's medical license, but the suspension is stayed; reprimands Licensee; assesses a \$10,000 civil penalty; places Licensee on probation for ten years; requires that Licensee complete an assessment at CPEP and complete any education plan; requires that Licensee complete courses in medical ethics and prescribing; and prohibits Licensee, or any physician assistant under Licensee's supervision, from treating chronic pain.

***Hasan, Shagufta Anbereen, MD; MD20989; Portland, OR**

On October 2, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to provide a post-operative instruction sheet and informed consent form to every patient which have been pre-approved by the Board's Medical Director, and obtain a pre-approved surgical mentor to review and assist in every circumcision case.

***Hasan, Shagufta Anbereen, MD; MD20989; Portland, OR**

On October 2, 2014, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's June 28, 2013, Interim Stipulated Order.

***Hlava, Nicole Beth, MD; MD153761; Santa Clara, CA**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and fraud or misrepresentation in applying for or procuring a license to practice in this state. This Order surrenders Licensee's medical license while under investigation.

***Howe, Gary Allen, PA; PA165991; Burns, OR**

On October 1, 2014, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's 2014 Consent Agreement.

***Huebner, Mary Freericks, PA; PA00752; Medford, OR**

On October 2, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2010 Corrective Action Agreement.

***Hutson, Daniel Boniface, PA; PA153460; Portland, OR**

On October 2, 2014, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 4, 2013, Stipulated Order.

***Kahaner, Nancy Rae, DO; DO15080; Portland, OR**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board. This Order retires Licensee's osteopathic license while under investigation.

***Lee, Patrick Yuk-Hoi, MD; MD16880; Portland, OR**

On September 22, 2014, Licensee entered into an Interim Stipulated Order in which he agrees to have a board-certified surgeon assist in certain abdominal and pelvic surgeries pending the completion of the Board's investigation into his ability to safely and competently perform these surgeries.

***Mauras, Kessa, DPM; DP153769; Hood River, OR**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence in the practice of medicine. This Order reprimands Licensee; assesses a civil penalty of \$2,500; requires Licensee to complete courses in medical documentation and medical ethics; subjects Licensee's practice to no-notice chart audits by the Board; requires that Licensee receive pre-approval from a board certified podiatrist for all procedures requiring general or regional anesthesia; and implements a protocol to reduce the risk of wrong-site surgery.

***Mays, Maureen Ellen, MD; MD25708; Portland, OR**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; violation of the federal Controlled Substances Act; and prescribing without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping. This Order reprimands Licensee; assesses a \$5,000 civil penalty; requires Licensee to complete courses on medical documentation, medical ethics and boundaries; places Licensee on probation for five years; prohibits Licensee from prescribing for herself, family, friends, or employees; prohibits Licensee from supervising a physician assistant; prohibits Licensee from practicing pediatric psychiatry and from prescribing to persons under the age of 18 for mental health conditions.

***McNabb, Earl Dean, DPM; DP00344; Keizer, OR**

On October 2, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on charting, and obtain and complete an educational plan from CPEP which is to include an educational preceptor.

***Morishita, Megumi, MD; MD25973; Newport, OR**

On October 2, 2014, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2013 Corrective Action Agreement.

***Overs, Shannon Nicole, MD; MD154069; Portland, OR**

On October 2, 2014, Licensee entered into a Stipulated Order with the Board. This Order surrenders Licensee's medical license while under investigation.

Rivadeneira Almenara, Adriana, LAc; AC166926; Portland, OR

On October 7, 2014, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to obtain 20 hours of mentoring from a Board approved practice mentor.

***Sachdev, Naina, MD; MD16352; Lake Oswego, OR**

On October 2, 2014, the Board issued a Final Order for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; willfully violating any rule adopted by the board, board order, 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 revokes Licensee's medical license, assesses a \$10,000 civil penalty, and assesses costs of the disciplinary proceedings.

***Selby, David William, DO; DO14260; Lake Oswego, OR**

On October 2, 2014, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's 2012 Stipulated Order.

***Sills, Shawn Michael, MD; MD25091; Medford, OR**

On October 1, 2014, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's July 12, 2012, Stipulated Order.

***Teplick, Stanley Bruce, MD; MD19317; Beaverton, OR**

On October 2, 2014, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's 2012 Stipulated Order.

***Thomas, Harold Andrew, Jr., MD; MD14766; Lake Oswego, OR**

On September 25, 2014, 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.

***Tillett, Steven Gary, DPM; DP00300; Portland, OR**

On October 2, 2014, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved professional boundaries course.

***Valenzuela, Eduardo Rodolfo, PA; PA161878; Eugene, OR**

On October 2, 2014, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's July 11, 2013, Stipulated Order.

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

On October 2, 2014, the Board issued a Default Final Order for unprofessional or dishonorable conduct; making statements that licensee knows or should know are false or misleading regarding skill or the efficacy or value of medicine or remedy prescribed or administered by the licensee or at the direction of the licensee in the treatment of any disease or condition of the human body; and gross or repeated acts of negligence. This Order revokes Licensee's medical license, assesses a \$10,000 civil penalty and assesses the costs of the disciplinary proceedings.

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.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
LORNE MAX CROSS, MD) STIPULATED ORDER
LICENSE NO. MD27400)

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. Lorne Max Cross, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On July 29, 2014, 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 sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7) impairment, as defined by ORS 676.303; ORS 677.190(13) gross or repeated acts of negligence, and ORS 677.190(23) violation of federal Controlled Substance Act.

3.

Licensee signed an Interim Stipulated Order on October 4, 2013, voluntarily withdrawing from the practice of medicine pending completion of the Board's investigation. Licensee is board certified in anesthesiology and was formerly employed by the Oregon Anesthesiology Group.

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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 that he engaged in conduct described in paragraph 2. The Board finds that Licensee violated ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(7), as defined by ORS 676.303; ORS 677.190(13), and ORS 677.190(23). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

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

- 5.1 Licensee is reprimanded.
- 5.2 Licensee is placed on probation for ten years. Licensee must report in person to the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a probationer interview unless directed to do otherwise by the Board or its Compliance Officer. After two years of compliance with this Order, Licensee may submit a written request to modify or terminate this term.
- 5.3 Licensee may only practice medicine in practice settings that have been pre-approved by the Board's Medical Director.
- 5.4 Licensee must not prescribe Schedule II or III medications to any individual patient in excess of 15 days during a calendar year.
- 5.5 Licensee must remain under the care of a licensed physician or other licensed health care provider pre-approved by the Board's Medical Director.

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1 5.6 The Interim Stipulated Order, dated October 4, 2013, terminates on the date
2 this Order is signed by the Board Chair.

3 5.7 Licensee stipulates and agrees that this Order becomes effective the date it is
4 signed by the Board Chair.

5 5.8 Licensee must obey all federal and Oregon state laws and regulations
6 pertaining to the practice of medicine.

7 5.9 Licensee stipulates and agrees that any violation of the terms of this Order
8 shall be grounds for further disciplinary action under ORS 677.190(17).

9

10 IT IS SO STIPULATED THIS 19th day of September, 2014.

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SIGNATURE REDACTED

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✓ LORNE MAX CROSS, MD

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14 IT IS SO ORDERED THIS 2nd day of October, 2014.

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OREGON MEDICAL BOARD
State of Oregon

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SIGNATURE REDACTED

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DONALD GIRARD, MD
BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
PETER JAMES FRANCIS, MD) ORDER TERMINATING
LICENSE NO. MD126335) CORRECTIVE ACTION AGREEMENT
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1.

On January 9, 2014, Peter James Francis, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On May 23, 2014, Licensee submitted documentation that he has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the January 9, 2014, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
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SATYAJEET YASHWANTRAO) ORDER TERMINATING
GAEKWAD, MD) CORRECTIVE ACTION AGREEMENT
LICENSE NO. MD26995)

1.

On January 10, 2013, Satyajeet Yashwantrao Gaekwad, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On May 19, 2014, Licensee submitted documentation that he has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the January 10, 2013, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

1 demand letter to Subject A, in which he asserted that she owed him \$75,000. He acknowledged
2 that she had made some installment payments, but that she still owed him \$55,000. In this letter,
3 Licensee threatened Subject A by demanding that either she immediately pay the entire amount
4 due or he would report her to the Board for alleged misconduct and that she would "be at the
5 mercy" of the Board. About six weeks later, on the date specified in the demand letter,
6 Licensee reported Subject A to the Board for an alleged violation of the Medical Practice Act.

7 3.2 Patient B, an adult female with a family history of breast cancer, underwent a
8 mammogram as part of a routine physical on November 9, 2009. The technician noted that the
9 patient had recently developed an inverted nipple on her left breast and advised her to have it
10 checked by her physician. Patient B went to Licensee's clinic the following day, and was seen
11 by Licensee's Physician Assistant, who discussed her condition with Licensee. It was decided
12 (and charted) that Patient B should undergo an MRI (magnetic resonance imaging) to further
13 evaluate this abnormal finding. There was no follow-up and the MRI was never obtained.
14 Patient B called the clinic in December to inquire about the referral for the MRI, but never
15 received an answer or a call back. On January 7, 2010, Patient B returned to the clinic and asked
16 once again for an MRI on her left breast. Licensee agreed that this was necessary, but again,
17 there was no follow-up, and the MRI was not ordered or performed. Patient B returned to the
18 clinic on October 18, 2010, for her annual examination and underwent a mammogram that
19 resulted in an abnormal finding, culminating in a diagnosis of an infiltrating lobular carcinoma in
20 her left breast. Licensee's failure to provide timely follow-up contributed to a delay in diagnosis
21 of a life threatening disease.

22 3.3 The Board reviewed Licensee's charts and found that in regard to two chronic pain
23 patients (Patients C and D); Licensee breached the standard of care in the manner in which he
24 managed these high risk and medically complex patients on high dose opioid therapy (Schedule II
25 controlled substances) and benzodiazepines (Schedule IV). Licensee failed to follow up on
26 inconsistent urine drug screening tests (UDS), failed to act on evidence of illegal drug abuse,
27 authorized early prescription refills of controlled substances in the face of aberrant behavior, and
28 continued refills when there was credible reason to suspect patient diversion or misuse. Licensee

1 also infrequently consulted with pain treatment specialists and did not adhere to the terms of his
2 own pain treatment agreement with these patients.

3 4.

4 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
5 Licensee understands that he has the right to a contested case hearing under the Administrative
6 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
7 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
8 Order in the Board's records. Licensee neither admits or denies but the Board finds that he
9 engaged in conduct that violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as
10 defined in ORS 677.188(4)(a); and ORS 677.190(13) gross or repeated acts of negligence.
11 Licensee understands that this Order is a public record and is a disciplinary action that is
12 reportable to the National Data Bank and the Federation of State Medical Boards.

13 5.

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

16 5.1 The license of Licensee to practice medicine is suspended for 90 days, but the
17 suspension is stayed.

18 5.2 Licensee is reprimanded.

19 5.3 Licensee must pay a civil penalty of \$10,000, payable in installments of \$2,000
20 every two months, until it is paid in full. This first payment of \$2,000 is due 60 days from the
21 effective date of this Order.

22 5.4 Licensee is placed on probation for ten years. Licensee must report in person to
23 the Board at each of its quarterly meetings at the scheduled times for a probation interview,
24 unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.
25 After three years of demonstrated compliance with the terms of this Order, Licensee may submit
26 a written request to modify the terms of this Order.

27 5.5 Within 180 days from the signing of this Order by the Board Chair, Licensee must
28 at his own expense enroll in and complete a physician assessment at the Center for Personalized

1 Education for Physicians (CPEP). Licensee must sign all necessary releases to allow full
2 communication and exchange of documents and reports between the Board and CPEP. Licensee
3 must timely and successfully complete the recommended CPEP Education or Remediation Plan,
4 if any, at Licensee's expense. This plan must be reviewed and approved by the Board's Medical
5 Director prior to implementation.

6 5.6 Within 12 months from the signing of this Order by the Board Chair, Licensee
7 must complete a course in medical ethics pre-approved by the Board's Medical Director.

8 5.7 Within 12 months from the signing of this Order by the Board Chair, Licensee
9 must complete a prescribing course pre-approved by the Board's Medical Director.

10 5.8 Licensee must not treat chronic pain. For the purposes of this Order, chronic pain
11 is defined as pain that persists or progresses over a period of time greater than 30 days. Licensee
12 must not prescribe any medication for pain for any patient in excess of 30 days for any one year
13 period.

14 5.9 Any physician assistant supervised by Licensee must abide by the same
15 prescribing limits as Licensee as described in term 5.8

16 5.10 Licensee may request termination of terms 5.8 and 5.9 upon successful
17 completion of terms 5.3, 5.5, 5.6, and 5.7.

18 5.11 Licensee stipulates and agrees that this Order becomes effective the date it is
19 signed by the Board Chair.

20 5.12 Licensee must obey all federal and Oregon state laws and regulations pertaining
21 to the practice of medicine.

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4.

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

4.1 Licensee must prepare a post-operative instruction sheet that contains Licensee's contact information for review and approval by the Board's Medical Director. Licensee must provide the post-operative instruction sheet to every patient before she performs surgery.

4.2 Licensee must use an informed consent form preapproved by the Board's Medical Director.

4.3 Licensee must obtain a surgical mentor that is pre-approved by the Board's Medical Director who will review every circumcision case prior to surgery and assist in every circumcision procedure. After assisting in no fewer than 20 cases, Licensee may, with the endorsement of her surgical mentor, provide a written request to the Board to terminate this requirement. The mentor's endorsement must include a written report regarding the cases in which assistance was provided, with an assessment of Licensee's surgical skill and judgment.

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

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

IT IS SO AGREED this 4th day of Sept, 2014.

SIGNATURE REDACTED

SHAGUFTA ANBEREEN HASAN, MD

IT IS SO AGREED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
SHAGUFTA ANBEREEN HASAN, MD) ORDER TERMINATING
LICENSE NO. MD20989) INTERIM STIPULATED ORDER
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1.

On June 28, 2013, Shagufta Anbereen Hasan, MD (Licensee) entered into an Interim Stipulated Order with the Oregon Medical Board (Board). This Order placed restrictions on Licensee's Oregon medical license pending the conclusion of the Board' investigation.

2.

On October 2, 2014, the Board closed its investigation. The Board terminates the June 28, 2013, Interim Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
NICOLE BETH HLAVA, MD) STIPULATED ORDER
LICENSE NO, MD153761)
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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. Nicole Beth Hlava, MD (Licensee) is a licensed physician in the State of Oregon.

2.

Licensee is board-certified in anesthesia and critical care medicine. The Board opened an investigation on December 23, 2013, regarding Licensee's non-compliance with mandatory reporting requirements on her initial license application and other possible violations of the Medical Practice Act.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to surrender her license while under investigation, consistent with the terms of this Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies 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), and 677.190(8) fraud or misrepresentation in applying for or procuring a license to practice in this state.

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2 4.
3 Licensee and the Board agree that the Board will close this investigation and resolve this
4 matter by entry of this Stipulated Order, subject to the following conditions:

5 4.1 Licensee will surrender her Oregon medical license while under investigation
6 effective the date the Board Chair signs this Order.

7 4.2 Licensee stipulates and agrees that any violation of the terms of this Order shall
8 be grounds for further disciplinary action under ORS 677.190(18).

9 5.
10 This Order becomes effective the date it is signed by the Board Chair.

11 IT IS SO STIPULATED this 16th day of September 2014.

12 **SIGNATURE REDACTED**

13 Nicole Beth Hlava, MD

14
15 IT IS SO ORDERED this 2nd day of October 2014.

16 OREGON MEDICAL BOARD

17 **SIGNATURE REDACTED**

18 Donald E. Girard, MD
19 Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
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MARY FREERICKS HUEBNER, PA) ORDER TERMINATING
LICENSE NO. PA00752) CORRECTIVE ACTION AGREEMENT
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1.

On April 8, 2010, Mary Freericks Huebner, PA (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On July 29, 2014, 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 April 8, 2010, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

1 This modification becomes effective the date this Order is signed by the Board Chair.
2 All other terms of April 4, 2013, Stipulated Order are unchanged and remain in full force and
3 effect.

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5 IT IS SO ORDERED this 2nd day of October, 2014

6 OREGON MEDICAL BOARD
7 State of Oregon

8 SIGNATURE REDACTED

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10 DONALD GIRARD, MD
11 Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
PATRICK YUK-HOI LEE, MD) INTERIM STIPULATED ORDER
LICENSE NO. MD16880)
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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 Yuk-Hoi Lee, 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.

Licensee voluntarily agrees to enter into this Interim Stipulated Order with the Board, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following terms effective the date this Order is signed by the Board Chair:

3.1 Licensee must have a board-certified general surgeon or colorectal surgeon act as a surgical assistant for all abdominal and anterior approach pelvic surgeries in patients with prior abdominal/pelvic surgery, a history of abdominal/pelvic radiation, or a tumor involving urologic or vascular structures. Abdominoperineal resection and low anterior resection in patients with

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1 neo-adjuvant radiation who have never had surgery are not subject to the requirements of a
2 board-certified surgical assistant.

3 3.2 Licensee must continue care with his healthcare provider who will submit reports
4 of Licensee's attendance to the Board.

5 3.3 Licensee understands that violating any term of this Order will be grounds for
6 disciplinary action under ORS 677.190(17).

7 3.4 Licensee understands this Order becomes effective the date he signs it.

8 4.

9 At the conclusion of the Board's investigation, this Order will be reviewed in an
10 expeditious manner. If the Board determines, following that review, that this Order shall not be
11 lifted, Licensee may request a hearing to contest that decision.

12 5.

13 This order is issued by the Board pursuant to ORS 677.410, which grants the Board the
14 authority to attach conditions to the license of Licensee to practice medicine. These conditions
15 will remain in effect while the Board conducts a complete investigation in order to fully inform
16 itself with respect to the conduct of Licensee. Pursuant to ORS 677.425, Board investigative
17 materials are confidential and shall not be subject to public disclosure, nor shall they be admissible
18 as evidence in any judicial proceeding. However, as a stipulation this Order is a public document
19 and is reportable to the National Databank and the Federation of State Medical Boards.

20 IT IS SO STIPULATED THIS 22 day of September 2014.

21 SIGNATURE REDACTED

22 ~~PATRICK~~ YUK-HOI LEE, MD

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24 IT IS SO ORDERED THIS 25th day of September, 2014.

24 OREGON MEDICAL BOARD

25 SIGNATURE REDACTED

26 KATHLEEN HALEY, JD U
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
KESSA MAURAS, DPM)
LICENSE NO DP153769) STIPULATED ORDER
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1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including podiatric physicians, in the state of Oregon. Kessa Mauras, DPM (Licensee) is a licensed podiatric physician in the state of Oregon.

2.

On July 15, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, pursuant to ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a) and (b); and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

3.

Licensee is a podiatric physician with a practice in Hood River, Oregon. Licensee's acts and conduct that violated the Medical Practice Act are:

3.1 Patient A, an adult with an active lifestyle, and a history of Diabetes (type II or unspecified type), presented to Licensee on December 4, 2012, with a chronic ulceration overlying the plantar surface of the left foot. Licensee examined Patient A and conducted an incision and drainage and debridement of the ulcer. Patient A presented again on April 9, 2013. Licensee's chart note reflects that Patient A's complaint pertained to the 4th metatarsal, with a

1 new blood blister on the left foot. Licensee subsequently scheduled Patient A for surgery.
2 Licensee prepared a pre-operative admission order on July 29, 2013, reflecting a diagnosis of
3 "Left 4th metatarsal resection." Licensee filled out a handwritten surgery scheduling request
4 form on the same date, stating that the scheduled surgery was "Left 4th Metatarsal Head
5 Resection." On an attached diagram of the foot, Licensee circled the left 4th metatarsal, and
6 hand wrote the notation "Left 4th metatarsal head resection." On August 28, 2013, Patient A and
7 Licensee executed a consent to operation form, in which Licensee had written the following
8 description of the planned surgery: "Left metatarsal head resection, left foot." Licensee
9 conducted the surgery on August 30, 2013. Her operative report states that she conducted a
10 "Left 4th metatarsal head resection, left 4th metatarsal head bone biopsy, surgical excisional
11 debridement of ulcer with skin flap." Licensee's post-operative chart note reflects the following
12 entry: "Surgery date: 4th Met Head Resection, Bone biopsy, surgical excisional debridement of
13 ulcer, skin flap." The pathology report reflected that the bone section excised by Licensee and
14 submitted for study noted no inflammation or neoplasm. Licensee saw Patient A over the course
15 of three post-operative visits. On September 3, 2013, a fluoroscopic image revealed that the
16 distal aspect of Patient A's third metatarsal had been surgically removed, and that the 4th
17 metatarsal was intact. Patient A was readmitted to the hospital on October 15, 2013, with
18 cellulitis of the left foot. Another physician informed Patient A at that time that his third
19 metatarsal had been removed. The patient was transferred to Portland St. Vincent Hospital, and
20 the 4th metatarsal of the left foot was surgically removed. Pathology revealed evidence of
21 osteomyelitis at the left 4th metatarsal phalangeal joint region. Licensee failed to inform Patient
22 A that she had performed wrong site surgery. When asked by the Board to explain, Licensee
23 asserts that she really intended to conduct a resection of the 3rd metatarsal from the outset, and
24 that all her chart notes were done in error. Licensee's explanation contradicts all of her notes and
25 her executed informed consent form, and is not credible. Licensee's conduct resulted in the
26 unnecessary surgical removal of the third metatarsal and delayed the surgical resection of the 4th
27 metatarsal, resulting in patient harm. This constitutes gross negligence.

1 3.2 The Board conducted a review of charts for patients (Patients B – D) under
2 Licensee’s care, revealing a pattern of substandard practice that included limited or cursory
3 documentation of her physical examinations; limited use of diagnostic studies, such as X-rays,
4 bone scans and magnetic resonance imaging (MRI); undue delay and ineffective treatment in
5 follow-up of post-operative complications, to include delayed treatment of wounds. Specific
6 concerns follow:

7 a. Patient B, a diabetic (type II), initially presented for treatment of an ulcer on the
8 right hallux, left hallux erythema and a large plantar wart on the left foot in February of 2012. In
9 May of 2012, Licensee performed an amputation of the left hallux, second metatarsal head
10 resection of the left foot and attempted surgical closure of the ulceration of the right hallux.
11 Licensee amputated the right hallux in August of 2012. The wound was very slow to heal. Post-
12 operative care continued until December 31, 2012. In November 2013, Patient B presented with
13 an abscessed right foot and Licensee performed surgery in November 2013, including an incision
14 and drainage of the right foot, with amputation of the second digit, excision of an ulcer, a skin
15 flap, and bone biopsy. Patient B experienced post-operative complications, and the right foot
16 was slow to heal. Even though the wound had not yet healed, Licensee conducted elective foot
17 surgery in January, 2014, subjecting Patient B to the unnecessary risk of harm.

18 b. Patient C, a diabetic (type II) presented with an ulcer on the bottom of the left foot
19 in January of 2013, and initially received conservative wound care, until March of 2013, when
20 Licensee performed a third metatarsal head resection. Licensee failed to obtain pre-operative
21 diagnostic imaging and failed to order a wound culture. Licensee failed to document the
22 nutritional status or the management of Patient C’s diabetic condition.

23 c. Patient D, a diabetic, presented to Licensee in January of 2012, with a history of
24 previous podiatric surgical procedures and a recent hospitalization for irrigation and drainage of
25 the right foot. Licensee conducted an examination and noted weak palpable pulses. Licensee
26 scheduled Patient D for surgery to resect metatarsal heads 2 and 4 on the right foot. A pre-
27 operative x-ray did not show signs of osteomyelitis; nevertheless, Licensee performed the

1 scheduled surgery in March, 2013. Performing elective surgery on this elderly patient with no
2 open wounds or infection was not medically indicated. Licensee also failed to follow up on
3 Patient D's reported weak pulses by ordering a vascular study or obtaining a consultation.

4 4.

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

6 Licensee understands that she has the right to a contested case hearing under the Administrative
7 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
8 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
9 Order in the Board's records. Licensee admits that she engaged in conduct that violated ORS
10 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a) and (b);
11 and ORS 677.190(13) gross or repeated negligence in the practice of medicine. Licensee
12 understands that this Order is a public record and is a disciplinary action that is reportable to the
13 National Data Bank and the Federation of State Medical Boards.

14 5.

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

17 5.1 Licensee is reprimanded.

18 5.2 Licensee must pay a civil penalty of \$2,500, payable in full within 60 days from
19 the signing of this Order by the Board Chair.

20 5.3 Within 180 days from the signing of this Order by the Board Chair, Licensee must
21 successfully complete a course on medical documentation and a course on medical ethics that are
22 pre-approved by the Board's Medical Director.

23 5.4 Licensee's medical practice is subject to random, no notice chart audits by the
24 Board's designee.

25 5.5 All surgical procedures performed by Licensee requiring general or regional
26 anesthesia must be pre-approved by a board-certified podiatrist or board certified orthopedic
27 surgeon who has been pre-approved by the Board's Medical Director. After one year Licensee

1 may request modification or termination of this term with the endorsement of the approved
2 physicians reviewing the surgical procedures

3 5.6 Licensee must implement a protocol to reduce the risk of wrong-site surgery.
4 These elements shall be documented in the medical chart: (1) a preoperative verification process;
5 (2) marking the surgical site; and (3) leading a "time out" to verify patient identification, the
6 planned procedure and the surgical site prior to starting any surgery.

7 5.7 After two years of compliance with the terms of this Order, Licensee may submit
8 a written request to modify or terminate any provision of this Order.

9 5.8 Licensee stipulates and agrees that this Order becomes effective the date it is
10 signed by the Board Chair.

11 5.9 Licensee must obey all federal and Oregon state laws and regulations pertaining
12 to the practice of medicine.

13 5.10 Licensee stipulates and agrees that any violation of the terms of this Order shall
14 be grounds for further disciplinary action under ORS 677.190(17).

15

16 IT IS SO STIPULATED THIS 18 day of September, 2014.

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SIGNATURE REDACTED

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KESSA MAURAS, DPM

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20 IT IS SO ORDERED THIS 2nd day of October, 2014.

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OREGON MEDICAL BOARD
State of Oregon

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SIGNATURE REDACTED

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DONALD GIRARD, MD
BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
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MAUREEN ELLEN MAYS, MD) STIPULATED ORDER
LICENSE NO. MD25708)
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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. Maureen Ellen Mays, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On July 29, 2014, 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 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; ORS 677.190(23) violation of the federal Controlled Substances Act; and ORS 677.190(24) prescribing without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits or denies, but the Board finds that she engaged in conduct that violated ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS

1 677.190(13); ORS 677.190(23); and ORS 677.190(24). Licensee understands that this Order is a
2 public record and is a disciplinary action that is reportable to the National Data Bank and the
3 Federation of State Medical Boards.

4 4.

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

7 4.1 Licensee is reprimanded.

8 4.2 Licensee must pay a civil penalty of \$5,000, payable in full within 60 days from
9 the signing of this Order by the Board Chair.

10 4.3 Within 270 days from the signing of this Order by the Board Chair, Licensee must
11 successfully complete a course on medical documentation, a course on medical ethics, and a
12 boundary course that are pre-approved by the Board's Medical Director.

13 4.4 Licensee is placed on probation for five years. Licensee must report in person to
14 the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a
15 probationer interview unless directed to do otherwise by the Board or its Compliance Officer.

16 4.5 Licensee must not prescribe for herself, members of her immediate family,
17 friends, employees, or staff of any clinic where she practices medicine.

18 4.6 Licensee must not serve as a supervisor for a physician assistant.

19 4.7 Licensee must refrain from practicing pediatric psychiatry, and must not prescribe
20 medications for persons under the age of 18 for mental health conditions.

21 4.8 Licensee stipulates and agrees that this Order becomes effective the date it is
22 signed by the Board Chair.

23 4.9 Licensee must obey all federal and Oregon state laws and regulations pertaining
24 to the practice of medicine.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
EARL DEAN MCNABB, DPM)
LICENSE NO. DP00344) CORRECTIVE ACTION AGREEMENT

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including podiatric physicians, in the state of Oregon. Earl Dean McNabb, DPM (Licensee) is a licensed podiatric physician in the state of Oregon.

2.

On February 14, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in regards to Licensee. In this document, the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a); and ORS 677.190(13) gross or repeated acts of negligence.

3.

As part of the Board's investigation, Licensee agreed to undergo an assessment at the Center for Personalized Education for Physicians (CPEP). The CPEP Assessment Report, dated April 10-11, 2014, stated that Licensee "demonstrated knowledge of podiatry that was generally adequate with areas in which he was out of date. His clinical judgment and reasoning were variable, ranging from acceptable to inadequate." The report identified certain educational needs, and recommended that Licensee establish a relationship with an experienced educational preceptor in podiatry, and to engage in continuing medical education and self-study.

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4.

In regard to the above-referenced matter, Licensee and the Board desire to settle this matter by entry of this agreement. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this agreement in the Board's records. The Board agrees to close the current investigation and makes no finding in regard to any violation of the Medical Practice Act. This agreement is a public document and is not a disciplinary action, but is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

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

5.2 Licensee must ask CPEP to prepare an Education Plan to implement the educational needs identified in the CPEP Report, to include working with an educational preceptor. After presenting this plan to the Board's Medical Director for review and approval, Licensee must, within 18 months after approval by the Board's Medical Director, successfully complete the recommended CPEP Education Plan at Licensee's expense.

5.3 Licensee must sign and fully cooperate with the CPEP education plan and must sign all necessary releases to allow full and complete communication between CPEP and the Board. Licensee must ensure that all CPEP reports concerning Licensee, to include the final written report, are provided directly from CPEP to the Board.

5.4 The terms of the Agreement remain in effect regardless of the practice location of Licensee, to include a practice location outside of the state of Oregon.

5.5 After successfully completing the CPEP Education Plan, Licensee may submit a written request to the Board to terminate this Agreement.

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

1 5.7 Licensee agrees that any violation of the terms of this Agreement constitutes
2 grounds to take disciplinary action under ORS 677.190(17).

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4 IT IS SO AGREED THIS 1 day of October , 2014.

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 EARL DEAN MCNABB, DPM

8 IT IS SO AGREED THIS 2 day of October , 2014.

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 OREGON MEDICAL BOARD
 State of Oregon

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 DONALD GIRARD, MD
 BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
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MEGUMI MORISHITA, MD) ORDER TERMINATING
LICENSE NO. MD25973) CORRECTIVE ACTION AGREEMENT
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1.

On March 7, 2013, Megumi Morishita, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On August 4, 2014, 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 March 7, 2013, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
SHANNON NICOLE OVERS, MD) STIPULATED ORDER
LICENSE NO. MD154069)

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. Shannon Nicole Overs, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On December 27, 2013, the Board opened an investigation regarding Licensee's non-compliance with mandatory reporting requirements.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to surrender her license while under investigation, consistent with the terms of this Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. By entering into this Order, the Licensee understands that although the Board makes no finding at this time as to whether her conduct violated the Medical Practice Act, this document is a public record and is reportable to the National Data Bank and the Federation of State Medical Boards.

4.

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

1 4.1 Licensee surrenders her license to practice medicine while under investigation.
2 This surrender of license becomes effective the date the Board Chair signs this Order.

3 4.2 Throughout the time that the medical license of Licensee remains in a
4 surrendered status, Licensee is prohibited from practicing any form of medicine in Oregon.

5 4.3 In the event Licensee should submit an application for a new Oregon medical
6 license, Licensee understands that the Board will reopen this investigation.

7 4.4 Licensee stipulates and agrees that any violation of the terms of this Order
8 would be grounds for further disciplinary action under ORS 677.190(17).

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IT IS SO STIPULATED this 9 day of August, 2014.

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SIGNATURE REDACTED

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SHANNON NICOLE OVERS, MD

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IT IS SO ORDERED this 7th day of October, 2014.

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OREGON MEDICAL BOARD

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State of Oregon

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SIGNATURE REDACTED

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DONALD GIRARD, MD

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BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

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IN THE MATTER OF:)
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NAINA SACHDEV, MD) FINAL ORDER
LICENSE NO. MD16352)
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HISTORY OF THE CASE

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On January 14, 2013, the Oregon Medical Board (Board) issued a Complaint & Notice of Proposed Disciplinary Action to Naina Sachdev, M.D. On February 1, 2013, Dr. Sachdev requested an administrative hearing.

On March 1, 2013, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw to preside over the matter.

On April 25, 2013, ALJ Rackstraw convened a prehearing conference via telephone. Senior Assistant Attorney General Warren Foote represented the Board. California attorney Kevin Mirch, California attorney Marvin Firestone, and Texas attorney Peter Ferrara represented Dr. Sachdev.

On July 10, 2013, Mr. Firestone filed a Notice of Withdrawal as Counsel for Naina Sachdev, M.D. On August 27, 2013, Mr. Ferraro filed a Notice of Withdrawal as Counsel for Naina Sachdev, M.D. Also on August 27, 2013, Oregon attorney Wayne Mackeson filed a Notice of Withdrawal of Wayne Mackeson, P.C.

On September 16, 2013, Dr. Sachdev, by and through Mr. Mirch, filed a Motion to Dismiss. Also on September 16, 2013, Oregon attorney Anthony McNamer filed a Notice of Appearance as co-counsel (with Mr. Mirch) for Dr. Sachdev.

On September 24, 2013, the Board filed an Answer to Motion to Dismiss.

On September 25, 2013, ALJ Rackstraw convened a status conference via telephone. Mr. Foote represented the Board. Mr. Mirch represented Dr. Sachdev. During the conference, Mr. Mirch requested, on behalf of Dr. Sachdev, that the hearing set to begin on October 14, 2013 be postponed. ALJ Rackstraw denied the request for postponement.

On September 30, 2013, Mr. Mirch was approved for *Pro Hac Vice* admission in Oregon, for purposes of this matter.

On October 4, 2013, the Board filed a Motion for a Qualified Protective Order.

1 On October 7, 2013, ALJ Rackstraw denied Dr. Sachdev's Motion to Dismiss.
2

3 On October 11, 2013, Dr. Sachdev, by and through Mr. Mirch, filed a Response to
4 Motion [for] Qualified Protective Order. In the Response, Dr. Sachdev requested that all patient
5 records be excluded from the hearing.
6

7 On October 14, 2013, ALJ Rackstraw convened a hearing at the Board's office in
8 Portland, Oregon. Mr. Foote represented the Board. Mr. Mirch represented Dr. Sachdev. ALJ
9 Rackstraw granted the Board's Motion for a Qualified Protective Order, denied Dr. Sachdev's
10 request to exclude all patient records from the hearing, and signed a Qualified Protective Order.
11

12 The hearing occurred from October 14 to 18, 2013 and from October 21 to 25, 2013. The
13 following witnesses testified: Naina Sachdev, M.D.; Pamela Turner, M.D.; Kim Reynolds, R.N.;
14 Amanda Smith; Mary Johnson; Dorothy Ryan; Tara Lundberg; Terry Lewis, Board Investigator;
15 Richard Bitonti, former Board Investigator; Kathleen Maynez, nurse practitioner (N.P.); Natalie
16 McFall; Nancy Gaskins; Nicole Tunstall; Nichole Black; Lynnette Diller; Melissa Barnes;
17 Naveen Sachdev, M.D.; Susan Giberson; Janet Unrein; Daniel Unrein; Mellissa Aldrich;
18 Mikalan Moiso; Jennifer Scott, M.D., psychiatrist; Peter Ferraro, J.D.; Marvin Firestone, J.D.,
19 M.D.; Joseph Thaler, M.D., Board Medical Director; Stephen Holt, M.D., an expert witness for
20 Dr. Sachdev; Jeffrey Menashe, M.D., oncologist; James William Forsythe, M.D., homeopathic
21 M.D.; and Tyler Warner, Diversion Investigator with the U.S. Drug Enforcement Administration
22 (DEA).¹ The Board notes that Edward Boyko, MD, also testified in support of Dr. Sachdev.
23

24 Also present at the hearing, for varying lengths of time, were attorney Marie Mirch,
25 assistant to Mr. Mirch; Mr. McNamer, local counsel with whom Mr. Mirch associated in this
26 matter; Eric Brown, Chief Investigator for the Board; Michele Provinsal, Investigations
27 Coordinator for the Board; David Grube, M.D., Board consultant; Kathleen Haley, Board
28 Executive Director; and Kim McLain, Mary Jacks, and Jessie Brown, court reporters.
29

30 The evidentiary record closed at the conclusion of the hearing on October 25, 2013.
31

32 On October 28, 2013, ALJ Rackstraw convened a status conference via telephone. Mr.
33 Foote represented the Board. Mrs. Mirch appeared for Mr. Mirch, on behalf of Dr. Sachdev.
34 The parties agreed to present oral closing arguments on November 15, 2013, with each party
35 allowed one hour. The Board reserved the right to use part of its allotted hour for rebuttal.
36

37 After the status conference, on October 28, 2013, Mrs. Mirch requested that the parties be
38 granted at least one and one-half hours each for oral closing arguments. The Board objected to
39 the request. On October 29, 2013, ALJ Rackstraw denied the request.
40

41 On November 15, 2013, the parties reconvened at the Board's office in Portland, Oregon
42 for closing arguments. Mr. Foote represented the Board. Mr. Mirch represented Dr. Sachdev.
43 Dr. Sachdev, Mrs. Mirch, Ms. Provinsal, Mr. Brown, and Ms. McLain were also present.
44

45 ¹ Following Dr. Sachdev's multiple objections to Mr. Warner's testimony, the entire testimony was
46 stricken on the grounds that it was irrelevant, unnecessary, and exceeded the scope of the Board's
rebuttal.

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2 Also on November 15, 2013, the OAH received a written transcript of the evidentiary
3 portion of the hearing. On November 29, 2013, the OAH received a written transcript of the
4 parties' closing arguments. The hearing record closed in its entirety on that date, and ALJ
5 Rackstraw took the matter under advisement.
6

7 On June 24, 2014, ALJ Rackstraw issued a Proposed Final Order. Counsel for Dr.
8 Sachdev subsequently submitted a motion requesting an extension of time to file exceptions to
9 the Proposed Order. On July 2, 2014, the Board granted the motion requesting an extension of
10 time, so that exceptions were due by noon, August 18, 2014.
11

12 On August 18, 2014, the Board received a 326 page document entitled Exceptions to
13 Proposed Order, with 121 enumerated exceptions, and multiple attachments.
14

15 On September 4, 2014, Dr. Sachdev, accompanied by her counsel Kevin Mirch, appeared
16 before the Board and presented oral exceptions.
17

18 ISSUES

19
20 1. Whether Dr. Sachdev willfully violated the terms of the Interim Stipulated Order by
21 engaging in the practice of medicine after June 7, 2012. ORS 677.190(17); ORS 677.085.
22

23 2. Whether Dr. Sachdev committed one or more violations of the federal Controlled
24 Substances Act. ORS 677.190(23).
25

26 3. Whether Dr. Sachdev prescribed controlled substances without a legitimate medical
27 purpose, prescribed controlled substances without following accepted procedures for
28 examination of patients, and/or prescribed controlled substances without following accepted
29 procedures for recordkeeping. ORS 677.190(24).
30

31 4. Whether Dr. Sachdev engaged in unprofessional or dishonorable conduct. ORS
32 677.190(1)(a); ORS 677.188(4). Whether Dr. Sachdev committed gross negligence or repeated
33 acts of negligence in the practice of medicine. ORS 677.190(13).
34

35 5. If one or more violations are proven, whether the Board may revoke Dr. Sachdev's
36 Oregon medical license, assess a \$10,000 civil penalty, and assess the costs of the proceedings.
37 ORS 677.205(1) and (2).
38

39 EVIDENTIARY RULINGS

40 The following exhibits were offered and admitted into the record without any objections:
41

- 42 • Board Exhibits: A1 through A18 (including A17 at 44a, 45a, and 46a),
43 A20 through A72, and A76 through A93.
- 44 • Sachdev Exhibits: R1 through R3, R7, R9, R12, R15 through R44, R47,
45 R48, R53, R56 through R68, R72 through R74, R76 through R88, R94
46

1 through R96, R100, R104, R110, R111, R113, R115, R116, R123,
2 R124, R136 through R147, R150 through R152, R155 through R157,
3 R159 through R165, R168, R170 through R174, R176, R177, R179,
4 R181, R186 through R213, and R217 through R220.
5

6 The following exhibits were offered and admitted into the record over the opposing
7 party's objections:
8

- 9 • Board Exhibits: A19, A20, A81, and A94.
- 10 • Sachdev Exhibits: R180, R215, and R216.
- 11

12 The following exhibits were offered but not admitted into the record, based on the
13 opposing party's objections:
14

- 15 • Sachdev Exhibits: R114, R125, R148, R182 through R185, and R214.
- 16 • Article titled "State proposes temporary ban on most cosmetologist laser
17 use," offered by Dr. Sachdev during Closing Argument.
18

19 The following are also included in the record:
20

- 21 • Board Pleadings P1 through P8;
- 22 • Certificate of Compliance for *Pro Hac Vice* Admission for Kevin Mirch;
- 23 • Motion to Dismiss, and supporting documentation;
- 24 • Response to Motion to Dismiss, and supporting documentation;
- 25 • Motion for a Qualified Protective Order;
- 26 • Response to Motion [for] Qualified Protective Order; and
- 27 • Qualified Protective Order.
28

29 MOTION TO DISMISS 30

31
32 In her Motion to Dismiss, Dr. Sachdev moved to dismiss all Board allegations related to
33 the investigation conducted by Board Investigator Richard Bitonti. Dr. Sachdev contended that
34 Mr. Bitonti lacked adequate investigative training, that Mr. Bitonti did not conduct a thorough
35 chart review, that Mr. Bitonti threatened one or more of Dr. Sachdev's employees with criminal
36 charges to induce them to quit work for her, and that Mr. Bitonti's inadequate investigation
37 resulted in the Board filing "an improper Adverse Action Report which stated that [Dr. Sachdev]
38 was incompetent to practice medicine." Motion to Dismiss at 1-2. Dr. Sachdev argued that the
39 Board was "poisoned" by Mr. Bitonti's investigation and that "the mere filing of an Adverse
40 Action Report prior to the hearing shows improper bias." *Id.* at 3.
41

42 Along with its Answer to Licensee's Motion to Dismiss, the Board submitted an
43 Affidavit of Richard A. Bitonti and a copy of Mr. Bitonti's resume. As set forth in Mr. Bitonti's
44 affidavit and professional resume, he was a Board investigator from July 2011 to May 2013, and
45 he has more than 29 years of sworn law enforcement experience, more than 9 years of
46 supervisory/managerial law enforcement experience, and 15 years of experience relating to

1 administrative investigations. Dr. Sachdev's contention that Mr. Bitonti lacked adequate
2 investigative training is not supported by the available evidence.²
3

4 To support her contention that Mr. Bitonti failed to conduct a thorough chart review
5 when investigating her case, Dr. Sachdev provided an Affidavit of Peter E. Ferraro, former
6 counsel for Dr. Sachdev. In the affidavit, Mr. Ferraro relates that during an onsite records
7 review, Mr. Bitonti and another Board investigator did not request copies of all the patient
8 records they reviewed. Dr. Sachdev argues that Mr. Bitonti used partial files "to create his best
9 case against [her]." Motion to Dismiss at 1-2. The Board has provided evidence that Dr.
10 Sachdev was invited on multiple occasions to provide the Board with complete patient records
11 during the Board's investigation. See December 30, 2011 Bitonti letter, April 6, 2012 Bitonti
12 letter, August 24, 2012 Bitonti letter. Dr. Sachdev's contention that Mr. Bitonti improperly
13 reviewed partial files to "create his best case" against her is not supported by the available
14 evidence.
15

16 With her Motion to Dismiss, Dr. Sachdev submitted a Declaration of Mellissa Aldrich, a
17 former employee of Dr. Sachdev. In the declaration, Ms. Aldrich asserts that another employee
18 of Dr. Sachdev, Melisa Barns, reported to Ms. Aldrich that Mr. Bitonti "threatened her and told
19 her that he would file charges against her personally if she did not quit working for Dr.
20 Sachdev." Aldrich Declaration at 2. In his affidavit, Mr. Bitonti denied threatening to file
21 criminal charges against any witness or coercing or advising any witness to stop working for Dr.
22 Sachdev. He further stated that he could not recall speaking with a witness by the name of Ms.
23 Barns during the investigation involving Dr. Sachdev. Bitonti Affidavit at 2. The preponderance
24 of available evidence does not support Dr. Sachdev's contention that Mr. Bitonti threatened any
25 of Dr. Sachdev's employees or advised or coerced them to cease their employment with her.
26

27 In the Motion to Dismiss, Dr. Sachdev contended that the Board improperly reported that
28 she was incompetent to practice medicine, and that the Board's "improper filing" of the Adverse
29 Action Report caused her application for license renewal in Illinois to be denied, subjected her to
30 reciprocal discipline in Florida and California, and decimated her medical practice. Motion to
31 Dismiss at 2-3. The Board was required under 45 C.F.R. §60.8(a) to report to the National
32 Practitioner Data Bank Dr. Sachdev's interim agreement to voluntarily surrender her license.
33 According to the Adverse Action Report, the Board reported that, pursuant to an interim
34 stipulated order, Dr. Sachdev agreed to voluntarily withdraw from practice and place her license
35 in inactive status pending completion of the Board's investigation into her ability to competently
36 and safely practice medicine. Contrary to Dr. Sachdev's contention, the Adverse Action Report
37 does not indicate that the Board reported that she was incompetent to practice medicine. The
38 preponderance of the available evidence establishes that the Board acted properly and in
39 accordance with 45 C.F.R. §60.8(a) when reporting information regarding Dr. Sachdev's
40 voluntary withdrawal from practice to the National Practitioner Data Bank.
41

42 For the reasons set forth above, Dr. Sachdev's Motion to Dismiss is denied. The Board
43 affirms this ruling by the ALJ.
44
45

46 ² For additional details regarding Mr. Bitonti's professional experience, see the Hearing Transcript at
pages 965 to 971.

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FINDINGS OF FACT

Background

1. Dr. Sachdev graduated from Chicago Medical School in 1986. Her intention was to become a plastic surgeon. After completing one year of a general surgery residency at the Oregon Health and Science University (OHSU), she began a three-year general surgery residency at the University of Chicago. While in Chicago, she developed an interest in nutrigenomics.³ She did not complete the residency due to personal and family issues. (Tr. at 37, 2635-2638.)

2. Dr. Sachdev subsequently returned to Oregon and completed an internal medicine residency at Emanuel Hospital. (Tr. at 2637-2638.) In 2003, she began practicing internal medicine on a part-time basis as a solo practitioner. She saw approximately 12 patients per day. (*Id.* at 2683.) She is not board certified in internal medicine. (*Id.* at 37.)

3. While practicing internal medicine, Dr. Sachdev's interest in nutrigenomics continued, and she began studying functional medicine. (Tr. at 2638, 2640, 2652, 2671.) Functional medicine integrates traditional Western medical practices (*i.e.* allopathic medicine) with alternative medicine,⁴ and focuses on the prevention of disease through nutrition, exercise, diet, laboratory testing and other diagnostic techniques, pharmaceuticals and botanical medicines, supplements, detoxification programs, and stress-management techniques. Functional medicine utilizes a patient-centered approach to medical practice, and addresses the whole person instead of just an isolated set of symptoms. Functional medicine practitioners consider the interactions among genetic, environmental, and lifestyle factors that can influence chronic disease and influence long-term health. Practitioners look at gastrointestinal, neurotransmitter, immune, and hormonal systems and consider whether imbalances exist. Practitioners consider the biochemical individuality of each person, based on a concept of genetic and environmental uniqueness. (Exs. R191, R192, R194, R198; tr. at 2643-2646, 2650, 2661.)

4. In approximately 2003, Dr. Sachdev began training in functional medicine. She attended conferences and lectures, and she completed a functional medicine fellowship through the Academy of Anti-Aging and Regenerative Medicine. She also trained at the Institute of Functional Medicine. (Tr. at 2671, 2676-2677, 2679-2682.) She became board certified by the American Academy of Anti-Aging and Regenerative Medicine in the field of anti-aging in regenerative medicine. (*Id.* at 37-38, 181.)

³ Nutrigenomics is the study of how nutrients interact with and change gene expression. (Tr. at 2639-2640.)

⁴ Allopathic medicine is taught in traditional medical schools in the United States and Western Europe. There is a scientific basis for the treatments. Alternative medicine consists of treatments that fall outside the purview of the standard medical school curriculum, and includes such things as herbal medications, nutritional supplements, and acupuncture. (Tr. at 1810-1811.) Integrative medicine is generally defined as the combination of allopathic and alternative medicine. (*Id.* at 2602.)

1
2 5. Dr. Sachdev eventually opened the Advanced Aesthetics and Integrative Medical
3 Center (the clinic). Up until June 7, 2012, she was the medical director of the clinic. (Tr. at 38.)
4 The clinic had two parts: a “cosmetic side” and a “medical side.” (*Id.* at 501.) Dr. Sachdev
5 practiced integrative and functional medicine at the clinic.⁵ (*Id.* at 40, 2653.)
6
7
8

9 *Clinic Staff*

10
11 6. Kathleen Maynez, F.N.P., worked as a licensed family nurse practitioner at the clinic
12 from December 13, 2011 to approximately August 21, 2012. Prior to obtaining her nurse
13 practitioner license in approximately 2005, she worked as a registered nurse for approximately
14 eight years. (Tr. at 865, 890-891.) Dr. Sachdev hired Ms. Maynez to conduct wellness
15 examinations, and to see patients for acute care issues. Ms. Maynez did not initially have any
16 involvement with nutraceuticals. (*Id.* at 867.) Ms. Maynez resigned in August 2012 after
17 learning that insurance companies had informed the clinic’s biller that the companies would no
18 longer consider Ms. Maynez a credentialed provider if she continued to practice at the clinic.
19 (*Id.* at 890-891.)
20

21 7. Dorothy Ryan worked as an aesthetician at the clinic from approximately March 2012
22 to August 20, 2012. Her primary duties included performing facials, chemical peels, and laser
23 treatments. She also assisted Dr. Sachdev with the preparation and delivery of Botox treatments.
24 (Tr. at 480; Ex. A91.)
25

26 8. Patient C worked as a licensed aesthetician at the clinic from late 2009 to February
27 2012. (Tr. at 1276-77, 1287.) On February 3, 2012, Dr. Sachdev terminated Patient C’s
28 employment because of alleged issues involving Dr. Sachdev’s husband, Dr. Naveen Sachdev
29 (Dr. Naveen). (Ex. A16 at 2; tr. at 1288; *see* Ex. R1 at 7.)
30

31 9. Natalie McFall worked as an office manager at the clinic from approximately
32 February 2012 through July 2012. Her primary responsibilities included managing daily office
33 operations, implementing a new software system, increasing spa business, managing payroll,
34 ordering inventory, and training and hiring staff. (Tr. at 951-953.)
35

36 10. Mary Johnson worked as a front office supervisor at the clinic from approximately
37 March 2012 to July 31, 2012. Her duties included answering phones, interacting with patients,
38 and selling nutraceuticals to patients. (Tr. at 530, 556; Ex. A91.)
39

40 11. Nicole Tunstall worked as a laser treatment and skincare product sales consultant at
41 the clinic from approximately March 2012 to mid-August 2012. (Tr. at 944-945.)
42

43 12. Melissa Barnes worked as a medical biller at the clinic from approximately May
44 2012 to late August 2012. (Tr. at 1314-1315.)
45

46 ⁵ At hearing, Dr. Sachdev stated, “I’m an internist. I was trained as an internist. * * *. But I really am practicing functional medicine.” (Tr. at 2652-2653.)

1
2 13. Tara Lundberg worked at the clinic from March 1, 2012 to early August 2012. She
3 initially worked as a clinic receptionist, but she subsequently became a back-office medical
4 assistant (MA). Her MA duties included obtaining vitals and chief complaints from patients,
5 performing blood draws, filling prescriptions, and ordering labs at the direction of the clinic's
6 providers. (Tr. at 510-511.)
7

8 14. Amanda Smith worked as an MA at the clinic from approximately July 30, 2012 to
9 August 28, 2012. She worked directly with Ms. Maynez, and her primary responsibilities
10 included rooming patients, pulling charts, taking vitals, collecting specimens, giving injections,
11 and obtaining information from patients. (Tr. at 606-607, 608.) Dr. Sachdev terminated Ms.
12 Smith's employment due to a suspicion that Ms. Smith was leaking clinic information to the
13 Board. (*Id.* at 611-613.)
14

15 15. Patient D worked as an MA at the clinic from January 2010 to April 18, 2012. Dr.
16 Sachdev terminated Patient D's employment, but then subsequently rehired her to perform
17 aesthetician work. (Exs. A15 at 4, A91; tr. at 188-189, 959.)
18

19 16. Patient B worked as an MA at the clinic from approximately February 2010 to
20 February 2012. (Ex. R1 at 11.) Patient B quit working at the clinic shortly after, and in response
21 to, Patient C's employment termination. (Tr. at 3546.)
22

23 17. Amanda Wright began working as an MA at the clinic in June 2011. She
24 subsequently quit. (Ex. R1 at 9.)
25

26 18. Michelle Eyres began working as an office assistant/personal assistant at the clinic in
27 approximately early January 2012. (Ex. A16 at 2.)
28

29 19. Whitney Hayden worked as an MA at the clinic from August 2009 to February 2012.
30 (Ex. R1 at 12.)
31

32 *Board Investigation*
33

34 20. A licensee has a duty to provide complete medical records when requested by the
35 Board. (Tr. at 2424-2425.)
36

37 21. In a letter dated December 30, 2011, Board Investigator Richard Bitonti informed Dr.
38 Sachdev that the Board had received a complaint regarding one of Dr. Sachdev's patients
39 (Patient F). The letter identified the patient by name, and alleged that Dr. Sachdev had allowed a
40 staff person to remove skin tags on the patient. The letter further alleged that the removal caused
41 excessive scarring on the patient and that allowing a staff person to perform the procedure
42 qualified as practicing medicine without a license. The letter requested that Dr. Sachdev provide
43 the Board with the following by January 13, 2012:
44

- 45 1. A summary report on this matter, explaining in sufficient detail your
46 response to the allegation.

1
2 2. Legible copies of ALL PATIENT RECORDS you maintain on the
3 patient: Including but not limited to all Progress Notes, Consultations,
4 Diagnostic Studies, Medication Flow Sheets, Telephone Logs, and other
5 Provider records maintained in your chart.
6

7 (Ex. A1 at 1; capitalization in original; tr. at 972-973.) The letter directed Dr. Sachdev not to
8 “alter or destroy any records or materials related to the matter under investigation until such
9 point that the Board has concluded the investigation.” (Ex. A1 at 1; emphasis omitted.)
10

11 22. On or about January 23, 2012, the Board received Dr. Sachdev’s written letter
12 response to Mr. Bitonti’s December 30, 2011 letter. Dr. Sachdev’s letter stated, in part:
13

14 My records reflect that [Patient F] was seen and treated at my office on
15 April 25, 2011 and July 5, 2011. She came in for an office visit for
16 removal of skin tags. On April 25, 2011, I removed numerous skin tags
17 on her neck and anterior chest area. During the visit, my staff member,
18 Nichole Black, a licensed aesthetician, removed some of the skin tags
19 under my supervision.
20

21 At the second office visit on July 5, 2011, [Patient F] returned for
22 additional skin tags removal. No scarring or burning was noted nor did
23 the patient report any instance of scarring from her earlier treatment.
24 During this second visit, I removed all of her skin tags on her neck and
25 anterior chest area. * * * * *. There was no notification to our office by
26 the patient about any complications related to having her skin tags
27 removed until this complaint.
28

29 (Ex. A2 at 1.) Along with the letter, Dr. Sachdev provided the Board with chart notes regarding
30 Patient F. (*Id.*; see Ex. A41; tr. at 973-975.)
31

32 23. In April 2012, Mr. Bitonti and Board Investigator Terry Lewis became aware that the
33 federal Drug Enforcement Agency (DEA) was investigating Dr. Sachdev’s clinic. (Tr. at 656,
34 662.)
35

36 24. In a letter dated April 6, 2012, Mr. Bitonti informed Dr. Sachdev that the Board had
37 received a second complaint against her. The letter included the following allegations:
38

39 [D]ispensing controlled substances without an OMB certificate,
40 inappropriate or excessive prescribing/dispensing of controlled substances,
41 failure to adequately chart or document care you have provided, providing
42 substandard care, personal use of controlled substances and/or self-
43 prescribing, and refusal to treat a patient in need of care.
44

45 (Ex. A3 at 1; tr. at 980-981.) The letter requested that Dr. Sachdev provide the Board with,
46 among other things, the following by April 27, 2012:

1
2 Controlled substances inventory and dispensing logs from January 2010 to
3 present.

4
5 * * * * *

6
7 All medical records including office encounters, progress records,
8 medication lists, lab records, consults, and any handwritten or electronic
9 procedure notes for the following patients:

10 [Patients G, H, E, B, D, and C.]⁶

11
12
13 In addition to the records, please provide a brief summary of the care you
14 have provided to each of the above patients.

15
16 (Ex. A3 at 1-2; emphasis in original.) The letter directed Dr. Sachdev not to “modify, alter, or
17 destroy any records or materials related to the matter under investigation until such point that the
18 Board has concluded the investigation.” (*Id.* at 2; emphasis omitted.)

19
20 25. In a letter dated April 12, 2012, Mr. Bitonti requested that no later than 5:00 p.m. on
21 April 13, 2012, Dr. Sachdev provide the Board access to the clinic’s inventory and dispensing
22 logs “for all controlled substances you have received, dispensed and administered since January
23 1, 2010” for purposes of inspection and review. (Ex. A4; tr. at 982.)

24
25 26. By letter dated April 13, 2012, Dr. Sachdev’s then-attorney, Connie Elkins
26 McKelvey, informed Mr. Bitonti that enclosed with the letter were “the inventory and dispensing
27 logs for all controlled substances which Dr. Naina Sachdev has received, dispensed and
28 administered for the last two years.” (Ex. A86 at 1; tr. at 982, 984-986.) The letter further stated
29 that the logs “were recently compiled from contemporaneous records including purchasing
30 records and medical records.” (Ex. A86 at 1.)

31
32 27. In a letter dated May 16, 2012, Mr. Bitonti requested that no later than June 30, 2012,
33 Dr. Sachdev provide the Board with “all medical records” for herself and her husband, Naveen
34 Sachdev. (Ex. A5; tr. at 986-987.)

35
36 28. On or about May 16, 2012, the Board received Dr. Sachdev’s written letter response
37 to Mr. Bitonti’s April 6, 2012 letter. In her letter, Dr. Sachdev summarized the care she had
38 provided for Patients B, C, D, E, G, and H. (Ex. A6 at 1-10.) She also summarized the care she
39 had provided to herself. She wrote in part, “I am healthy and do not presently have a regular
40 treating physician. * * *. I now recognize and appreciate the [Board’s] position about having a
41 regular treating provider and plan to establish with a provider in the near future.” (*Id.* at 9-10.)
42 Dr. Sachdev provided the Board with chart notes regarding Patients B, C, D, E, G, and H. She
43 gave no indication to the Board that the chart notes she provided were not the complete medical
44 records for those patients. (Tr. at 981-982.)

45
46 ⁶ The letter contained the patient’s actual names, including those of two patients not involved in the
present matter. (See Ex. A3 at 2.)

1
2 29. While the Board continued its investigation, on June 7, 2012, Dr. Sachdev signed an
3 Interim Stipulated Order (ISO). (Ex. A8.) By signing the ISO, Dr. Sachdev agreed to the
4 following conditions, effective June 7, 2012:
5

6 3.1 Licensee voluntarily withdraws from the practice of medicine and her
7 license is placed in Inactive status pending the completion of the Board's
8 investigation into her ability to safely and competently practice medicine.
9

10 3.2 Licensee understands that violating any term of this Order will be
11 grounds for disciplinary action under ORS 677.190(17).
12

13 3.3 Licensee must notify the [Board] within 10 days as to how patients
14 may access or obtain their medical records.
15

16 (*Id.* at 1.)
17

18 30. In a letter dated June 12, 2012, Mr. Bitonti requested that no later than July 2, 2012,
19 Dr. Sachdev provide the Board with the following:
20

21 1. Age and diagnoses of all female patients receiving IM Testosterone[.]
22

23 2. Age and all diagnoses for all patients having Tumescant Liposuction[.]
24

25 3. A summary of the care you have provided to Naveen Sachdev, MD
26 from 2007 to current. Please identify Dr. Naveen Sachdev's other treating
27 physicians, if any, and whether or not you have consulted with them
28 regarding his care.
29

30 (Ex. A7 at 1; tr. at 987.)
31

32 31. On or about August 24, 2012, Mr. Bitonti and Mr. Lewis met with approximately
33 seven or eight former clinic employees (including Ms. Maynez, Ms. Ryan, and Ms. Johnson) to
34 give the employees an opportunity to report any concerns regarding Dr. Sachdev and/or the
35 clinic to the investigators. During the meeting, one or more individuals described conduct by Dr.
36 Sachdev that included providing patient care after June 7, 2012. (Tr. at 669-671, 717, 906-907,
37 990-991, 1098, 1313; *see* Ex. R1 at 1.)
38

39 32. In a letter dated August 24, 2012, Mr. Bitonti informed Dr. Sachdev that the Board
40 was requesting her presence for an interview by the Board's Investigative Committee on
41 September 27, 2012. (Ex. A9 at 1-3; tr. at 988.) The letter stated, in part:
42

43 Please come to the interview prepared to discuss the concerns listed above.
44 Please bring any documents, including billing records and patient charts, if
45 applicable, regarding the concerns listed above that will aid you in your
46 response to Committee questions during your interview.

1
2 (Ex. A9 at 1.)
3

4 33. In a letter dated August 28, 2012, Mr. Bitonti informed Dr. Sachdev that the Board
5 had received additional complaints against her, including allegations of inappropriate and
6 excessive prescribing of controlled substances, violations of the terms set forth in the ISO,
7 unprofessional conduct, and fraudulent billing practices. The letter requested that Dr. Sachdev
8 provide the Board with certain documents by September 11, 2012. (Ex. A10 at 1; tr. at 988-990.)
9

10 34. On September 27, 2012, the Board's Investigative Committee interviewed Dr.
11 Sachdev at the Board's office. Attorneys Marvin Firestone and Peter Ferraro represented Dr.
12 Sachdev at the interview. (Ex. A11 at 1.)
13

14 35. In a letter dated October 6, 2012, Mr. Bitonti informed Dr. Sachdev that the Board
15 was conducting an investigation into allegations that she had violated the terms of the ISO. The
16 letter provided a summary of the specific allegations and requested that by November 1, 2012,
17 Dr. Sachdev provide the Board with a written response to the allegations and a written summary
18 of her clinic activities and responsibilities since June 7, 2012. The letter also informed Dr.
19 Sachdev that the Board wished to conduct a chart inspection on or before October 12, 2012. (Ex.
20 A12 at 1-2; tr. at 997.) Mr. Bitonti and Mr. Firestone subsequently scheduled the chart
21 inspection for October 10, 2012. (Tr. at 677-678, 1975.)
22

23 36. On October 10, 2012, Mr. Bitonti and Mr. Lewis arrived at the clinic for the chart
24 inspection. (Tr. at 674-676, 998.) Mr. Ferraro was present at the clinic to help facilitate the
25 inspection. (*Id.* at 674, 998, 1975, 1991-1992.) Mr. Bitonti requested specific patient charts to
26 review, including the charts of Patients A, I, and J. (*Id.* at 998-999.) Clinic staff provided the
27 requested files to the investigators for their inspection. Mr. Bitonti thereafter requested copies of
28 the full charts for Patients I and J. He also requested a copy of at least some portion of Patient
29 A's chart. (*Id.* at 1975-1978, 1992-1993, 2247-2248, 2288.) Because the clinic's copy machine
30 was slow to produce copies, it was agreed that clinic staff would make the requested copies
31 available for Mr. Bitonti to pick up at a later date. He picked up the copies one or two days
32 thereafter. (*Id.* at 999, 2246-2247, 2288.)
33

34 37. In a letter dated October 19, 2012, Mr. Firestone responded to the allegations in the
35 October 6, 2012 letter and requested that the Board terminate the ISO and reactivate Dr.
36 Sachdev's medical license. (Ex. A13 at 1-5.) In the letter, Mr. Firestone asserted that Dr.
37 Sachdev "has fully complied with the terms of the ISO agreement and has removed herself from
38 patient care after June 7, 2012." (*Id.* at 1.) The letter stated, in part:
39

40 Dr. Sachdev acted reasonably under the circumstances and although not
41 practicing following June 7, 2012, she upheld her duty not to abandon her
42 patients. She hired physicians and staff to continue to provide care to her
43 patients. All contact with her staff with regards to patient care was general
44 in nature or, on a very limited basis, involved answering specific questions
45 about prior care in order to [e]nsure proper continuity of care. The
46 information exchanged between herself and her staff was never intended

1 to direct patient care and was only to effectuate a safe transfer of care of
2 her patients. Dr. Sachdev never intervened in any patient treatment
3 decisions.

4
5 * * * * *

6
7 [Dr. Sachdev] only made herself available to her staff to provide
8 information necessary for other care providers to provide continuity of
9 care and/or transfer of care to other providers and/or provided generalized
10 information regarding applicable treatment protocols.

11
12 * * * * *

13
14 Dr. Sachdev did not direct [] or authorize unlicensed staff to order lab tests
15 or diagnostic testing. She did ensure that already established protocols
16 were followed; no lab testing was ordered by her. For example, many of
17 her patients were required to have testing once or twice a year as per
18 protocol.

19
20 Dr. Sachdev[] used the time away from medical practice to organize her
21 chart system. If she noticed a patient was due for lab testing, she
22 reminded staff. These were all lab orders and testing that had already been
23 scheduled prior to her signing the ISO.

24
25 * * * * *

26
27 Dr. Sachdev never directed her staff to prescribe medications nor change
28 dosages of medications[.]

29
30 Dr. Sachdev may have spoken to patients when seeing them in the office
31 [and] asked patients how they were, but [she] did not convey opinions
32 about their medical care, medications and/or dosing.

33
34 * * * * *

35
36 There was one instance where, prior to a nurse practitioner performing a
37 [B]otox treatment on a patient [Patient A], Dr. Sachdev was asked about
38 the patient's past [B]otox treatment injection points because the nurse had
39 questions about the locations and doses used for the patient in the past.
40 Dr. Sachdev was asked to point out prior injection locations on the
41 patient's face where she had previously administered [B]otox treatments
42 and the amounts used in the past. Dr. Sachdev identified these locations
43 and informed the NP that she considered these locations to be a more
44 advanced treatment and warned the [NP] not to inject in those locations as
45 it was beyond the [NP]'s experience level. * * *. Dr. Sachdev's
46 involvement was merely to allow continuity of care. * * *. [A]fter

1 [e]nsuring continuity of care, Dr. Sachdev left it to the [NP] to handle and
2 left the room well before any treatment was ever undertaken.

3
4 (*Id.* at 2-4; emphasis omitted.)
5

6 38. In May 2013, Mr. Bitonti left employment with the Board. Mr. Lewis assumed
7 responsibility as the Board investigator on Dr. Sachdev's case. (Tr. at 649, 679.) Mr. Lewis did
8 not conduct any further investigation. (*Id.* at 694, 724.)
9

10 *Clinic Operations after June 7, 2012*
11

12 39. After the ISO went into effect, Dr. Sachdev ceased to be the medical director of the
13 clinic. She assumed the role of clinic manager. (Tr. at 38.) After the ISO first went into effect
14 on June 7, 2012, Dr. Sachdev came into the clinic only after business hours. She eventually
15 came to the clinic during business hours as well. (*Id.* at 531-532.) Eventually, she came to the
16 clinic on an almost daily basis. (*Id.* at 512.)
17

18 40. Ms. Elkins McKelvey informed Dr. Sachdev that she was allowed to teach, "provide
19 continuity of care," and provide patient history. (Tr. at 2616.) At hearing, with regard to
20 providing continuity of care after the ISO went into effect, Dr. Sachdev testified, in part:
21

22 What I was concerned about the most, okay, as a doctor giving up my
23 practice that * * * [with] so many high profile patients that I could – I
24 could be sued in a heartbeat.
25

26 And so a lot of them had to have blood tests. And in my chart note, let's
27 say * * * a chart note on January 12th says, "Come back. RTC for thyroid
28 function test in six to eight months[.]"
29

30 So if I was just like in the clinic doing administrative duties or on occasion
31 when I had to provide something to my attorney and I had to look at the
32 chart notes, I would flip * * * [to] my note. What did I see the patient for
33 last. And it said recheck thyroid test. And I'm like, okay, we're in August
34 now. This was supposed to be done in June and it's not been done.
35

36 So, I – again, I'd always just go ask Kathleen[,] but just tell her to read
37 this note.
38

39 * * * * *

40
41 I could direct her to read a previous note that was before my ISO. It was
42 not new. There was not one new thing that I would have ever added. I
43 simply was so afraid of getting sued by other patients.
44

45 * * * * *
46

1 And so I really tried to provide any continuity of care, if I could. If I saw
2 a chart note that said [*sic*], I said [to an MA] "Please, go tell Kathleen to
3 go – to just look at this note. Read this note. Did any provider read this
4 note?"
5

6 (*Id.* at 2817-2819.)
7

8 41. On June 18, 2012, Dr. Robert McQueen, M.D., became a part-time clinic provider.
9 (Tr. at 872; Ex. R43 at 2, 5.) Dr. McQueen was not credentialed and he did not carry medical
10 malpractice insurance when he first began working at the clinic. (Tr. at 957, 1320.) Dr.
11 McQueen began treating the majority of Dr. Sachdev's former patients who received
12 testosterone. (*Id.* at 890.) Dr. McQueen's clinic employment ended on August 21, 2012. (Ex.
13 R43 at 5.)
14

15 42. Dr. Naveen became the interim director of the clinic after Dr. McQueen left. (Tr. at
16 38-39.) Dr. Naveen is board certified in internal medicine and cardiology. At the time of the
17 hearing, he continued to work at the clinic on a periodic basis. At hearing, in response to the
18 question, "Did Dr. Naina [Sachdev] ever issue any orders to you on how certain patients were to
19 be treated," Dr. Naveen answered "No." (*Id.* at 1982-1984.)
20

21 43. After the ISO went into effect, Ms. Maynez worked increased hours at the clinic and
22 began managing the care for many patients who Dr. Sachdev had previously treated for chronic
23 conditions. (Tr. at 868-870, 957-958; Ex. R43 at 2.) Ms. Maynez noticed that some chronic pain
24 management patients did not have pain management plans in their charts, some patient charts
25 lacked documentation or imaging to support the basis for chronic pain medication, and some
26 charts lacked documentation as to how the patients were responding to the pain medication. (Tr.
27 at 870, 887-888.) Ms. Maynez also noticed that some patients for whom Dr. Sachdev had been
28 prescribing Adderall had charts that did not contain documentation to support treatment with that
29 medication.⁷ (*Id.* at 890.)
30

31 44. Ms. Maynez believed that there was a "lack of follow-up procedures" with regard to
32 prescription refills for some of Dr. Sachdev's former patients. (Tr. at 870-871.) For example,
33 Ms. Maynez noticed that some patients being treated for chronic conditions and receiving
34 prescription refills had not been into the clinic or had routine labs tests performed for an
35 extended period of time. Ms. Maynez believed that such patients required updated lab tests
36 before their prescriptions could be refilled. (*Id.* at 870-871, 877, 888.) Ms. Maynez was
37 concerned that some patients who Dr. Sachdev had been treating with thyroid supplementation
38 had thyroid testing that indicated over-supplementation, yet the patients remained on the same
39

40 _____
41 ⁷ Ms. Maynez stated at the hearing:

42 The concerns I had with patients receiving Adderall, when I looked back in the
43 charts I didn't see any full assessment that had been done. And for my practice I
44 need to have a psychological evaluation to determine in fact that that's their
45 diagnosis.
46

(Tr. at 890.)

1 supplementation dosages for as long as one year without having any repeated thyroid testing
2 conducted. (*Id.* at 889.)
3

4 45. On June 18, 2012, after the ISO had gone into effect, Ms. Maynez received a text
5 message from Dr. Sachdev, which included a forwarded text exchange between Dr. Sachdev and
6 a patient. (Tr. at 873-876; Ex. A85.) The exchange between Dr. Sachdev and the patient was as
7 follows:
8

9 Hi Dr. Naina. I hope all is progressing well with u. Keep me updated
10 please. I have one quick medical question [a]n[d] then I promise never to
11 ask u another. I just don't want to make a big mistake....The [W]ellbutrin
12 is definitely giving me energy but it does not seem to be helping my
13 severe depression. Can I add a half or whole Zoloft in half in the
14 evening... maybe replacing it with the evening Wellbutrin. It seems to be
15 much more effective for depression. Let me know. [T]hank you!!!
16

17 Yes I will let Kathleen know to do that and she will document in [yo]ur
18 chart u have added half tablet Zoloft at night[.]
19

20 Ok, thanks much!
21

22 (Ex. A85 at 1-3.) In the text message to Ms. Maynez, Dr. Sachdev wrote, "Please have [I]nna or
23 Tara document this[.] (*Id.* at 3.)
24

25 46. At hearing, Dr. Sachdev testified that she did not intend to provide treatment to the
26 patient via the text message exchange. (Tr. at 3702-3703.) She testified, in part:
27

28 [The patient] self-manipulated. This is very important. She's telling me
29 that she on her own added a Zoloft half a tablet. * * * * *. Probably had it
30 [the Zoloft] from before or something. She did it. I don't know how she
31 did it but she did it. * * * * *. I'm not involved in her care. A patient text
32 messages me. She is self-manipulated [*sic*] on her medication. * * * * *.
33

34 Now I can't practice [because of the] ISO. I have no motive. I have too
35 much to lose realizing – realize that. So what I have to do though, what's
36 coming in my mind though is I've got to get this documented. Okay.
37 She's self-manipulating. Okay. So immediately I'm already on high alert
38 I'm going to be sued by – because of all this going on by patients or
39 something. So I'm thinking, okay, she just added two medicines. No one
40 is evaluating her. You know, I've got to let – I've got to get this
41 documented to the office. Okay. So I text the patient back and I say
42 * * * * * "Yeah, I'll let * * * [K]athleen know for you to do that[.]"
43

44 I'm not telling her [to add the Zoloft tablet] – she's already done it. She's
45 already self-manipulated it.
46

1 * * * * *

2
3 If I had wanted to treat the patient, I wouldn't even forward the text on. I
4 know I have an ISO[.]

5
6 (*Id.* at 3702-3703.)
7

8 47. After the ISO went into effect, Dr. Sachdev provided Ms. Maynez and the MAs with
9 direction regarding bioidentical hormone treatments and nutraceuticals⁸ for patients.⁹ (Tr. at
10 531-532, 535.) Ms. Maynez was not trained with regard to or experienced with bioidentical
11 hormone treatment. Dr. McQueen was not always in agreement with prescribing bioidentical
12 hormones to clinic patients. (*Id.* at 533-535.)
13

14 48. On more than one occasion after the ISO went into effect, Ms. Johnson
15 communicated with Dr. Sachdev via text message regarding patient care. Ms. Johnson would
16 ask Dr. Sachdev, via text messages, what kinds of nutraceuticals to give to specific patients and
17 what dosages of hormones should be prescribed for specific patients.¹⁰ (Tr. at 532-533.)
18

19 49. On an almost daily basis after the ISO went into effect, Ms. Johnson observed Dr.
20 Sachdev discussing patient care issues—including lab results and hormone testing—with clinic
21 staff. (Tr. at 550.)
22
23
24

25 ⁸ Dr. Sachdev explained at hearing that “nutraceuticals” are vitamins and dietary supplements. (Tr. at
26 2698.) The American Association of Clinical Endocrinologists defines “nutraceuticals” as follows:
27

28 Nutraceuticals are dietary supplements that contain a concentrated form of a
29 presumed bioactive substance originally derived from a food, but now present in
30 a nonfood matrix, and used to enhance health in dosages exceeding those
31 obtainable from normal foods.
32

33 (Ex. R194 at 7.)

34 ⁹ Ms. Johnson testified at hearing that Dr. Sachdev would help the other providers by “looking over the
35 hormones and giving direction on what we were supposed to do for patients that were on specific types of
36 hormone medications.” (Tr. at 531.)
37

38 ¹⁰ Ms. Johnson testified at hearing that the clinic was “kind of short staffed so I would ask [Dr. Sachdev]
39 questions about what kind of medicine to give or what dose or if a patient has something—some kind of
40 medical condition[,] what we would give them for it.” (Tr. at 533.) Ms. Johnson further testified:
41

42 If a patient was having anxiety, let's say that, [Dr. Sachdev] would say this is the
43 medication, or if they have this diagnosis or this problem, these are the
44 nutraceuticals that you would give to them and they would take this many a day
45 or whatever the directions were.
46

(*Id.* at 597.)

1 50. On one occasion after the ISO went into effect, Dr. Sachdev reviewed several patient
2 charts to find diagnoses codes to include in a testosterone log. While doing so, she noticed that
3 some of the patients were overdue for blood work. She wrote down a list of labs that several
4 patients needed, provided that list to Ms. Johnson, and directed Ms. Johnson to have the labs
5 ordered. (Tr. at 551-552, 592, 599; *see* Ex. A87.) The list stated “need blood work,” and
6 included the names of at least four patients, along with diagnoses and requested lab tests.¹¹ (Ex.
7 A87.) Ms. Johnson did not follow through with having the labs ordered because her employment
8 ended before she could have one of the clinic providers (*i.e.* Dr. McQueen or Ms. Maynez)
9 authorize the labs.¹² (Tr. at 597-599.)

10
11 51. Dr. Sachdev discussed patient care with Ms. Lundberg on more than one occasion
12 after the ISO went into effect. For example, Dr. Sachdev would review labs for patients and then
13 tell Ms. Lundberg which labs should be ordered for the patients. (Tr. at 513-514.) Dr. Sachdev,
14 on at least one occasion after the ISO went into effect, told Ms. Lundberg which nutraceuticals a
15 patient should stop taking, based on the side effects the patient was experiencing. (*Id.* at 515.)
16 On one occasion after the ISO went into effect, Dr. Sachdev came into the clinic and told Ms.
17 Lundberg that she had just spoken with a patient in the parking lot who reported that Dr.
18 McQueen had decreased the quantity of Vicodin or Hydrocodone prescribed for the patient. Dr.
19 Sachdev told Ms. Lundberg that Dr. Sachdev knows the patient, that she knows he is in a lot of
20 pain, and that he needs a larger quantity of the medication. Dr. Sachdev instructed Ms. Lundberg
21 to relay that information to Dr. McQueen. Ms. Lundberg subsequently relayed the information
22 to Dr. McQueen. (*Id.* at 516-517.) On another occasion after the ISO went into effect, Ms.
23 Lundberg sent a text message to Dr. Sachdev relaying that a male patient was complaining of
24 symptoms of erectile dysfunction (ED). In the text, Ms. Lundberg listed the medications and
25 nutraceuticals the patient was taking and asked Dr. Sachdev whether any of them would cause
26 the ED symptoms. Dr. Sachdev responded via text message that a certain nutraceutical the
27 patient was taking, 5-HTP spray, would cause the ED symptoms and she stated that the patient
28 should discontinue it. (*Id.* at 518-519, 526-527.) In response to the information received from
29 Dr. Sachdev, the patient subsequently discontinued the 5-HTP spray. (*Id.* at 526-527.)

30
31 52. In approximately mid-July 2012, Dr. Sachdev conducted training at the clinic for Ms.
32 Ryan, Ms. Tunstall, and Ms. Maynez. During the training, Dr. Sachdev injected her own face
33 with Botox from a pre-made syringe. (Tr. at 945-947, 2815-2816.)

34
35 53. Through at least September 13, 2013, a website accessible at <<http://nainamd.com>>
36 advertised the clinic. (Ex. A84 at 1-9; Tr. at 689-691.) The website stated, in part:

37
38 Dr. Sachdev, passionately known as “Dr. Naina,” has successfully
39 established herself as a leader in the medical field in the Pacific
40 Northwest. With a thriving practice that focuses on Aesthetic, Integrative

41
42
43 ¹¹ In an interview with Mr. Bitonti on August 24, 2012, Ms. Johnson stated that Dr. Sachdev told her to
44 get the lab work done for the listed patients as soon as possible because the Board had requested the
45 charts for those patients. Mr. Bitonti noted in his Investigative Case Report that the names on the list
46 were, in fact, names on the “OMB [Board] testosterone list.” (Ex. R43 at 3, 6.)

¹² An MA cannot order a laboratory procedure or test. (Tr. at 595.)

1 and Functional Medicine, this internist and Anti-Aging expert serves as a
2 Medical Director of the Advanced Aesthetics and Integrative Medical
3 Center[.]
4

5 * * * * *

6
7 Our Medical Director, Dr. Naina Sachdev, M.D., received her medical
8 degree from the University of Chicago Medical School[.]
9

10 Among other accolades and achievements, Dr. Naina is board certified by
11 the American Academy of Anti-Aging (A4M), certified by the ACAM and
12 has completed a fellowship in functional medicine.
13

14 (Ex. A84 at 2, 4.) The website listed two “NainaMD Locations”—the clinic in Lake Oswego,
15 Oregon and the Anti-Aging and Regenerative Clinic in Beverly Hills, California.¹³ (*Id.* at 6.)
16

17 *Lake Oswego Police Investigation re: Forged Prescriptions*
18

19 54. After reviewing prescription drug monitoring program records for Dr. Sachdev, Mr.
20 Bitonti discovered that Patient D and her roommate (AR) were both listed as receiving
21 Phentermine prescriptions from Dr. Sachdev. He further discovered that the clinic had no patient
22 records for AR. Mr. Bitonti suspected that AR’s Phentermine prescriptions might be fraudulent,
23 so he reported the information to the Lake Oswego Police Department (LOPD). (Tr. at 992-995;
24 Ex. A15 at 3.) The LOPD investigated the matter and concluded that Patient D had fraudulently
25 called in Phentermine prescriptions for AR and another friend (KW), neither of whom treated
26 with Dr. Sachdev. (Ex. A15 at 3-5; *see also id.* at 6-8, 12-13.) The LOPD referred the case to
27 the district attorney’s office for review and prosecution. (*Id.* at 5, 11.)
28

29 55. On or about April 17, 2012, Patient D informed Dr. Sachdev that she was continuing
30 to take Phentermine, without Dr. Sachdev’s knowledge, and that she had called in prescriptions
31 without Dr. Sachdev’s permission. (Tr. at 3466-3467.) On April 18, 2012, Patient D met with
32 Dr. Sachdev, Ms. McFall, and Ms. Maynez. Patient D admitted to calling in prescriptions for her
33 roommate and another friend. (Ex. A15 at 4.) Patient D signed a letter, dated April 18, 2012,
34 that stated:
35

36 This letter is to confirm my acknowledgement about my concern which I
37 spoke to Dr. Naina over the phone this past weekend.
38

39 I had told her that I had called in prescriptions for phentermine for myself
40 to pharmacies without authorization from her this past year.
41

42 I will no longer call in any prescriptions without authorization from Dr.
43 Naina Sachdev.
44
45
46

¹³ Dr. Sachdev has a medical practice in California. (*See* Ex. A84 at 6; tr. at 691.)

1 I will adhere to the protocol which was already in place regarding that
2 phentermine is for short[-]term use such as three months with no refills
3 each time.
4

5 I also failed to document as Dr. Naina had asked me to do so in my chart
6 when she did sign [a] prescription for short[-]term use for myself.
7

8 (Ex. R212 at 1; tr. at 3467-3472.)
9

10 56. On April 3, 2012, Ms. Eyres called the LOPD to report that Patient C, who had
11 previously been but was no longer employed at the clinic, was suspected of forging signatures of
12 Dr. Sachdev and Ms. Maynez on Adderall prescriptions. (Exs. A14 at 2, A16 at 2.) The LOPD
13 commenced an investigation. (See Exs. A14, A16.) An LOPD officer met with Dr. Sachdev and
14 Ms. Maynez and showed them six prescriptions for Adderall filled by Patient C. Five of the
15 prescriptions (dated March 23, 2011, May 13, 2011, July 8, 2011, August 29, 2011, and
16 November 15, 2011) appeared to bear Dr. Sachdev's signature and one (dated February 6, 2012)
17 appeared to bear Ms. Maynez's signature. (Ex. A14 at 2, 7-13.) Dr. Sachdev informed the
18 LOPD officer that only the Adderall prescription dated November 15, 2011 was not her
19 signature. (*Id.* at 2, 8.) Ms. Maynez informed the officer that the signature on an Adderall
20 prescription dated February 6, 2012 was not her signature. (*Id.* at 2, 4-5; *see id.* at 9, 16; tr. at
21 912.) During an individual investigatory interview, Patient C denied ever signing prescriptions.
22 She reported that she did not know who signed the November 15, 2011 prescription, but that Ms.
23 Maynez signed the February 6, 2012 prescription. (Ex. A14 at 6.) The LOPD suspended the
24 case against Patient C for lack of evidence, and noted that the case was "pending depending on
25 medical records and further evidence." (*Id.*)
26

27 *Medical Opinions*

28

29 57. Dr. Pamela Turner, M.D., has been board certified in internal medicine since 1985.
30 After completing her residency in 1985 at the University of Massachusetts, she practiced for five
31 years in a multi-specialty group of ten physicians in McMinnville, Oregon. She then relocated to
32 Corvallis, Oregon, where she practiced at the Corvallis Clinic for 17 years. In 2008, she retired
33 from the Corvallis Clinic and moved to Portland, Oregon. Approximately six months later, she
34 began contracting with Providence Medical Group (Providence). At present, she continues
35 working as a contractor for Providence, providing immediate care at Providence Immediate Care
36 centers. (Tr. at 223-225.) While at the Corvallis Clinic, Dr. Turner served as a member of the
37 in-house peer review committee for several years, including one year as the committee chair. In
38 addition, she was a member of the peer review committee at Good Samaritan Hospital in
39 Corvallis. During her tenure on that committee, she also served as the chair for some period of
40 time. (*Id.* at 226.)
41

42 58. On June 1, 2012, the Board retained Dr. Turner as a medical consultant to review
43 patient charts for the Board's investigation regarding Dr. Sachdev. Dr. Turner ultimately
44 reviewed 17 patient charts. (Tr. at 226, 285.) Her task was to render an expert opinion as to
45
46

1 thecommunity standards for the practice of internal medicine. (*Id.* at 1639.) She prepared a
2 report for the Board, dated June 25, 2012, with her opinions.¹⁴ (*See* Ex. R28; tr. at 287.)
3

4 59. Dr. James William Forsythe, M.D., H.M.D., is a medical doctor and homeopathic
5 medical doctor. He has a background in pathology, and he is certified in internal medicine,
6 oncology, and homeopathy. Since approximately 1996, he has been practicing integrative
7 medicine, specifically integrative oncology. (Tr. at 3522-3528.) He has never been licensed to
8 practice medicine in Oregon. (*Id.* at 3535.)
9

10 60. Dr. Stephen Holt, M.D., has practiced medicine for approximately 40 years. He is
11 board certified in internal medicine, gastroenterology, and clinical nutrition. He is the author of
12 approximately 30 books, primarily regarding integrative medicine. (Tr. at 2599-2600; Ex.
13 R190.) He has never been licensed to practice medicine in Oregon. (*Id.* at 2605.)
14

15 61. Dr. Edward Boyko, M.D., is certified in and practices internal medicine.¹⁵ (Tr. at
16 2428-2429.) He has never been licensed to practice medicine in Oregon. (*Id.* at 2431.)
17

18 62. Dr. Joseph Thaler, M.D., is board certified in internal medicine. He practiced
19 internal medicine for 29 years. Between 1999 and 2005, he served as a governor-appointed
20 member of the Board. He is the current Medical Director of the Board. He has never practiced
21 alternative medicine. (Tr. at 2301-2302.)
22

23 *Patient Charts and Documentation*

24

25 63. A chart note is documentation of an office visit or phone call. Chart notes may also
26 collectively refer to a patient's medical records, including problem lists, patient questionnaires,
27 medical assistant notes, and handwritten and dictated office visit notes. (Tr. at 317-318.) A
28 patient's medical record or chart is the story of the patient's complaints, the physician's thought
29 process, and any medications prescribed or tests ordered. (*Id.* at 2305.)
30

31 64. There is a general maxim among physicians that "[I]f it is not in the chart, it didn't
32 happen." (Tr. at 237, 1688-1689, 1820.) It is a recognized standard among practicing physicians
33 in Oregon. (*Id.* at 1688-1689.)
34

35 65. The quality and accuracy of a physician's chart notes affect the physician's delivery
36 of care to patients. There are both safety and outcome issues related to the failure to adequately
37 document. Complete and accurate chart notes assist with continuity of care in the physician's
38 own practice. For example, if a patient has a different recollection from an office visit than the
39 physician, the physician can go back to the chart notes and confirm information. Complete and
40 accurate chart notes are also important because if a patient changes providers, the new provider
41 has the benefit of reviewing the patient's chart notes to understand the patient's past medical
42
43

44 ¹⁴ The Board elected not to pursue discipline against Dr. Sachdev for the thyroid concerns noted in Dr.
45 Turner's report.

46 ¹⁵ *See* Exhibit R139 for Dr. Boyko's extensive curriculum vitae.

1 history and treatment.¹⁶ Complete and accurate chart notes are also important for coordination of
2 care (*i.e.* if the physician refers a patient to a specialist or consulting physician). (Tr. at 240,
3 1816-1817, 1833.) When a physician refers a patient to a specialist or consulting physician, the
4 patient's chart should reflect that a referral was made and for what reason it was made. (*Id.* at
5 2470.)
6

7 66. A SOAP note is a chart note with four components. The first component includes
8 the patient's subjective history. The second component includes the physician's objective
9 physical examination and observations. The third component includes the physician's
10 assessment of the problem[s]. The fourth component includes the plan for treatment. (Tr. at
11 246.)
12

13 67. A physician is expected to document in a patient's chart a diagnosis and the basis for
14 the diagnosis when prescribing a specific treatment. If there is no documentation of a diagnosis
15 or how a physician arrived at a diagnosis, there is no way to ascertain whether a treatment was
16 indicated. (Tr. at 244, 2441-2442.) When a patient returns for a follow-up visit, a physician is
17 expected to document how the patient is responding to treatment, and also document the plan for
18 going forward. (*Id.* at 246-247, 2441-2442.)
19

20 68. A physician must conduct a PAR conference when prescribing medication to a
21 patient. "PAR" refers to "procedure," "alternatives," and "risks." (Tr. at 233.) This means that
22 the physician must explain to the patient the procedure (or medication being prescribed), the
23 risks associated with the procedure or medication, and any alternatives to the procedure or
24 medication.¹⁷ (*Id.*)
25
26

27
28 ¹⁶ At hearing, Dr. Thaler testified as follows with regard to charting and continuity of care:

29
30 [I]f I were taking over the practice of another physician, I would go to the
31 medical record and I would see what medications were prescribed, what the
32 diagnosis was, what tests were ordered, and then I would try to do my best job at
33 taking care of the patient. * * * * *. History should be in the chart.

34 * * * * *

35
36 [I]n your medical record should be an outline of what you're treating the patient[]
37 with, why you're treating the patient[]. * * *. What the patient's past medical
38 history is. * * *. All of that information should be there so if you're not there,
39 either on an ISO or vacation or tragically died, * * * there's some record there.

40 (Tr. at 2357-2358.)
41

42 ¹⁷ Dr. Turner explained at hearing that a physician has an obligation to discuss potential risks of a
43 prescribed medication to a patient, even though the patient will receive written materials from a pharmacy
44 that discuss risks, side effects, *etc.* In her opinion, there is a legitimate concern that patients do not read
45 written materials they are given and the package inserts that accompany prescription medications are
46 often extremely detailed and difficult to interpret. (Tr. at 342.)

1 69. The standard of care for an Oregon physician who prescribes medication with
2 potential severe side effects is for the physician to discuss the risks with the patient, obtain
3 patient consent, and note the discussion in the patient's chart.¹⁸ (Tr. at 2334.) It would meet the
4 standard for the physician to note in the chart, for example, "The potential side effects of the
5 medication were reviewed." (*Id.* at 2336-2338; *see, e.g.*, R188 at 13.) It is not necessary for a
6 physician to explain to a patient *every* potential side effect of a medication or treatment. (*Id.* at
7 2328.)
8

9 70. To meet the standard of care in Oregon, a physician who prescribes a medication for
10 off-label use must explain to the patient that what the physician is recommending is not Food and
11 Drug Administration (FDA)-approved. (Tr. at 233, 237.)
12

13 71. Lab reports, consultation reports, and other documents generated by a person or
14 entity other than the physician should be marked (by initialing or otherwise) to signify that the
15 physician has reviewed them. (Tr. at 1813-1814.) This practice standard is intended to prevent a
16 physician from missing an important document, such as a lab report. (*Id.* at 1833.) Dr.
17 Sachdev's customary practice (prior to signing the ISO) was to review labs and either initial
18 them or write "APPT" (signifying that an MA needed to schedule an appointment) if a lab was
19 abnormal or if Dr. Sachdev otherwise wanted an appointment with the patient. (*Id.* at 2710; *see*
20 *also id.* at 3733.) Dr. Sachdev's customary practice did not include initialing patient
21 questionnaire forms (*e.g.* MSQs). (*Id.* at 3732-3733.)
22

23 72. A physician has a responsibility to read through transcribed chart notes to correct
24 errors and fill in blanks before the notes become a part of the formal patient chart. (Tr. at 240,
25 1854.)
26

27 73. Dr. Sachdev's customary practice was to dictate a chart note for each patient visit.
28 (Exs. R43 at 13; tr. at 2705, 2708.) She utilized an overseas transcription company to transcribe
29 the dictated notes. (Tr. at 2706-2707; *see* Ex. R201.) The transcribed notes sometimes
30 contained blank areas, nonsensical sentences, and errors. (Tr. at 239; Exs. R43 at 13, 15; A42 at
31 1; *see e.g.* Exs. A19 at 27; A28 at 3; A35 at 2-3, 9, 14, 16; A41 at 15, 19; A55 at 40; A61 at 42-
32 43; R218.) Dr. Sachdev did not have a routine practice of reviewing, correcting, and signing off
33 on the transcribed dictations. If transcribed records had been requested by, and were being
34 provided to, another provider or entity, Dr. Sachdev would then correct the transcribed notes to
35 cure the errors or fill in blank spots.¹⁹ (Ex. R43 at 13-15; tr. at 3731.)
36

37 74. During the Board's Investigative Committee interview on September 27, 2012, Dr.
38 Sachdev responded to several questions regarding her charting. (Ex. A11 at 16.) When asked
39 whether her practice was to review, proofread, and correct her chart notes, she stated, "I do
40 normally. That's the normal standard protocol. I should be—the dictations are printed out and
41

42 ¹⁸ Dr. Thaler testified at hearing that the discussion of risks is patient-specific, and that if, for example, a
43 physician were prescribing medication to a diabetic patient that could potentially increase the patient's
44 blood-sugar level, the physician would want to fully explain that risk to the patient. (Tr. at 2338.)

45 ¹⁹ At hearing, Dr. Sachdev's attorney asked why some blank spots appeared in the dictated chart notes for
46 Patient J. Dr. Sachdev replied, in part, "If I – it's – I never went back and filled it because it was pretty
obvious to me." (Tr. at 3107-3108.)

1 I'm to review them." (*Id.*) When Board Member, Dr. McKimmy pointed out to Dr. Sachdev
2 that a dictated note for Patient E contained six blanks, Dr. Sachdev stated, "Obviously it's an
3 oversight and I—and I'm not perfect and I see that." (*Id.*) Dr. McKimmy then responded, "All
4 of the transcribed notes [for Patient E] have blanks in them and none of them have been
5 corrected." (*Id.*) When asked whether she felt that her charting for Patient D was adequate, Dr.
6 Sachdev answered, "I do. I do because I understand it. I—I can fully go through the reasoning
7 of why I did and what I did. I * * * have no problem with that." (Ex. A11 at 16.) After
8 acknowledging an incomplete dictation for Patient D, Dr. Sachdev stated, "[I]t's not that I would
9 lose sight of my reasoning if—if an incomplete dictation was there. I should still be able to
10 know the patient despite if the note was there or not. That's knowing your patients and I know
11 my patients." (*Id.*)
12

13 75. With regard to the adequacy of Dr. Sachdev's charting for the patients at issue, Dr.
14 Holt testified at hearing that "[n]o charts are perfect" and that "overall I find the level of chart
15 keeping to be satisfactory." (*Id.* at 2603, 2601.) He believes that the record keeping standards
16 articulated by Dr. Turner in this proceeding exceed those that are usual and customary in medical
17 practice. He further opined:
18

19 I believe that Dr. Turner was focusing in on certain issues that—
20 concerning documentation that were [*sic*] actually already in the chart.
21 And I was somewhat concerned that these charts have multiple areas of
22 entry of information, including progress notes, but there was also
23 coexisting service for esthetic medicine where there was some crossover
24 of information between the charts.
25

26 (*Id.* at 2602.) He opines that Dr. Sachdev practiced integrative medicine "in a good high
27 standard of care." (*Id.*)
28

29 76. Clinic staff use different colored files, depending on the type of documents being
30 stored in the files. Manila files were for regular patient charts. Red files were for integrative
31 treatments not covered by insurance (B-12 injections, for example). Purple charts were for
32 weight management treatments. Pink charts were for aesthetic treatments. Teal charts were for
33 detox treatments. Orange charts were for overseas patients. Blue charts were for out-of state
34 patients in the United States. (Tr. 2666, 2668-2670.)
35

36 77. Clinic staff use various forms at the clinic. One such form is the Medical Symptoms
37 Questionnaire (MSQ). (Tr. at 2653-2654; Ex. R196; *see also* Ex. R195.) Functional medicine
38 practitioners frequently use the MSQ as part of a patient's medical history. (Ex. R195 at 1.) The
39 MSQ contains 14 domains (*e.g.* neurological, skin, endocrine, gastrointestinal, *etc.*), each
40 containing multiple listed symptoms. A patient filling out the form assigns a number between
41 zero (never or almost never has the symptoms) and four (frequently has the symptom and the
42 effect is severe) to each symptom, based on his or her typical health profile in the past 30 days.
43 (Ex. R196 at 1-2.) Dr. Sachdev would then review the form, assess the symptoms, and look for
44 any system imbalances. (Tr. at 2661-2662.) Dr. Sachdev's customary practice was to require a
45 patient to fill out an MSQ at every office visit, unless the patient had already done so within the
46

1 preceding 30 days. (*Id.* at 58, 2659-2660.) Neither the reliability nor the validity of the MSQ
2 has been studied. (Ex. R195 at 1.)
3

4 78. Clinic staff use a form titled “Adrenal Fatigue Quick Check.” (*See* Ex. A46 at 30-31;
5 tr. at 3183.) A patient fills out the form and rates the listed symptoms on a scale of one to five,
6 with one indicating that the symptom is not a problem for the patient and five indicating that the
7 symptom is a severe problem for the patient. (Ex. A46 at 30; tr. at 3183.) The form provides Dr.
8 Sachdev with additional information that she can use to correlate if the patient appears to be
9 having hormone imbalances (including hypothalamic, pituitary, or adrenal). (Tr. at 3183.) The
10 symptoms listed on the form are not specific to one medical condition; rather, the symptoms
11 could be associated with numerous medical conditions, including ADD/ADHD, depression,
12 anxiety, or psychosis. (*Id.* at 2062-2063.)
13

14 79. Clinic staff use a form titled “Patient RX List.” (Tr. at 2664; Ex. R197.) An MA
15 checks in a patient and notes on the RX List what medications the patient is taking, including the
16 dosage and frequency. (Tr. at 1484, 2665.) Clinic staff also use a form titled “Patient
17 Nutraceutical List.” (Ex. R199.) As with the Patient RX List, an MA notes on the Patient
18 Nutraceutical List what nutraceuticals a patient is taking. (Tr. at 2700.)
19

20 80. Clinic staff uses a form titled “Progress Notes.” (Ex. R200.) An MA fills out the top
21 portion of the form, which includes the following patient information: name, date of birth, date
22 of last service, date of last history and physical/wellness exam, allergies, blood pressure,
23 temperature, weight, height, body mass index (BMI), tobacco use, hormone replacement therapy,
24 date of last saliva test, and chief complaint. (*See id.*; tr. at 2703-2705.) In addition to dictating
25 the entire office visit, Dr. Sachdev would write certain notes from the visit on the patient’s
26 Progress Notes form. (Tr. at 2705.)
27

28 81. Clinic staff uses a form titled “Nutraceuticals Protocol.” (Ex. R202.) An MA fills
29 out the top portion of the form, which included the patient’s name, last date of service, and date
30 of birth. (*See id.*; tr. at 2713.) Dr. Sachdev would fill out the remainder of the form. Under the
31 heading “Nutraceuticals,” she would note any new nutraceuticals being prescribed, as well as
32 whether she was changing or stopping any previously prescribed ones. Under the heading
33 “Protocol,” she would note new medications or changes to medications, including hormone
34 creams. Under the heading “Over the Counter Medications,” she would specify what type[s] of
35 over the counter vitamins or medications she recommended. Under the heading, “Diets,” she
36 would note any recommendations or changes with respect to diet. (Tr. at 2713-2714.) Clinic
37 protocol was for each patient to leave the clinic with his or her own copy of the protocol form.
38 (*Id.* at 2715.)
39

40 82. Clinic staff uses a form titled “Patient Medical Health Problem List (Long-Term).”
41 (*See* Ex. A32 at 1.) Clinic protocol is to fill out and place the form at the front of each patient
42 file. (Tr. at 3447-3448.)
43

44 83. Prior to prescribing Adderall to a patient for the treatment of attention-deficit
45 disorder or attention-deficit/hyperactivity disorder (ADD/ADHD), Dr. Sachdev would have the
46 patient fill out a short self-screening questionnaire titled “Adult Self-Report Scale-V1.1 (ASRS-

1 V1.1) Screener.” (See Ex. A19 at 89; tr. at 240-241, 2059, 3548.) The ASRS-V1.1 Screener
2 states, in part:
3

4 The following questionnaire can be used as a starting point to help you
5 [the patient] recognize the signs/symptoms of Adult ADHD but it is not
6 meant to replace consultation with a trained healthcare professional. An
7 accurate diagnosis can only be made through a clinical evaluation.
8 Regardless of the questionnaire results, if you have concerns about
9 diagnosis and treatment of Adult ADHD, please discuss your concerns
10 with your physician.
11

12 (Ex. A19 at 89.) The ASRS-V1.1 Screener contains six questions,²⁰ and it directs the patient to
13 check the appropriate box for each question, based on how the patient has felt and conducted
14 himself or herself for the past six months. (*Id.*)
15

16 84. Prior to prescribing Adderall to a patient, Dr. Sachdev would also have the patient
17 fill out a longer questionnaire titled “Adult ADHD-RS-IV with Adult Prompts.” (See Ex. A19 at
18 90-91; tr. at 241, 3549.) This longer form states, in part:
19

20 [This form] is an 18-item scale based on the DSM-IV-TR criteria for
21 ADHD that provides a rating of the severity of symptoms. The adult
22 prompts serve as a guide to explore more fully the extent and severity of
23 ADHD symptoms and create a framework to ascertain impairment.
24

25 The first nine items assess inattentive symptoms and the last 9 items assess
26 hyperactive-impulsive symptoms. Scoring is based on a 4-point Likert-
27 type severity scale: 0 = none, 1 = mild, 2 = moderate, 3 = severe.

28 * * * * *. Significant symptoms in clinical trials are generally considered
29 at least a “2” – moderate.
30

31 (*Id.* at 90-91.)
32

33 85. When prescribing bioidentical hormones (including testosterone) to patients, Dr.
34 Sachdev had the patients sign a form titled “Informed Consent.” (Tr. at 72; see Ex. A19 at 93-
35 94.) The form states, in part:
36

37 I hereby consent to the drawing of blood, an overall Bio-Identical
38 Hormone Replacement Therapy (hereinafter, “Hormone Therapy”)
39 treatment regimen, other hormone replacement therapies, laboratory
40 procedures, medical or surgical treatment or any other diagnostic or
41 therapeutic treatment or services rendered to me by the staff of * * * Naina
42 Sachdev M.D. Inc (hereinafter, NSMDInc) under the general or special
43 instructions of the physician.
44

45 ²⁰ For example, the first question asks, “How often do you have trouble wrapping up the final details of a
46 project, once the challenging parts have been done?” (Ex. A19 at 89.) Each question has the following
possible responses: never; rarely; sometimes; often; and very often. (*Id.*)

1
2 * * * * *

3
4 Where medication[s] are prescribed including, but not limited to, Bio-
5 Identical Hormones, I am aware and understand that these medications
6 have the potential for side effects due to individual variations.
7

8 * * * * *

9
10 I understand that no medication is risk-free during pregnancy. I am aware
11 that I am not to risk pregnancy while on medication. If I feel I might
12 become pregnant, I will not start medication until all my doctors have
13 spoken to me. If I become pregnant, I will alert my doctors immediately.
14

15 * * * * *

16
17 I understand that Hormone Therapy is not indicated for all persons
18 because of various medical conditions, individual variations, or use of
19 certain medications. I am aware that NSMDinc will inform me if the
20 medical history that I have provided would either postpone or prevent
21 treatment.
22

23 * * * * *

24
25 By signing this Informed Consent, I hereby represent that I have read,
26 understand, accept, and agree to the foregoing; received copy thereof; and
27 am personally empowered, or am duly authorized by the patient as the
28 patient's general agent, to execute the above.
29

30 (Ex. A19 at 93-94.) The form does not specify that certain medications, such as testosterone,
31 may be prescribed for off-label use. The form also does not specify the risks associated with
32 particular medications, such as topical testosterone, IM testosterone, and Adderall. (*See id.*)
33

34 *Controlled Substances – Generally*

35
36 86. Adderall (amphetamine salts) is a Schedule II controlled substance. (Tr. at 242; 21
37 C.F.R. §1308.12(d)(1).) Percocet (oxycodone and acetaminophen) and OxyContin (oxycodone)
38 are also Schedule II controlled substances. (21 C.F.R. §1308.12(b)(1)(xiii).) A written
39 prescription is required to fill Schedule II controlled substances. Those prescriptions cannot be
40 filled via phone. (Tr. at 242, 1818.)
41

42 87. Testosterone is a Schedule III controlled substance. (21 C.F.R. §1308.13(f)(1).)²¹
43 Vicodin (hydrocodone) is also a Schedule III controlled substance. (Tr. at 339; 21 C.F.R.
44 §1308.13(e).)
45

46 ²¹ See 21 C.F.R. §1300.1(b) (defining an anabolic steroid as “any drug or hormonal substance, chemically
and pharmacologically related to testosterone”).

1
2 88. The following are Schedule IV controlled substances:
3

- 4 • Xanax (alprazolam) (21 C.F.R. §1308.14(c)(2).)
- 5 • Valium (diazepam) (21 C.F.R. §1308.14(c)(16).)
- 6 • Soma (carisoprodol) (21 C.F.R. §1308.14(c)(2).)
- 7 • Ambien (zolpidem) (21 C.F.R. §1308.14(c)(53).)
- 8 • Phentermine (21 C.F.R. §1308.14(f)(9).)
- 9 • Lunesta (eszopiclone) (21 C.F.R. §1308.14(c)(53)

10
11 89. Standard of care dictates that when a patient begins taking prescribed controlled
12 substances, the physician should have one or more follow-up visits with the patient in short
13 intervals. Once the patient is on a stable medication regimen, it is reasonable for the physician to
14 have clinical follow-up visits approximately every six months. (Tr. at 1817.) A clinical follow-
15 up would include an office visit where the physician evaluates and documents how the patient is
16 responding to the medication[s], including whether the patient is experiencing any side effects.²²
17 Documentation that merely indicates that a patient is doing “fine” is insufficient because it does
18 not address the symptoms that caused the physician to make the diagnosis, and it does not
19 indicate which symptoms have improved, how the medication is being tolerated, or whether
20 there have been side effects. (*Id.* at 1819.)
21

22 *Controlled Substances – Adderall to Treat ADD/ADHD*
23

24 90. The only FDA-approved uses for Adderall include 1) treating ADD/ADHD in
25 children and 2) narcolepsy. All other uses are considered off-label. (Tr. at 2043.)
26

27 91. The *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text*
28 *Revision (DSM-IV-TR)* is widely accepted in the medical community. (Tr. at 247.) The DSM-
29 IV-TR sets forth the diagnostic criteria for mental disorders. According to the DSM-IV-TR, an
30 ADHD diagnosis requires that a person have at least six of nine listed symptoms for at least six
31 months to a degree that is maladaptive or inconsistent with developmental level, with impairment
32 from the symptoms present in two or more settings (*e.g.* work, home, or school). (*Id.* at 248,
33 1807; *see Diagnostic and Statistical Manual of Mental Disorders* 92-93 (4th ed, text revision
34 2000); Ex. R157 at 3.)
35

36 92. Symptoms of ADD/ADHD include symptoms of inattention, procrastination,
37 disorganization, and inability to complete tasks. (Tr. at 2056; Ex. R157 at 4.) Approximately 50
38 percent of the time, ADD is comorbid with other conditions—for example, depression, anxiety,
39 bipolar disorder, Tourette’s syndrome, obsessive-compulsive disorder, and sleep disorder. (Tr. at
40 2052-2053; Ex. R157 at 6.)
41
42
43
44

45 ²² For example, a follow-up visit for a patient taking Adderall should include a physical examination to
46 ensure that the patient’s blood pressure and pulse are not elevated by the medication. (Tr. at 1819.)

1 93. Assessment of ADD/ADHD symptoms can be complicated by the nonspecific nature
2 of the symptoms, and by their resemblance to impairments that occur in other disorders. For
3 example, inattentive symptoms associated with ADD/ADHD might resemble concentration
4 impairments that occur in PTSD, anxiety, or major depressive disorder. (Ex. R157 at 6.)
5

6 94. Prior to arriving at an ADD/ADHD diagnosis for a patient, Dr. Boyko recommends
7 that the patient see a mental health professional. (Tr. at 2435.)
8

9 95. Dr. Jennifer Scott, a board-certified psychiatrist, treats adult ADD/ADHD in her
10 private practice.²³ (Tr. at 2034-2035.) Prior to rendering a mental health diagnosis, Dr. Scott
11 obtains a written history of a person's mental health problems and past treatment. She uses a
12 basic anxiety screen and a basic depression screen. She conducts an initial office visit of one
13 hour and 15 minutes. She also requests records from other practitioners. It may take her several
14 visits before she can make a determination/diagnosis. (*Id.* at 2051-2052.) She considers the
15 clinical interview with a patient to be the most important part of assessing a person. (*Id.* at
16 2048.) If she sees ADD/ADHD indicators, she will have the person complete the Adult Self-
17 Report Scale. (*Id.* at 2048, 2053.) She considers the scale a "starting point." (*Id.* at 2060-2061.)
18

19 96. Clinicians use various rating scales and screening forms when assessing a person for
20 ADD/ADHD. (Tr. at 2047-2048; Ex. R157 at 6-8.) The scales and forms can provide valuable
21 information to the clinician, but they should not constitute the only basis on which to make an
22 ADD/ADHD diagnosis. (Tr. at 1455, 1659; *see* Ex. R157 at 3, 5-6.)
23

24 97. A 2009 article titled "ADHD in Adults: Update for Clinicians on Diagnosis and
25 Assessment" appeared in *Primary Psychiatry*. (Ex. R157.) The article states, in part:
26

27 The clinical evaluation and interview are essential to the diagnosis of
28 ADHD in adults. This includes discussion regarding patient recall of any
29 childhood symptoms of ADHD. Current symptoms and their impact on
30 work, home, and social functioning should also be explored. Clinicians
31 should assess the patient's family history and observable impairments of
32 family members, including disorganization, job/financial instability, and
33 alcohol/substance use disorders. Rating scales * * * can be useful in
34 gathering information from patients regarding childhood and current
35 symptoms. If possible, a collateral interview with a family member during
36 the assessment can provide valuable information that the patient may not
37 self[-]report. Alternatively, a family member may complete an ADHD
38 rating scale as an observer to complement and confirm the patient's
39 symptoms and impairment report.
40

41 * * * * *

42
43 During clinical evaluation, symptoms assessment is essential but not
44 sufficient to diagnose this disorder. The chronicity and pervasiveness of
45
46

²³ Dr. Scott and Dr. Sachdev have referred patients to one another over the years. (Tr. at 2035.)

1 ADHD symptoms, as well as impairment due to ADHD symptoms, are
2 critical to the correct diagnosis of ADHD in adults.

3
4 (*Id.* at 3, 9.)
5

6 98. In Dr. Turner's opinion, the ADD/ADHD screens that Dr. Sachdev uses in her
7 practice are good tools. However, Dr. Turner believes that basing an ADD/ADHD diagnosis on
8 the screens alone does not constitute an adequate diagnostic evaluation. (Tr. at 1659.) In Dr.
9 Turner's opinion, an adequate clinical evaluation for ADD/ADHD should include consideration
10 of the patient's functioning in different spheres of life, how the patient's symptoms affect that
11 functioning, historical information regarding the patient's functioning in school,²⁴ whether the
12 patient received an ADD/ADHD diagnosis during childhood (and, if so, on what basis), what
13 medications the patient may have previously taken for ADD/ADHD, and whether the patient has
14 any comorbid conditions (*e.g.* anxiety, depression). (*Id.* at 1457-1458, 1488, 1492.)
15

16 99. There are two "black box"²⁵ warnings for Adderall. (Tr. at 242.) One warning is
17 regarding cardiovascular events, including risks of sudden death and stroke, and warns that
18 patients need to be evaluated for cardiovascular disease before being prescribed Adderall. The
19 other warning is regarding potential abuse and the possibility of dependency. Contraindications
20 to taking Adderall include breastfeeding, hypertension, hyperthyroidism, and glaucoma. (*Id.*)
21

22 *Controlled Substances – Phentermine*

23
24 100. Phentermine is a stimulant medication. Risks of the medication include elevated
25 blood pressure and heart rate, heart palpitations, anxiety, restlessness, tremulousness, insomnia,
26 and addiction. (Tr. at 234, 252, 2445.) Phentermine is contraindicated for patients with cardiac
27 disease, hypertension, hyperthyroidism, glaucoma, pregnancy, or a history of drug abuse. (*Id.* at
28 234.)
29

30 101. In Oregon, a physician may initiate treatment with Phentermine for the purpose of
31 weight reduction if one of the following conditions exist: (1) Patient's body mass index exceeds
32 30 Kg/M sq for patients with a body mass index (BMIs) greater than 27; or (2) Patient's body
33 mass index exceeds 27 Kg/M sq and the excess weight represents a threat to the patient's health
34 (as with hypertension, diabetes, or hypercholesterolemia.)". (OAR 847-015-0010(2)(a)(A), (B);
35 tr. at 231.) The FDA has approved the short-term use of Phentermine for up to three months.
36 (Tr. at 232.) Under **OAR 847-015-0010(3)**, Phentermine may be prescribed for longer than three
37 months if certain criteria are met. Such use would be considered "off label." (Tr. at 234-235;
38 *see* **OAR 847-015-0010(3)**.)
39

40
41
42 ²⁴ At hearing, Dr. Turner explained that it is rare for ADD/ADHD to suddenly appear in adulthood. (Tr.
43 at 1457.)
44

45 ²⁵ A "black box" warning signifies that there are serious risks associated with the medication. (Tr. at
46 237.)

1 *Controlled Substances – Testosterone*

2
3 102. The FDA has approved the use of topical testosterone creams for men.
4 Testosterone creams come with a “black box” warning. (Tr. at 237.) There is a serious risk of
5 inadvertent spreading of testosterone cream from the patient’s skin to the skin of a woman or
6 child, which could result in serious harm to the woman or child.²⁶ (*Id.* at 237, 1662.)
7

8 103. The FDA has not approved the use of testosterone (topical or intramuscular) to treat
9 low libido or low energy in women. (Tr. at 236.) However, there is a growing consensus in the
10 medical community regarding the beneficial use of testosterone for post-menopausal women.
11 (*Id.* at 293-294, 302, 1642; *see* Ex. A92.) The use of testosterone to treat sexual dysfunction in
12 pre-menopausal women is not a widely accepted practice and it is not considered a “standard
13 treatment.” (Tr. at 294, 302-303, 1809-1810.) In Dr. Forsythe’s opinion, there are no known
14 harmful effects associated with treating pre-menopausal women with low doses of testosterone.
15 (*Id.* at 3530-3531, 3533.)
16

17 104. In Dr. Forsythe’s opinion, there are no known adverse effects associated with
18 prescribing testosterone to a patient with multiple myeloma. He believes that testosterone could
19 help build the red blood cells in anemic patients with multiple myeloma. (Tr. at 3530, 3533.) He
20 believes that multiple myeloma has been “quite responsive to the integrative therapies.” (*Id.* at
21 3529.)
22

23 105. Testosterone therapy for women carries the following risks: masculinization
24 (which may include change/lowering of voice and facial hair growth); menstrual cycle effects;
25 risk to the fetus if a person becomes pregnant; and a theoretical risk of endometrial and breast
26 cancer. (Tr. at 2326-2327, 2446.) In addition, side effects from too much testosterone can
27 include insomnia, tremor, shakiness, irritability, palpitations, anxiety, bloating, and belching.
28 (*Id.* at 3539.)
29

30 106. In Dr. Thaler’s opinion, when prescribing testosterone to pre-menopausal women,
31 the physician should warn the patient about risks to a fetus, inquire as to what birth control
32 method[s] the patient is using, ask whether the patient understands the importance of birth
33 control during the therapy, and chart the discussion. (Tr. at 2328-2329.) Given the risks that
34 testosterone poses to a fetus, Dr. Turner believes that a physician should have pre-menopausal
35 women take a pregnancy test prior to starting testosterone therapy. (*Id.* at 1810.)
36

37 107. A 2003 article titled “Transdermal Testosterone Therapy Improves Well-Being,
38 Mood, and Sexual Function in Premenopausal Women” appeared in *Menopause: The Journal of*
39 *the North American Menopause Society*. (Ex. R177.) The article discussed a study of
40 premenopausal women, between the ages of 30 and 45 years, with low libido and low
41 testosterone levels who undertook topical testosterone therapy. The testosterone therapy resulted
42 in improved well-being, mood, and sexual function in the study participants. (*Id.* at 1-2, 4, 6-8.)
43

44 ²⁶ The potential harm to women includes acne, androgen pattern balding, clitoral enlargement, lowering of
45 HDLs, and raising of LDLs. The potential harm to children includes those listed for women, as well as
46 bone maturation. (Tr. at 238.)

1
2 108. A 2005 article titled “Testosterone Therapy in Women: A Review” appeared in the
3 *International Journal of Impotence Research*.²⁷ (Ex. A92.) The article discusses the use of low-
4 dose testosterone therapy to improve sexual functioning (including libido, sexual desire, arousal,
5 frequency, and satisfaction) in post-menopausal women. The authors conclude that, based on
6 numerous controlled clinical trials, the use of such therapy is efficacious for the treatment of low
7 libido and sexual dysfunction in post-menopausal women who are adequately estrogenized. (*Id.*
8 at 1, 8-9.) The article recommends that monitoring of testosterone therapy in women include
9 assessment of the therapy’s efficacy and its side effects. (*Id.* at 7.) The article states that
10 “[w]omen who elect to receive androgen therapy must be fully informed of the risks and benefits
11 of therapy and that they are engaging in off-label use of this medication.” (*Id.* at 8; tr. at 1674.)
12

13 *Controlled Substances – “office stock”*

14
15 109. A patient prescription history report from Oregon’s Prescription Drug Monitoring
16 Program shows that Patient C filled prescriptions for hydrocodone-acetaminophen 5-325
17 (Vicodin) and diazepam 5 mg (Valium) on December 12, 2011, at the Rite Aid pharmacy located
18 around the corner from the clinic. The prescription was written under Patient C’s name, and the
19 prescribing physician is listed as Dr. Sachdev. The same patient prescription history report
20 shows that Patient B filled a prescription for oxycodone-acetaminophen 5-325 (Percocet) on
21 December 12, 2011, at the same Rite Aid pharmacy. The prescription was written under Patient
22 B’s name, and the prescribing physician is listed as Dr. Sachdev. (Ex. A88 at 1-6; tr. at 1011,
23 1014-1019; *see also* Ex. A89 at 2-3.)
24

25 110. On December 12, 2011, Dr. Sachdev performed a tumescent liposuction procedure
26 on Patient H. (Ex. A55 at 21-32.) Patient D assisted Dr. Sachdev with the surgery. (Ex. A55 at
27 21.) A document titled “Surgery Data,” dated December 12, 2011, states that Patient H received
28 5 mg of Valium at 3:45 p.m. and one Percocet tablet at 5:14 p.m. (Ex. A55 at 21.)
29

30 111. An undated document references the “discharge” of Patient H. (Ex. A55 at 39.)
31 The document notes that the patient’s blood pressure was 94/60, that her pulse was relaxed, and
32 that she took four tablets of oxycodone-acetaminophen 5-325 (*i.e.* Percocet). (*Id.*)
33

34 112. During the September 27, 2012 Investigative Committee interview, Dr. Sachdev
35 informed the committee that she has never kept narcotics (including office stock) at the clinic,
36 and that she expected liposuction patients to have their own pain medications. (Ex. A11 at 16-
37 17.) She further stated:
38

39 I do recall an incident where I was in a procedure. The patient needed
40 pain medication. I looked to my staff and I said, “Where’s her pain
41 meds?” And they said they would get it. Obviously, the patient didn’t
42 bring it. I assumed that they were going to call the prescription in the
43

44
45 ²⁷ At the hearing, Dr. Sachdev often referred to the article as the “Cedars-Sinai article.” The article’s
46 authors are both listed as being associated with the Department of Medicine, Internal Medicine,
Endocrinology at Cedars-Sinai Medical Center. (*See* Ex. A92 at 1.)

1 patient's name. After the fact, I have learned in review of what has
2 happened to me that did not happen.

3
4 * * * * *

5
6 It was called in on my name.

7
8 (*Id.* at 17.) In response to the question, "Were there narcotics, prescriptions called in under
9 employees' names and then brought back to the office?" Dr. Sachdev told the committee the
10 following:

11
12 [W]hen I terminated [Patient C] on February 3rd of 2011, she said, "I want
13 my pain meds thrown out." That was the first time I became aware that
14 there was [*sic*] pain medications on the premises that she had and they
15 were in her name and, apparently, all the office staff thought that I kn[e]w
16 about it.

17
18 (*Id.*)

19
20 113. At hearing, in response to the question "[D]id you ever request that any staff
21 members fill prescriptions at a pharmacy and bring the medications back to the clinic[] so you
22 could later use them for patients," Dr. Sachdev answered "No." (Tr. at 3700-3701.) Dr. Sachdev
23 further testified that she did not perform liposuction procedures often enough to justify having
24 Patients B and C each obtain 60 tablets of medication to be used as office stock for those
25 procedures. (*Id.* at 3700.)

26
27 114. Ms. Wright informed Mr. Bitonti during an interview on March 21, 2012 that Dr.
28 Sachdev wanted to have a supply of pain medications at the clinic because she was starting to
29 perform Smart Liposuction procedures. Ms. Wright further reported that Dr. Sachdev wrote
30 prescriptions for Vicodin and OxyContin to several members of her clinic staff to fill at the local
31 pharmacy. She reported that the staff filled the prescriptions, they returned the medications to
32 the clinic, and the medications were subsequently used on patients. (Ex. R1 at 10.)

33
34 115. Patient B informed Mr. Bitonti during an interview on March 22, 2012 that Dr.
35 Sachdev wrote her a prescription for Norco or OxyContin and directed her to have it filled at the
36 Rite Aid in Lake Oswego. Patient B reported that she filled the prescription and brought it back
37 to the clinic, where it was stored for use on surgical patients. She also reported that Dr. Sachdev
38 wrote prescriptions to other employees for the same purpose. (Ex. R1 at 12.)

39
40 116. Ms. Hayden informed Mr. Bitonti during an interview on March 21, 2012 that Dr.
41 Sachdev wrote pain medication prescriptions to Ms. Black and to Ms. Capusan for them to fill at
42 the Rite Aid pharmacy in Lake Oswego. She reported that the medications were thereafter kept
43 on hand at the clinic and given to patients needing pain medication. (Ex. R1 at 12.)

44
45 117. Patient C informed Mr. Bitonti during an interview on April 18, 2012 that she filled
46 a prescription for pain medication written by Dr. Sachdev so that the medication could be used at

1 the clinic for “office stock.” (Ex. R1 at 12-13.) She admitted to Mr. Bitonti that she knew the
2 practice was illegal, and that upon the termination of her employment, she emptied the contents
3 of the bottle bearing her name and took the bottle with her. (*Id.* at 13.)
4

5 118. It is against the standard of care for an Oregon physician to request or allow an
6 employee to fill a prescription in the employee’s name and then use the medication as office
7 stock for clinic patients. Transfer of medication from one patient to another is against the
8 standard of care. If a physician wants to have office stock to administer to patients during clinic
9 procedures, the physician should order the medication, store it appropriately in a locked cabinet,
10 and log that it is at the clinic. Before using the medication on a patient, the physician should
11 enter an order to use the medication on the patient, take the medication out of stock, log what has
12 occurred, and then administer it to the patient. (Tr. at 1829-1830.)
13

14 *Controlled Substances – Logs and Storage*
15

16 119. The clinic uses a computer software system called Lytec to maintain patient
17 records, including records of testosterone injections and nutraceutical sales. (Tr. at 541, 546.)
18

19 120. Federal Drug Enforcement Administration (DEA) investigators made two visits to
20 the clinic. (Tr. at 537.) The first visit occurred on April 12, 2012. The purpose was to inspect
21 controlled substances logs and storage areas at the clinic and to conduct an inventory audit. The
22 investigators were unable to conduct the inspection and audit that day because Dr. Sachdev (or
23 someone on her behalf) denied the investigators clinic access. The DEA thereafter obtained a
24 Civil Inspection Warrant from a federal judge. (Ex. R1 at 13.)
25

26 121. Prior to and at the time of the first DEA visit, bioidentical hormone creams and
27 Lunesta, a sleep medication and controlled substance, were stored in an unlocked cabinet in a
28 back office at the clinic where the MAs worked. (Tr. at 537-538, 581-584.) Prior to and at the
29 time of the first DEA visit, the only controlled substance log physically available for inspection
30 was a handwritten log of testosterone injections, and it was not up-to-date. At the time of the
31 first DEA visit, there was no existing log with regard to the clinic’s Lunesta supply. (*Id.* at 539.)
32

33 122. After the first DEA visit, Ms. Johnson was directed to create Excel spreadsheet logs
34 for the testosterone injections, other bioidentical hormones, and Lunesta.²⁸ (Tr. at 539, 553,
35 570.) She created the Excel spreadsheets using information that was printed from the Lytec
36 system, with handwritten notations and tallies added to the Lytec print-outs, and with
37

38
39 ²⁸ At hearing, Ms. Johnson testified that she could not remember if the instruction to create the logs came
40 from Dr. Sachdev or from Ms. McFall. (Tr. at 539, 565.) Ms. Johnson further testified:

41 I was to create logs in Excel spreadsheets of everything. All the bioidentical
42 hormones, the Lunesta that we could remember but we had never written down.
43 The prior MAs had never written down where or who they gave them to so we
44 didn’t have any logs for those but I was to create logs for the injections and
45 everything else.
46

(*Id.* at 539.)

1 supplemental information (e.g. diagnosis codes and patient addresses) she obtained from looking
2 at patient charts. (*Id.* at 558, 570, 596.)
3

4 123. After the first DEA visit, Ms. Johnson created an Excel spreadsheet titled “Female
5 Testosterone Injection Log with Diagnosis Codes.” (Tr. at 540-541; Ex. A66 at 1-2.) The data
6 in the spreadsheet came from both the available handwritten logs of testosterone injections and
7 from a print out of records in the Lytec system. (Tr. at 541.)
8

9 124. After the first DEA visit, the MAs counted the injectable testosterone that the clinic
10 had in stock at the time. Ms. Johnson reviewed invoices showing quantities of injectable
11 testosterone that the clinic had received from Central Drug. (Tr. at 542.) Using that combined
12 information, Ms. Johnson created an Excel spreadsheet titled “Inventory Control Log,” which
13 showed the quantity of injectable testosterone that should have been at the clinic as of the date
14 the log was created. (*Id.* at 541-542; Ex. A67 at 1-2.)
15

16 125. After the first DEA visit, Ms. Johnson created an Excel spreadsheet titled
17 “Controlled Substance Log, Testosterone PKT 100 MG/ML,” which showed testosterone in
18 syringes that was provided to patients. (Ex. A68 at 1; tr. at 543.) She also created an Excel
19 spreadsheet titled, “Controlled Substance Log, Testosterone 100 MG/ML,” which showed
20 testosterone cream that was provided to patients. (Ex. A68 at 2-3; tr. at 543.) She also created
21 an Excel spreadsheet titled, “Controlled Substance Log, Testosterone 2 MG/ML,” which showed
22 testosterone cream that was provided to patients. (Ex. A69 at 1-22; tr. at 546-547.) She also
23 created an Excel spreadsheet titled, “Controlled Substance Log, Testosterone Injection Female,”
24 which showed testosterone injections that were provided to female patients. (Ex. A68 at 5-19; tr.
25 at 543-544.) Ms. Johnson created the spreadsheets after an MA printed out a report from the
26 Lytec system. (Tr. at 546.)
27

28 126. By letter dated April 13, 2012, Ms. Elkins McKelvey informed Mr. Bitonti that
29 enclosed with the letter were “the inventory and dispensing logs for all controlled substances
30 which Dr. Naina Sachdev has received, dispensed and administered for the last two years.” (Ex.
31 A86 at 1.) The letter further stated that the logs “were recently compiled from contemporaneous
32 records including purchasing records and medical records.” (*Id.*) During one or more
33 conversations with Ms. Elkins McKelvey, she informed Mr. Bitonti that the clinic records used
34 to compile the logs were in existence, but simply not in log form. (Tr. at 1071-1074.)
35

36 127. On April 13, 2012, the DEA conducted its second visit to the clinic. DEA
37 investigators found that the clinic’s controlled substances were secured and that dispensing logs
38 were present. (Ex. R1 at 13.)
39

40 128. With regard to controlled substances logs, Dr. Sachdev informed the Board’s
41 Investigative Committee on September 27, 2012, that such logs were “readily available” when
42 the DEA came to her clinic in April 2012. (Ex. A11 at 17.) She further stated:
43

44 Had they given me a chance to just print it out, I would have been able to
45 print it out. Instead my legal counsel [at that time] said [“no”]. And—and
46

1 I was told to—three days that I had to come up with—comply with the
2 handwritten logs. They were in the computer.

3
4 (*Id.*)

5
6 *Patient A*

7
8 129. On December 28, 2011, Patient A had a laser Genesis facial treatment performed at
9 the clinic. (Ex. A17 at 40-41; tr. at 2806.) On March 22, 2012, Patient A had a Botox treatment
10 at the clinic. (Ex. A17 at 42-44A; tr. at 2807.) A “Botox Treatment Form” dated March 22,
11 2012 includes a diagram of the face with handwritten notations indicating how many units of
12 Botox were injected into each area of Patient A’s face. (Ex. A17 at 44A.) According to the
13 diagram, she received a total of 43 Botox units, primarily in the forehead area. (*Id.*)
14

15 130. Sometime prior to July 25, 2012, Patient A indicated on a clinic “Skin Typing”
16 form that her face reacted normally to the sun and that she rarely burned. (Ex. A17 at 35.) On
17 another clinic form, she checked a box to indicate that she did not sunburn easily. (*Id.* at 38.)
18

19 131. On July 25, 2012, Patient A came to the clinic for Botox treatment. Dr. Sachdev
20 went into the treatment room and spoke with Patient A. Dr. Sachdev then directed Ms. Ryan to
21 perform a laser Genesis facial treatment on Patient A, prior to Patient A receiving Botox. Patient
22 A had not been scheduled to receive a laser treatment that day. Ms. Ryan noticed that Patient
23 A’s facial skin appeared tan with a small amount of underlying redness. Based on her previous
24 experience and training, Ms. Ryan believed that it was improper to use a laser on tanned skin.
25 She also believed that it was improper to perform a laser treatment on skin immediately before or
26 after Botox treatment because the heat in the skin from the laser treatment could make the Botox
27 travel to unintended areas. Despite her concerns, Ms. Ryan performed laser treatment on Patient
28 A. Dr. Sachdev was not present during the laser treatment. (Tr. at 483-486.)
29

30 132. An average Genesis laser treatment requires 2,000 to 3,000 laser pulses. Ms. Ryan
31 wanted to be conservative when performing the laser treatment on Patient A that day, given her
32 tanned skin and upcoming Botox treatment. Prior to starting the laser treatment, Ms. Ryan asked
33 whether Dr. Sachdev wanted her to use “500 pulses or so” on Patient A, to which Dr. Sachdev
34 responded that Ms. Ryan should use 2,000. (Tr. at 485.) Ms. Ryan commenced the laser
35 treatment on Patient A. After approximately 350 pulses, Ms. Ryan determined that Patient A’s
36 skin was not tolerating the treatment well. Ms. Ryan stopped the laser treatment at that time.
37 Ms. Ryan then went and got Ms. Maynez, who was going to perform the Botox treatment on
38 Patient A. (*Id.* at 485-486.)
39

40 133. Prior to Ms. Maynez performing the Botox treatment on Patient A, Dr. Sachdev
41 modified the amount of Botox units to be administered and the positioning of the Botox
42 injections.²⁹ (Tr. at 486, 496; *compare* Ex. A17 at 44A with *id.* at 45A.)
43
44

45
46 ²⁹ At hearing, Ms. Ryan testified, in part:

1
2 134. At hearing, in response to the question of whether she instructed Ms. Maynez on
3 how much Botox to provide to Patient A, Dr. Sachdev testified, in part:
4

5 [I] did not instruct her. [W]hen I came in the room [Ms. Maynez] was
6 nervous, so I said, * * * “Well, look at your chart. Look at what we – look
7 at [what] you’ve been taught. Look at your – these ones.”
8

9 So she looked at – I pointed this out in [Patient A’s] chart. [I said, “Make
10 sure you are looking at your nerves, the – right here, how the nerves come
11 up and how the muscles are,” and then this document here on page 46A.
12 And I said, “Look at the notes you took [during the Botox training]. So
13 what are you supposed to do?”
14

15 And then I said, you know, that’s the chart notes. I said, you – I taught
16 you this. It’s going to be okay. I kind of reassured her. I said, “I know
17 you know how to do it.” And then I left[.]
18

19 (Tr. at 2824-2825.)
20

21 135. On September 14, 2012, Mr. Bitonti interviewed Patient A. Patient A reported that
22 she had been slightly sunburned when she underwent laser and Botox treatment on July 25,
23 2012. She also informed Mr. Bitonti that Ms. Maynez was uncertain as to where to place the
24 Botox needle on July 25, 2012, and that Dr. Sachdev told Ms. Maynez where to do so by
25 pointing to the spot where the needle needed to be placed. (Ex. R43 at 5; tr. at 1133, 2243.)
26

27 *Patient B*
28

29 136. Patient B began treating with Dr. Sachdev in November 2004. (Tr. at 3545-3546;
30 see Ex. A19 at 1-2.) Dr. Sachdev eventually hired Patient B to work as an MA at the clinic. (Tr.
31 at 3545.)
32

33 137. During a November 15, 2004 office visit, Patient B complained of headaches and
34 irregular menstrual periods. She was 16 years old at the time. (Ex. A19 at 2.) A November 15,
35 2004 progress note states that Patient B was experiencing occipital and frontal pressure,
36 lightheadedness, issues with hot and cold, and an inability to think clearly and concentrate. (Ex.
37 A19 at 1.)
38

39 138. In a chart note dated January 31, 2005, Dr. Sachdev noted that Patient B continued
40 to have irregular menstrual periods. (*Id.* at 6.) In a chart note dated August 22, 2005, Dr.
41 Sachdev noted that Patient B’s menstrual periods had become “fairly regular.” (*Id.* at 7.) In a
42

43 Kathleen [Maynez] was determining how many and in what areas and Dr.
44 Sachdev modified how many units in certain areas or what areas to place it in or
45 not to place it in.
46

(Tr. at 496.)

1 chart note dated September 8, 2006, Dr. Sachdev noted that Patient B was experiencing
2 insomnia, irregular menstrual periods, severe premenstrual (PMS) symptoms, and cold sweats.
3 Dr. Sachdev ordered laboratory testing. (*Id.* at 17.)
4

5 139. The lab results showed that Patient B was anemic, that she had an “extremely high”
6 free testosterone level of 25, and a “very high” dihydrotestosterone level of 278. (Ex. A19 at
7 19.) Her free testosterone level was elevated to nearly three times the normal level. (Tr. at
8 1503.)
9

10 140. On September 22, 2006, Patient B saw Dr. Sachdev to discuss the results of her lab
11 work. In the corresponding chart note, Dr. Sachdev stated, in part:
12

13 She does not have hirsutism and at this point there is still a possibility of
14 polycystic ovary disease, but I am not going to pursue this until I first start
15 her on Yasmin OCPs and I am also going to put her on nutrition protocol
16 to reduce her DHT and free testosterone levels and see how she does. I
17 suspect when we do so, her acne[] will significantly clear up.
18

19 (*Id.*)
20

21 141. In Dr. Turner’s opinion, having learned of Patient B’s abnormally high testosterone
22 level, Dr. Sachdev should have taken a history, performed a physical exam, and ordered imaging
23 studies to rule out an androgen-producing ovarian tumor. Dr. Sachdev did not take a history,
24 perform a pelvic exam, or order any imaging studies. (Tr. at 249, 1503, 1643-1644; *see* Ex.
25 A19.) Dr. Sachdev did not order another recheck of Patient B’s testosterone level for nearly five
26 years.³⁰ (Tr. at 249, 1503; *see* Exs. A19, A21.)
27

28 142. In chart notes dated January 25, 2006, May 12, 2006, June 13, 2006, and September
29 22, 2006, Dr. Sachdev noted that Patient B had continuing issues with acne. (Ex. A19 at 11, 13,
30 14, 19.)
31

32 143. In a chart note dated September 9, 2007, Dr. Sachdev noted that Patient B
33 complained of headaches, fatigue, insomnia, anxiety attacks, and hot flashes. Dr. Sachdev
34 diagnosed Patient B with “[h]eadaches/dizziness/anxiety/panic attacks/generalize[d] anxiety/mild
35 depression.” (Ex. A19 at 25.) Dr. Sachdev believed that Patient B was deficient in serotonin,
36 and she elected to start her on 10 mg of Lexapro per day. (*Id.* at 24-25.)
37

38 144. In a chart note dated October 8, 2007, Dr. Sachdev noted that Patient B “is doing
39 much better on Lexapro.” (Ex. A19 at 27.) Dr. Sachdev further noted:
40

41 She is not having the highs and lows in terms of her mood. She is more
42 upbeat. She has been able to go to school and is feeling more motivated.
43

44 ³⁰ In its notice, the Board did not allege any violations with regard to Dr. Sachdev’s treatment (or lack
45 thereof) of Patient B’s abnormally high testosterone level in 2006. That issue will therefore not be
46 addressed in this decision.

1 * * *. She is less emotional about everything. So, definitely the Lexapro
2 seems to be working well for her. * * * * *. She has had no headaches,
3 no palpitations, no chest pain, no shortness of breath, and no belly pain.³¹
4

5 (*Id.*)
6

7 145. In a chart note dated July 21, 2008, Dr. Sachdev noted that Patient B had been
8 taking oral contraceptives for dysmenorrhea, and that her dysmenorrhea had resolved with their
9 continued use. She also noted that Patient B was no longer taking Lexapro and that the patient
10 was “feeling good.” (Ex. A19 at 31.) She also noted that she planned to check the patient’s
11 CBC due to the patient’s history of anemia and current complaints of fatigue. (*Id.* at 31-32.)
12

13 146. In a chart note dated October 23, 2009, Dr. Sachdev noted that Patient B was again
14 experiencing dysmenorrhea, despite her continued use of oral contraceptives. (Ex. A19 at 37.)
15 The dysmenorrhea continued, accompanied by abdominal pain. In November 2009, Dr. Sachdev
16 referred Patient B to a gynecologist to rule out endometriosis. (*Id.* at 40.)
17

18 147. On September 1, 2010, Patient B saw Dr. Sachdev regarding a complaint of
19 paresthesias. The chart note for that visit states that the patient was experiencing, among other
20 things, a significant amount of stress, as well as fatigue and sluggishness. (Ex. A19 at 43.)
21

22 148. An MSQ dated September 1, 2010 indicates that Patient B was experiencing
23 frequent severe insomnia, fatigue, and sluggishness; frequent non-severe faintness; occasional
24 severe anxiety, fear, and/or nervousness; and occasional non-severe acne. The form also
25 indicates that the patient was experiencing various significant digestive tract and joint/muscular
26 symptoms. (Ex. A19 at 83-84.)
27

28 149. An MSQ dated November 29, 2010 indicates that Patient B was experiencing
29 frequent severe fatigue, sluggishness, apathy, lethargy, restlessness, and weakness/tiredness;
30 frequent non-severe vomiting, insomnia, hair loss, chest pain, irregular heartbeat, rapid heartbeat,
31 and anxiety, fear, and/or nervousness; occasional severe mood swings; and occasional non-
32 severe acne. (Ex. A19 at 85-86.)
33

34 150. A November 29, 2010 progress note states that Patient B complained of fatigue,
35 insomnia, palpitations, irritable bowel syndrome (IBS), and mood swings. (Ex. A19 at 45.) The
36 record does not contain a transcribed chart note for November 29, 2010. (*See Evidentiary*
37 Record.)
38
39
40

41 ³¹ The chart note twice makes reference to Patient B taking the antidepressant Zoloft, and under the
42 heading “A/P” recommends that Patient B continue with 50 mg of Zoloft per day. (Ex. A19 at 27.)
43 Patient B’s medical file contains evidence that her insurance plan would not pay for Lexapro and that Dr.
44 Sachdev prescribed Zoloft for the patient beginning September 12, 2007. (*Id.* at 53, 63, 65.) Patient B’s
45 chart notes do not, however, reference the change in medications (*see generally* Ex. A19), and the
46 conflation of the two medications in the October 8, 2007 dictated note makes it difficult to determine
 which medication[s] she was actually taking at the time.

1 151. On or about March 7, 2011, Patient B signed Dr. Sachdev's standard "Informed
2 Consent" form. (See Ex. A19 at 93-94; tr. at 3561.) On or about that date, Dr. Sachdev started
3 Patient B on progesterone. (Tr. at 3562.)
4

5 152. A March 8, 2011 progress note indicates that Patient B complained of fatigue and
6 lack of energy. The note also indicates that the patient "thinks she is getting sick." (Ex. A19 at
7 46.) The record does not contain a transcribed chart note for March 8, 2011. (See Evidentiary
8 Record.)
9

10 153. On March 23, 2011, Patient B filled out the short ADHD screening form (Adult
11 Self-Report Scale), and the longer ADHD questionnaire (Adult ADHD-RS-IV with Adult
12 Prompts). (Ex. A19 at 89-91; tr. at 67, 3547-3549.) On the longer questionnaire, "3" (indicating
13 "severe") is circled for the following items: difficulty sustaining attention in activities; doesn't
14 listen; can't organize; easily distractible; forgetful in daily activities; on the go, "driven by a
15 motor;" and intrudes/interrupts others. (Ex. A19 at 90-91.)
16

17 154. The record does not contain a progress note, a transcribed note, or an MSQ for
18 March 23, 2011. (See Evidentiary Record; tr. at 3558.)
19

20 155. Dr. Sachdev prescribed Adderall to Patient B from March 23, 2011 to at least
21 September 2011. (Exs. A19 at 52, A22 at 1-4; tr. at 3577-3578.) Patient B's chart notes do not
22 contain any documentation as to the efficacy of the Adderall treatment. (Tr. at 248; see Ex.
23 A19.)
24

25 156. At the hearing, with respect to her determination that Patient B had ADHD and her
26 decision to prescribe Adderall to the patient, Dr. Sachdev testified, in part:
27

28 [E]arly on I did think that she probably had something because I saw her
29 working. She had some issues. But I'm not – I'm going to treat her other
30 comorbid conditions. So I was more interested in like seeing if she's –
31 maybe anemia might be the cause. Maybe is she depressed? In the past, I
32 did treat her with antidepressants. She was a very complex patient.
33 Always tired.
34

35 (Tr. at 3556.)
36

37 157. On June 28, 2011, Dr. Sachdev ordered laboratory work for Patient B. She wrote
38 the following diagnosis codes for the order: anemia; fatigue; and dysmenorrhea. (Ex. A19 at 48;
39 tr. at 3560.)
40

41 158. On June 29, 2011, Patient B's lab results showed that she had low levels of DHEA
42 sulfate (117.6), free testosterone (< 0.04), and total testosterone (10), and high levels of sex
43 hormone-binding globulin (> 200). The test results also showed that Patient B's serum ferritin
44 levels were low. (Ex. A21 at 23; tr. at 3565-3567.)
45
46

1 159. The use of oral contraceptives increases a woman's level of sex hormone-binding
2 globulin. This, in turn, binds up testosterone and results in lower free testosterone levels. (Tr. at
3 1666, 3565-3567; Ex. A92 at 2-3.) DHEA is a precursor to testosterone; low levels of DHEA
4 sulfate make it difficult for a person to make testosterone. (*Id.* at 3565-3567.)
5

6 160. The record contains no chart notes that discuss the June 29, 2011 lab results. (*See*
7 Ex. A19.)
8

9 161. A low level of free testosterone is not necessarily an indicator that a patient needs
10 testosterone supplementation. (Tr. at 1668-1670; *see* Exs. A77 at 2, A92 at 3, R160 at 7-8.) The
11 authors of the article "Transdermal Testosterone Therapy Improves Well-Being, Mood, and
12 Sexual Function in Premenopausal Women" recommend that oral contraceptive users who are
13 experiencing side effects from low testosterone try another contraceptive method, rather than
14 adding testosterone therapy. (Ex. R177 at 7.)
15

16 162. In approximately July 2011, Patient B informed Dr. Sachdev that she had low libido
17 and that it was affecting her relationship with her significant other. (Tr. at 3563-3564.)
18

19 163. On July 21, 2011, Dr. Sachdev began prescribing topical testosterone to Patient B.
20 (Ex. A19 at 92; tr. at 3570.) The only document in the record that notes this prescription is a
21 Nutraceutical Protocol dated July 21, 2011. (Ex. A19 at 92; *see id. generally.*)
22

23 164. On November 21, 2011, Dr. Sachdev ordered additional lab work for Patient B.
24 (Ex. A19 at 50.) On November 22, 2011, Patient B's lab results showed that Patient B still had
25 low free testosterone (< 0.08) and total testosterone (23), and high levels of sex hormone-binding
26 globulin (> 200). (Ex. A21 at 25; tr. at 3574.)
27

28 165. Dr. Sachdev determined that the topical testosterone was not effective in increasing
29 Patient B's testosterone levels. (Tr. at 3574.) The record does not contain any chart notes or
30 progress notes that reference the ineffectiveness of the topical testosterone. (*See* Ex. A19.)
31

32 166. In late 2011, Dr. Sachdev gave Patient B a test dose response of 10 mg of injectable
33 testosterone.³² (Ex. A20 at 1; tr. at 3574.) The patient's response to the injection was merely
34 "okay." (Tr. at 3574.) Dr. Sachdev elected not to continue with testosterone injections for
35 Patient B. However, when the patient was "still not doing well" in January 2012, Dr. Sachdev
36 gave the patient another test dose response of 10 mg of injectable testosterone on January 27,
37 2012. (Ex. A20 at 1; tr. at 3574.)
38

39 167. Patient B's medical records contain no chart notes or progress notes that outline the
40 need for Patient B to begin IM testosterone therapy. The medical records also contain no follow-
41 up documentation as to the efficacy of the treatment and whether Patient B experienced any side
42 effects. (*See* Ex. A19; tr. at 249, 1644-1645, 2325-2326.) The medical records contain no
43

44 ³² At hearing, Dr. Sachdev testified that this occurred on December 7, 2011. (Tr. at 3574.) However, an
45 Injection Log shows that Patient B received her first testosterone injection on November 29, 2011. (Ex.
46 A20 at 1.)

1 documentation that Dr. Sachdev informed the patient of the potential risks and side effects
2 specifically associated with testosterone, or that she relayed the “black box” warning. (Tr. at
3 237-238, 249, 1660-1662, 2325-2326; see Ex. A19.)
4

5 *Patient C*
6

7 168. On July 8, 2010, Patient C, who was 38 years old at the time, began treating with
8 Dr. Sachdev. The patient complained of worsening menstrual period cycles, dysmenorrhea,
9 intestinal pain, heartburn, muscle aches, weakness, fatigue, excessive weight, restlessness, and
10 insomnia. Dr. Sachdev obtained the patient’s relevant medical history, which became a dictated
11 chart note dated July 8, 2010. In the chart note, Dr. Sachdev discussed Patient C’s previous
12 issues with painful menstrual cycles, cervical cancer, chronic myelogenous leukemia (CML),
13 weight gain, and pregnancies. Dr. Sachdev also noted that Patient C had multiple surgical
14 procedures (related to cholecystitis, bile leak peritonitis, intraabdominal abscesses, and a
15 perforated liver) during her mid-30s, which ultimately resulted in Patient C being hospitalized
16 for 35 days. (Ex. R217 at 1-2.) The chart note states, in part:
17

18 She was in the hospital for 35 days and then was finally discharged in a
19 stable condition after being on multiple antibiotics and heavy duty pain
20 medications[.] She then at that point had to deal with getting off
21 painkillers. Obviously, she developed addiction to that and so she has
22 slowly weaned herself off, which she did over the next course of about
23 two and a half weeks.³³
24

25 (*Id.* at 2.)
26

27 169. On an Adrenal Fatigue Quick Check form dated July 8, 2010, Patient C indicated
28 that she had significant issues (*i.e.* a rating of at least “3” on a “0” to “5” scale) with regard to
29 difficulty getting up in the morning (3),³⁴ digestion problems (5), having to keep moving or else
30 getting tired (3), and getting a second wind in the evening and staying up late (4). (Ex. A28 at
31 5.) Of the symptoms on that list that Patient C indicated she experienced, the following can be
32 indications or symptoms of ADD/ADHD: difficulty getting up in the morning (3), thoughts
33 being less focused/brain fog (2), poor memory (1), and feeling overwhelmed by all that needs to
34 be done (1). (Tr. at 3654-3656; Ex. A28 at 5.)
35

36 170. On an MSQ form dated July 8, 2010, Patient C indicated that she experienced,
37 among other things, frequent non-severe insomnia, flushing/hot flashing, and hyperactivity;
38 frequent severe canker sores and excessive weight issues; and occasional severe restlessness.
39 (Ex. A28 at 6-7.)
40
41
42
43

44 ³³ At hearing, Patient C denied any history of overusing narcotic pain medication. (*Id.* at 1279.)
45

46 ³⁴ Each number in parentheses refers to the rating that Patient C accorded to the particular symptom/issue.
(See Ex. A28 at 5.)

1 171. The following symptoms on the MSQ can be indications or symptoms of
2 ADD/ADHD: hyperactivity, restlessness, learning disabilities, difficulty making decisions, and
3 poor comprehension and concentration. (Tr. at 3658-3662; Ex. A28 at 6-7.)
4

5 172. At the hearing, with regard to Patient C's previous issues with painkillers, Dr.
6 Sachdev testified, in part:
7

8 [O]bviously, she developed an addiction to that and so she has slowly
9 weaned herself off at the age of 30, which over the next – over the next
10 course at home was two and a half weeks.
11

12 So in medicine, commonly, when you have a two and a half weeks
13 complicated by surgical, [*sic*] all surgeons know that. You've got
14 complications for a surgery, and if you give pain medications, they know
15 that you have to wean off and you can wean off in about two and a half to
16 three weeks. That's a very special situation. That's not somebody that
17 you can really say [*is*] overusing narcotic pain medicines. I wouldn't –
18 when she gave me this history, I did not – my reasoning was that I did not
19 consider her an over[-]user of pain – narcotic pain medication. It is when
20 they continue to use that. It's when they continue to confess to you that,
21 you know, yeah, I continue to use this or I'm on chronic pain medicines[.]
22

23 (Tr. at 3674-3675.) Dr. Sachdev did not consider Patient C to be at risk of overusing medication
24 at that time. (*Id.* at 3675.)
25

26 173. On an MSQ form dated August 5, 2010, Patient C indicated that she experienced,
27 among other things, frequent non-severe insomnia and restlessness; frequent severe excessive
28 weight issues; and occasional non-severe hyperactivity and fatigue. (*Id.* at 9-10.)
29

30 174. On August 5, 2010, Patient C had a follow-up visit with Dr. Sachdev regarding her
31 severe metamenorrhagia, premenstrual issues, and fatigue. Based on Patient C's test results and
32 continuing symptoms, Dr. Sachdev determined that the patient had thyroid dysfunction and
33 adrenal fatigue.³⁵ Dr. Sachdev decided to initiate Levoxyl for the thyroid, a gut-healing regimen,
34 and vitamin D replacement therapy. (Ex. R218.)
35

36 175. A progress note dated November 4, 2010 states that Patient C was following up
37 with Dr. Sachdev after a hospital emergency room visit. (Ex. R77 at 690.) The record contains
38 no dictated chart note for November 4, 2010. (*See* Exs. R77, A28.)
39

40 176. On April 25, 2011, Patient C treated with Dr. Sachdev. The patient complained of
41 abdominal pain for the previous five days. Given Patient C's medical and surgical history, Dr.
42 Sachdev determined that further evaluation, including a CT scan, was necessary. (Ex. R77 at
43 691.)
44

45 ³⁵ While it appears from the August 5, 2010 chart note that Dr. Sachdev diagnosed Patient C with a third
46 condition, the dictated note is incomplete. (*See* Ex. R218 at 1) (“I think she has got thyroid dysfunction
issues, adrenal fatigue and she _____[.]”).

1
2 177. Patient C's medical file contains an undated ASRS-V1.1 Screener filled out by
3 Patient C. (Ex. A28 at 17; tr. at 3664-3665.) Patient C's medical file also contains an undated
4 Adult ADHD-RS-IV with Adult Prompts questionnaire that indicates the patient has severe
5 issues with regard to 16 of the 18 ADHD symptoms listed therein. (Ex. A28 at 18-19; tr. at
6 3666.)
7

8 178. Sometime in early or mid-2011, Dr. Sachdev began prescribing Adderall to Patient
9 C. (See Exs. A14 at 2, 7-13; A28 at 21; tr. at 81-82, 1279-1282, 3682-3683, 3686, 3689, 3691-
10 3692, 3694-3695.)
11

12 179. On June 9, 2011, Patient C presented to Dr. Sachdev with complaints of a rash. In
13 the corresponding chart note, Dr. Sachdev stated that the patient reported having "a lot of boils,
14 fluid filled like lesions, which are more like impetigo type lesions around her neck, face and the
15 groin area and also underneath her arms." (Ex. R77 at 00692.) Dr. Sachdev recommended blood
16 work and a diabetes screen. In the chart note, Dr. Sachdev also noted that the patient's
17 abdominal pain had improved and that, based on a surgical consult, her abdominal issues were
18 believed to be the result of adhesions. (*Id.*)
19

20 180. On June 23, 2011, Patient C had a follow-up visit with Dr. Sachdev to review blood
21 test results. The patient continued to complain of fatigue, abdominal issues, rashes, and acne.
22 Dr. Sachdev determined that she should optimize Patient C's thyroid function, initiate targeted
23 amino acid therapy and iron replacement therapy, and start her on an alternative treatment
24 regimen to treat her progesterone levels. (Ex. R77 at 00693.)
25

26 181. On August 9, 2011, Patient C had a follow-up visit with Dr. Sachdev to discuss her
27 infection issues. Dr. Sachdev noted that the patient continued to have facial lesions, general
28 malaise symptom, and fatigue. (Ex. R77 at 00695.)
29

30 182. The "Patient Medication List" for Patient C lists 10 mg of Adderall on April 25,
31 2011, October 26, 2011, and November 17, 2011. (Ex. A28 at 21.)
32

33 183. On October 26, 2011, Patient C had a follow-up visit with Dr. Sachdev. The
34 corresponding chart note states under "Past Medical History" that Patient C "was addicted to
35 pain medication." (Ex. A28 at 1; tr. at 1808.) The chart note indicates that Patient C complained
36 of edema, fatigue, headaches, gastrointestinal issues, hyperactivity, restlessness, chills, insomnia,
37 mood swings, easy bruising, swollen glands, and cold intolerance. Dr. Sachdev opined that
38 Patient C's fatigue and edema were due to her thyroid not being optimized. (Ex. A28 at 1.) On
39 an MSQ form dated October 26, 2011, Patient C indicated that she experienced, among other
40 things, frequent severe insomnia, canker sores, easy bruising, and cold intolerance; and frequent
41 non-severe UTIs and swollen glands. (*Id.* at 11-12.)
42

43 184. On November 17, 2011, Patient C presented to Dr. Sachdev with complaints of
44 dysuria and right ear pain. The corresponding chart note states under "Past Medical History"
45 that Patient C had, among other things, "ADHD" and a "[h]istory of narcotic addiction,
46 secondary to all the above complications and then she weaned herself off." (Ex. A28 at 2.) This

1 chart note is the only document in the record that mentions ADHD with regard to Patient C. (See
2 Exs. A28, A29.) On an MSQ form dated November 17, 2011, Patient C indicated that she
3 experienced, among other things, frequent severe insomnia, chills, cold intolerance, and edema;
4 and frequent non-severe hyperactivity, restlessness, and swollen glands. (Ex. A28 at 14-16.)
5

6 185. The record contains no chart notes or progress notes that document Dr. Sachdev
7 prescribing Adderall to Patient C. Similarly, the record contains no chart notes or progress notes
8 that indicate why the medication was prescribed and how the patient responded to the treatment.
9 (See Ex. A28; tr. at 251.)
10

11 186. A history of drug addiction is a "black box" warning for Adderall because the
12 medication can be addictive. In Dr. Turner's opinion, prior to prescribing Adderall to a patient
13 with a history of narcotic addiction, a reasonable physician would perform a drug screen to
14 ensure the patient was no longer using narcotics. (Tr. at 1808-1809.) In a patient with a history
15 of drug addiction, there are other classes of drugs that may be more appropriate to treat a
16 diagnosis of ADD/ADHD. (*Id.* at 1497.)
17

18 *Patient D*
19

20 187. On March 1, 2011, Dr. Sachdev began treating Patient D. (Ex. A32 at 2; tr. at
21 3450.) An MSQ dated March 1, 2011 indicates, in part, that Patient D was experiencing frequent
22 non-severe acne and excessive weight; occasional severe fatigue and water retention; and
23 frequent severe food cravings, compulsive eating, and binge eating/drinking. (Ex. A32 at 20-21.)
24 A clinic MA handwrote the following on a progress note, dated March 1, 2011:
25

26 This is a new patient. She is looking to establish care with you as the
27 primary care physician.
28

29 [The patient] is complaining of fatigue in the morning. She has a very
30 hard time getting out of bed as well as bringing her weight down. [She]
31 also has just discovered that she is positive for HPV.
32

33 (*Id.*; tr. at 3451.) The MA also noted that Patient D's height was five feet and six and three-
34 fourths inches, and her weight was 143.7 pounds. (Ex. A32 at 2.) On the same form, Dr.
35 Sachdev noted the patient's family history and menstrual history. Dr. Sachdev also noted a
36 review of the patient's systems. Dr. Sachdev diagnosed Patient D with fatigue and menstrual
37 disorder, and she ordered lab tests for the patient. (Tr. at 3451-3452; see Ex. A32 at 2.)
38

39 188. On March 11, 2011 Patient D saw Dr. Sachdev for a follow-up regarding her lab
40 results. An MA noted on a progress note that Patient D's height was five feet and six and three-
41 fourths inches, and her weight was 143 pounds. (Ex. A32 at 3.) A March 11, 2011 chart note
42 states the following:
43

44 HPI: The patient is here for follow[up] of her blood work and fatigue. As
45 per last visit mentioned, every other period[] she has been having horrible
46 cramps 33 to 36 days apart which was never the case and then she is also

1 having really fatigue issues. She is here for follow[up] of her test results.
2 She is a poor T4 to T3 converter and low normal vitamin D levels. She
3 also has had _____.³⁶
4

5 (*Id.* at 4.) On a Nutraceutical Protocol form dated March 11, 2011, Dr. Sachdev listed
6 testosterone cream, along with the recommended dosage and instructions for use, under the
7 section titled "Protocols." (*Id.* at 22.)
8

9 189. Patient D's medical records contain no chart notes or progress notes that discuss the
10 indications for prescribing testosterone cream (*i.e.* topical testosterone) to Patient D. (*See Ex.*
11 A32 at 1-90; tr. at 2445.) The medical records also contain no documentation that Dr. Sachdev
12 relayed the "black box warning" regarding testosterone cream to the patient. (*See Ex.* A32 at 1-
13 90; tr. at 253.)
14

15 190. On April 7, 2011, Patient D underwent a body composition analysis, which showed
16 that her total body weight of 139.1 pounds included 33.3 pounds of body fat.³⁷ (*Ex.* A32 at 65.)
17 A May 9, 2011 body composition analysis showed that her total body weight of 144.4 pounds
18 included 37.3 pounds of body fat. (*Id.* at 66.)
19

20 191. In approximately June 2011, Dr. Sachdev began to notice that Patient D was binge
21 eating at work. One or more patients commented to Dr. Sachdev about Patient D eating such
22 things as potato chips while working with patients. When Dr. Sachdev subsequently asked
23 Patient D about the eating behavior, the patient stated that she thought maybe her hormones were
24 "all messed up." (Tr. at 3458-3459, 3489-3490.)
25

26 192. On June 16, 2011, Dr. Sachdev ordered follow-up lab testing for Patient D to check,
27 among other things, Patient D's testosterone level. (*See Ex.* A32 at 5; tr. at 3541-3542.)
28

29 193. Between March 11, 2011 and July 21, 2011, Patient D gained six pounds. (Tr. at
30 3489; *see Ex.* A32 at 3, 6.)
31

32 194. On July 21, 2011, Patient D saw Dr. Sachdev for a follow-up visit. An MA noted
33 on a progress note that Patient D's height was five feet and six and three-fourths inches, and her
34 weight was 149 pounds. (*Ex.* A32 at 6.) At that time, Patient D's BMI was 24. (Tr. at 88; *Ex.*
35 A32 at 6.) An MSQ dated July 21, 2011 indicates, in part, that Patient D was experiencing
36 frequent non-severe binge eating/drinking and compulsive eating; occasional severe acne, hair
37 loss, and water retention; and frequent severe hot flashes, food cravings, and excessive weight.
38 (*Ex.* A32 at 23-24.) Dr. Sachdev prescribed a four-week course of Phentermine to Patient D
39 because she wanted to prevent Patient D from gaining any additional weight while she worked
40 on balancing Patient D's hormones.³⁸ (Tr. at 83-86, 89-90, 3461-3463; *see Ex.* A32 at 16.) Dr.
41

42 _____
43 ³⁶ The dictated chart note ends abruptly, with no mention of the blood work results, a review of
44 symptoms, or an assessment/plan. (*See Ex.* A32 at 4.)

45 ³⁷ Body composition analysis determines a person's percentage of body fat relative to body mass, and
46 involves the concepts of endogenous and exogenous obesity. (Tr. at 89.)

³⁸ At hearing, Dr. Sachdev testified, in part:

1 Sachdev specifically considered Patient D's six-pound weight gain between March and July
2 2011, Patient's D's body composition analyses, and Patient D's elevated dihydro-testosterone
3 levels, (which can be associated with polycystic ovarian disease, and other hormone imbalance
4 conditions that could be precursors to diabetes or pre-diabetes). (Tr. at 89-90.)
5

6 195. Aside from the electronic medical record (Ex. A32 at 16), which shows that a 30-
7 day prescription for 15 mg of Phentermine was faxed to Target Pharmacy on July 21, 2011,
8 Patient D's chart contains no documentation that Dr. Sachdev prescribed Phentermine to the
9 patient. Patient D's chart contains no documentation that Dr. Sachdev informed the patient of
10 the risks associated with Phentermine treatment or that she informed the patient of the off-label
11 use of the medication.³⁹ (See *id.* at 1-90; tr. at 252.)
12

13 196. A September 7, 2011 body composition analysis showed that Patient D's total body
14 weight of 145.1 pounds included 43.2 pounds of body fat. (Ex. A32 at 69.)
15

16 197. On October 26, 2011, Patient D saw Dr. Sachdev for a follow-up visit. The patient
17 complained of fatigue, irregular menstrual cycles, and "having a short fuse." (Ex. A32 at 7.) An
18 MSQ dated October 26, 2011 indicates, in part, that Patient D was experiencing occasional
19 severe insomnia, fatigue, and hair loss and occasional non-severe flushing/hot flashes. (*Id.* at 26-
20 28.) Dr. Sachdev continued to prescribe testosterone cream to Patient D. (See *id.* at 29.)
21

22 198. On November 21, 2011, Patient D saw Dr. Sachdev for a follow-up visit. (Ex. A32
23 at 8-10.) An MA noted on a progress note that Patient D's height was five feet and seven inches,
24 and her weight was 145 pounds. (*Id.* at 8.) A corresponding chart note states, in part:
25

26 CHIEF COMPLAINT: Lightheadedness, dizziness and brain fog[.]
27

28 HPI: The patient * * * states that * * * she went for [a] workout and
29 start[ed] to experience this. She did not have any actual loss of
30 consciousness. * * *. She noticed that when she eats certain foods she
31 gets tremendous abdominal bloating and sometimes brain fog issues. So,
32 she may have some food allergies[.] So, we discussed food allergy testing
33 at this point[.]
34
35

36
37 My concern was further weight gain. * * * *. I was concerned about the rate at
38 which she was gaining. Again it's the rate. I always look at the delta change.
39

40 (Tr. at 3461.) During the September 27, 2012 interview with the Board's Investigative Committee, Dr.
41 Sachdev informed the committee that she prescribed Phentermine for Patient D because the patient was
42 binge eating. (Ex. A11 at 9.) A small clinical trial in 2000 looked at the use of Phentermine in
43 conjunction with Prozac for binge eating in obese persons. The binge eating suppression was determined
44 to be no better on the two medications than with cognitive behavioral therapy. (Tr. at 232-233, 255-256.)

45 ³⁹ In addition to the general risks associated with taking Phentermine, the medication is a mild stimulant
46 and could exacerbate anxiety. This would have constituted a potential risk (and perhaps even a
contraindication) for Patient D because she indicated on a February 23, 2011 clinic consultation form that
she had a history of anxiety or excessive stress. (See Ex. A32 at 38; tr. at 1823-1824.)

1 REVIEW OF SYSTEMS: [S]he denies any headaches. No insomnia. No
2 tremors or shakiness. She denies any allergy symptoms. She denies any
3 palpitations, chest pain, or anxiety or emotional swings. She just has some
4 mild PMS issue[s] before [her] period. She has no shortness of breath or
5 wheezing. She [has] no nausea or vomiting. She complains of bloating
6 and belching, passing gas[,] all of these symptoms with certain foods * * *
7 and also some brain fog. She experiences sometimes just a lack of focus
8 when she feels lightheadedness or when she eats certain foods[.]
9

10 CURRENT MEDICATIONS: [S]he is on bioidentical testosterone cream,
11 low dose[,] and a nutraceutical list that was fully listed in her chart.
12

13 * * * * *

14
15
16 SOCIAL HISTORY: [S]he denies any drug, alcohol or nicotine abuse
17 history.
18

19 * * * * *

20
21 ASESSMENT/PLAN: Dizziness and lightheadedness, etiology is unclear.
22 It could be hypoglycemic episode and could be food allergy related with
23 the brain fog issue that she also complains of and I think food allergy
24 would be very appropriate to check. * * * all of her blood work has been
25 normal thus far.
26

27 (*Id.* at 9-10.) During the office visit, Dr. Sachdev followed up on some of the common
28 symptoms of too much testosterone (*e.g.* insomnia, irritability, anxiety). (Tr. at 3539; *see* Ex.
29 A32 at 9-10.)
30

31 *Patient E*

32
33 199. At the age of nine, Patient E was diagnosed with severe dermatomyositis, a rare
34 autoimmune disorder that attacks the vessels in the muscles. She thereafter had several years of
35 invasive injectable treatment, including high-dose prednisone, methotrexate, and immunoglobulin.
36 Her disease went into remission, but she then developed polycystic ovarian syndrome (PCOS),
37 insulin resistance, heavy menstrual periods, significant weight gain (approximately 30 pounds in
38 an eight-month period), and low iron levels. Patient E sought treatment from a PCOS expert in
39 Arizona. Some of her symptoms began to improve with Metformin treatment. Patient E also
40 sought treatment for her insulin resistance at the Holtorf Center in California. Her earlier
41 diagnoses were confirmed, and she was also diagnosed with hypothyroidism. She began taking a
42 T4/T3 preparation, and subsequently a T3 preparation. After some of her symptoms started
43 worsening, she saw Dr. Sachdev for treatment. (Tr. at 1333-1335; *see also* Ex. A35 at 2-3, 95.)
44

45 200. On November 15, 2010, Patient E (who was 15 years old at the time) first treated
46 with Dr. Sachdev. (Ex. A35 at 2; tr. at 2833, 2837.) After reviewing Patient E's medical history

1 and various lab reports, Dr. Sachdev determined that she would address the patient's thyroid
2 issues first. Dr. Sachdev suspected that Patient E's thyroid was being suppressed by too much
3 T3. Dr. Sachdev ordered various lab tests, including thyroid function tests. (Tr. at 2837-2840;
4 Ex. A35 at 3.) On November 15, 2010, Patient E's weight was 155 pounds. (Ex. A35 at 2; tr. at
5 95.)
6

7 201. On November 22, 2010, Patient E had a follow-up appointment with Dr. Sachdev.
8 Based on the thyroid test results, Dr. Sachdev made some modifications to Patient E's thyroid
9 regimen. To address the patient's PCOS, Dr. Sachdev initiated targeted amino acid therapy and
10 performed "extensive nutritional counseling." (Ex. A35 at 4.) On November 22, 2010, Patient
11 E's weight was 159 pounds. (*Id.*; tr. at 95.)
12

13 202. On December 1, 2010, Patient E had another follow-up visit with Dr. Sachdev. The
14 chart note states, in part:
15

16 The patient is not feeling good. The Armour Thyroid actually * * * was
17 making her feel bloated. She was having nausea and some headaches.
18 She has continued to have some dizziness, nausea and headaches. There
19 has also been about [a] 5[-]pound weight gain. She is having puffy facies
20 [*i.e.* a puffy face] after we have gone off the higher dose of the T3. I
21 suspect that has been explained to them. * * * * *. I think the underlying
22 issue is still adrenal fatigue. We are going to now initiate an adrenal
23 saliva test, but I did go ahead and modif[y] the adrenal fatigue regimen for
24 her. I also explained to them the concept of iodide/iodine and also we are
25 going to optimize her thyroid function as well. * * * * *.
26

27 (Ex. A35 at 5.) On December 1, 2010, Patient E's weight was 158 pounds. (*Id.*)
28

29 203. On December 1, 2010, Dr. Sachdev prescribed Phentermine for Patient E with the
30 goal of preventing further weight gain. Dr. Sachdev believed that it was prudent to stop the
31 patient from gaining additional weight while she tried to get the patient's thyroid function
32 optimized. Dr. Sachdev believed that Patient E was at significant risk for diabetes and further
33 metabolic dysfunction, and that additional weight gain would be detrimental to her health. (Tr.
34 at 95-96, 1336-1337, 1361, 2844, 2847-2849, 2852, 2860, 2865, 2878, 2881-2882.)
35

36 204. The December 1, 2010 chart note does not mention Phentermine, any basis for
37 prescribing Phentermine, or any discussion that Dr. Sachdev had with the patient and/or the
38 patient's mother regarding the risks of Phentermine.⁴⁰ (*See* Ex. A35 at 5.)
39

40 205. A Nutraceutical Protocol form dated December 1, 2010 lists Phentermine under the
41 section titled "Protocol." (Ex. A35 at 37; tr. at 2872-2873.) The document states that one to two
42 15-mg tablets of Phentermine were prescribed to Patient E on a short-term basis. (Ex. A35 at 37;
43 tr. at 2874.) The form contains no other information with regard to Phentermine. (*See* Ex. A35 at
44 37.)
45

46

⁴⁰ Patient E's mother was actively involved in Patient E's care. (Tr. at 98.)

1 206. Patient E's electronic medical record shows that Dr. Sachdev prescribed
2 Phentermine to the patient on December 1, 2010, December 29, 2010, and March 18, 2011. (Tr.
3 at 2842-2843; *see* Ex. A35 at 80.) Patient E's BMI ranged from 23.8 to 24.4 during the time
4 Phentermine was prescribed to her. This is considered within the normal range. (Tr. at 254; *see*
5 Exs. A35 at 5-9.) BMI only takes height and weight into consideration; it does not take body
6 composition into account. There is an emerging trend in the medical community to consider
7 body composition, and not just BMI, to identify a patient's risk for significant diseases. (Tr. at
8 2846-2849; *see* Exs. R206, R207, R208.)
9

10 207. Patient E's medical records contain no chart notes or progress notes that indicate the
11 prescribing of Phentermine to Patient E, that discuss the basis for prescribing the medication, or
12 that note any discussion Dr. Sachdev had with the patient and/or the patient's parent[s] regarding
13 the medication's risks. (Tr. at 254; *see* Ex. A35.)
14

15 208. During the September 27, 2012 interview with the Board's Investigative
16 Committee, Dr. Sachdev stated that she prescribed Phentermine for Patient E because the patient
17 was binge eating, and the binge eating "was out of control."⁴¹ (Ex. A11 at 9.) Patient E's chart
18 notes and progress notes do not contain any reference to binge eating. (*See* Ex. A35.)
19

20 209. On December 29, 2010, Patient E had another follow-up visit with Dr. Sachdev.
21 They reviewed the patient's lab results and discussed her abdominal/gastrointestinal issues. Dr.
22 Sachdev conducted a physical examination and noted, among other things, that Patient E had no
23 edema in the extremities. The December 29, 2010 chart note does not mention Phentermine, its
24 efficacy, or whether Patient E was experiencing any side effects from it. (Ex. A35 at 6-7.)
25

26 210. On February 18, 2011, Patient E had another follow-up visit with Dr. Sachdev. The
27 chart note states, in part:
28

29 The issues still remain. Her thyroid is still not optimally balanced * * *
30 and she still has gut issues. * * * * *. [Patient E's mother] is also
31 complaining that [Patient E] has generalized puffiness and edema. This is
32 very unusual for a young girl and even the lymphatic massage therapist
33 has noticed that.
34

35 (Ex. A35 at 8.)
36

37 211. On March 2, 2011, Patient E had another follow-up visit with Dr. Sachdev. The
38 corresponding chart note states, in part:
39

40 _____
41 ⁴¹ Dr. Sachdev told the Investigative Committee the following with regard to Patient E and binge eating:

42 She was binge eating. She was binge eating during the time – I was trying to find
43 all her metabolic dysfunctions, imbalances, her disease processes, and during my
44 evaluation period – you know, the mother was – she – the patient was devastated
45 by it. I – binge eating was out of control. She self-reported it * * * [.]
46

(Ex. A11 at 9.)

1
2 The patient has several issues. Firstly the iron replacement therapy is
3 becoming really hard. * * * * *. Second issue is that as soon as I change
4 her thyroid medication she had bec[o]me more puffy, weight gain issues,
5 and just she did not respond well to it. * * * * *. I had also had her on
6 alternate treatment regimen for IBS issues and I just think that was also a
7 detox regimen and it was very strong dosing that I had originally given
8 her. We are reducing that dos[age]. She should do much better with that
9 as well. So all these issues were discussed.

10
11 (Ex. A35 at 9.)
12

13 212. On April 11, 2011, Patient E had another follow-up visit with Dr. Sachdev. In the
14 corresponding chart note, Dr. Sachdev noted that the patient's fatigue and IBS/diarrhea
15 symptoms had improved significantly, that her abdominal bloating had decreased, and that
16 "[e]ven the puffiness issues that she had, she is doing so much better." (Ex. A35 at 10.) Dr.
17 Sachdev determined that Patient E's weight remained a significant issue and she decided to focus
18 on getting the patient's metabolic rate regulated, addressing her adrenal fatigue, and optimizing
19 her thyroid. (*Id.*)
20

21 213. On May 20, 2011, Patient E saw Dr. Sachdev for a follow-up visit. The
22 corresponding chart note states, in part:
23

24 She is feeling that the fatigue has resolved. * * * * *. The only issue[]
25 that she has [i]s excessive weight now * * * [so] we can now start to
26 focus on a proper diet and exercise regimen program and diet is
27 optimized[.] [*sic*]
28

29 * * * * *

30
31 [S]he is going to now enter a diet and weight loss regimen.
32

33 (Ex. A35 at 11.)
34

35 214. Dr. Sachdev decided to initiate a human Chorionic Gonadatropin (hCG) weight-
36 loss regimen in an attempt to control Patient E's weight. (Tr. at 1362, 3042; *see* Ex. A37.)
37

38 215. On May 25, 2011, Patient E's mother signed a document on Patient E's behalf titled
39 "Consent for Human Chorionic Gonadatropin (hCG) Weight-Loss Program. (Ex. A37 at 2.) An
40 hCG progress note states, in part:
41

42 DOS: 5/25/11
43

44 hCG Start Date: 5/28/11 Beginning WH: 156.5 HT: 5' 8
45

46 Current Weight: 156.5 Goal Weight: 135

1
2 Current Health Conditions: see med[ical] file
3

4 Notes: Councelled [*sic*] on hCG diet and injections. Pt starting injections
5 on Saturday 5/28/11[.] F/U weekly due to PCOS medications.
6

7 (*Id.* at 9.)
8

9 216. On June 3, 2011, Patient E weighed 152.3 pounds, with 48.7 pounds of body fat.
10 (Ex. A37 at 10; tr. at 3040-3041.) An hCG progress note dated June 3, 2011 states that Patient E
11 lost 4.3 pounds and that she also lost muscle mass. The note further states that her dose was
12 lowered to 0.15 and that chromium was added. (Ex. A37 at 11.)
13

14 217. On June 10, 2011, Patient E weighed 151.9 pounds, with 39.9 pounds of body fat.
15 (Ex. A37 at 12; tr. at 3044.) An hCG progress note dated June 10, 2011 states that Patient E had
16 a total weight loss of 4.6 pounds and that her muscle mass increased since the previous week.
17 (Ex. A37 at 13.)
18

19 218. On June 15, 2011, Patient E weighed 152.1 pounds, with 38.8 pounds of body fat.
20 (Ex. A37 at 14; tr. at 3046.) An hCG progress note dated June 15, 2011 states that Patient E had
21 a total weight loss of 4.4 pounds (*i.e.* she had weight gain since the previous week). The note
22 further states that the patient was “doing ok,” but that her weight was not dropping very quickly.
23 (Ex. A37 at 15.) Her dose was lowered to 0.1 for the next week. (*Id.*)
24

25 219. On June 22, 2011, Patient E weighed 151.5, with 45 pounds of body fat. (Ex. A37
26 at 16; tr. at 3047.) An hCG progress note dated June 22, 2011 indicates that Patient E was
27 referred to Dr. Sachdev.⁴² (Ex. A37 at 17.)
28

29 220. Dr. Sachdev determined that the hCG regimen was not working for Patient E,⁴³ so
30 she discontinued it. (Tr. at 3047.) On June 29, 2011, Patient E weighed 151.9 pounds, with 47
31 pounds of body fat. (Ex. A37 at 18; tr. at 3047.) An hCG progress note dated June 29, 2011
32 states “D/C [Discontinued] hCG per Dr. Naina due to medical issues w/ PCOS.” (Ex. A37 at
33 19.) On a Nutraceutical Protocol dated June 29, 2011, “hCG D/C” appears in handwriting under
34 the heading “Diets.” (Ex. A35 at 55.)
35

36 221. On June 29, 2011, Patient E had another follow-up visit with Dr. Sachdev. The
37 corresponding chart note states, in part:
38

39 The patient is complaining of again generalized edema, generally around
40 her abdominal area, her hands, face is swollen and her knees. * * * * *
41 What I really think this patient has is * * * an autoimmune dysfunction
42

43
44 ⁴² The hCG progress notes were presumably written by clinic staff.

45 ⁴³ Patient E’s mother testified at hearing that the hCG regimen required that Patient E consume large
46 quantities of water and that Patient E “ballooned up ten to 15 pounds in a week [and] * * * her knees and
ankles were absolutely non-existent.” (Tr. at 1338, 1363.)

1 and inflammation and we really have to address both of these from a
2 functional medicine perspective. * * * * *. So, nutrigenomic regimen was
3 again recommended and discussed[.]
4

5 (Ex. A35 at 12.)
6

7 222. On July 14, 2011, Patient E treated with pediatric rheumatologist Victoria
8 Cartwright, M.D. (Ex. A40 at 11-16; *see* Ex. A35 at 76-78.) In a corresponding chart note, Dr.
9 Cartwright noted that Patient E complained of fatigue and edema. Under the heading
10 “Recommendations,” Dr. Cartwright’s chart note stated, in part:
11

12 2. Cannot comment on specific etiology for her edema. I would like to be
13 sure that she is not hypoproteinemic or hyponatremic for any reason, as I
14 did not see a comprehensive metabolic panel in her recent laboratory
15 studies. I have seen edema associated with dermatomyositis, but this is
16 associated with active disease. * * * * *. I have heard of edema
17 associated with hypothyroidism, so she may benefit from a closer look at
18 her thyroid issues[.]
19

20 (*Id.* at 11-12.)
21

22 223. Dr. Sachdev and Patient E’s mother researched the issue of idiopathic orthostatic
23 edema in adolescent girls.⁴⁴ A 2005 article published in *Pediatrics Review*, titled “Orthostatic
24 Edema in Adolescents: More Than Walking on Water,” discussed treatment of orthostatic
25 edema in adolescents with dextroamphetamine (*i.e.* amphetamine salts/Adderall). (Ex. A39 at 8;
26 tr. at 256, 3059-3066.) Because Adderall is a vasoconstrictor, it can tighten up the vascular walls
27 so that fluid cannot pass into a person’s tissues. Instead, the fluid is released by the body through
28 urination. (Tr. at 2042, 3063.) Patient E’s mother asked Dr. Sachdev about the possibility of
29 treating Patient E’s edema with Adderall. (*Id.* at 1343, 1364.)
30

31 224. On July 18, 2011, Patient E treated with Dr. Sachdev. A corresponding chart note
32 states, in part:
33

34 [S]o now we are actually dealing with perhaps orthostatic edema in
35 adolescents, the issue is really is that there is abnormal vasodilation that
36 increases capillary permeability and increases venous return to the heart.
37 So things that will reduce the capillary permeability and would also
38 constrict at the capillary level and increase[] venous return would be very
39 beneficial, one of them is Adderall and so I am going to initiate that
40 treatment[.] * * * * *. [A]ll of this was discussed in detail.⁴⁵ * * * * *.
41

42 ⁴⁴ Edema is the abnormal collection of fluid in the body. Orthostatic edema refers to edema in dependent
43 areas of the body. (Tr. at 256.)
44

45 ⁴⁵ At hearing, Dr. Sachdev testified that when she notes in a patient chart that a treatment was “discussed
46 in detail,” that includes discussing the side effects of the treatment and any directions for administration
of the treatment (*e.g.* dosage instruction for a medication). (Tr. at 3094-3095.)

1 The patient verbally understands the treatment plan of care and then we
2 will further evaluate and treat.

3
4 (Ex. A35 at 14.) A Nutraceutical Protocol dated July 18, 2011 notes that Dr. Sachdev prescribed
5 Adderall to Patient E. (*Id.* at 61.)

6
7 225. On August 11, 2011, Patient E had another follow-up visit with Dr. Sachdev. The
8 chart note for that visit states, in part:

9
10 The patient is continuing to have generalized edema. Also, we discussed
11 the idiopathic orthostatic edema as leading to all her generalized edema
12 issues. * * * * *. [I] looked * * * to see if there was any correlation
13 between optimizing her thyroid function and her generalized edema issues
14 and there seems to be a definite correlation, when we lowered the dose,
15 she felt definitely much more fatigued.

16
17 (Ex. A35 at 16.) The chart note also includes discussion regarding adjusting the patient's thyroid
18 medications, food allergy testing, autoimmune dysfunction, and menstrual issues. (*Id.*)

19
20 226. On August 26, 2011, Patient E had another follow-up visit with Dr. Sachdev. The
21 chart note for that visit states, in part:

22
23 The patient has had remarkable improvement with the adjustment of the
24 thyroid medications. We initially thought she might have orthostatic
25 edema, but she lost about 10 pounds and the edema is now resolved just be
26 making adjustments in her alternative treatment regimen and optimizing
27 the thyroid function. This is so dramatic. * * *. The patient is much less
28 fatigued. * * *. All of her issues, the fatigue, the brain fog, the joint
29 pains, the muscle aches and pains and everything have resolved[.]

30
31 (Ex. A35 at 19.) Upon physical examination, Dr. Sachdev noted no generalized or peripheral
32 edema. (*Id.* at 19.)

33
34 227. During the September 27, 2012 Investigative Committee interview, Dr. Sachdev
35 informed the committee that she prescribed Adderall for Patient E to treat the patient's
36 orthostatic edema. (Ex. A11 at 15.) Dr. Sachdev specifically told the committee:

37
38 [S]he had edema that was unexplained. * * *. I sent her to a pediatric
39 rheumatologist who said, "I can't—I don't know the reason for her
40 edema." It was evaluated before. No one could seem to find the reason
41 she had edema. And it was a dependent edema. Water level test was
42 done. I made the diagnosis of orthostatic edema. And orthostatic edema,
43 the treatment of choice is dextroamphetamines.

44
45 [W]e said let's try a trial of low dose because of the increased
46 permeability. In my note, I have a full documentation of my reasoning

1 for—for that. And so we tried low dose Adderall and she had a great
2 response.

3
4 (*Id.*)

5
6 228. Dr. Turner has no concerns about Dr. Sachdev's decision to prescribe Adderall to
7 treat Patient E's orthostatic edema. (Tr. at 1439-1440, 1447.)

8
9 229. At the time of the hearing, Patient E had been on Adderall for three years. She has
10 been able to maintain her weight at 135 pounds. (Tr. at 1338-1339, 1345, 1363.) Patient E's
11 mother considers Dr. Sachdev the first medical practitioner who effectively integrated treatment
12 for Patient E's overlapping conditions (*i.e.* autoimmune disorder, PCOS, insulin resistance,
13 hypothyroidism, and idiopathic orthostatic edema). (*Id.* at 1336.)

14
15 *Patient F*

16
17 230. A physician has an obligation to ensure that staff perform work consistent with the
18 physician's standards. (Tr. at 259, 1824-1825.)

19
20 231. Medical aestheticians are aestheticians with advanced aesthetic training who
21 typically work in medical settings.⁴⁶ Patient C had sufficient training and expertise to be
22 considered a medical aesthetician, and Dr. Sachdev considered Patient C to be a highly skilled
23 aesthetician. (Tr. at 2745, 2748-2749, 2786-2787, 2792.)

24
25 232. Dr. Sachdev trained Patient C to perform electrocautery⁴⁷ using a high-frequency
26 device called a Super Frecator. (Tr. at 1294, 2738-2742; *see* Exs. R203, R204.) Patient C
27 observed Dr. Sachdev perform electrocautery procedures on multiple occasions. (Tr. at 2787-
28 2788.) In total, Patient C performed the procedure herself under the direction and guidance of
29 Dr. Sachdev between three and six times. (*Id.* at 1292-1293, 2783.)

30
31 233. In mid to late 2010, Patient F began treating with Dr. Sachdev for issues relating to
32 perimenopause and depression. (Tr. at 192, 2721; *see* Ex. A41 at 25-26.)

33
34 234. On April 20, 2011, Dr. Sachdev removed multiple skin lesions from the right side
35 of Patient F's neck. (Ex. A41 at 15; tr. at 195-196.) After injecting the area with lidocaine, Dr.
36 Sachdev removed approximately 30 lesions via electrocauterization and two lesions via excision.
37 (Ex. A41 at 15.)

38
39 235. On April 25, 2011, Patient F returned to the clinic to have additional lesions
40 removed from the right side of her neck. After injecting the area with lidocaine, Dr. Sachdev

41
42 ⁴⁶ The term "medical aesthetician" is not defined under Oregon law, and the Oregon Health Licensing
43 Agency does not specifically license an aesthetician as such. (*See* tr. at 2745, 2748.)

44
45 ⁴⁷ Electrocautery (also referred to as electrocauterization) involves the use of an electrical device to cut or
46 cauterize tissue. It is commonly used during surgeries to stop bleeding. (Tr. at 2398-2399.)

1 removed multiple lesions via electrocauterization and one lesion via excision.⁴⁸ (Ex. A41 at 13;
2 tr. at 196-197.)
3

4 236. On July 5, 2011, Patient F returned to the clinic to have lesions removed from the
5 left side of her neck. (Tr. at 195, 2785; Ex. A41 at 11.) Dr. Sachdev injected the area with
6 lidocaine and then left the room. (Tr. at 201, 2786.) Patient C began removing multiple lesions
7 from Patient F's neck via electrocauterization.⁴⁹ (Tr. at 2785-2786, 201.) At one point during
8 the removal procedure, Patient F felt as though she had been burned and she jumped. In
9 response, Patient C asked Patient F if it hurt. Patient F replied "yes," and Patient C continued to
10 remove lesions. (*Id.* at 203.) Patient F told Patient C at least one more time that the procedure
11 was hurting her. Patient C continued to perform the procedure. (*Id.* at 204.)
12

13 237. Dr. Sachdev did not inform Patient F that Patient C was going to be removing any
14 of the lesions on July 5, 2011. (Tr. at 204.)
15

16 238. Sometime after July 5, 2011, Patient F became aware that the left side of her neck
17 had sustained a full thickness burn.⁵⁰ Neither Dr. Sachdev nor Patient C was aware that Patient F
18 was burned during the July 5, 2011 electrocautery procedure. (Tr. at 1277, 1293, 2690, 2692,
19 2793; Ex. A2 at 1.) Patient F has scars on the left side of her neck from the electrocautery
20 procedure she received on July 5, 2011. (Tr. at 203; *see* Ex. A90 at 4.)
21
22

23 ⁴⁸ While it is possible that Patient C removed some of Patient F's lesions on April 25, 2011, the record
24 does not support such a finding by a preponderance of the evidence. At hearing, Patient F testified that
25 she could not recall whether Patient C removed any skin lesions on that date. (Tr. at 196-197.) Patient C
26 testified that to the best of her recollection, she performed electrocautery on Patient F on two separate
27 occasions. (*Id.* at 1294.) An April 25, 2011 chart note, presumably written by Patient C, states that Dr.
28 Sachdev removed approximately 20 lesions and Patient C removed approximately 10 lesions. (Ex. A41 at
29 13.) An April 25, 2011 chart note, written by Dr. Sachdev, states that 30 lesions were removed on that
30 date, but the note does not specify who removed the lesions. (*Id.* at 14.) At hearing, Dr. Sachdev insisted
31 that she removed all of Patient F's lesions on April 25, 2011. (Tr. at 2735, 2785.) However, in a January
32 23, 2012 letter to the Board, Dr. Sachdev stated that Patient F visited the clinic on only two occasions to
33 have lesions removed (April 25, 2011 and July 5, 2011) and that Patient C removed some of the lesions
34 on April 25, 2011. (Ex. A2 at 1.)

35 ⁴⁹ Patient F testified that on July 5, 2011, after injecting her with lidocaine, Dr. Sachdev left the room and
36 Patient C then removed all the lesions. (Tr. at 201.) A July 5, 2011 chart note, written by Dr. Sachdev,
37 states that approximately 20 lesions were removed on that date, but it does not specify who performed the
38 removal. (Ex. A41 at 11.) At hearing, Dr. Sachdev conceded that Patient C removed some of Patient F's
39 lesions on July 5, 2011, but contended that she (*i.e.* Dr. Sachdev) removed the majority of them. (Tr. at
40 2785-2786.) However, in a January 23, 2012 letter to the Board, Dr. Sachdev stated that she removed all
41 of Patient F's lesions on July 5, 2011. (Ex. A2 at 1.) In a subsequent interview with Mr. Bitonti, Dr.
42 Sachdev stated that clinic staff compiled the summary of events contained in the January 23, 2012 letter,
43 and that she merely signed off on it, assuming it was accurate. (Ex. A1 at 8.)

44 ⁵⁰ A full thickness burn is also referred to as a third-degree burn. (*See* Tr. at 205.) At hearing, Dr.
45 Sachdev disputed that Patient F had a full thickness burn. However, Dr. Sachdev then testified,
46 somewhat contradictorily, that Patient F may have gotten burned and ended up with the result that she did
due to the fragility of the skin during menopause. (*Id.* at 2792-2793.)

1 239. On November 7, 2011, Patient F called the clinic and requested copies of her
2 medical records. (Ex. A2 at 1.) On November 11, 2011, she visited the clinic and again
3 requested copies of her records. She became upset when staff provided her only with records
4 that originated from Dr. Sachdev's clinic, and not with records that had been sent to the clinic
5 from other physician's offices or testing facilities. (Tr. at 202-203, 213-214, 218-220; see Ex.
6 A2 at 1.) In approximately November 2011, Patient F provided the Board with a copy of her
7 medical records from the clinic. (Tr. at 974-975, 979.)
8

9 *Patient G*

10
11 240. On August 16, 2011, acupuncturist Jasmine Patel, LAc, referred Patient G to Dr.
12 Sachdev with the request that Dr. Sachdev work on the patient's thyroid issues and increase the
13 patient's Vitamin D3 level. (Ex. A46 at 22; tr. at 99-100, 3142-3143.)
14

15 241. Patient G has multiple myeloma. (Ex. A46 at 3; see Ex. R188; tr. at 262, 3152-
16 3153.) Multiple myeloma is bone marrow cancer. (Test. of Forsythe.) Treating multiple
17 myeloma is outside the scope of practice of a general internist. (Ex. R28 at 1.) Providing advice
18 regarding chemotherapy is not part of the standard practice for an internist. (Tr. at 263.) Dr.
19 Sachdev viewed her role in treating Patient G as that of an "adjunct" to the patient's cancer
20 treatment, so that the patient could increase her quality of life issues. (*Id.* at 112, 3229.)
21

22 242. On August 25, 2011, Dr. Sachdev had an initial consultation with Patient G. (Ex.
23 A46 at 3-6.) Patient G's husband, Peter, was heavily involved in the patient's care. He
24 accompanied Patient G to each appointment with Dr. Sachdev. (Tr. at 103-106, 3191.)
25

26 243. On an August 25, 2011 Adrenal Fatigue Quick Check form, Patient G indicated that
27 she had, among other things, significant issues with fatigue, lethargy, memory, focus, and
28 diminished sexual interest. (Ex. A46 at 30-31; tr. at 3160.) On an August 25, 2011 MSQ form,
29 Patient G indicated that she experienced, among other things, frequent headaches, dizziness,
30 insomnia, heartbeat irregularity, breathing difficulties, joint and muscle pain and stiffness, and
31 poor memory. She also indicated that she experienced occasional hot flashes and rashes. (Ex.
32 A46 at 32-34; tr. at 3157.) In Dr. Sachdev's opinion, the above symptoms may all relate to
33 menopause and suggest hormonal imbalance issues. Before initiating bioidentical hormone
34 replacement therapy, Dr. Sachdev's usual and customary practice is to perform blood testing.
35 (Tr. at 3151, 3158-3162.)
36

37 244. On August 25, 2011, Dr. Sachdev took a detailed history of the patient. The chart
38 note for that visit states, in part:
39

40 [A]t 52 years * * * just before menopause she noticed the perimenopause
41 symptoms[.] * * * [M]igraine headaches [were] devastating just before
42 periods. Finally she became menopausal by 52 years of age and she
43 actually went on bioidentical hormone replacement therapy at 54 years of
44 age. She really did very well with it, but stopped it because there were
45 some concerns about again bioidentical HRT with the association of the
46

1 breast cancer risk. She stopped about two years ago. She took * * *
2 Bioidentical HRT for about two years[.]

3
4 So over the last year * * * the patient started noticing the change in her
5 endurance level. * * * * *. The patient does recall that all her problems
6 really started * * * in 2010 when she actually had a dental treatment [and]
7 right after that she started to experience extreme fatigue[,] insomnia,
8 depression symptoms. * * * * *. In October of 2010 * * * she was found
9 to be anemic. * * * * *. [I]n March of 2011 * * * she was found to be still
10 anemic. * * * * *.

11
12 She then was given a diagnosis of multiple myeloma at OHSU[.] [Dr.
13 Sachdev notes numerous details regarding that diagnosis and the patient's
14 various laboratory results] * * * * *. So DHEA levels were 39, but serum
15 progesterone levels are 0.5, estradiol levels are 12. * * * * * [A cancer
16 specialist] recommended that she just needs low dose chemo⁵¹ and the
17 protocol would be * * * dexamethasone [and] she would be on acyclovir
18 and then the Zometa * * * along with the calcium and vitamin D. [S]o the
19 current situation is where do they go next, how do they enhance what all
20 needs to be done. So at this point we have a lengthy discussion * * * [.]
21 Actually I am going to start her and optimize her mitochondrial function
22 and start her on bioidentical hormone replacement therapy regimen and do
23 any immune enhancement protocol on her almost immediately.

24
25 (*Id.* at 4-5.) In the same chart note, Dr. Sachdev noted, in part, the following under the heading
26 "Assessment/Plan":

27
28 The patient has multiple myeloma without any lytic lesion, low dose
29 chemotherapy has been recommended and really with all her other
30 symptoms she is having I definitely want to initiate bioidentical. The plan
31 is to do appropriate blood testing and testing to initiate bioidentical
32 hormone replacement therapy regimens and address and optimize her
33 thyroid function as well. * * *. There is a lot of urgency in today's
34 evaluation. So we are going to start these treatment regimens
35 immediately[.]

36
37 (*Id.* at 6.)

38
39 245. On August 26, 2011, Patient G had a follow-up appointment with Dr. Sachdev. The
40 chart note for that visit states, in part:

41
42
43
44 _____
45 ⁵¹ Dr. Sachdev was not recommending chemotherapy for the patient. Rather, she was merely noting in
46 the chart that Patient G's oncologist had recommended low-dose chemotherapy. (Tr. at 3153, 3188-
3189.)

1 The patient is here for a follow[-]up of multiple myeloma, which is newly
2 diagnosed, and here to have a protocol which needs to be started. The idea
3 is to optimize her for the regimen that she is about to face. She is going to
4 be undergoing low-dose chemotherapy[.] * * *. Her blood work is
5 pending and at this point, we had an extensive discussion to start her on
6 bioidentical hormone replacement therapy. * * * * *
7

8 Review of symptoms, she is having major, major issues, the headaches,
9 the faintness, the dizziness, the insomnia, bags and circles under her eyes.
10 She is having irregular skipped heartbeats, rapid pounding heartbeat. She
11 is having difficulty with increased shortness of breath, cough, pains and
12 aches in her joints, stiffness and limitation of her movement, poor
13 memory, poor concentration, easy bruising, and frequent illnesses. So, we
14 are going to initiate bioidentical hormone replacement therapy regimen,
15 informed consent was given, RBS was discussed[.]⁵²
16

17 (Ex. A46 at 8-9.) Dr. Sachdev also noted that Patient G had “very significant anemia,” for which
18 a red blood cell transfusion was ordered. (*Id.* at 9.)
19

20 246. Dr. Sachdev elected to begin the bioidentical hormone replacement therapy regimen
21 for Patient G prior to testing the patient’s hormone levels because she strongly believed that the
22 laboratory results would confirm that the patient’s hormone levels were low. Because the patient
23 was dealing with a life-threatening illness, Dr. Sachdev believed there was an immediate need to
24 get the patient started on the hormone regimen. (Tr. at 3177-3178.) Dr. Sachdev prescribed
25 DHEA cream, estrogen cream, progesterone cream, and testosterone cream to Patient G. (Ex.
26 A46 at 8; tr. at 3178, 3179.) In Dr. Sachdev’s opinion, there are no contraindications to using
27 bioidentical hormone replacement therapy in a patient with multiple myeloma. (Tr. at 3165.)
28

29 247. To measure Patient G’s hormone levels, Dr. Sachdev utilized a 24-hour urine
30 hormone testing procedure that employs gas chromatography. (Ex. A48 at 7; tr. at 3169-3171.)
31 This method is considered the “gold standard” for measuring hormones. (Tr. at 3170.) Patient
32 G’s urine was collected on September 18, 2011 and received by the laboratory on September 21,
33 2011. A laboratory report dated September 26, 2011 showed that the patient’s estradiol was 0.3
34 (low), her total estrogens were 2.6 (low), her testosterone was 2.1 (low), her androstenediol was
35 6.7 (low), her DHEA was 48 (low-normal), and her pregnanediol was 423 (low-normal).⁵³ (Ex.
36 A48 at 7; tr. at 3171-3173.)
37

38 248. Patient G treated with oncologist Jeffrey Menashe, M.D., for approximately four to
39 five months in 2011. (Tr. at 2753.) In a chart note dated September 23, 2011, Dr. Menashe
40 states, in part:
41
42
43

44 ⁵² “RBS” refers to “risks, benefits, and side effects.” (Tr. at 3178.)

45 ⁵³ Androstenediol is a metabolite of testosterone. Pregnanediol is a metabolite of progesterone. (Tr. at
46 3174-3175.)

1 [Patient G] returns for follow[-]up of her IgA lambda multiple myeloma
2 diagnosed in April of this year. She initially was treated with naturopathic
3 therapy but received initial Velcade/dexamethasone therapy in late
4 August[.]

5
6 * * * * *

7
8 Clinically, [Patient G] is improved. After much reflection, she prefers not
9 to continue with Velcade for now because of presumed toxicity with initial
10 treatment. * * * * *. If her response to single-agent steroid therapy is
11 suboptimal, we will consider again incorporating Velcade into her
12 treatment regimen.

13
14 (Ex. R188 at 13.)

15
16 249. On September 28, 2011, Patient G had another follow-up visit with Dr. Sachdev.
17 After reviewing the patient's laboratory results with her, Dr. Sachdev adjusted the patient's
18 bioidentical hormone replacement therapy regimen. (Ex. A46 at 11; tr. at 3185.) A chart note
19 for the visit states, in part:

20
21 A/P: Multiple myeloma/anemia/menopausal disorder/adrenal fatigue,
22 exhaustion. Adjustments were made. Her biological HRT or alternative
23 treatment regimens were modified extensively today. Discussed in great
24 detail. *We also discussed chemotherapy regimen, try to go to low to dose*
25 *Velcade and with the prednisone 20 mg p.o. q.d., which she has recently*
26 *been on may be switched to higher dose discussed this with the doctors.*

27
28 (Ex. A46 at 11; emphasis added.) When dictating the italicized portion of the above chart note,
29 Dr. Sachdev had intended for it to reflect that Patient G and/or Peter merely relayed information
30 to Dr. Sachdev about the patient's oncology regimen, and that Dr. Sachdev told them to discuss
31 it with the oncologist.⁵⁴ (Tr. at 106.)

32
33 250. On November 2, 2011, Patient G had another follow-up visit with Dr. Sachdev. In
34 the corresponding chart note, Dr. Sachdev stated that the patient's fatigue, insomnia, hot flashes,
35 libido, joint and muscle pain, depression, and anxiety had all improved. (Ex. A46 at 15-16.) The
36 chart note also states, in part:

37
38 She is also pursuing alternative treatment regimen, which have been
39 working very well for her upon my recommendations she is very pleased
40 at that and so again a very extensive discussion on her multiple myeloma
41 and how she can prevent it even through alternative treatment regimens.

42
43 ⁵⁴ At hearing, Dr. Sachdev testified that she did not have a "discussion" with Patient G and Peter
44 regarding chemotherapy or lowering the patient's chemotherapy dose. Rather, she simply listened as the
45 patient and/or Peter told her about the chemotherapy treatment that was being recommended by the
46 oncologist. (Tr. at 103-104.)

1
2 (*Id.* at 15.) Dr. Sachdev did not intend for the chart note to convey that she told the patient that
3 alternative treatment regimens could prevent multiple myeloma. When dictating the chart note,
4 Dr. Sachdev was actually referring to the prevention and/or treatment of anemia through
5 alternative treatment regimens (*i.e.* testosterone therapy).⁵⁵ (Tr. at 109-112.)
6

7 251. Dr. Sachdev discussed with Patient G and Peter an article titled “Age-Associated
8 Increased Interleukin-6 Gene Expression, Late-Life Diseases, and Frailty.” (Ex. R210; tr. at
9 3223-3228.) The article states, in part:

10 Interleukin-6 (IL-6) is a multifunctional, proinflammatory cytokine that
11 has been implicated in the pathogenesis of several chronic diseases
12 associated with aging, including osteoporosis, Alzheimer’s disease (AD),
13 and neoplasia. IL-6 is tightly regulated and is normally not detected in the
14 serum of healthy young individuals unless there is trauma, infection, or
15 other stress.
16

17 * * * * *

18 Both experimental data and clinical observations suggest that IL-6 may be
19 involved in the pathogenesis of some or all of these diseases [which were
20 previously referenced, and included multiple myeloma]. * * *.
21 [L]ymphoma and myeloma cells have been shown, both in vivo and in
22 vitro, to produce IL-6, and the level of IL-6 production by these neoplastic
23 cells correlates with serum levels and with survival.
24
25

26 * * * * *

27 The importance of IL-6 in the pathogenesis of multiple myeloma in
28 humans has been suspected for many years, perhaps because it was
29 initially identified as a necessary factor for myeloma cell growth in vitro.
30
31
32

33
34 ⁵⁵ Dr. Sachdev considered an article titled “Low Testosterone Levels and the Risk of Anemia in Older
35 Men and Women” (Ex. R209) when prescribing testosterone to Patient G. (Tr. at 110, 3217-3221.) The
36 article states, in part, that “low testosterone levels could be a susceptibility factor for anemia that has been
37 generally neglected. We suggest that low testosterone levels should be considered a potential cause or
38 cocause of anemia in older men and women.” (Ex. R209 at 7.) Dr. Sachdev was particularly interested in
39 the following excerpt from the article:

40 The mechanism through which testosterone stimulates [red blood cell formation]
41 is unclear. Testosterone enhances the proliferation of erythroid burst-forming
42 units and colony-forming units by stimulating specific nuclear receptors, and this
43 effect is completely abolished by pretreating marrow cells with [antiandrogens],
44 which selectively block androgen binding to nuclear androgen receptors.
45

46 (*Id.* at 6; tr. at 3221.) Dr. Sachdev construed the above as suggesting that testosterone is unique in red
blood cell formation, and it could therefore prove beneficial in treating anemia. (Tr. at 110, 3221.)

1 IL-6 levels are high in patients with multiple myeloma, and myeloma cells
2 themselves have high levels of IL-6 receptors[.]

3
4 * * * * *

5
6 Overwhelming evidence has indicated that IL-6 stimulates proliferation of
7 tumor cells of the B-cell lineage. This conclusion has led to the
8 development of IL-6 inhibitors as a treatment strategy.

9
10 (Ex. R210 at 1, 11-13; endnote references omitted.) The article goes on to discuss the inhibitory
11 action of androgens on IL-6 protein expression. (*Id.* at 6-7; tr. at 3224, 3226-3227.)
12 Testosterone is an androgen and a down regulator of IL-6. (Tr. at 3224, 3227.) Based on the
13 article, Dr. Sachdev suggests the possibility that testosterone could affect the outcome of
14 multiple myeloma. (*Id.* at 3226-3227.)

15
16 252. After reviewing a laboratory report dated November 8, 2011 that showed hormone
17 levels for Patient G (Ex. A48 at 16), Dr. Sachdev determined that the patient's free testosterone
18 level had not significantly increased. Dr. Sachdev suspected that the patient was not adequately
19 absorbing the testosterone cream, and that sublingual testosterone would therefore be a
20 reasonable option to try. (Tr. at 3200.)

21
22 253. On November 23, 2011, Patient G had another office visit with Dr. Sachdev. (Ex.
23 A46 at 18-19.) The chart note for that visit states, in part:

24
25 HPI: She was having extreme fatigue issues * * * but she has been so
26 much improved after addressing her bioidentical HRT regimen and
27 immune enhancing protocol. Her platelet count is increasing to 167 and
28 we are waiting for the serum protein electrophoresis results. * * * * *. At
29 this point she has been doing really well with the optimization of
30 bioidentical HRT regimen. * * * * *. So at this point what we are going
31 to see is how she does with an excess SPEP after she has been on the
32 immune enhancement and optimize of her bioidentical HRT regimen.

33
34 REVIEW OF SYSTEMS: [S]he has sometimes hot flashes, excessive
35 sweating. She has occasional irregular skipped heartbeats, rapid pounding
36 heartbeat at times, some feelings of nausea but other than that she is so
37 much improved. Her libido has improved a lot.

38
39 (*Id.* at 18.) Dr. Sachdev also noted in the chart that Patient G's fatigue and malaise had
40 "improved significantly" and that her depression and anxiety were "much improved." (*Id.* at 19.)

41
42 254. On November 23, 2011, Dr. Sachdev switched Patient G to sublingual testosterone.
43 (Ex. A46 at 19; tr. at 3197, 3200-3201.) Patient G subsequently called the clinic and complained
44 that she did not like the sublingual testosterone.⁵⁶ Dr. Sachdev switched the patient to IM

45
46 ⁵⁶ At hearing, Dr. Sachdev testified that there should be an electronic medical record (EMR) of the phone
call, but the record was not printed out and the clinic now has a new EMR system. (Tr. at 3202-3203.)

1 testosterone.⁵⁷ (Tr. at 3202; *see* Ex. A47 at 1-2.) The patient's IM testosterone records were
2 kept in a red chart (separate from her general medical records) because the injections were not
3 covered by insurance. (Tr. at 3203.)
4

5 255. In Dr. Turner's opinion, prescribing testosterone to Patient G was "reasonable,"
6 given that the patient was post-menopausal. (Tr. at 293-294, 302, 1642.)
7

8 256. In Dr. Turner's opinion, adequate coordination of care between Dr. Sachdev and
9 Patient G's treating oncologist would have included some type of communication between Dr.
10 Sachdev and the oncologist. (Tr. at 1751-1752.) Dr. Sachdev never communicated with Dr.
11 Menashe regarding Patient G, and she never provided any treatment records to Dr. Menashe.
12 (*Id.* at 2754-2757.) Dr. Sachdev believed it was unnecessary to communicate with Patient G's
13 treating oncologist[s], because Peter agreed to do so.⁵⁸ (*Id.* at 105, 3191-3192, 3194.) Dr.
14 Menashe was aware that Patient G was receiving testosterone from Dr. Sachdev. (*Id.* at 2753;
15 *see* Ex. R188.) He did not have any concerns regarding Patient G's use of testosterone during
16 her cancer treatment. (Tr. at 2757.)
17

18 257. Dr. Sachdev allowed Patient G to purchase a stock bottle of testosterone from the
19 clinic.⁵⁹ The patient was moving to Hawaii and Dr. Sachdev did not want there to be an
20 interruption in her testosterone treatment.⁶⁰ The bottle contained enough testosterone for
21 approximately 10 injectable doses. The patient assured Dr. Sachdev that she would be monitored
22 by a doctor in Hawaii. (Tr. at 113-116, 3230-3232.) Dr. Sachdev made a written notation,
23 which she placed in Patient G's chart, to show that she dispensed the stock bottle of testosterone
24 to the patient. (Ex. A46 at 82; 113-114, 116, 3265-3269.)
25

26 258. On March 8, 2012, Patient G called Dr. Sachdev from Hawaii. During the phone
27 call, Patient G updated Dr. Sachdev on her medical status. Among other things, Patient G
28 reported that she had increased then decreased her Prednisone (which had been prescribed by
29 another physician). Patient G also reported that she was experiencing pain radiating down her
30 femur. Dr. Sachdev recommended that Patient G get a CBC and follow up with her physician in
31

32
33 ⁵⁷ Patient G's Injection Log shows that she received IM testosterone on November 4, 9, and 17, 2011.
34 (Ex. A47 at 1.) At hearing, Dr. Sachdev explained that her usual and customary practice for a patient
35 undergoing a bioidentical HRT regimen is to give the patient two or three test response doses of IM
36 testosterone to see how the patient responds to it. This helps Dr. Sachdev to determine the appropriate
37 dose of testosterone to prescribe for the patient. (Tr. at 3207-3208.)

38 ⁵⁸ At hearing, in response to the question "Did you have any conversation with any of [Patient G's]
39 treating oncologists," Dr. Sachdev replied, in relevant part, "There was no need for me because I actually
40 asked that to [*sic*] the husband. He was such a fabulous person in – in communicating and – and we
41 brought that discussion up. And he said I will go into – and I said fine." (Tr. at 105.)

42 ⁵⁹ During a March 22, 2012 interview with Mr. Bitonti, Patient G confirmed that the clinic sold her the
43 stock bottle of testosterone for \$800. (Ex. R1 at 11.)
44

45 ⁶⁰ If Dr. Sachdev had ordered testosterone for the patient from the usual pharmacy, it may have taken up
46 to two weeks for the patient to receive it. (Tr. at 3231.)

1 Hawaii. Dr. Sachdev wrote down details of the phone call on a progress note. (Ex. A46 at 80;
2 tr. at 116-117, 3273, 3285-3286.)
3

4 259. At the time of the hearing, Patient G's multiple myeloma was in remission. (Tr. at
5 3286.)
6

7 *Patient H*
8

9 260. In 2011, Patient H began treating with Dr. Sachdev. (See Ex. A55 at 3-17.) Her
10 medical history was notable for Celiac disease, as well as bilateral hip replacements in 2008.
11 (Tr. at 3588; Ex. A55 at 5-6.)
12

13 261. On December 12, 2011, Dr. Sachdev performed a tumescent liposuction procedure
14 on Patient H.⁶¹ (Ex. A55 at 21-32; tr. at 123, 3590.) Patient H informed clinic staff that she was
15 not taking prednisone at the time of that medical visit. (See Ex. A55 at 17; tr. at 3589.) Dr.
16 Sachdev was under the impression that Patient H had not taken prednisone for "several months"
17 prior to December 12, 2011. (Tr. at 3589.)
18

19 262. In a December 12, 2011 "Lipo Post-Op Note," Dr. Sachdev noted that Patient H had
20 topical erythema (*i.e.* redness) in the lower abdominal area. (Ex. A55 at 36; tr. at 3606-3609.)
21

22 263. As a precaution against infection, following the procedure on December 12, 2011,
23 Dr. Sachdev prescribed 500 mg of Keflex (cephalexin), to be taken twice per day for 10 days, to
24 Patient H. (Ex. A55 at 36, 40; tr. at 3603-3609.) The typical dose of this antibiotic is 500 mg,
25 four times per day. Dr. Sachdev had concerns regarding how the antibiotic might negatively
26 affect the patient, given her Celiac disease. She determined that the lower dosage (*i.e.* only twice
27 per day, instead of four) would be best for Patient H. (Tr. at 3604.)
28

29 264. In Dr. Thaler's opinion, the dosage of Keflex that Dr. Sachdev prescribed to Patient
30 H was not sufficient to treat a potential post-operative infection. (Tr. at 2450.)
31

32 265. On December 14, 2011, Patient H returned to the clinic for a post-operative check-
33 up. She complained of pain in the lower abdominal area. Dr. Sachdev observed minimal
34 bruising, which she considered normal for post-operative liposuction. Dr. Sachdev also observed
35 a small area of erythema in the lower abdominal (including pubic and right groin) area, which
36 was swollen and warm to the touch. Patient H had a temperature of 99.4 degrees. Dr. Sachdev
37 observed no signs of tachycardia or sepsis. (Ex. A55 at 40, 42; tr. at 3615.) Dr. Sachdev
38 consulted with Drs. Benedict and Johnson (each of whom had liposuction experience) regarding
39 Patient H. The physicians told Dr. Sachdev that 48 hours post-op was "pretty early" to have a
40 seroma or an infection. (Ex. A55 at 40.)
41

42 266. On December 14, 2011, Dr. Sachdev informed Patient H that she should stay in
43 Oregon for another day or two (*i.e.* not return home to Idaho right away) so that she could
44 continue being monitored for signs of infection. Minutes later, Patient H handed Dr. Sachdev
45

46 ⁶¹ Patient H lived in Idaho, but at the time, she was staying with relatives in Oregon who also treat with
Dr. Sachdev. (Tr. at 3587, 3614; see Ex. A55 at 2-3.)

1 her cell phone and told Dr. Sachdev to talk to the patient's then-boyfriend, Idaho orthopedic
2 surgeon Stanley Waters, MD. Dr. Waters was extremely upset because he had been unaware that
3 Patient H was undergoing the liposuction procedure in Oregon. He informed Dr. Sachdev that
4 Patient H had taken steroids a few months prior and that she had received a facet joint steroid
5 injection approximately one week prior. He also told Dr. Sachdev that he wanted Patient H to
6 return to Idaho immediately. Dr. Sachdev told him that she thought it best that Patient H not fly
7 home that day. Dr. Sachdev also told him that she would have a surgeon examine Patient H to
8 rule out tachycardia, sepsis, and necrotizing fasciitis. (Tr. at 124, 3596-3598, 3610-3613; Ex.
9 A55 at 40.)

10
11 267. Shortly after Dr. Sachdev spoke with Dr. Waters, surgeon Ali Khaki, MD, came to
12 the clinic and examined Patient H. Dr. Khaki determined that Patient H had no signs of
13 tachycardia, sepsis, or necrotizing fasciitis. (Tr. at 130, 3613-3615; Ex. A55 at 40.)

14
15 268. Dr. Sachdev resigned herself to the fact that Patient H would be flying home to
16 Idaho that day, despite her advice to the patient. Dr. Sachdev knew that the flight was only 1.5
17 hours, that Dr. Waters would be meeting the patient at the airport, and that Dr. Waters was
18 willing to take the patient immediately to the hospital if necessary. (Tr. at 3615-3617.) As an
19 additional precaution, Dr. Sachdev decided to perform a blood test (specifically, a "CBC" and a
20 "chem profile") on Patient H. (*Id.* at 3615.) At 1:30 p.m. on December 14, 2011, Patient H's
21 blood was collected and sent for testing. (Exs. A56 at 6, A55 at 40-43; tr. at 3615-3616, 3621.)

22
23 269. When Patient H left the clinic at approximately 3:00 p.m. on December 14, 2011 to
24 fly back to Idaho, Dr. Sachdev did not yet know the patient's blood test results. (Tr. at 134,
25 3615-3616, 3622, 3630, 3643; *see* Ex. A56 at 6-7.)

26
27 270. Dr. Sachdev decided to administer a low-dose of intramuscular (IM) antibiotic to
28 Patient H before she left for the airport. Dr. Sachdev determined that administering 250 mg of
29 the antibiotic Rocephin (ceftriaxone) would provide the patient with antibiotic protection for an
30 approximate four to six-hour period—enough time for Patient H to fly to Idaho and meet up with
31 Dr. Waters.⁶² Dr. Sachdev also made sure that Patient H took a dose of the oral antibiotic
32 Keflex, which Dr. Sachdev had previously prescribed to her, before she left the clinic. (Ex. A55
33 at 41; tr. at 3616-3619.)

34
35 271. Rocephin is a long-acting antibiotic, and the standard dose for treatment of a wound
36 infection is one to two grams. A dose of 250 mg would only be an appropriate effective dose for
37 treating a condition such as gonorrhea. (Tr. at 271, 1770.)

38
39 272. In Dr. Turner's opinion, Dr. Sachdev administered an inadequate dose of Rocephin
40 to Patient H on December 14, 2011. (Tr. at 1770-1772.)

41
42 273. On the morning of December 15, 2011, Dr. Sachdev received the blood test results
43 for Patient H. The results showed, in part, that Patient H had a potassium level of 2.8. The
44

45
46 ⁶² Dr. Sachdev explained at hearing that a dose of one gram would be expected to provide antibiotic
protection to a person for approximately 24 hours. (Tr. at 3618.)

1 standard range for a person's potassium level is 3.7 to 5.5. (Ex. A56 at 7; tr. at 3622-3624,
2 3626.)

3
4 274. Hypokalemia is a low potassium level in the blood. A potassium level below 3 is
5 "very concerning." (Tr. at 267-268.) The primary risk associated with hypokalemia is cardiac
6 arrhythmia (*i.e.* abnormal heart rhythms). The treatment for hypokalemia is a potassium
7 supplement pill. If a patient is stable, the treatment should be administered no later than
8 approximately 12 hours after learning of the condition. (*Id.* at 268-269.)

9
10 275. A person who experiences an acute decrease in potassium level would be
11 symptomatic. (Tr. at 3626.) Dr. Sachdev never observed any symptoms of a low potassium
12 level in Patient H. When she received the patient's test results, showing the low potassium level,
13 she suspected that Patient H had chronic hypokalemia. (*Id.* at 3629, 3640.) Although she
14 determined that it was important to immediately report the results to the patient, she did not
15 believe that the chronic condition was life-threatening or as serious as if it were an acute
16 hypokalemic episode. (*Id.* at 3640.)

17
18 276. If Patient H had disclosed to Dr. Sachdev prior to the surgical procedure on
19 December 12, 2011 that she had chronic hypokalemia and was taking potassium supplements,
20 Dr. Sachdev would have checked the patient's potassium level prior to performing the surgery.
21 (Tr. at 3636.)

22
23 277. Immediately after receiving the test results on December 15, 2011, Dr. Sachdev
24 directed Patient C to call Patient H to report the results. Patient C was unable to reach Patient H
25 after several attempts. (Tr. at 126, 3622, 3624, 3630-3631.)

26
27 278. Dr. Sachdev eventually, on December 15 or 16, 2011, called Dr. Waters to inform
28 him of Patient H's test results, including the patient's low potassium level.⁶³ Dr. Waters
29 informed Dr. Sachdev that Patient H had a history of hypokalemia, that she was not always
30 compliant in taking her potassium supplements, and that he would inform the patient's internist
31 about it. (Tr. at 125-126, 3624-3627-3629, 3635; Ex. A55 at 41.) If the patient had lived in
32 town, and not flown back to Idaho, Dr. Sachdev would have addressed the patient's hypokalemia
33 herself. (Tr. at 129.)

34
35 279. On December 16, 2011, Dr. Sachdev dictated a chart note regarding the events of
36 December 14 through 16, 2011 with Patient H. (Tr. at 3605-3606; Ex. A55 at 40-41.) The chart
37 note states, in part:

38
39 I, Dr. Sachdev, felt comfortable after drawing the CBC and the
40 electrolytes. Gave her small injection of Rocephin [so] that she could
41 leave and travel. I did call Dr. Stanley Waters with the results. She was
42 hyperkalemic and I did find out later that she was on potassium
43 supplements, because she has tendency to worse [*sic*] hyperkalemia.

44
45
46 ⁶³ On an August 10, 2011 HIPPA authorization form, Patient H had authorized Dr. Sachdev to discuss
Patient H's medical information with Dr. Waters. (Ex. A55 at 15.)

1 (Ex. A55 at 41.) Dr. Sachdev's reference to hyperkalemia (and not hypokalemia) was a dictation
2 or transcription error. (Tr. at 128, 3632-3633.)
3

4 280. During the September 27, 2012 Investigative Committee interview, Dr. Sachdev
5 informed the committee that she prescribed Ceftriaxone for Patient H because the patient had a
6 urinary tract infection (UTI). (Ex. A11 at 14.) Dr. Sachdev specifically told the committee:
7

8 [T]he concern was I was still covering for a superficial infec[tion], but she
9 had a urinary tract infection and that's really what I covered her for. Her
10 urine was abnormal in the chart, if you look that day. Because she had a
11 fever, I wanted to make sure that she may not have developed a urinary
12 tract infection alongside with that. I felt fine that she was on the Keflex
13 that I started her on, but she had a urinary tract infection, so I didn't feel—
14 with traveling, she's going to get more dehydrated, so I thought she could
15 follow up with that[.]
16

17 (*Id.*)
18

19 281. At hearing, in response to the question, "[D]id you provide [the IM antibiotic] for a
20 urinary tract infection," Dr. Sachdev responded as follows:
21

22 I – one of the things I do is, again, this is my cautiousness. It's always –
23 well, she has a fever. You just can't assume it's from an infection. What
24 if she had a urine – so I took a urine dipstick. And on the dipstick she
25 really didn't – she came out negative for the white count. We have those
26 results. The dipstick showed that she didn't have a urinary tract infection,
27 but then I always think, okay, again, functionalism. What if she had less
28 than 100,000 bacteria to declare an infection? What if she's budding and
29 then she's going to be going to the airport. She's going to be dehydrated.
30 Oh, good, perfect. [Rocephin] will cover that, too. * * *. 250 [mg] will
31 cover the wound infection. She's not compliant with her medication. I
32 can cover her urinary tract infection. So all that stuff is going in my mind
33 and I thought it was a perfect thing to give. * * *. In view of the fact that
34 I also was cautious about the dose because she's got Celiac disease. I'm
35 not going to get her now the diarrhea and a flare-up with that. * * *. So
36 that's my thinking.
37

38 (Tr. at 3638-3639.) Dr. Sachdev's December 16, 2011 chart note for Patient H does not mention
39 a urinary tract infection or the possibility that Patient H might have such an infection. (*See* Ex.
40 A55 at 40-41.)
41

42 282. During the Board's investigation, neither Dr. Sachdev nor her attorneys informed
43 Mr. Bitonti that there were additional patient records they wished to provide regarding Patient H.
44 (Tr. at 1029-1030.)
45

46 *Patient I*

1
2 283. Patient I began treating with Dr. Sachdev in approximately 1996. (Tr. at 2074; *see*
3 Ex. A59 at 23.) She has received treatment for multiple medical issues, including hormonal,
4 mental health, and chronic pain issues. (*See* Ex. A58 at 118, 119, 130; tr. at 2094.) Dr. Sachdev
5 considers Patient I a “very complicated patient.” (Tr. at 152.)
6

7 284. Prior to treating with Dr. Sachdev, Patient I treated with pain management
8 specialists and other physicians who prescribed pain medications, including Vicodin, to her.
9 Patient I has also treated with one or more specialists (*e.g.* an orthopedist) while treating with Dr.
10 Sachdev. (Tr. at 152-154, 2077, 2108; *see* Ex. A60 at 1-4.)
11

12 285. At hearing, Dr. Sachdev testified that Patient I was already taking Ambien, Vicodin,
13 and Xanax before she prescribed those medications for her. (Tr. at 152-156.)
14

15 286. Patient I was involved in a car accident in 2005 or 2006. Sometime after the
16 accident, Dr. Sachdev began prescribing Vicodin for Patient I’s back pain. (Tr. at 2109.)
17

18 287. A Patient Medication List, found at Exhibit A58 at 96, is the earliest documentation
19 of Patient I’s medication regimen with Dr. Sachdev. (*See* Ex. A58.) According to that
20 document, as of at least August 9, 2010, Dr. Sachdev was prescribing Vicodin, Ambien, Soma,
21 and Adderall to Patient I. (*Id.* at 96; tr. at 3310.)
22

23 288. Electronic prescription records show that Dr. Sachdev prescribed Vicodin to Patient
24 I thirteen times from December 24, 2010 to December 27, 2011, Soma five times from
25 September 27, 2010 to December 2, 2011, Ambien eight times from May 13, 2011 to January 12,
26 2012, and Xanax five times from September 9, 2011 to approximately December 27, 2011. (*See*
27 Ex. A58 at 39-76.)
28

29 289. At hearing, in response to the question, “[W]hen did you first start getting
30 prescribed Adderall and who was the prescriber,” Patient I replied, in relevant part:
31

32 Initially, Dr. Sachdev recommended it and wanted me to go get a test
33 through a psychiatrist or to go get actually tested for it, for ADD. * * *
34 So she recommended, and I said I would set up an appointment. And in
35 the meantime she did prescribe it to make sure that, you know, I got
36 started right away because I was having such difficulties.
37

38 (Tr. at 2104-2105.)
39

40 290. Patient I’s medical records show a prescription authorization request dated
41 September 28, 2011 for 15 tablets of 0.25 mg Xanax for Patient I. The request was approved on
42 September 29, 2011. The authorization request form shows that prescriber “Naina Sachdev”
43 wrote a prescription for the same medication on September 9, 2011, which Patient I filled on
44 September 11, 2011. (Ex. A58 at 54.) Patient I’s medical records contain no chart notes,
45 progress notes, or other documentation discussing those Xanax prescriptions. (*See id. generally.*)
46

1 291. Patient I's medical records do not reference when Dr. Sachdev first began
2 prescribing Vicodin, Soma, Ambien, Adderall, and Xanax to Patient I. (See Ex. A58.)
3

4 292. Dr. Sachdev prescribed Ambien for Patient I's insomnia and fibromyalgia issues.
5 (Tr. at 154-155, 2111.) She prescribed Soma for Patient I's muscular pain and spasms. (Id. at
6 2112.)
7

8 293. Patient I treated with Dr. Sachdev on December 4, 2009, August 9, 2010, August
9 18, 2010, January 3, 2011, May 26, 2011, July 26, 2011, October 10, 2011, and January 13,
10 2012. (See Ex. A58 at 1, 96, 131-132.)
11

12 294. A chart note dated December 4, 2009 does not reference Patient I taking any
13 medications. (Ex. A58 at 131-132.)
14

15 295. On January 3, 2011, Patient I treated with Dr. Sachdev. (Ex. A58 at 129-132.) An
16 MSQ dated January 3, 2011⁶⁴ indicates, in part, that Patient I was experiencing frequent
17 insomnia of a non-severe nature. (Id. at 107.) A chart note dated January 3, 2011 states, in part:
18

19 HPI: The patient is having several issues. Firstly is that of her ongoing
20 ADD issues. She definitely needs to be on Adderall. There have been
21 financial issues that she is having to face. This has caused her [a]
22 tremendous amount of stress in her life and pretty much in how she is
23 dealing * * * she is starting to feel depressed. She actually took the
24 questionnaire, is going to enter the Summit Research Protocol Study⁶⁵ and
25 she is on bioidentical hormone replacement therapy. She is certainly not
26 suicidal, she does not have a bad attitude, does not feel that things are
27 hopeless, but she has a lot of the symptoms where she just feels that she is
28 depressed. So, her other issue, which is also most important, is her right
29 shoulder. I have looked at the x-rays. It showed calcific tendonitis. This
30 is an extremely painful condition. On top of that, she has a history of
31 fibromyalgia and chronic back pain issues. She is having much more back
32 pain, which * * * is depleting her endorphin and encephalin levels leading
33 again to neurotransmitter imbalances, which is leading to the feelings of
34 depression. So, it is a vicious cycle that she is in and in order for me to try
35 to break that I think it is a great idea that she can enter the Summit
36 Protocol Study, but I would want her to really address her inhibitory
37 neurotransmitter support and namely I would start her on Lexapro and I
38 think this would really help relieve anxiety, would help[] her to sleep
39

40
41 ⁶⁴ The record does not contain the second page of the January 3, 2011 MSQ for Patient I. (See Ex. A58.)

42
43 ⁶⁵ On or about December 26, 2010, after seeing a television advertisement for Summit Research Center,
44 Patient I called to inquire about a research program involving depression. On or about January 2, 2011,
45 she went to the Summit Research Center and met with psychotherapist Dr. Scott Losk for approximately
46 two hours. Dr. Losk informed Patient I that she was not an appropriate candidate for the research
program, and that Dr. Sachdev's treatment protocol for Patient I was the same as he would recommend.
(Tr. at 2079-2081, 2105.)

1 better. * * * * *. At this point, in terms of functional medicinal approach,
2 we really need to address her neurotransmitter imbalances, a quick fix
3 would be simply to start Lexapro and see what happens and again she will
4 let me know if she is going to enter the study, get a full evaluation and
5 then let me know and then we can always get her started on the
6 medications. I am also going to recommend some alternative treatment
7 regimens for the muscle tightness that she is having over the neck area[.]
8 There are [a] lot of trigger points that are positive for fibromyalgia. * * *
9 * *. The patient is under so much pain right now that we have to amend
10 the chronic pain management contract I am going to have with her as she
11 is going through about one and a half tablets of Vicodin twice a day. Until
12 she gets her depression under control[], gets her evaluation done and gets
13 her calcific tendonitis resolved, I am going to * * * prescribe her 3
14 Vicodin tablets a day and we will give it on a weekly basis of about 21
15 tablets in a week and there will be no other prescribing doctor[]. * * *. If
16 for some reason the medicines need to be changed she can let me know
17 and I can discuss that with the specialist that she will be * * * seeing.
18

19 (*Id.* at 130.) On a Nutraceutical Protocol form dated January 3, 2011, Dr. Sachdev listed
20 Adderall under the section titled "Protocol." (*Id.* at 106.) The form does not list any instructions
21 or dosage amounts for Adderall. (*See id.*)
22

23 296. Sometime prior to January 21, 2011, Dr. Sachdev requested an orthopedic
24 consultation for Patient I's right shoulder pain. (Tr. at 137-138; *see* Ex. A60 at 1.) On January
25 21, 2011, Patient I saw an orthopedist at the Orthopedic & Fracture Clinic. She was diagnosed
26 with calcific tendonitis. (Ex. A60 at 1-4.)
27

28 297. On May 26, 2011, Patient I had a follow-up visit with Dr. Sachdev regarding her
29 fibromyalgia and neck and back pain. A chart note dated May 26, 2011 states, in part:
30

31 The patient is having acute neck pain exacerbation again along the
32 scapular strain along with pain in her upper back area. She has
33 fibromyalgia, but she is having again another flare up. * * *. The only
34 thing that she has been on is pain management contract, but she is very
35 uncomfortable. She has been doing about four Vicodin a day, but there is
36 no Tylenol to that, so I am going to try to lower her dose of Tylenol and I
37 will just do more hydrocodone, probably switch her to Vicodin 7.5 mg
38 tablets and we will see how she does with three tablets a day. So, at this
39 point we are going to _____⁶⁶ to see how this regimen works for
40 her. I have also recommended [an] alternative treatment regimen, which
41 really works well for her as well. Combined with these two treatments,
42 the patient tends to do a lot better.
43

44 * * * * *

45
46 ⁶⁶ The chart note contained this blank line. (*See* Ex. A58 at 127.)

1
2 A/P: Acute fasciitis/neck pain/scapular pain/myositis/myalgias. The
3 patient also signed a chronic pain management contract * * * and will
4 follow up over the next 8 to 10 weeks.
5

6 (Ex. A58 at 127.)
7

8 298. On July 26, 2011, Patient I saw Dr. Sachdev for a comprehensive wellness exam.
9 (Ex. A58 at 121-124.) An MSQ dated July 26, 2011 indicates, in part, that Patient I was
10 experiencing occasional severe insomnia, as well as frequent hot flashes and excessive
11 sweating.⁶⁷ (*Id.* at 105.) A July 26, 2011 chart note states, in part:
12

13 [T]he patient went off antidepressant therapy, because she could no longer
14 afford it and actually has been doing okay with it.
15

16 * * * * *

17
18 [T]he patient has gone off the Cymbalta. She is on Vicodin 5 mg on p.r.n.
19 basis, Zolpidem 10 mg p.o. q.h.s. p.r.n. basis for sleep. She is on Soma
20 350 mg p.o. q.d. p.r.n. basis[.] Adderall 30 mg p.o. b.i.d. She is on
21 bioidentical HRT[.]
22

23 * * * * *

24
25 REVIEW OF SYSTEMS:
26

27 * * * * *

28
29 Musculoskeletal: [I]ntermittent chronic neck pain, back pain issues, she
30 always has.
31

32 * * * * *

33
34 Psychological: No unusual stress or depression. Actually she is off the
35 antidepressants and feeling happy.
36

37 (*Id.* at 124-125.)
38

39 299. On October 10, 2011, Patient I saw Dr. Sachdev for a follow-up visit. An MSQ
40 dated October 10, 2011 indicates that Patient I was experiencing occasional insomnia, migraines,
41 anxiety, and irritability of a severe nature; poor memory and poor concentration of a non-severe
42 nature; and frequent depression and mood swings of a non-severe nature. (Ex. A58 at 104-105.)
43 An October 10, 2011 chart note states, in part:
44
45
46

⁶⁷ The record does not contain the second page of the July 26, 2011 MSQ for Patient I. (*See* Ex. A58.)

1 CHIEF COMPLAINT: Anxiety and exacerbation of her chronic neck and
2 back pain.

3
4 HPI: The patient is * * * under [a] tremendous amount of stress. * * * *
5 *. She cannot sleep. Her fibromyalgia symptoms have flared up. She is
6 grinding her teeth. She is having headaches again. She is having
7 insomnia, her migraine headaches are back in terms of her neurologic
8 system. She is also having parasthesias. She is having pains and aches in
9 her joints, pains and aches in her muscles, and muscle weakness. * * *.
10 The fatigue is starting to come back. She feels that sometimes she cannot
11 focus. She is starting to feel again emotional mood swings, anxiety and
12 panic attacks. She actually had to go when I was out of [town] to see
13 another doctor just to get a few tablets of Xanax.⁶⁸ Her situation is really,
14 really bad. We had a lengthy discussion with regard to that.

15
16 REVIEW OF SYSTEMS: * * * * *.

17
18 Neurologic: As mentioned the migra[i]n[e]s and insomnia issues

19
20 * * * * *

21
22 Constitutional: Binge eating, craving certain foods, excessive weight,
23 fatigue, sluggishness and restlessness.

24
25 Psychiatry: Poor memory. Poor concentration. Feelings of depression,
26 anxiety, insomnia, irritability, or panic attacks.

27
28 * * * * *

29
30 CURRENT MEDICATIONS: She is doing Vicodin 7.5/500 mg. She is
31 doing up to one tablet three times a day, Zolpidem generic, Ambien 10 mg
32 p.o. p.r.n. basis. Soma 350 mg p.o. p.r.n. basis, Adderall, she is taking 30
33 mg * * * twice a day. * * *.

34
35 * * * * *

36
37 ASSESSMENT/PLAN:

38 1. Chronic neck and back pain exacerbation. I am going to continue to
39 have her do the Vicodin. I am asking her to really sit down and focus on
40 meditation and relaxation techniques which she is going to do.

41
42
43
44
45 ⁶⁸ A physician at the Portland Clinic had prescribed Xanax to Patient I when the patient presented with
46 symptoms of anxiety and panic. (Tr. at 2109-2110.)

1 2. Panic attacks. Secondary to financial distress. I am going to give her
2 Xanax 0.25 mg p.o. b.i.d. on a p.r.n. basis[.]⁶⁹
3

4 (Ex. A58 at 118-119.) The lowest possible dosage of Xanax is 0.25 m.g. (Tr. at 3312-3313.)
5

6 300. After October 10, 2011, Dr. Sachdev continued to prescribe Xanax to Patient I on
7 an as-needed basis for treatment of her anxiety. (Tr. at 152-153, 2110; see Ex. A58 at 41-45.)
8

9 301. On January 13, 2012, Patient I had a follow-up visit with Dr. Sachdev. (See Ex.
10 A58 at 96, 116.) An MSQ dated January 13, 2012 indicates that Patient I was experiencing
11 occasional severe insomnia. (*Id.* at 100-101.) The patient's medical file contains a handwritten
12 progress note regarding the January 13, 2012 visit, but no transcribed chart note. (*Id.* at 116; see
13 *id.* at 1-160.)
14

15 302. Dr. Sachdev had Patient I sign contracts regarding the long-term use of controlled
16 substances for chronic pain. (Ex. A58 at 60-65; tr. at 139.) Each contract specified, among other
17 things, that Patient I was only to obtain controlled substances from Dr. Sachdev, absent specific
18 authorization for an exception, and that she was only to obtain them from a specifically selected
19 pharmacy. (See Ex. A58 at 60, 62, 64.)
20

21 303. Dr. Sachdev's customary practice was to provide no refills on pain medication. (Tr.
22 at 157.) However, if she had a long-standing relationship and a good rapport with a patient on a
23 chronic pain management contract, she would allow the patient to go two to three months
24 without an office visit, while continuing to receive pain medication prescriptions. (*Id.* at 168.)
25 With possibly one or two exceptions, Dr. Sachdev provided Patient I with only 30-day
26 prescriptions, with no refills. (*Id.* at 2119-2120.)
27

28 304. Patient I took Vicodin and Adderall daily. Her use of Vicodin would increase if she
29 sustained some type of injury that caused her pain level to worsen beyond its usual level. She
30 took Soma, Ambien, and Xanax less than daily. (Tr. at 156, 159, 2112, 3315.)
31

32 305. Adderall is a stimulant with side effects that include anxiety and insomnia. Xanax
33 is a benzodiazepine and an anxiolytic. Ambien is a hypnotic. (Tr. at 274, 276.) Dr. Turner
34 believes it is possible that the Xanax and Ambien were being used to treat side effects from the
35 Adderall. (*Id.* at 274, 278.) In Dr. Turner's opinion, prescribing Adderall, Xanax, and Ambien
36 concurrently to a patient is "unusual." (*Id.* at 278.)
37

38 306. Adderall may increase the effects of Vicodin. For example, it could make the
39 effects of the Vicodin last longer or it could worsen the opioid side effects of diminished central
40 nervous function. Using Xanax and Vicodin at the same time could result in excessive sedation.
41 However, prescribing those two medications concurrently is not improper. (Tr. at 275-276.)
42

43 307. In Dr. Turner's opinion, prescribing the combination of five medications (Vicodin,
44 Soma, Ambien, Xanax, and Adderall) required careful periodic review, with documentation of
45

46 ⁶⁹ At hearing, Dr. Sachdev testified that she advised Patient I not to take Xanax within four to six hours of
taking sleep medication. (Tr. at 154.)

1 how each medication was working for the patient and whether she was experiencing any side
2 effects. In Dr. Turner's opinion, the dosages of the medications Dr. Sachdev prescribed to
3 Patient I were not dangerously high or atypical.⁷⁰ (Tr. at 277-278.)
4

5 308. In Dr. Turner's opinion, if Patient I was taking medication[s] prescribed by another
6 physician while treating with Dr. Sachdev, Dr. Sachdev should have documented what the
7 patient was taking and who had prescribed the medication[s]; done a complete history and
8 physical to understand the indications for the medication[s], what other medication[s] she may
9 have taken, and what prior consultations she may have had; evaluated the use of the
10 medication[s] to determine efficacy; and made a long-term plan for continuation,
11 discontinuation, or modification of the medication[s]. (Tr. at 1785-1787, 1800.)
12

13 309. In Dr. Boyko's opinion, the regimen of prescribed medications was not excessive.
14 (Tr. at 2429-2430.) At hearing, in response to the question, "Do you have concerns about the
15 drug interaction between Xanax, Ambien, Adderall, hydrocodone, and Soma?" Dr. Boyko
16 replied, in part:
17

18 Not if a patient is being monitored. * * *. [P]hysicians often find that
19 patients have multiple medical conditions which require multiple
20 treatments, which will increase the possibility of interaction. And if a
21 patient is followed by his or her provider to guard against harmful
22 interactions, then my concern is minimized in that case.
23

24 (*Id.* at 2431-2432.) With a patient on a complex medication regimen, such as Patient I, Dr.
25 Boyko recommends that the patient follow-up with the prescribing physician at least two to four
26 times per year. He believes that it is even more important for the patient to have access to the
27 physician and the physician's office in the event an issue arises. (*Id.* at 2432.)
28

29 310. On August 21, 2012, Patient I requested a copy of her medical records from the
30 clinic. (Ex. A58 at 141.) The records provided to her were not complete. For example, certain
31 test results and questionnaire sheets were missing. The records also appeared to contain some
32 discrepancies regarding prescription medications. (Tr. at 2077-2078, 2084-2085, 2092, 2102.)
33 Patient I called the clinic to inquire about missing records. Clinic staff informed Patient I that
34 the clinic could not release any records to her that contained Dr. Sachdev's handwritten notes.
35 Clinic staff told Patient I that they could obtain some additional records for her from "archives."
36 (*Id.* at 2103-2104.) Patient I subsequently received additional records from the clinic, but not her
37 entire medical record. (*Id.* at 2104.)
38

39 311. A document dated September 20, 2012 states:
40

41 Dr. Naveen had me call [Patient I] to inform her we can no longer
42 continue to fill most of her RX's because the multiple use of medications
43

44 ⁷⁰ During her hearing testimony, Dr. Turner pointed out that Patient I's medical records contain no
45 documentation of PAR conferences for any of the prescribed medications. (Tr. at 277.) However, the
46 Board's notice does not allege a violation with regard to a failure to inform Patient I of the potential risks
and side effects of her prescribed medications. That issue will therefore not be addressed in this decision.

1 is shown to increase potential risk of drug duplication, drug interaction
2 and adverse side effects. [The patient] is aware and understands that we
3 can no longer fill all RX's. I will find some places to refer her to so she
4 can get further care[.]
5

6 (Ex. A58 at 140.) On October 9, 2012, Dr. Naveen referred Patient I to Oregon Pain Associates
7 for pain management regarding her migraines, chronic back and neck pain, and fibromyalgia.
8 (*Id.* at 136-137.)
9

10 *Patient J*

11
12 312. Patient J is the daughter of Patient I. (Tr. at 2122, 3105; *see* Ex. A61 at 43.) She
13 first treated with Dr. Sachdev on October 19, 2010, when she was 15 years old. (Ex. A61 at 43;
14 tr. at 3107.)
15

16 313. On an October 19, 2010 MSQ, Patient J indicated that she was experiencing
17 occasional severe coughing and gagging and occasional non-severe headaches, acne, and
18 hives/rashes/dry skin.⁷¹ (Ex. A61 at 40.) On an Adrenal Fatigue Checklist, Patient J indicated
19 that she was experiencing severe problems with getting up in the morning, lethargy, low mood,
20 poor memory, afternoon lows, continuing fatigue, less enjoyment or happiness in life, brain
21 fog/loss of focus, decreased tolerance for stress/noise/disorder, and feeling overwhelmed by all
22 that needs to be done. (*Id.* at 41.)
23

24 314. An October 19, 2010 chart note states, in part:
25

26 At 12 years, there were certain social situations that happen[ed], which
27 started to cause her internal stress. She is a very sensitive individual.
28 First, her parents divorced, a year later she lost her best friend to
29 meningoencephalitis. * * *. [The patient] was a stellar athlete, very good
30 in basketball * * * and suddenly the coach left, so a lot of issues, the team
31 spirit fell apart and she found herself again in a situation that is changing.
32 She has really not had a steadiness over the last three years. [S]he actually
33 switched school[s] from some of the harassment and some issues that
34 happened in the high school[.] So, she has gone through four major
35 changes within the last one and a half years. In addition to that, she got
36 into a really very nice relationship, which turns out under the influence of
37 alcohol, she was physically abused. [S]he is now feeling depressed[.] * *
38 * * *. [F]atigue is an issue she is having along with mood swings and just
39 feeling of depression and frequent illness, urgent urination, significant
40 adrenal fatigue issues. So, at this point, the patient is feeling depressed.
41 We had a lengthy discussion with her mom and getting her into
42 psychotherapy. Most probably, I can put her on short-term depression
43 medication. It is serious major depression, as I have discussed with her, I
44 am not comfortable without having the patient go on something. They
45 will closely monitor with me.
46

⁷¹ The record does not contain the second page of the MSQ. (*See* Ex. A61.)

1
2 * * * * *. Initially, because she is suffering from depression, I really want
3 to refer her to a psychotherapist, doing to the [*sic*] neurotransmitter test,
4 which will more accurately help me prescribe the optimum medication for
5 her rather than simply starting her just on a medication. She [ha]s
6 managed for this long. I have asked her if she wants me to initiate
7 medication. Her father prefers her not to start on medication without a
8 proper evaluation, so we will start with a psychotherapist, proper
9 evaluation, neurotransmitter test and then that will effectively help us to
10 optimize her medication regimen as well.
11

12 (Ex. A61 at 43-44, 55-56.)
13

14 315. At hearing, Dr. Sachdev testified as follows with regard to her initial treatment
15 approach with Patient J:
16

17 In my first visit with her I knew that she probably had ADD issues but I
18 don't treat it. I'm going to look for other reasons. I'm going to look for
19 comorbid, but I was already setting in my mind specifically asking
20 questions. * * * * *
21

22 Because I realized that this is going to go into a comorbid depression,
23 anxiety condition, I started to focus on that first before I was going to
24 focus on any ADD issues.
25

26 (Tr. at 3111-3112.)
27

28 316. On November 10, 2010, Patient J had an appointment with Dr. Sachdev to discuss
29 her neurotransmitter test results. A chart note for that visit states, in part:
30

31 [T]he patient has been having a lot of issues of anxiety and depression and
32 at this point what I want to address is her neurotransmitter imbalance. * *
33 * * *. At this point what I want to do is really address her focus issues,
34 which is a huge issue for her. We are going to start her [on] Pristiq. So
35 we are going to give her samples for a month[.] * * * * *. So all this was
36 discussed in detail with the patient. The patient verbally understands the
37 treatment plan of care.
38

39 * * * * *

40
41 A/P
42

43 1. Metabolic dysfunction/depression/vitamin D deficiency/adrenal
44 fatigue. At this point, I am going to initiate Rx of Pristiq 50 mg p.o. q.d.
45 and alternative treatment regimen initiated, vitamin D3 replacement
46 therapy initiated. RTC in four weeks[.]

1
2 (Ex. A61 at 42, 53.)
3

4 317. Patient J filled a Pristiq prescription on January 15, 2011, and Dr. Sachdev
5 authorized additional refills of the medication on February 7, 2011. (Ex. A61 at 24.)
6

7 318. On May 3, 2011, Patient J completed the short ADD/ADHD screening form (*i.e.* the
8 ASRS-V1.1). (Ex. A61 at 35.) On that date, she also completed the Adult ADHD-RS-IV with
9 Adult Prompts. She had a score of 51 on that form, which signifies a “severe” rating. (*Id.* at 36-
10 37; tr. at 3124-3125.)
11

12 319. An MSQ dated May 3, 2011 indicates that Patient J was experiencing occasional
13 non-severe headaches, dizziness, hives/rashes/dry skin, irregular/skipped heartbeat, rapid or
14 pounding heartbeat, chest pain, and shortness of breath.⁷² (Ex. A61 at 34.)
15

16 320. On May 3, 2011, Patient J treated with Dr. Sachdev. The chart note for the visit
17 states, in part:
18

19 The patient is acutely here. * * * * *. When her mom left * * * the room,
20 she explained to me * * * how she really wants to have [a] relationship
21 with her mother. She is stressing internally a great deal. She is barely
22 going to school. She cannot focus. She cannot get up. She feels tired.
23 The Pristiq did not help her at all. So she went off the antidepressant. She
24 has been doing the same since the time that she saw me, which has been
25 several months. * * * * *. She is having fatigue issues, headaches, binge
26 eating and excessive weight[.] * * * * *. After her mother left [the room],
27 I also discussed with the patient further on how she feels. A lot of her
28 issues are more focus related. Her mother has ADD and so I am starting
29 to suspect that she may have ADD issues and that may be very significant
30 for her. So this is a serious issue that we have to deal with[.]
31

32 P/E: The patient is alert. She is tearful. * * * * *.
33

34 A/P:
35

36 * * * * *
37

38 2. Depression. I really do not think is [*sic*] more than depression, it is a
39 lack of focus and all of that. I think we did an ADHD screening along
40 with the DSM 18-point scale for ADHD symptoms and she ca[me] back
41 high for both [of] those. So I am going to initiate Adderall. I had a
42 discussion with regard to the medication use of Adderall 10 mg non-
43 extended release. We are going to start with p.o. b.i.d. We are going to
44 initiate with one-half tablet p.o. b.i.d. and then slowly workup [*sic*] to one
45 tablet p.o. b.i.d. maybe even two tablets p.o. b.i.d. I will see her back in
46

⁷² The record does not contain the second page of the MSQ. (See Ex. A61.)

1 about two to three weeks, because there is so much going on with her[.]
2 * * * * *. So all of this was discussed in detail. The patient verbally
3 understands [the] treatment plan of care.
4

5 3. ADHD. Initiate Adderall.
6

7 (Ex. A61 at 50-51.)
8

9 321. At hearing, Dr. Sachdev testified as follows regarding her decision to prescribe
10 Adderall to Patient J, and Patient J's results on that medication:
11

12 This is a * * * patient that was actually functioning very well. She was in
13 high school very, very well. And then suddenly I guess perhaps her
14 parents go through a divorce * * * and she stops functioning. She can't go
15 out of the house. She's gaining weight. She now starts to flunk school
16 where she's done extremely, extremely well. * * * * *.
17

18 So I said, "Let's have her see a counselor and then let's – she probably
19 needs to be on antidepressant[s]." And * * * then antidepressants were
20 tried. Nothing affected her. She went to counseling. [I] mentioned she
21 see a psychiatrist. I think [the family] was limited by * * * money[.]
22 * * *. So there were all of those dynamics going on. And so several
23 months I think went by. [I] think the patient definitely saw counselors but
24 I don't know if she saw them regularly. That's what I don't know. So she
25 didn't do well. No matter what we * * * [tried.]
26

27 [I] tried, of course, my integrative methods and all, and I was really
28 surprised. I said something should have worked here. And then I started
29 asking her a few questions. I said, "Do you get distracted?" I just started
30 asking her a few of the ADD screening [questions]. I said, "Let me have
31 you take [the] ADD screen." She took it and I said, "Let's just see for a
32 month. Let's – we're going to prescribe her Adderall." * * * * *.
33

34 So after I did the screen – and I was so happy. I thought. "Oh my gosh. I
35 bet you she's got – she probably has ADD." And so I said, "Okay. Let's
36 [try Adderall] for a month," – and then what I do is – I don't like to give
37 the extended release. I always like to give the smaller.
38

39 So we tried Adderall; very great results. She had fabulous results. This
40 lady went to functioning. She went back to school, started getting A's.
41 * * *. I mean, she was functional, totally functional.
42

43 (Tr. at 174-176.)
44

45 322. Patient J's medical file contains no documentation to establish that Patient J was
46 evaluated for ADD/ADHD by a psychologist or psychiatrist. Her medical file contains no

1 evidence that she was engaged in mental health therapy or counseling. Her medical file contains
2 no evidence that she tried antidepressant medications other than Pristiq. (See Exs. A61, A63.)
3

4 323. An MSQ dated May 10, 2011 indicates that Patient J was experiencing occasional
5 severe hives/rashes/dry skin and occasional non-severe acne and excessive sweating.⁷³ (Ex. A61
6 at 32.)
7

8 324. On May 10, 2011, Patient J saw Dr. Sachdev for a women's wellness exam. (Ex.
9 A61 at 48-49.) On a May 10, 2011 chart note, Dr. Sachdev stated, in part:
10

11 The patient is here really to get her Pap done, but I was also concerned
12 from the last visit. She is already doing much, much better in terms of her
13 fatigue, lack of focus issues and a lot of issues that she had. The Adderall
14 is working really well for her. * * *. She is actually doing about 10 mg
15 twice a day with significant improvement in her symptoms. She has
16 already taken control of just her focus, her energy and just her mood and
17 has already significantly improved.
18

19 * * * * *

20
21 A/P:

- 22
23 1. Preventive Pap done.
24
25 2. ADD. The patient is doing really well on the Adderall 10 mg p.o.
26 b.i.d. dosing and she is doing great.
27

28 (*Id.* at 48.)
29

30 325. On March 9, 2012, Patient J had a follow-up visit with Dr. Sachdev.⁷⁴ (See Ex. A61
31 at 29, 47.) An MSQ dated March 9, 2012 indicates that Patient J was experiencing occasional
32 severe headaches, acne, and anxiety/fear/nervousness; and occasional non-severe flushing,
33 excessive sweating, depression, and anger/irritability/aggressiveness. (*Id.* at 31.) A handwritten
34 progress note dated March 9, 2012 indicates that the reason for the visit was to reassess for
35 Adderall. (*Id.* at 47.) The record contains no dictated chart note for that visit.⁷⁵ (See *id.*
36 *generally*; tr. at 279-280.)
37
38
39

40
41 ⁷³ The record does not contain the second page of the MSQ. (See Ex. A61.)

42 ⁷⁴ Patient J's medical records contain no chart notes or progress notes to indicate that Patient J treated
43 with Dr. Sachdev between May 10, 2011 and March 9, 2012. (See Ex. A61.)

44 ⁷⁵ At hearing, Dr. Sachdev testified that, consistent with her usual and customary practice, she would have
45 dictated a chart note to correspond with Patient J's March 9, 2012 visit. She suspects that a former
46 employee may have been manipulating charts and preventing certain chart notes, such as this one, from
reaching the transcription service. (Tr. at 3138-3140.)

1 326. On July 5, 2012, Dr. McQueen authorized a prescription for a 30-day supply of
2 Adderall for Patient J. (Ex. A61 at 21.) On September 12, 2012 Dr. Naveen authorized a
3 prescription for a 30-day supply of Adderall for Patient J. (*Id.* at 20.)
4

5 327. In the opinions of Drs. Turner and Thaler, Dr. Sachdev failed to conduct an
6 adequate clinical evaluation to establish a diagnosis of ADD/ADHD for Patient J. (Tr. at 1802,
7 2451-2452.) In Dr. Thaler's opinion, Dr. Sachdev should have more extensively evaluated the
8 patient's school functioning and attention history to determine if she had long-term symptoms of
9 ADD/ADHD. (*Id.* at 2451-2452.)
10

11 328. In Dr. Turner's opinion, Dr. Sachdev did not meet the standard of care as to Patient
12 J because of the lack of adequate clinical evaluation, documentation, and follow-up regarding the
13 patient's Adderall treatment. (Tr. at 280.)
14

15 329. In Dr. Boyko's opinion, Patient J's medical records support the Adderall treatment
16 regimen and they contain documentation as to how the patient responded to the treatment. (Tr. at
17 2430.)
18

19 *Physician Self-Treatment and Treatment of Family Members*
20

21 330. The American Medical Association (AMA) has an opinion with regard to a
22 physician's treatment of himself or herself or an immediate family member. AMA Opinion 8.19
23 states, in part:
24

25 Physicians generally should not treat themselves or members of their
26 immediate families. Professional objectivity may be compromised when
27 an immediate family member or the physician is the patient; the
28 physician's personal feelings may unduly influence his or her professional
29 medical judgment, thereby interfering with the care being delivered[.]
30

31 * * * * *

32 It would not always be inappropriate to undertake self-treatment or
33 treatment of immediate family members. In emergency settings or
34 isolated settings where there is no other qualified physician available,
35 physicians should not hesitate to treat themselves or family members until
36 another physician becomes available. * * *. Except in emergencies, it is
37 not appropriate for physicians to write prescriptions for controlled
38 substances for themselves or immediate family members.
39
40

41 (Ex. A81 at 1.)
42

43 331. In Dr. Turner's opinion, the Board and the AMA strongly recommend against self-
44 treatment by a physician because a physician cannot objectively assess herself, nor can she do an
45 adequate physical examination on herself. (Tr. at 1827-1828.) In Dr. Thaler's opinion, a
46

1 physician should not self-prescribe controlled substances because a physician is not an objective
2 observer of herself as a patient. (*Id.* at 2452-2453.)
3

4 332. The same standards that apply to the provision care for other patients also apply in
5 the context of self-treatment. For example, the physician is still required to adequately chart,
6 provide indications for treatment, and document efficacy. (Tr. at 1834.)
7

8 333. In the article, "Treating Family Members: A Case Study," the Board's Medical
9 Director, Joseph Thaler, M.D., discussed the issue of physicians providing medical treatment to
10 family members. (Ex. R220.) The article appeared in a Board publication in the spring of 2013.
11 In the article, Dr. Thaler relates an experience he had in treating his 10-year-old daughter, who
12 he later learned had developed scarlet fever. He also cites to a 2008 article, "What Do You Do
13 When Your Loved One Is Ill? The Line Between Physician and Family Member," that appeared
14 in the *Annals of Internal Medicine* in 2008. (*Id.*) Dr. Thaler notes that the authors of the 2008
15 article suggest that physicians, when confronted with medical situations involving family
16 members, ask themselves, "What would I do in this situation if I did not have a medical degree?"
17 and consider avoiding taking any actions that require a medical license. (*Id.*) In his article, Dr.
18 Thaler states that the Board agrees with that advice. (*Id.*)
19

20 334. Oregon law does not prohibit a physician from providing medical care to family
21 members. The same standards that apply to the provision care for other patients also apply to
22 treatment of family members. For example, the physician is still required to adequately chart,
23 provide indications for treatment, and document efficacy. (Tr. at 1834, 2384-2386.) If a family
24 member presents to the physician and requests continuation of a prior treatment from a previous
25 provider, the physician has an obligation to do a thorough history, physical exam, evaluation, and
26 assessment before (potentially) continuing the treatment. (*Id.* at 1834-1835.)
27

28 *Dr. Sachdev's Self-Treatment with Testosterone*
29

30 335. In 2011, Dr. Sachdev began self-treating with injectable testosterone after lab
31 studies, which she ordered, showed that she had low testosterone levels. (Tr. at 40-41, 3708; *see*
32 Exs. A68 at 7-19, R85 at 001643.) At hearing, she explained why she elected to treat herself
33 with testosterone as follows:
34

35 [My blood test] showed low testosterone levels. My blood tests showed
36 that. It would be – it would be harmful for me not to treat myself.
37 Nobody else knew about testosterone. I'm the only one who knows. I
38 elected to treat myself. I did not hide it.
39

40 (Tr. at 3708.)
41

42 336. A log showing testosterone injections that were provided to clinic patients shows
43 that Dr. Sachdev received injectable testosterone on May 12, 16, and 25, 2011; June 1, 7, 13, 20,
44 and 28, 2011;⁷⁶ July 5, 11, 18, and 25, 2011; August 2, 8, 15, and 22, 2011; September 12, 19,
45

46 ⁷⁶ The log shows that Dr. Sachdev received two injections each day on June 7, 13, 20, and 28, 2011. (Ex. A68 at 8.)

1 and 30, 2011; October 7, 13, 19, and 26, 2011; November 3, 10, 15, 22, and 28, 2011; December
2 2, 6, 13, 16, 20, and 28, 2011; January 3, 9, 16, 23, and 30, 2012; February 6, 13, 21, and 26,
3 2012; March 2, 12, 19, and 26, 2012; and April 4, 2012.⁷⁷ (Ex. A68 at 7-19.)
4

5 337. There are no chart notes or progress notes documenting an indication for Dr.
6 Sachdev taking testosterone, nor is there any documentation of its efficacy.⁷⁸ (See Ex. R85.)
7

8 *Treatment of Naveen Sachdev with Testosterone*
9

10 338. A log showing testosterone injections that were provided to clinic patients shows
11 that Dr. Naveen received injectable testosterone on October 18, 21, and 25, 2011; November 3,
12 10, 17, and 28, 2011;⁷⁹ January 9, 2012; and February 17, 2012. (Ex. A68 at 12-13, 15, 17.)
13

14 339. Dr. Sachdev did not personally administer the testosterone injections to Dr. Naveen.
15 She directed clinic staff to do so. (Tr. at 184.) She never conducted an examination of Dr.
16 Naveen. (*Id.* at 187.)
17

18 340. At hearing, when the Board’s counsel questioned Dr. Sachdev about providing
19 treatment to Dr. Naveen, Dr. Sachdev stated, in part: “I did not provide – I did not provide
20 medical care as a physician. * * * *. I was not his doctor.” (Tr. at 183.) When asked whether
21 she administered any injections to Dr. Naveen, Dr. Sachdev replied as follows:
22

23 I was continuing the recommendations that were made by his doctors that
24 he had in India. He came and he said – he was low testosterone. He was –
25 I was acting more out of a wife and a wife who happened to be a doctor,
26 wanted to have and continue the care. He – he had a lot of medical
27 conditions, serious medical conditions, very poorly compliant patient and
28 he was supposed to be on this and he would never be on it. And I would
29 tell my staff, I literally told my staff, I said, “I cannot tell him. You need
30 to tell him to get in here and at least continue his shots that he’s supposed
31 to be on.”
32

33 (*Id.* at 183-184; *see also id.* at 3709.)
34

35 **CONCLUSIONS OF LAW**
36

37
38 ⁷⁷ The 2012 information contained in the log conflicts with Dr. Sachdev’s hearing testimony that she did
39 not continue testosterone injections after 2011. (See tr. at 40.)

40 ⁷⁸ At hearing, when the Board’s counsel asked Dr. Sachdev if she improved after treating herself with
41 injectable testosterone, she replied, in part, “I would say I did it more because of just the – I was low. I
42 don’t – I think I was the same. My energy level was the same[.]” (Tr. at 182.) After additional
43 questioning, she replied, “I improved my blood test results and I feel that – I was doing such low dose
44 that I would say I did it more because metabolically I wanted to stay normal. My levels were low and I
45 wanted to stay normal.” (*Id.* at 183.)

46 ⁷⁹ The log shows that Dr. Naveen Sachdev received two injections each day on October 18, 21, and 25,
2011; and on November 3, 2011. (Ex. A68 at 12.)

1
2 1. Dr. Sachdev willfully violated the terms of the Interim Stipulated Order by engaging
3 in the practice of medicine after June 7, 2012.
4

5 2. With respect to whether Dr. Sachdev committed violations of the federal Controlled
6 Substances Act, the Board's Notice is deficient. The Board may not therefore rely on the Notice
7 to establish a violation of ORS 677.190(23), and the issue of whether such violations occurred
8 will not be addressed in this Proposed Order.
9

10 3. Dr. Sachdev prescribed controlled substances without following accepted procedures
11 for examination of patients, and she prescribed controlled substances without following accepted
12 procedures for recordkeeping.
13

14 4. Dr. Sachdev engaged in unprofessional or dishonorable conduct. She also committed
15 gross negligence or repeated acts of negligence in the practice of medicine.
16

17 5. The Board may revoke Dr. Sachdev's Oregon medical license, assess a \$10,000 civil
18 penalty, and assess the costs of the proceedings.
19

20 OPINION

21
22 The Board alleges that Dr. Sachdev committed several violations of the Medical Practice
23 Act, for which the Board has proposed revocation of her medical license, a \$10,000 civil penalty,
24 and assessment of the costs of the disciplinary proceeding. The Board has the burden of
25 establishing by a preponderance of the evidence that the violations alleged in the Complaint &
26 Notice of Proposed Disciplinary Action (Notice) occurred and that the proposed sanctions are
27 appropriate. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position
28 in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683,
29 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the
30 proponent of the fact or position); *Metcalfe v. AFSD*, 65 Or App 761, 765 (1983) (in the absence
31 of legislation specifying a different standard, the standard of proof in an administrative hearing is
32 preponderance of the evidence). Proof by a preponderance of the evidence means that the fact
33 finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General*
34 *Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).
35

36 Pursuant to ORS 677.265, the Board is vested with the authority to regulate the practice
37 of medicine in Oregon. ORS 677.190 authorizes the Board to discipline an Oregon physician for
38 any of several delineated reasons. The Board has proposed disciplining Dr. Sachdev under the
39 following provisions of ORS 677.190:
40

41 (1)(a) Unprofessional or dishonorable conduct.

42 * * * * *

43
44
45 (13) Gross negligence or repeated negligence in the practice of medicine[.]
46

1 * * * * *

2
3 (17) Willfully violating any provision of this chapter or any rule adopted
4 by the board, board order, or failing to comply with a board request
5 pursuant to ORS 677.320.

6
7 * * * * *

8
9 (23) Violation of the federal Controlled Substances Act.

10
11 (24) Prescribing controlled substances without a legitimate medical
12 purpose, or prescribing controlled substances without following accepted
13 procedures for examination of patients, or prescribing controlled
14 substances without following accepted procedures for record keeping.

15
16 The Board's allegations, as set forth in its Notice, are addressed below.

17
18 **1. Willful Violation of Interim Stipulated Order (ISO)**

19
20 On June 7, 2012, Dr. Sachdev entered into an ISO with the Board, thereby agreeing to
21 voluntarily withdraw from the practice of medicine and to have her license placed in inactive
22 status, effective June 7, 2012. The Board alleges that Dr. Sachdev violated the ISO by engaging
23 in the practice of medicine after June 7, 2012. ORS 677.085 explains what constitutes the
24 practice of medicine, as follows:

25
26 A person is practicing medicine if the person does one or more of the
27 following:

28
29 (1) Advertise, hold out to the public or represent in any manner that the
30 person is authorized to practice medicine in this state.

31
32 (2) For compensation directly or indirectly received or to be received,
33 offer or undertake to prescribe, give or administer any drug or medicine
34 for the use of any other person.

35
36 (3) Offer or undertake to perform any surgical operation upon any person.

37
38 (4) Offer or undertake to diagnose, cure or treat in any manner, or by any
39 means, methods, devices or instrumentalities, any disease, illness, pain,
40 wound, fracture, infirmity, deformity, defect or abnormal physical or
41 mental condition of any person.

42
43 (5) Except as provided in ORS 677.060, append the letters "M.D." or
44 "D.O." to the name of the person, or use the words "Doctor," "Physician,"
45 "Surgeon," or any abbreviation or combination thereof, or any letters or
46 words of similar import in connection with the name of the person, or any

1 trade name in which the person is interested, in the conduct of any
2 occupation or profession pertaining to the diagnosis or treatment of human
3 diseases or conditions mentioned in this section.
4

5 Under ORS 677.190(17), the Board may discipline an Oregon physician for “[w]illfully
6 violating any * * * board order[.]” *Black’s Law Dictionary* 1630 (8th ed 2004) defines “willful”
7 as “[v]oluntary and intentional, but not necessarily malicious.”
8

9 The Board contends that Dr. Sachdev engaged in the practice of medicine after June 7,
10 2012 because she repeatedly managed and directed patient care at the clinic by directing clinic
11 staff to order lab work, perform certain tasks with regard to patient care, and refill prescriptions.
12 In addition, the Board contends that Dr. Sachdev communicated with a patient with regard to a
13 medication dosage and approved the patient’s request to adjust the dosage. Finally, the Board
14 contends that Dr. Sachdev continued to hold herself out as a licensed physician after June 7,
15 2012, as evidenced on her clinic website.
16

17 Dr. Sachdev denies that she managed and directed patient care after June 7, 2012. She
18 advances two different arguments to support her position. First, she asserts that attorney Elkins
19 McKelvey informed her that after June 7, 2012, she could continue to engage in teaching
20 activities with her staff, she could provide patient histories to staff, and she could ensure
21 continuity of care for patients. Dr. Sachdev contends that her conduct after June 7, 2012 did not
22 exceed those parameters, and that the conduct does not therefore constitute the practice of
23 medicine. Second, and somewhat alternately, she asserts that after June 7, 2012, she functioned
24 merely as an MA at the clinic.⁸⁰
25

26 *A. July 25, 2012 Treatments on Patient A*
27

28 The Board alleges that on July 25, 2012, Dr. Sachdev directed care for Patient A with
29 regard to a Genesis laser facial treatment and a Botox treatment. Dr. Sachdev denies the
30 allegations.
31

32 At hearing, aesthetician Dorothy Ryan testified that on July 25, 2012, Dr. Sachdev
33 directed her to perform a laser facial treatment on Patient A, despite the patient’s face being
34 slightly sunburned, and despite the fact that the patient was scheduled to have Botox treatment
35 that day. Ms. Ryan further testified that Dr. Sachdev told her how many laser pulses to use for
36 the laser treatment.
37

38 Dr. Sachdev testified at hearing that she recalled speaking to Patient A, but she did not
39 recall the patient being sunburned or undergoing laser facial treatment on July 25, 2012.
40 Transcript at 2811, 2828-2829. Dr. Sachdev disputed the likelihood that Patient A would have
41 been sunburned because the patient had previously indicated on a “Skin Typing” form that her
42 face reacted normally to the sun and that she rarely burned. *See* Exhibit A17 at 35. Dr. Sachdev
43

44 ⁸⁰ The Board disagrees that Dr. Sachdev was functioning merely as an MA, and contends that she was
45 actually making diagnostic decisions and directing care. The preponderance of the evidence supports the
46 Board’s position.

1 disputed the likelihood that Patient A had a laser treatment on July 25, 2012 because the patient's
2 file does not contain a laser treatment sheet for that date.⁸¹ Transcript at 2828-2829.

3
4 Although the record contains no treatment sheet showing that Patient A received a laser
5 facial treatment on July 25, 2012, there is a consent form for the laser treatment dated July 25,
6 2012, and it bears the signatures of Patient A and Ms. Ryan. See Exhibit A17 at 49; transcript at
7 505. Ms. Ryan testified at hearing that, consistent with her customary practice, she also filled
8 out a treatment sheet for the patient on that date. Transcript at 504-506. Ms. Ryan appeared
9 forthright at hearing, and she has no known motive to provide untruthful testimony.⁸² In
10 addition, during a September 14, 2012 interview with Mr. Bitonti, Patient A confirmed that she
11 received laser treatment on July 25, 2012. Exhibit R43 at 5; transcript at 1133, 2243. The
12 evidence establishes, more likely than not, that Ms. Ryan performed Genesis laser facial
13 treatment on Patient A on July 25, 2012, and that she did so at Dr. Sachdev's direction.

14
15 At hearing, Ms. Ryan testified that on July 25, 2012, Dr. Sachdev modified the amount of
16 Botox units to be administered to Patient A and the positioning of the Botox injections prior to
17 nurse practitioner Kathleen Maynez performing the Botox treatment. Transcript at 486, 496;
18 compare Ex. A17 at 44A with *id.* at 45A. During her September 14, 2012 interview with Mr.
19 Bitonti, Patient A stated that Ms. Maynez was uncertain as to where to place the Botox needle on
20 July 25, 2012, and that Dr. Sachdev pointed to the spot where the needle needed to be placed.
21 Exhibit R43 at 5; transcript at 1133, 2243.

22
23 Dr. Sachdev denies that she told Ms. Maynez where and how much Botox to give to
24 Patient A on July 25, 2012. Dr. Sachdev insists that she merely provided Ms. Maynez with
25 historical information as to the injection location and dosage for Patient A. At hearing, Dr.
26 Sachdev testified that she pointed to the patient's chart, told Ms. Maynez to look at the chart and
27 her training notes, reassured Ms. Maynez that she could perform the procedure, and then left the
28 treatment room.

29
30 In an October 19, 2012 letter to the Board, Dr. Sachdev's former attorney described Dr.
31 Sachdev's involvement in Patient A's Botox procedure as follows:

32
33 [D]r. Sachdev was asked about the patient's past [B]otox treatment
34 injection points because the nurse had questions about the locations and
35

36 ⁸¹ At hearing, Dr. Sachdev testified as follows with regard to whether on July 25, 2012 she discussed
37 laser treatment for Patient A with Ms. Ryan:

38
39 On 7-25th I historically discussed her laser treatment. This is very important
40 because what you're getting at and I need to – I want to explain * * * that I did
41 not recommend a new treatment or provide medical care. I provide continuity of
42 care and the history which was always told by my attorneys, my legal counsel[.]

43 (Tr. at 49-50.)
44

45 ⁸² Unlike some other former employees (e.g. Patient B, Patient C, Patient D, Amanda Smith), Ms. Ryan
46 was not terminated from employment, she was not alleged to have committed any illegal acts pertaining
to prescription drugs, and she was not alleged to have altered or removed patient records.

1 doses used for the patient in the past. Dr. Sachdev was asked to point out
2 prior injection locations on the patient's face where she had previously
3 administered [B]otox treatments and the amounts used in the past. Dr.
4 Sachdev identified these locations and informed the NP that she
5 considered these locations to be a more advanced treatment and warned
6 the [NP] not to inject in those locations as it was beyond the [NP]'s
7 experience level. * * *. Dr. Sachdev's involvement was merely to allow
8 continuity of care. * * *. [A]fter [e]nsuring continuity of care, Dr.
9 Sachdev left it to the [NP] to handle and left the room well before any
10 treatment was ever undertaken.
11

12 Exhibit A13 at 2-4 (emphasis omitted). According to the letter, Dr. Sachdev answered questions
13 regarding the previous injection locations and dosages for Patient A's Botox treatment, she
14 pointed out prior injection locations with their corresponding dosages on the patient's face, and
15 she told Ms. Maynez not to inject the patient's face in certain spots because it was too advanced
16 for Ms. Maynez's level of expertise.
17

18 The record establishes, more likely than not, that Dr. Sachdev directed Ms. Maynez's
19 treatment of Patient A by telling Ms. Maynez where and how much Botox to inject in Patient A's
20 face. Dr. Sachdev's assertions that her conduct comprised the mere "relaying of patient history"
21 or some allowable degree of "ensuring continuity of care" are not persuasive. Ms. Maynez had
22 Patient A's chart, which contained the facial diagram showing where and in what amount the
23 patient had previously received Botox treatment. Any relaying of patient history should have
24 started and stopped with Dr. Sachdev telling Ms. Maynez to simply look at the patient's chart.
25 But Dr. Sachdev did more than that—she showed Ms. Maynez where to make one or more
26 injections, she discussed dosage amounts with her, and she told her to avoid injecting certain
27 areas because they were beyond her expertise level. If Ms. Maynez was sufficiently qualified to
28 perform the Botox treatment, there should have been no need for Dr. Sachdev to take any actions
29 to "ensure continuity of care." The ALJ concluded (and the Board agrees) that Dr. Sachdev
30 engaged in the practice of medicine, pursuant to ORS 677.085(4).
31

32 Because Dr. Sachdev's conduct was voluntary and intentional, and the conduct occurred
33 after June 7, 2012, Dr. Sachdev willfully violated the ISO. The Board has, therefore, proven a
34 violation of ORS 677.190(17).
35

36 *B. June 18, 2012 Patient Text Message*
37

38 On June 18, 2012, Dr. Sachdev had the following text message exchange with a patient:
39

40 Hi Dr. Naina. * * * * *. I have one quick medical question [a]n[d] then I
41 promise never to ask u another. I just don't want to make a big
42 mistake....The [W]ellbutrin is definitely giving me energy but it does not
43 seem to be helping my severe depression. Can I add a half or whole
44 Zoloft in half in the evening... maybe replacing it with the evening
45 Wellbutrin. It seems to be much more effective for depression. Let me
46 know. [T]hank you!!!

1
2 Yes I will let Kathleen know to do that and she will document in [yo]ur
3 chart u have added half tablet Zoloft at night[.]
4

5 Ok, thanks much!
6

7 Exhibit A85 at 1-3. Dr. Sachdev then forwarded the text message exchange to Ms. Maynez with
8 the following request: "Please have [I]nna or Tara document this[.] *Id.* at 3.
9

10 The Board construes Dr. Sachdev's response to the patient, and her subsequent
11 forwarding of the text message to Ms. Maynez as managing and directing patient care, and
12 therefore practicing medicine. At hearing, Dr. Sachdev insisted that she did not intend to provide
13 treatment to the patient, and she justified her actions as follows:
14

15 [The patient] self-manipulated. This is very important. She's telling me
16 that she on her own added a Zoloft half a tablet. * * * * *. A patient text
17 messages me. She is self-manipulated [*sic*] on her medication. * * * * *.
18

19 Now I can't practice [because of the] ISO. I have no motive. I have too
20 much to lose realizing – realize that. So what I have to do though, what's
21 coming in my mind though is I've got to get this documented. Okay.
22 She's self-manipulating. Okay. So immediately I'm already on high alert
23 I'm going to be sued by – because of all this going on by patients or
24 something. So I'm thinking, okay, she just added two medicines. No one
25 is evaluating her. You know, I've got to let – I've got to get this
26 documented to the office. Okay. So I text the patient back and I say * * *
27 * * "Yeah, I'll let * * * [K]athleen know for you to do that." * * * * *.
28

29 I'm not telling her [to add the Zoloft tablet] – she's already done it. She's
30 already self-manipulated it.
31

32 Transcript at 3702-3703.
33

34 Dr. Sachdev's testimony misconstrues the patient's text message. The patient did not tell
35 Dr. Sachdev that she had already added Zoloft to her medication regimen. Nothing in the
36 patient's text message indicates that she had already taken that action. On the contrary, the
37 patient seemed to be taking a cautious approach to the potential medication change by asking Dr.
38 Sachdev if such a change would be okay ("Can I add a half or whole Zoloft in half in the
39 evening") because she did not want "to make a big mistake." Exhibit A85 at 1. Rather than
40 telling the patient that she was unable to respond to her question and referring her to Ms.
41 Maynez, Dr. Sachdev informed the patient that she could modify her medication and that she
42 would inform Ms. Maynez of the modification.
43

44 Dr. Sachdev was not merely acting as an MA when she made a treatment decision
45 regarding the patient's request to modify her medication regimen. Rather, Dr. Sachdev's actions
46

1 amount to managing and directing that patient's care and, in turn, constitute the practice of
2 medicine under ORS 677.085(4).

3
4 Dr. Sachdev's conduct (*i.e.* consenting to the patient's medication change request and
5 relaying the information to Ms. Maynez with further instruction) was voluntary and intentional,
6 and the conduct occurred after June 7, 2012. Thus, Dr. Sachdev willfully violated the ISO and
7 the Board has proven a violation of ORS 677.190(17).

8
9 *C. Other Instances of Directing/Managing Patient Care*

10
11 It is undisputed that sometime after June 7, 2012, Dr. Sachdev was reviewing patient
12 charts and noticed that some patients were overdue for blood work. She wrote a list of labs the
13 patients needed, provided that list to then-front office supervisor Ms. Johnson, and directed Ms.
14 Johnson to have the labs ordered. Dr. Sachdev contends that her actions were allowable because
15 the overdue blood work was blood work that she had ordered prior to signing the ISO, and she
16 was merely ensuring continuity of care. At hearing, she testified, in part:

17
18 [A] lot of [patients] had to have blood tests. And in my chart note, let's
19 say * * * a chart note on January 12th says, "Come back. RTC for thyroid
20 function test in six to eight months[.]"

21
22 So if I was just like in the clinic doing administrative duties or on occasion
23 when I had to provide something to my attorney and I had to look at the
24 chart notes, I would flip * * * [to] my note. What did I see the patient for
25 last. And it said recheck thyroid test. And I'm like, okay, we're in August
26 now. This was supposed to be done in June and it's not been done.

27
28 So, I – again, I'd always just go ask Kathleen[,] but just tell her to read
29 this note.

30
31 * * * * *

32
33 I could direct her to read a previous note that was before my ISO. It was
34 not new. There was not one new thing that I would have ever added. I
35 simply was so afraid of getting sued by other patients.

36
37 * * * * *

38
39 [I]f I saw a chart note that said [*sic*], I said [to an MA] "Please, go tell
40 Kathleen to go – to just look at this note. Read this note. Did any
41 provider read this note?"

42
43 Transcript at 2817-2819.

44
45 Ms. Lundberg, who previously worked as an MA at the clinic, testified at hearing with
46 regard to Dr. Sachdev's involvement in patient care after June 7, 2012. For example, she

1 testified that Dr. Sachdev told her on one occasion which nutraceuticals a patient should stop
2 taking, based on the side effects the patient was experiencing. She testified that on another
3 occasion Dr. Sachdev told her that she had just spoken with a patient in the parking lot who
4 reported that Dr. McQueen had decreased his quantity of pain medication, and that Dr. Sachdev
5 knew the patient needed a larger quantity of the medication. Dr. Sachdev instructed Ms.
6 Lundberg to relay that information to Dr. McQueen. She testified that on another occasion she
7 sent a text message to Dr. Sachdev relaying that a male patient was complaining of ED
8 symptoms and asking whether certain medications and nutraceuticals the patient was taking
9 would cause the ED symptoms. Dr. Sachdev responded via text message that 5-HTP spray
10 would cause the ED symptoms and that the patient should discontinue it. Ms. Lundberg also
11 testified that after June 7, 2012, Dr. Sachdev would sometimes review labs for patients and then
12 tell Ms. Lundberg which labs should be ordered.
13

14 Ms. Johnson also testified at hearing as to Dr. Sachdev's involvement in patient care after
15 June 7, 2012. She testified that Dr. Sachdev would tell Ms. Maynez (who lacked bioidentical
16 hormone therapy training and experience) and clinic MAs what to do with regard to hormone
17 treatments for patients. Ms. Johnson also testified that she occasionally communicated with Dr.
18 Sachdev via text message regarding patient care, receiving answers to questions such as what
19 kinds of nutraceuticals to give to specific patients and what dosages of hormones specific
20 patients should receive.
21

22 At hearing, both Ms. Lundberg and Ms. Johnson testified in a forthright manner. They
23 answered questions directly and stated when they were uncertain of an answer. Each witnesses'
24 testimony was internally consistent, and neither of them have any apparent motive to provide
25 untruthful testimony.⁸³ The ALJ concluded that Ms. Lundberg and Ms. Johnson are reliable
26 witnesses, and therefore accorded their testimony significant weight. The Board agrees.
27

28 Dr. Sachdev's answers at hearing were frequently non-responsive to the questions posed
29 by the Board's counsel, her own counsel, and sometimes ALJ Rackstraw. Sometimes the non-
30 responsiveness appeared evasive, but other times she just appeared to be preoccupied with
31 providing what she presumably viewed as vital background information or with stressing a
32 particular point. At times, her testimony was internally inconsistent. Moreover, portions of her
33 testimony conflicted with previous statements she provided to the Board's Investigative
34 Committee, with previous Board correspondence she signed, and with her own chart notes. She
35 repeatedly and emphatically tried to justify numerous actions she took relating to patient care
36 after June 7, 2012, as actions that she believed were allowable for the purpose of ensuring
37 continuity of care. Similarly, she stressed that certain actions were nothing more than her
38 provision of historical patient information to Ms. Maynez and clinic staff. She also emphasized
39 the enormity of the pressure she felt to prevent herself from being sued. To that end, she
40 testified, in part:
41
42
43
44

45 ⁸³ And, as is the case with Ms. Ryan, neither Ms. Lundberg nor Ms. Johnson was terminated from
46 employment, is alleged to have committed illegal acts pertaining to prescription drugs, or is alleged to
have altered or removed patient records.

1 What I was concerned about the most, okay, as a doctor giving up my
2 practice that * * * [with] so many high profile patients that I could – I
3 could be sued in a heartbeat.

4
5 * * * * *

6
7 [Y]ou're just trying to provide continuity of care and if you – these labs
8 that might turn out to be abnormal, you might get sued. I mean, that was
9 my biggest concern. I lived in fear every day because of that.

10
11 And so I really tried to provide any continuity of care, if I could[.]

12
13 Transcript at 2817-2819.

14
15 Despite Dr. Sachdev's attempts to place much of her post-June 7, 2012 conduct under the
16 expansive umbrella of "ensuring continuity of care," the evidence persuasively establishes that
17 Dr. Sachdev was directing patient care and treatment at the clinic after June 7, 2012. Indeed, she
18 was essentially managing the clinic's providers by reviewing charts and making sure that they
19 practiced competently and obtained necessary blood work and lab tests for *their* patients.

20
21 Dr. Sachdev was understandably concerned about the ongoing care of the clinic's
22 patients. The evidence suggests that Ms. Maynez lacked the training and experience to treat
23 patients receiving bioidentical hormone treatment without Dr. Sachdev's assistance. And, given
24 Dr. Sachdev's idiosyncratic and incomplete charting, it is not surprising that clinic providers and
25 staff would be dependent on Dr. Sachdev to relay patient history and treatment protocols.
26 Nonetheless, when Dr. Sachdev signed the ISO, she agreed to refrain from the practice of
27 medicine after July 7, 2012. She did not do so.

28
29 Dr. Sachdev's conduct in advising Ms. Lundberg which nutraceuticals patients should
30 stop taking, directing Ms. Lundberg to tell Dr. McQueen that a patient should receive a larger
31 quantity of pain medication, reviewing labs and then telling Ms. Lundberg and Ms. Johnson
32 which labs should be ordered for patients, and answering Ms. Johnson's questions regarding
33 hormone dosages and nutraceuticals for patients amounts to managing and directing patient care
34 and treatment, and thereby constitutes the practice of medicine under ORS 677.085(4). Because
35 Dr. Sachdev's conduct was voluntary and intentional, and the conduct occurred after June 7,
36 2012, Dr. Sachdev willfully violated the ISO. The Board has, therefore, proven a violation of
37 ORS 677.190(17).

38
39 *D. Clinic Website after June 7, 2012*

40
41 Through at least September 13, 2013, a website accessible at <<http://nainamd.com>>
42 advertised the clinic and stated, in part:

43
44 Dr. Sachdev, passionately known as "Dr. Naina," has successfully
45 established herself as a leader in the medical field in the Pacific
46 Northwest. With a thriving practice that focuses on Aesthetic, Integrative

1 and Functional Medicine, this internist and Anti-Aging expert serves as a
2 Medical Director of the Advanced Aesthetics and Integrative Medical
3 Center[.]

4
5 * * * * *

6
7 Our Medical Director, Dr. Naina Sachdev, M.D., received her medical
8 degree from the University of Chicago Medical School[.]
9

10 Exhibit A84 at 2, 4; transcript at 689-691.

11
12 At hearing, Dr. Thaler testified that, in his opinion, the website continued to portray Dr.
13 Sachdev as a practicing physician and medical director of the clinic after June 7, 2012.
14 Transcript at 2422. Neither attorney questioned Dr. Sachdev about the website at hearing, and
15 Dr. Sachdev did not address the issue in closing argument.
16

17 The ALJ concluded that the portion of the website quoted above demonstrates that Dr.
18 Sachdev continued to hold herself out to the public as a practicing physician after June 7, 2012.
19 This constitutes the practice of medicine under ORS 677.085(1). In addition, her use of the
20 abbreviations “Dr.” and “M.D.” in conjunction with her name constitutes the practice of
21 medicine under ORS 677.085(5). However, to establish a violation of ORS 677.190(17), the
22 Board must prove that Dr. Sachdev willfully violated the ISO. With regard to the practice of
23 medicine after June 7, 2012 vis-à-vis the clinic website, the Board did not meet its burden. The
24 record contains no evidence as to why the website continued to represent Dr. Sachdev as a
25 practicing physician after June 7, 2012. Although it is *possible* that it was an intentional act by
26 Dr. Sachdev, it is equally as possible that the website inadvertently remained the same after June
27 7, 2012. The Board has not proven a violation of ORS 677.190(17) with regard to the website.
28

29 *E. Conclusion*

30
31 On July 25, 2012, Dr. Sachdev directed treatment of Patient A by telling Ms. Maynez
32 where and how much Botox to inject in Patient A’s face. On June 18, 2012, Dr. Sachdev
33 managed and directed a patient’s care by consenting to the patient’s request to modify her
34 medication and then relaying the information to Ms. Maynez with further instructions. On
35 multiple occasions after June 7, 2012, Dr. Sachdev managed and directed patient care at the
36 clinic by advising MAs on nutraceuticals and hormone dosages for specific patients, reviewing
37 labs and then telling MAs which labs should be ordered for patients, and directing an MA to tell
38 Dr. McQueen that a patient should receive a larger quantity of pain medication.
39

40 The evidence persuasively establishes that Dr. Sachdev engaged in the practice of
41 medicine, under ORS 677.085(4). Because her conduct was voluntary and intentional, and the
42 conduct occurred after June 7, 2012, she willfully violated the ISO. The Board has therefore
43 proven multiple violations of ORS 677.190(17).
44

45 **2. Violations of Federal Controlled Substances Act**

46

1 In its Notice, the Board contends that Dr. Sachdev violated the federal Controlled
2 Substances Act, in violation of ORS 677.190(23), by writing prescriptions for Vicodin and
3 OxyContin for clinic staff without medical justification and then using the medications for clinic
4 patients, by failing to store the medications in a locked container, and by failing to maintain
5 accurate dispensing logs.

6
7 The Board's Notice, however, fails to identify and cite to the particular sections of the
8 Controlled Substances Act that the Board alleges Dr. Sachdev violated. Thus, the Board did not
9 comply with ORS 183.415(3)(c), which requires a notice in a contested case to include, among
10 other things, "[a] reference to the particular sections of the statutes and rules involved." Oregon
11 appellate courts have interpreted ORS 183.415 as requiring citation to all administrative rules
12 and statutes that are substantially relevant, as well as to the statutes and rules that are allegedly
13 violated. See *Drayton v. Department of Transportation*, 186 Or App 1, 10-11 (2003); *Villanueva*
14 *v. Board of Psychologist Examiners*, 175 Or App 345, 356 (2001) (*Villanueva I*). Nothing in the
15 Oregon Administrative Procedures Act (APA) or court cases suggests that the "statutes and rules
16 involved" are limited to state law. Here, the Board alleges that Dr. Sachdev violated federal law
17 pertaining to controlled substances, thereby resulting in a violation of ORS 677.190(23). To
18 meet the requirements of the APA, the Board was required to specifically identify in its Notice
19 which federal statutes or regulations Dr. Sachdev allegedly violated.⁸⁴

20
21 In *Villanueva I*, the Oregon Court of Appeals held that the issue of whether the petitioner
22 had violated a specific ethical principle was not properly before the Board of Psychologist
23 Examiners because the notice to petitioner did not include reference to that ethical principal. 175
24 Or App at 358-59. The Board of Psychologist Examiners subsequently petitioned the court for
25 reconsideration, arguing that the lack of notice did not prejudice the petitioner. The court
26 rejected that argument and held that "the absence of adequate notice is prejudicial in and of
27 itself." *Villanueva v. Board of Psychologist Examiners*, 179 Or App 134, 138 (2002) (*Villanueva*
28 *II*); see also *Drayton*, 186 Or App at 11-13 (citing *Villanueva II* and finding lack of adequate
29 notice prejudicial).

30
31 With respect to the issue of whether Dr. Sachdev violated ORS 677.190(23), the Board's
32 Notice is deficient. The Board may not therefore rely on the Notice to establish a violation of
33 ORS 677.190(23), and the issue of whether such a violation occurred will not be addressed in
34 this Proposed Order.

35 36 **3. Violations involving controlled substances under ORS 677.190(24)**

37
38
39
40 ⁸⁴ For example, the Board could have chosen to cite to the following federal regulations in its notice: 21
41 C.F.R. §1306.04(b) (prohibiting an individual practitioner from issuing a prescription for a controlled
42 substance for subsequent general dispensing to patients); 21 C.F.R. §1301.75(a) and (b) (requiring that
43 controlled substances be stored "in a securely locked, substantially constructed cabinet"); 21 C.F.R.
44 §1304.03(b) and (d) (requiring that individual practitioners maintain controlled substances records); 21
45 C.F.R. §1304.04(a), (f), (g) (specifying manner in which individual practitioners must maintain records
46 and inventories); 21 C.F.R. §1304.11(a) (setting forth general inventory requirements); 21 C.F.R.
§1304.21(a) (setting forth general requirements for maintaining controlled substances records); and 21
C.F.R. §1304.22(a) and (c) (specifying information that dispensing physicians must include in records).

1 As previously stated, ORS 677.190(24) allows the Board to discipline a licensee for the
2 following:

3
4 Prescribing controlled substances without a legitimate medical purpose, or
5 prescribing controlled substances without following accepted procedures
6 for examination of patients, or prescribing controlled substances without
7 following accepted procedures for record keeping.
8

9 The Board's Notice cites violation of ORS 677.190(24) as one of the Board's grounds for
10 disciplinary action against Dr. Sachdev. The Notice does not, however, specify which alleged
11 conduct by Dr. Sachdev falls under that statutory provision.
12

13 *A. Prescribing without Legitimate Medical Purpose*

14
15 The Notice alleges that Dr. Sachdev prescribed controlled substances to several patients
16 without documenting the medical indications for the treatment. Those allegations are addressed
17 in Section (4) of this Proposed Order, "Unprofessional or Dishonorable Conduct / Gross or
18 Repeated Acts of Negligence." The Notice does not specifically allege that Dr. Sachdev
19 prescribed controlled substances without a "legitimate medical purpose." Moreover, the Board
20 has not defined what is meant by "legitimate medical purpose."
21

22 *B. Prescribing without Following Accepted Procedure for Examinations of Patients*

23
24 The Notice alleges that Dr. Sachdev provided substandard care to certain family
25 members. At hearing, the Board narrowed the allegation to just one family member, Dr. Naveen
26 Sachdev.
27

28 The evidence establishes that Dr. Sachdev prescribed testosterone injections to Dr.
29 Naveen Sachdev for the period October 18, 2011 to February 17, 2012. At hearing, she testified
30 that she was simply continuing the recommendations made by Dr. Naveen Sachdev's doctors in
31 India, and that she was acting more as a wife than as a physician. Despite Dr. Sachdev's
32 characterization of her role in Dr. Naveen Sachdev's testosterone treatment, the fact remains that
33 she prescribed the testosterone for him.
34

35 Dr. Turner credibly testified that a physician must do a thorough history, physical exam,
36 evaluation, and assessment on a patient before continuing any treatment started by another
37 provider, *even when the patient is a family member*. Dr. Sachdev conceded at hearing that she
38 never conducted an examination of Dr. Naveen Sachdev, despite prescribing the testosterone
39 injections.
40

41 The Board has established that Dr. Sachdev violated ORS 677.190(24) by prescribing a
42 controlled substance without following accepted procedures for examinations of patients.
43

44 *C. Prescribing without Following Accepted Procedures for Record Keeping*

45
46 OAR 847-015-0015 provides, in part:

1
2 Any practitioner dispensing or administering controlled substances from
3 the practitioner's office * * * shall maintain an inventory log showing all
4 controlled substances received, and administered or dispensed. This log
5 shall also list for each controlled substance, the patient's name, amounts
6 used, and date administered or dispensed. This log shall be available for
7 inspection on request by the Oregon Medical Board or its authorized
8 agents[.]
9

10 The Board contends that Dr. Sachdev prescribed controlled substances without following
11 acceptable procedures for record keeping, in violation of ORS 677.190(24), because prior to
12 April 12, 2012 she failed to maintain an adequate inventory log for those medications.
13

14 At hearing, Dr. Sachdev testified that the clinic had "readily available controlled
15 substance logs" that were "on the computer," and that there was a controlled substance log in
16 every patient file. Transcript at 3707-3708. She testified that the clinic also kept invoices for
17 each controlled substance. *Id.* at 3708. She similarly informed the Board's Investigative
18 Committee on September 27, 2012 that controlled substances logs were "readily available" when
19 the DEA came to her clinic in April 2012.⁸⁵ Exhibit A11 at 17.
20

21 Ms. Johnson credibly testified at hearing that prior to April 12, 2012, the only controlled
22 substance log physically available for inspection at the clinic was a handwritten log of
23 testosterone injections that was not up-to-date. She also testified that, at that time, there was no
24 existing log with regard to the clinic's Lunesta supply. She further testified that on or shortly
25 after April 12, 2012, she created Excel spreadsheets (*i.e.* "logs") for testosterone injections and
26 the Lunesta using information from the Lytec computer software system, with handwritten
27 notations and tallies added to the Lytec print-outs, and with supplemental information (*e.g.*
28 diagnosis codes and patient addresses) she obtained from patient charts.
29

30 Dr. Sachdev's assertions that prior to April 12, 2012 the clinic had "readily available
31 controlled substance logs" in its computer system are not supported by the evidence. Based on
32 Ms. Johnson's credible testimony, the logs she created were not a simple reiteration of data from
33 the Lytec system (*i.e.* they were not simply a print out of the alleged "readily available controlled
34 substances logs" on the computer). Instead, to create adequate, up-to-date logs (that comply with
35 **OAR 847-015-0015**), Ms. Johnson had to use print-outs from the Lytec computer system,
36
37
38

39
40 ⁸⁵ She further stated:

41 Had they given me a chance to just print it out, I would have been able to print it
42 out. Instead my legal counsel [at that time] said ["no"]. And—and I was told
43 to—three days that I had to come up with—comply with the handwritten logs.
44 They were in the computer.
45

46 (Ex. A11 at 7.)

1 she had to modify those print-outs with some hand-written notations and tallies, and she
2 had to supplement those print-outs with information she pulled from patient charts.⁸⁶
3

4 The Board has proven that, prior to April 12, 2012, Dr. Sachdev failed to comply with the
5 inventory log requirements of OAR 847-015-0015. In turn, the Board has established that
6 Dr. Sachdev violated ORS 677.190(24) by prescribing controlled substances without following
7 accepted procedures for record keeping.
8

9 4. Unprofessional or Dishonorable Conduct / Gross or Repeated Acts of Negligence

10 A. Applicable Law and Standards

11 Definition of Unprofessional or Dishonorable Conduct

12
13 ORS 677.188(4) defines "unprofessional or dishonorable conduct" as follows:
14

15 "Unprofessional or dishonorable conduct" means conduct unbecoming a
16 person licensed to practice medicine * * *, or detrimental to the best
17 interests of the public, and includes:
18

19 (a) Any conduct or practice contrary to recognized standards of ethics of
20 the medical * * * profession or any conduct or practice which does or
21 might constitute a danger to the health or safety of a patient or the public
22 or any conduct, practice or condition which does or might adversely affect
23 a physician's ability [to] safely and skillfully * * * practice medicine[;]
24

25 (b) Willful performance of any surgical or medical treatment which is
26 contrary to acceptable medical standards; and
27

28 (c) Willful and repeated ordering or performance of unnecessary
29 laboratory tests or radiologic studies; administration of unnecessary
30 treatment; employment of outmoded, unproved or unscientific treatments;
31 failure to obtain consultations when failing to do so is not consistent with
32 the standard of care; or otherwise utilizing medical service for diagnosis or
33 treatment which is or may be considered inappropriate or unnecessary.
34

35 Applicability of ORS 677.190(1)(b)

36
37 Dr. Sachdev contends that because she practices functional medicine, she falls under the
38 purview of ORS 677.190(1)(b), which pertains to a physician's use of alternative medical
39 treatment and provides, in relevant part:
40

41
42
43
44
45 ⁸⁶ Ms. Elkins McKelvy's April 13, 2012 letter to Mr. Bitonti supports Ms. Johnson's testimony. The
46 letter states, in part, that the enclosed controlled substances logs "were recently compiled from
contemporaneous records including purchasing records and medical records." (Ex. A86 at 1.)

1 For purposes of this subsection, the use of an alternative medical treatment
2 shall not by itself constitute unprofessional conduct. For purposes of this
3 paragraph:

4
5 (A) "Alternative medical treatment" means:

6
7 (i) A treatment that the treating physician, based on the physician's
8 professional experience, has an objective basis to believe has a reasonable
9 probability for effectiveness in its intended use even if the treatment is
10 outside recognized scientific guidelines, is unproven, is no longer used as
11 a generally recognized or standard treatment or lacks the approval of the
12 United States Food and Drug Administration;

13
14 (ii) A treatment that is supported for specific usages or outcomes by at
15 least one other physician licensed by the Oregon Medical Board; and

16
17 (iii) A treatment that poses no greater risk to a patient than the generally
18 recognized or standard treatment.

19
20 Dr. Sachdev did not specify which of her various treatment approaches constituted
21 alternative treatment under ORS 677.190(1)(b)(A), other than to assert generally that she
22 practiced functional medicine. Even if some of her treatment methods would otherwise meet the
23 definition of "alternative treatment," she failed to produce any evidence that at least one other
24 Oregon licensed physician agreed with her treatment approach. Consequently, ORS
25 677.190(1)(b) is inapplicable in this matter.

26
27 Determining the Standard of Care

28
29 ORS 677.265(1)(c) provides, in part:

30
31 In determining whether to discipline a licensee for a standard of care
32 violation, the Oregon Medical Board shall determine whether the licensee
33 used that degree of care, skill and diligence that is used by ordinarily
34 careful physicians in the same or similar circumstances in the community
35 of the physician or a similar community.

36
37 In *Spray v. Board of Medical Examiners*, 50 Or App 311 (1981), the Oregon Court of
38 Appeals held that a determination of whether a physician utilized inappropriate or unnecessary
39 medical treatment, thereby engaging in "unprofessional or dishonorable conduct" under ORS
40 677.190, must be determined on a case-by-case basis "through the testimony of qualified
41 physicians as to just what is the norm of treatment in the medical community in the particular
42 case and whether the course of treatment actually followed deviates from the norm[.]" *Spray*, 50
43 Or App at 319.

44
45 Here, the Board offered the expert testimony of internist Dr. Pamela Turner to establish
46 the standard of care applicable to the allegations against Dr. Sachdev. Dr. Turner did not offer

1 opinions as to any cosmetic or alternative treatments. The Board contends that because Dr.
2 Sachdev is an internist, and because the treatment issues in this matter involve Dr. Sachdev
3 prescribing conventional medications to treat conventional conditions, an internist such as Dr.
4 Turner is qualified to provide evidence of the appropriate standard of care applicable to the
5 alleged violations.

6
7 Dr. Sachdev, on the other hand, asserts that because she practices functional medicine,
8 which involves both allopathic and alternative medicine, the standard of care applicable to her
9 practice must be established through the expert testimony of an integrative physician (*i.e.* one
10 who practices both allopathic and alternative medicine).

11
12 The Board is not seeking to discipline Dr. Sachdev for her practice of functional
13 medicine as a whole. Rather, the Board has set forth specific allegations relating to specific
14 aspects of Dr. Sachdev's provision of care to specific patients. As previously discussed, with
15 respect to the standard of care allegations, the treatments Dr. Sachdev provided were not
16 "alternative treatments," as defined in ORS 677.190(1)(b). Rather, the treatments involved
17 conventional medications being used to treat conventional health conditions. As such, the ALJ
18 was persuaded that the treatments fell within the ambit of internal medicine. Dr. Turner is
19 qualified as a medical expert by education, training, and experience to testify as to the standard
20 of care for an internist prescribing the medications at issue to treat the conditions at issue.

21 22 Defining Gross Negligence and Repeated Acts of Negligence

23
24 The Board contends in its notice that Dr. Sachdev committed gross negligence or
25 repeated acts of negligence in the practice of medicine, in violation of ORS 677.190(13). ORS
26 Chapter 677 does not define what is meant by "gross negligence" or "repeated acts of
27 negligence." According to *Black's Law Dictionary* 1061 (8th ed 2004), "negligence" means "[a]
28 failure to exercise the standard of care that a reasonably prudent person would have exercised in
29 a similar situation." "Gross negligence" is defined as "[a] lack of slight diligence or care." *Id.* at
30 1062. In the professional negligence context, the Oregon Supreme Court has recognized that the
31 standard of care is that of "a reasonably prudent, careful and skillful practitioner of that
32 discipline in the community or a similar community under the same or similar circumstances."
33 *Coffey v. Bd. of Geologist Examiners*, 348 Or 494, 509, 510 (Or 2010), *citing Creasey v. Hogan*,
34 292 Or 154, 163 (1981) (malpractice claim against podiatrist); *see also Getchell v. Mansfield*,
35 260 Or 174, 179 (1971) (recognizing that a professional acts negligently by failing to follow "the
36 reasonable practice * * * in the community"). In *Coffey*, the Court stated that whether
37 professional "negligence" rises to the level of "gross negligence" is a question of degree. 348 Or
38 at 510. The Court further stated that "[g]ross negligence is the equivalent of reckless disregard
39 and is negligence of a substantially greater degree than that of ordinary negligence." *Id.*, *citing*
40 *Fassett v. Santiam Loggers, Inc.*, 267 Or 505, 508 (1973).

41 42 Determining Weight to Accord Allegations of Chart Manipulation by Clinic Staff

43
44 At hearing, Dr. Sachdev repeatedly alleged that the medical records she submitted to the
45 Board, and which were subsequently admitted into this contested case record, are incomplete or
46 inaccurate because clinic employees were manipulating patient files in or around early 2012.

1 She suggested on numerous occasions at hearing that if the Board and administrative law judge
2 had the benefit of viewing complete and unadulterated copies of the patient files at issue, then
3 many of the Board's alleged violations of the Medical Practice Act would prove unsubstantiated.
4

5 Dr. Sachdev did not establish that clinic employees manipulated the patient files at issue
6 in this case. In fact, the evidence suggests that the deficiencies in patient records were, more
7 likely than not, the result of inadequate charting practices. After Ms. Maynez began managing
8 the care for many of Dr. Sachdev's former patients after June 7, 2012, Ms. Maynez became
9 aware of some significant deficiencies in the patient's records. For example, she noticed that
10 some chronic pain management patients did not have pain management plans in their charts. She
11 also noticed that some patient charts lacked documentation or imaging to support the bases for
12 treatment. And, she noticed some charts lacked documentation as to how the patients were
13 responding to treatment. This suggests a pattern of deficient charting unaffected by the alleged
14 employee manipulation of patient records. Furthermore, even the patient charts at issue in this
15 proceeding that Dr. Sachdev did *not* contend were manipulated by clinic staff (*e.g.* records for
16 Patients E, G, H, and J) contain numerous and substantial deficiencies.
17

18 The ALJ was not persuaded, more likely than not, that the patient files at issue in this
19 proceeding were manipulated by office staff, or that any such manipulation would prove
20 materially relevant to a determination of whether Dr. Sachdev violated the Medical Practice Act.
21 Thus, Dr. Sachdev's claims of chart manipulation by clinic employees will not be considered a
22 valid defense to the Board's charting allegations discussed in the remainder of this Proposed
23 Order.
24

25 *B. Alteration of Medical Records*⁸⁷ 26

27 The Board contends that, pursuant to its requests for medical records, Dr. Sachdev
28 provided the Board with chart notes that the Board later determined had been altered without
29 appropriate annotations or explanations. The Board alleges that Dr. Sachdev altered the medical
30 records in an attempt to "conceal the delivery of care that was actually provided" to her patients.
31 Notice at 6.
32

33 The Board received two sets of records regarding Patient F—one set from the patient
34 herself in November 2011, and one set from Dr. Sachdev in approximately January 2012.
35

36 An April 25, 2011 chart note states that 30 lesions were removed from Patient F's neck
37 on that date. The note does not specify who removed the lesions. *See* Ex. A41 at 14. At
38 hearing, Dr. Sachdev authenticated this chart note as the note she dictated for the procedure.
39 Transcript at 2779. Another chart note, also dated April 25, 2011, states that Dr. Sachdev
40 removed approximately 20 lesions and Patient C removed approximately 10 lesions from Patient
41 F's neck on that date. This chart note lists Patient C's name at the bottom. Exhibit A41 at 13.
42

43 ⁸⁷ In its Notice, the Board did not correlate the conduct alleged with specific violations of the Medical
44 Practices Act. It is therefore unknown whether the Board considered the remaining alleged acts to be
45 violations of ORS 677.190(1)(a) (unprofessional or dishonorable conduct), ORS 677.190(13) (gross or
46 repeated negligence), or both. I will therefore consider both statutory subsections when determining
whether violations occurred as to the remaining allegations.

1 Dr. Sachdev testified that she did not dictate or write the chart note marked as Exhibit A41 at 13,
2 and that although it was not Patient C's customary practice to write chart notes, she believes
3 Patient C wrote the note. Transcript at 2729, 2735, 2737, 2778-2782.
4

5 There are also two different chart notes dated July 5, 2011. One July 5, 2011 chart note
6 states that approximately 20 lesions were removed on that date, and it does not specify who
7 performed the removal. Exhibit A41 at 11. At hearing, Dr. Sachdev authenticated this chart note
8 as the note she dictated for the procedure. Transcript at 2795. Another chart note, also dated
9 July 5, 2011, is substantially similar to the other chart note dated July 5, 2011, but it contains
10 hyphenated wound care instructions. See Exhibit A41 at 12. Dr. Sachdev denies dictating or
11 writing that chart note. Transcript at 2795.
12

13 At hearing, Dr. Sachdev testified repeatedly that one or more former clinic employees
14 (including Patient C) altered and withheld portions of patient records (including their own),
15 called in unauthorized prescriptions under her name, misreported information to the Board, and
16 otherwise conspired against her.
17

18 The Board has proven that it received conflicting records for Patient F. The Board has
19 not, however, proven by a preponderance of the evidence that Dr. Sachdev altered the records, or
20 that she directed someone to do so on her behalf.
21

22 *C. Prescribing Controlled Substances for Use as "Office Stock"*

23

24 The Board contends that Dr. Sachdev wrote prescriptions for controlled substances to
25 office staff and directed the staff to fill the prescriptions so that the medications could be kept as
26 "office stock" for surgical procedures. Dr. Sachdev denies the allegation.
27

28 It is against the standard of care for an Oregon physician to request or allow an employee
29 to fill a prescription in the employee's own name and then to use the medication as office stock
30 for clinic patients. Transfer of medication from one patient to another is against the standard of
31 care.
32

33 On December 12, 2011, Dr. Sachdev performed a tumescent liposuction procedure on
34 Patient H. A surgical data form dated December 12, 2011 states that the patient received 5 mg of
35 Valium at 3:45 p.m. and one Percocet tablet at 5:14 p.m. that day. Another document references
36 the discharge" of Patient H, and notes that the patient's blood pressure was 94/60, her pulse was
37 relaxed, and she took four tablets of oxycodone-acetaminophen 5-325 (*i.e.* Percocet).
38

39 At hearing, Ms. Black testified, in part: "[A] patient had come in for liposuction, and the
40 medications had not been called in. So it was called in under my name. And it was brought into
41 the clinic and it was administered for the patient[.] I would just say a few tablets of the
42 prescription, and the remainder of it was locked[.]" Transcript at 1285-1286.
43

44 A patient prescription history report from Oregon's Prescription Drug Monitoring
45 Program shows that Patient C filled prescriptions for hydrocodone-acetaminophen 5-325
46 (Vicodin) and diazepam 5 mg (Valium) on December 12, 2011, at a pharmacy near the clinic.

1 The prescription was written under Patient C's name, and the prescribing physician is listed as
2 Dr. Sachdev. The same patient prescription history report shows that Patient B filled a
3 prescription for oxycodone-acetaminophen 5-325 (Percocet) on the same day, at the same
4 pharmacy. The prescription was written under Patient B's name, and the prescribing physician is
5 listed as Dr. Sachdev.
6

7 Several former clinic employees informed Mr. Bitonti during interviews in March and
8 April 2012 that Dr. Sachdev had written prescriptions to one or more staff members to fill so that
9 the medications could be used as office stock during surgical procedures on patients. For
10 example, Ms. Hayden informed Mr. Bitonti that Dr. Sachdev wrote pain medication prescriptions
11 to Patients B and C for them to fill, and that the medications were thereafter kept at the clinic and
12 administered to other patients. Ms. Wright told Mr. Bitonti that Dr. Sachdev wanted to have a
13 supply of pain medications at the clinic because she was starting to perform Smart Liposuction
14 procedures. Ms. Wright specifically mentioned that Dr. Sachdev wrote prescriptions for Vicodin
15 and OxyContin to several members of her clinic staff for that purpose. Patient B informed Mr.
16 Bitonti that Dr. Sachdev wrote her a prescription for Norco or OxyContin, directed her to fill it,
17 and then stored the medicine at the clinic for use on surgical patients. Patient C similarly
18 informed Mr. Bitonti that she filled a prescription for pain medication written by Dr. Sachdev so
19 that the medication could be used at the clinic for office stock.⁸⁸
20

21 Dr. Sachdev denies ever writing prescriptions to clinic staff and directing that they fill the
22 prescriptions so the medications could later be used as office stock for clinic surgical procedures.
23 During the September 27, 2012 Investigative Committee interview, Dr. Sachdev informed the
24 committee that she has never kept narcotics (including office stock) at the clinic, and that she
25 expected liposuction patients to have their own pain medications. She further stated:
26

27 I do recall an incident where I was in a procedure. The patient needed
28 pain medication. I looked to my staff and I said, "Where's her pain
29 meds?" And they said they would get it. Obviously, the patient didn't
30 bring it. I assumed that they were going to call the prescription in the
31 patient's name. After the fact, I have learned in review of what has
32 happened to me that did not happen.

33 * * * * *

34 It was called in on my name.
35
36
37

38 Exhibit A11 at 17. In response to the question, "Were there narcotics, prescriptions called in
39 under employees' names and then brought back to the office?" Dr. Sachdev replied:

40
41 I later—when I terminated [Patient C] on February 3rd of 2011, she said, "I
42 want my pain meds thrown out." That was the first time I became aware
43

44 ⁸⁸ Patient C admitted to Mr. Bitonti that she knew the practice was illegal, and that upon the termination
45 of her employment, she emptied the contents of the bottle bearing her name and took the bottle with her.
46 Her statement regarding the destruction of the medication is consistent with her hearing testimony. (*See*
tr. at 1285-1286.)

1 that there was [sic] pain medications on the premises that she had and they
2 were in her name and, apparently, all the office staff thought that I kn[e]w
3 about it.
4

5 *Id.*
6

7 Because the record contains no copies of the actual prescriptions for the alleged “office
8 stock” medications, Dr. Sachdev contends that there is no way to authenticate her signature on
9 the prescriptions. She denies signing the alleged prescriptions and suggests that office staff
10 forged her signature.
11

12 However, in the case of Patient H, if Dr. Sachdev did not sign the prescriptions for
13 Percocet and Valium, she could not have reasonably expected staff to obtain the medications.
14 Percocet is a Schedule II controlled substance, and therefore requires a written prescription.
15 Office staff could not have called in the prescription as Dr. Sachdev alleged to the Board’s
16 Investigative Committee (*i.e.* “I assumed that they were going to call the prescription in the
17 patient’s name.”). *See* Exhibit A11 at 17. Dr. Sachdev must have either signed the prescription
18 for Percocet or allowed office staff to sign for her. If she signed the prescription herself, one
19 would expect her to notice in whose name the prescription was written. If she allowed office
20 staff to sign her name on the prescription, then that in itself likely constitutes unprofessional or
21 dishonorable conduct. Dr. Sachdev’s explanations regarding the Percocet and Valium
22 prescriptions are illogical and unpersuasive.
23

24 The evidence establishes, more likely than not, that Dr. Sachdev wrote prescriptions for
25 controlled substances to office staff and directed the staff to fill the prescriptions so that the
26 medications could be kept and used as “office stock” for surgical procedures. In so doing, Dr.
27 Sachdev breached the standard of care, and the Board has established violations of ORS
28 677.190(1)(a) and (13).
29

30 *D. Self-Treatment* 31

32 In its Notice, the Board alleges that Dr. Sachdev “has engaged in a pattern of conduct in
33 which she has received a series of self-prescribed testosterone injections (Schedule III) at her
34 office.” Notice at 8.
35

36 Although self-treatment is disfavored by the Board and the AMA, it is not, in itself, a
37 violation of the Medical Practice Act. However, the same standards of care that apply to a
38 physician’s treatment of a patient apply in the context of self-treatment—including the standards
39 regarding charting, providing indications for treatment, and documenting efficacy.
40

41 Dr. Sachdev does not dispute that she self-prescribed IM testosterone.⁸⁹ She testified at
42 hearing that she did so after lab testing showed that she had a low testosterone level. When
43

44 ⁸⁹ However, Dr. Sachdev’s statement at hearing that she did not continue testosterone injections after
45 2011 (Transcript at 40) conflicts with testosterone injection logs that list her as having received injections
46 in January, February, March, and April 2012. (*See* Ex. A68 at 7-19.)

1 asked whether she improved with the testosterone treatment, she testified, in part, “I would say I
2 did it more because of just the – I was low. I don’t – I think I was the same. My energy level
3 was the same[.]” Transcript at 182. After additional questioning, she replied, “I improved my
4 blood test results and I feel that – I was doing such low dose that I would say I did it more
5 because metabolically I wanted to stay normal. My levels were low and I wanted to stay normal.
6 *Id.* at 183.
7

8 There are no chart notes or progress notes documenting an indication for Dr. Sachdev’s
9 IM testosterone treatment, nor is there any documentation discussing the efficacy of the
10 treatment. Consequently, Dr. Sachdev breached the standard of care with regard to her self-
11 treatment. The Board has established violations of ORS 677.190(1)(a) and (13).
12

13 *E. Treatment of Dr. Naveen Sachdev*

14
15 The Board’s Notice alleges that Dr. Sachdev provided substandard care to certain family
16 members, that she failed to coordinate care of the family members with other healthcare
17 providers, and that she failed to appropriately chart the care she provided. As previously noted,
18 the Board specified at hearing that those allegations only pertain to Dr. Sachdev’s treatment of
19 Dr. Naveen Sachdev.
20

21 Oregon law does not prohibit a physician from providing medical care to family
22 members. However, as with self-treatment, the standards of care regarding charting, medical
23 indications, and documentation of efficacy apply.
24

25 Dr. Sachdev directed staff to administer testosterone injections to Dr. Naveen Sachdev on
26 multiple occasions between October 18, 2011 and February 17, 2012. As previously discussed,
27 Dr. Sachdev’s contentions that she was acting more as a wife than a physician, and that she was
28 merely continuing the recommendations made by Dr. Naveen Sachdev’s providers in India, are
29 not persuasive. Although she may have been prescribing the testosterone treatment for Dr.
30 Naveen Sachdev out of concern as his wife, she was nonetheless directing his care *as a*
31 *physician*.
32

33 Dr. Sachdev did not conduct an examination of Dr. Naveen Sachdev, she did not chart
34 any medical indications for the treatment, and she did not document the efficacy of the treatment.
35 In so failing, Dr. Sachdev breached the applicable standards of care. The Board has established
36 violations of ORS 677.190(1)(a) and (13).
37

38 *F. Prescribing Phentermine to Patients D and E*

39
40 Phentermine is a Schedule IV controlled substance. **OAR 847-015-0010** provides, in
41 relevant part:
42

43 (2) A physician may utilize a Schedule * * * IV controlled substance for
44 purposes of weight reduction in the treatment of Exogenous Obesity in a
45 regimen of weight reduction based on caloric restriction, behavior
46

1 modification and prescribed exercise, provided that all of the following
2 conditions are met:

3
4 (a) Before initiating treatment utilizing a Schedule * * * IV controlled
5 substance, the physician determines through review of the physician's own
6 records of prior treatment, or through review of the records of prior
7 treatment which another treating physician or weight-loss program has
8 provided to the physician, that one of the following conditions exist:

9
10 (A) Patient's body mass index exceeds 30 Kg/M sq; or

11
12 (B) Patient's body mass index exceeds 27 Kg/M sq and the excess weight
13 represents a threat to the patient's health (as with hypertension, diabetes,
14 or hypercholesterolemia.)

15 * * * * *

16
17
18 (3) Continuation of Schedule * * * IV designated as FDA short term use
19 controlled substances beyond three (3) months requires documentation of
20 an average two (2) pound per month weight loss during active weight
21 reduction treatment, or documentation of maintenance of goal weight. Use
22 of Schedule * * * IV controlled substances with FDA approval for
23 bariatric therapy and designated for long term use where FDA guidelines
24 are followed may also be used beyond three months.

25
26 (4) A violation of any provision of this rule, as determined by the Board,
27 shall constitute Unprofessional Conduct as the term is used in ORS
28 677.188(4)(a), (b), or (c), whether or not actual injury to a patient is
29 established.

30
31 In its Notice, the Board contends that Dr. Sachdev treated Patients D and E with
32 Phentermine, without explanation in their charts, and without documenting medical indications
33 for the treatment and how the patients responded to the treatment.

34
35 As set forth above, OAR 847-015-0010(2)(a) allows an Oregon physician to prescribe
36 Phentermine only if the patient's BMI exceeds 30, or the patient's BMI exceeds 27 and the
37 excess weight constitutes a threat to the patient's health. When Dr. Sachdev prescribed a four-
38 week course of Phentermine to Patient D on July 21, 2011, Patient D had a BMI of only 24.
39 When Dr. Sachdev prescribed Phentermine for Patient E from December 1, 2010 to March 18,
40 2011, Patient E had a BMI that ranged from merely 23.8 to 24.4. Therefore, despite Dr.

1 Sachdev's stated justifications for prescribing the medication to these patients,⁹⁰ her conduct in
2 doing so violated OAR 847-015-0010(2)(a) because neither patient met the BMI criteria set forth
3 in that rule. Pursuant to OAR 847-015-0010(4), Dr. Sachdev engaged in unprofessional conduct,
4 and the Board has therefore established violations of ORS 677.190(1)(a).
5

6 The Board's remaining allegations regarding Dr. Sachdev's treatment of Patients D and E
7 with Phentermine involve charting and documentation deficiencies.
8

9 Aside from Patient D's electronic medical record (Exhibit A32 at 16), which shows that a
10 30-day prescription for 15 mg of Phentermine was faxed to a pharmacy on July 21, 2011, Patient
11 D's medical records contain no documentation whatsoever that Dr. Sachdev prescribed
12 Phentermine to the patient. There are no chart notes or progress notes that mention Phentermine
13 or that discuss the basis for prescribing the medication to Patient D. Dr. Sachdev contends that
14 Patient D's body composition analyses and the MSQs in her medical record are indications for
15 the Phentermine treatment. While the data contained in those disparate documents may have
16 contributed to Dr. Sachdev's decision to prescribe the medication, without a chart note or
17 progress note stating that Dr. Sachdev was a) prescribing Phentermine; and b) that her decision
18 to do so was based on that data, her charting is deficient. Finally, there are no chart notes or
19 progress notes that indicate how Patient D responded to the treatment.
20

21 Similarly, Patient E's medical records contain no chart notes or progress notes that
22 indicate the prescribing of Phentermine to Patient E, or that discuss the basis for prescribing the
23 medication. Although Dr. Sachdev began prescribing the medication to Patient E on December
24 1, 2010, the December 1, 2010 chart note does not mention Phentermine or any basis for
25 prescribing the medication. A December 1, 2010 Nutraceutical Protocol form for Patient E lists
26 Phentermine under the protocol section, but the form contains no information regarding the
27 medical indication for prescribing Phentermine to the patient.
28

29 In addition, none of Patient E's chart notes or progress notes indicate how Patient E
30 responded to the Phentermine treatment. At hearing, Dr. Sachdev testified that when the patient
31 treated with her on December 29, 2010, the patient had temporarily stopped the medication
32 because of dizziness. Transcript at 2893-2894. However, Dr. Sachdev did not document that
33 information in the December 29, 2010 chart note. *See* Exhibit A35 at 6-7. When asked at
34 hearing whether she considers it important to note in a patient's chart that a patient reported
35 stopping a medication such as Phentermine, Dr. Sachdev replied, in part:
36
37
38

39 ⁹⁰ At hearing, Dr. Sachdev testified that she prescribed Phentermine to Patient D because she wanted to
40 prevent additional weight gain while she worked on balancing the patient's hormones. She specifically
41 considered Patient D's six-pound weight gain between March and July 2011, the patient's body
42 composition analyses, and the patient's elevated dihydro-testosterone levels.
43

44 Similarly, Dr. Sachdev testified that she prescribed Phentermine for Patient E with the goal of preventing
45 further weight gain while she tried to optimize the patient's thyroid function. She believed that Patient E
46 was at significant risk for diabetes and further metabolic dysfunction, and that additional weight gain
would be detrimental to her health.

1 Phentermine is something that – let’s say they stopped it. It’s not like it’s
2 life threatening that she continue it. So I was more interested in solving
3 what the pressing [issue] is, is that her abdominal issues take precedence,
4 some of her thyroid adjustments take precedence, so I’m okay with that.
5 And then as long as I’m having discussion – verbal discussion, continue it.
6

7 * * * * *. [W]hen I do my charting, * * * I’m looking for things that are
8 really going – you know, that are really going to be dangerous for the
9 patient. And if my patients are doing well, that’s fine. And – and if they
10 want to stop – for example, if they’ve been on a nutraceutical, I’m not
11 going to document. I mean, I look at the severity and then what they come
12 in with.
13

14 Transcript at 2895-2896. Dr. Sachdev’s charting opinions and practices, as expressed in her
15 testimony above, are contrary to the acceptable standard of care for Oregon physicians.
16

17 In conclusion, the evidence persuasively establishes that Dr. Sachdev prescribed
18 Phentermine to Patients D and E without explanation in their charts, and without documenting
19 medical indications for the treatment or how the patients responded to the treatment. This
20 conduct breached the standard of care, and the Board has therefore established violations of ORS
21 677.190(1)(a) and (13).
22

23 *G. Initiating hCG Weight-Loss Regimen for Patient E*
24

25 In its Notice, the Board contends that Dr. Sachdev initiated a series of hCG weight loss
26 injections for Patient E in May 2011 without supporting documentation. However, as set forth
27 below, Dr. Sachdev made numerous chart note references to Patient E’s issues regarding weight
28 gain and excessive weight. In addition, weekly hCG progress notes document the administration
29 of the weight loss injections, as well as Patient E’s response to the regimen.
30

31 Patient E began treating with Dr. Sachdev in November 15, 2010, at which time she
32 weighed 155 pounds. Dr. Sachdev initially focused on optimizing Patient E’s thyroid function
33 and addressing her PCOS.
34

35 A November 22, 2010 chart note states that Dr. Sachdev modified Patient E’s thyroid
36 regimen, initiated targeted amino acid therapy, and performed “extensive nutritional counseling.”
37 Exhibit A35 at 4. At that time, Patient E weighed 159 pounds. A December 1, 2010 chart note
38 mentions Patient E’s recent weight gain of nearly five pounds, and notes that Dr. Sachdev
39 modified the patient’s adrenal fatigue regimen. Although not documented in the chart note, Dr.
40 Sachdev also prescribed Phentermine for Patient E, with the goal of preventing any further
41 weight gain. At that time, Patient E weighed 158 pounds. A December 29, 2010 chart note
42 states that Dr. Sachdev reviewed lab results with Patient E and discussed the patient’s
43 abdominal/gastrointestinal issues.
44

45 A February 18, 2011 chart note states that Patient E continued to experience gut and
46 thyroid issues. A March 2, 2011 chart note states that modifications to Patient E’s thyroid

1 regimen resulted in weight gain and increased puffiness. Dr. Sachdev also noted that she was
2 reducing the patient's alternate treatment regimen for IBS issues. In an April 11, 2011 chart
3 note, Dr. Sachdev noted that Patient E's fatigue and IBS/diarrhea symptoms had improved
4 significantly and that her abdominal bloating had decreased. Dr. Sachdev also noted that Patient
5 E's weight remained a significant issue and that she would focus on getting the patient's
6 metabolic rate regulated, addressing her adrenal fatigue, and optimizing her thyroid.
7.

8 In a May 20, 2011 chart note, Dr. Sachdev stated that many of Patient E's issues had
9 improved, but that excessive weight remained a problem. She noted that they would begin to
10 focus on proper diet and exercise, and that the patient "is going to now enter a diet and weight
11 loss regimen." Exhibit A35 at 11. Dr. Sachdev decided to initiate a human Chorionic
12 Gonadatropin (hCG) weight-loss regimen in an attempt to control Patient E's weight.
13

14 On May 25, 2011, Patient E's mother signed a form titled "Consent for Human Chorionic
15 Gonadatropin (hCG) Weight-Loss Program. Exhibit A37 at 2. An hCG progress note dated
16 May 25, 2011 states that the patient weighed 156.6 pounds, that her goal weight was 135 pounds,
17 that she would begin hCG injections on May 28, 2011, that her health conditions were set forth
18 in her "medical file," that she received counseling on the hCG diet and injections, and that she
19 would be following up weekly due to her PCOS medications. Exhibit A37 at 9.
20

21 Additional hCG progress notes, dated June 3, 10, 15, and 22, 2011, document the
22 administration of each subsequent hCG injection, any dosage modifications, any weight gain or
23 loss since the previous week, and any muscle mass gain or loss.
24

25 An hCG progress note dated June 3, 2011 notes that Patient E lost 4.3 pounds and that
26 she also lost muscle mass. The note further states that her dose was lowered to 0.15 and that
27 chromium was added. An hCG progress note dated June 10, 2011 states that Patient E had a
28 total weight loss of 4.6 pounds and that her muscle mass had increased since the previous week.
29 An hCG progress note dated June 15, 2011 indicates that the patient experienced a weight gain
30 from the previous week. The note further states that the patient's weight was not dropping very
31 quickly, and that her dose was lowered to 0.1 for the next week. An hCG progress note dated
32 June 22, 2011 indicates that Patient E had a slight weight loss that week, but that her body fat
33 had increased. The note references that clinic staff referred the matter to Dr. Sachdev.
34

35 Dr. Sachdev determined that the hCG regimen was not working for Patient E, so she
36 discontinued it. An hCG progress note dated June 29, 2011 states "D/C [Discontinued] hCG per
37 Dr. Naina due to medical issues w/ PCOS." Exhibit A37 at 19. On a Nutraceutical Protocol
38 dated June 29, 2011, "hCG D/C" appears in handwriting under the heading "Diets." (Ex. A35 at
39 55.)
40

41 The ALJ concluded that Dr. Sachdev adequately documented the indications for the hCG
42 treatment, as well as Patient E's response to the treatment. Thus, the Board did not establish a
43 standard of care violation with regard to Dr. Sachdev's initiation of the hCG weight loss
44 regimen.
45
46

1 H. Removal of Patient F's Skin Lesions⁹¹

2
3 The Board contends that Dr. Sachdev allowed “an improperly trained assistant to perform
4 electrocautery removal of Patient F’s skin lesions[,] resulting in scarring to the patient’s neck.”
5 Notice at 4.
6

7 The record is confusing and contradictory with regard to when and to what extent Patient
8 C, a licensed aesthetician, removed lesions from patient F’s neck.⁹² At the very least, however,
9 the record establishes that on July 5, 2011, Dr. Sachdev allowed Patient C to remove multiple
10 lesions from Patient F’s neck using an electrocautery device. The record also establishes, more
11 likely than not, that Patient F sustained full-thickness burns and subsequent scarring as a result of
12 that lesion removal.
13

14 The Board presented evidence indicating that electrocautery falls outside of the scope of
15 practice for an aesthetician. ORS 690.005(6) defines “esthetics,” in part, as follows:
16

17 “Esthetics” means any of the following skin care practices performed on
18 the human body for the purpose of keeping the skin healthy and attractive
19 and not for medical diagnosis or treatment of disease or physical or mental
20 ailments:
21

22 (a) The use of the * * * mechanical or electrical apparatuses or appliances
23 for cleansing, stimulating, manipulating, exfoliating or applying lotions or
24 creams[.]⁹³
25

26 The Board’s Medical Director, Dr. Thaler, testified at hearing that using electrocautery to
27 remove skin lesions does not constitute mere “manipulating,” as referenced in the definition of
28 esthetics in ORS 690.005(6)(a). Transcript at 2394-2395. Rather, he opines that removal of skin
29 lesions via electrocautery is a form of surgery, and should therefore not be performed by an
30 aesthetician. *Id.* at 2400.
31

32 The ALJ concluded that it is unnecessary to determine whether performing electrocautery
33 falls outside the scope of practice for an aesthetician because the Board does not regulate
34 aestheticians and the Board has not charged Dr. Sachdev with a violation based on Patient C
35 allegedly practicing outside the scope of her licensed profession.⁹⁴ The only issue is therefore
36 whether Patient C was improperly or inadequately trained to perform electrocautery on Patient F.
37

38 ⁹¹ The Board’s notice contained an allegation that Dr. Sachdev prescribed Ativan to Patient F without
39 properly charting the medical indications for the treatment and how the patient responded to the
40 treatment. However, the Board withdrew that allegation during closing argument. (Tr. at 3976-3977.)
41

42 ⁹² See Footnotes 49 and 50.

43 ⁹³ The version of ORS 690.005 cited herein was in effect when the alleged conduct occurred. The statute
44 was amended in 2013, but for purposes of this analysis, there are no material differences.

45 ⁹⁴ The Board’s counsel confirmed at hearing that the Board’s allegation with regard to Patient F is
46 confined to whether Dr. Sachdev allowed an “under-trained” person to perform electrocautery, resulting
in harm to the patient. (Tr. at 1127.)

1
2 The fact that Patient F received an undesirable result (*i.e.* excessive burns and scarring)
3 after Patient C performed electrocautery to remove the patient's lesions does not, in itself,
4 establish that Patient C lacked training or was improperly trained to perform the procedure.
5 Rather, to determine whether Patient C was undertrained or improperly trained, it is necessary to
6 compare the training she received to the training that one would reasonably expect an individual
7 to receive prior to performing electrocautery.

8
9 The record establishes that Dr. Sachdev considered Patient C to be a highly skilled
10 medical aesthetician, that Patient C had observed Dr. Sachdev perform electrocautery on
11 multiple occasions prior to Patient C performing the procedure on Patient F, and that Patient C
12 performed the procedure more than once under the direction and guidance of Dr. Sachdev prior
13 to performing the procedure on Patient F.

14
15 The record contains no evidence as to whether or what training standards exist with
16 regard to a person performing electrocautery. Absent such evidence, the Board cannot sustain its
17 burden of proving, more likely than not, that Dr. Sachdev failed to meet those standards with
18 respect to her training of Patient C. Consequently, the Board has not established that Dr.
19 Sachdev engaged in unprofessional or dishonorable conduct, or committed gross or repeated
20 negligence, with respect to Patient F, in violation of ORS 677.190(1)(a) or (13).

21
22 *I. Treatment of Patient G*

23
24 In August 2011, Patient G was referred to Dr. Sachdev with the request that Dr. Sachdev
25 address her thyroid issues and increase her Vitamin D3 level. Patient G has multiple myeloma,
26 and Dr. Sachdev viewed her role in treating Patient G as an adjunct to the patient's cancer
27 treatment, with the hope of enhancing the patient's quality of life. Transcript at 112, 3229.

28
29 First, the Board alleges that Dr. Sachdev prescribed bioidentical hormones, including IM
30 testosterone, to Patient G without charting any rationale as to why the substances were medically
31 indicated. However, a review of the chart notes and other medical documentation supports the
32 medical indication for the treatment.

33
34 On August 25, 2011 MSQ and Adrenal Fatigue forms, Patient G indicated that she was
35 experiencing significant issues with fatigue, lethargy, memory, focus, diminished sexual interest,
36 headaches, dizziness, insomnia, heartbeat irregularity, breathing difficulties, and joint and
37 muscle pain and stiffness. She also indicated that she experienced occasional hot flashes and
38 rashes. In Dr. Sachdev's opinion, the above symptoms may all relate to menopause and suggest
39 hormonal imbalance issues.

40
41 During an August 25, 2011 office visit, Dr. Sachdev took a detailed history of the patient.
42 The chart note states, in part:

43
44 She then was given a diagnosis of multiple myeloma at OHSU[.] [Dr.
45 Sachdev notes numerous details regarding that diagnosis and the patient's
46 various laboratory results] * * * * *. So DHEA levels were 39, but serum

1 progesterone levels are 0.5, estradiol levels are 12. * * * * * [A cancer
2 specialist] recommended that she just needs low dose chemo⁹⁵ and the
3 protocol would be * * * dexamethasone [and] she would be on acyclovir
4 and then the Zometa * * * along with the calcium and vitamin D. [S]o the
5 current situation is where do they go next, how do they enhance what all
6 needs to be done. So at this point we have a lengthy discussion * * * [.]
7 Actually I am going to start her and optimize her mitochondrial function
8 and start her on bioidentical hormone replacement therapy regimen and do
9 any immune enhancement protocol on her almost immediately.

10
11 * * * * *

12
13 The patient has multiple myeloma without any lytic lesion, low dose
14 chemotherapy has been recommended and really with all her other
15 symptoms she is having I definitely want to initiate bioidentical. The plan
16 is to do appropriate blood testing and testing to initiate bioidentical
17 hormone replacement therapy regimens and address and optimize her
18 thyroid function as well. * * *. There is a lot of urgency in today's
19 evaluation. So we are going to start these treatment regimens
20 immediately[.]
21

22 Exhibit A46 at 4-6. An August 26, 2011, chart note states, in part:

23
24 [T]he idea is to optimize her for the regimen that she is about to face. She
25 is going to be undergoing low-dose chemotherapy[.] * * *. Her blood
26 work is pending and at this point, we had an extensive discussion to start
27 her on bioidentical hormone replacement therapy[.]
28

29 Review of symptoms, she is having major, major issues, the headaches,
30 the faintness, the dizziness, the insomnia, bags and circles under her eyes.
31 She is having irregular skipped heartbeats, rapid pounding heartbeat. She
32 is having difficulty with increased shortness of breath, cough, pains and
33 aches in her joints, stiffness and limitation of her movement, poor
34 memory, poor concentration, easy bruising, and frequent illnesses. So, we
35 are going to initiate bioidentical hormone replacement therapy regimen,
36 informed consent was given, RBS was discussed[.]⁹⁶
37

38 *Id.* at 8-9. On September 28, 2011, Patient G had another follow-up visit with Dr. Sachdev.
39 After reviewing the patient's laboratory results with her, Dr. Sachdev adjusted the patient's
40 bioidentical hormone replacement therapy regimen, and noted the changes in a chart note.
41

42
43
44 ⁹⁵ Dr. Sachdev was not recommending chemotherapy for the patient. Rather, she was merely noting in
45 the chart that Patient G's oncologist had recommended low-dose chemotherapy. (Tr. at 3153, 3188-
46 3189.)

⁹⁶ At hearing, Dr. Sachdev clarified that "RBS" refers to "risks, benefits, and side effects." (Tr. at 3178.)

1 The above chart notes quite extensively document the symptoms that Patient G was
2 experiencing and the treatment steps Dr. Sachdev intended to take (including bioidentical
3 hormone treatment) to address the patient's issues. At hearing, Dr. Sachdev elaborated on her
4 decision to initiate the bioidentical hormone treatment prior to receiving the patient's laboratory
5 results. She explained that she strongly believed that the laboratory results would confirm that
6 the patient's hormone levels were low, and given the life-threatening illness the patient had, Dr.
7 Sachdev believed there was an immediate need to get the patient started on the hormone
8 regimen. A laboratory report dated September 26, 2011 showed that the patient's estradiol was
9 0.3 (low), her total estrogens were 2.6 (low), her testosterone was 2.1 (low), her androstenediol
10 was 6.7 (low), her DHEA was 48 (low-normal), and her pregnanediol was 423 (low-normal).
11

12 After a November 8, 2011 lab report showed that the patient's free testosterone level had
13 not significantly increased, Dr. Sachdev suspected that the patient was not adequately absorbing
14 the testosterone cream, and that sublingual testosterone would be a reasonable option to try. A
15 November 23, 2011 chart note states, in part:
16

17 HPI: She was having extreme fatigue issues * * * but she has been so
18 much improved after addressing her bioidentical HRT regimen and
19 immune enhancing protocol. Her platelet count is increasing to 167 and
20 we are waiting for the serum protein electrophoresis results. * * * * *. At
21 this point she has been doing really well with the optimization of
22 bioidentical HRT regimen. * * * * *. So at this point what we are going
23 to see is how she does with an excess SPEP after she has been on the
24 immune enhancement and optimize of her bioidentical HRT regimen.
25

26 REVIEW OF SYSTEMS: [S]he has sometimes hot flashes, excessive
27 sweating. She has occasional irregular skipped heartbeats, rapid pounding
28 heartbeat at times, some feelings of nausea but other than that she is so
29 much improved. Her libido has improved a lot.
30

31 Exhibit A46 at 18. Dr. Sachdev also noted in the chart that Patient G's fatigue and malaise had
32 "improved significantly" and that her depression and anxiety were "much improved." *Id.* at 19.
33 The chart note documents the efficacy of the various treatments and notes significant
34 improvement in several areas, including increased libido, diminished fatigue, and improved
35 depression and anxiety levels. On November 23, 2011, Dr. Sachdev switched Patient G to
36 sublingual testosterone, and then ultimately to IM testosterone, because Patient G complained
37 that she did not like the sublingual form.
38

39 In Dr. Turner's opinion, prescribing testosterone to Patient G was "reasonable," given
40 that the patient was post-menopausal. Transcript at 293-294, 302, 1642. The ALJ concluded
41 that Dr. Sachdev adequately charted the medical indications for the bioidentical hormone
42 treatment (including the testosterone), and that she appropriately documented the efficacy of the
43 treatment.
44

45 Second, the Board alleges that Dr. Sachdev encouraged Patient G to reduce her dosage of
46 the chemotherapy drug Velcade, without documenting any explanation in the chart. The Board

1 further alleges that Dr. Sachdev failed to explain the risks of discontinuing chemotherapy “and
2 adopting [Dr. Sachdev’s] recommended form of treatment.” Notice at 6.
3

4 In a chart note dated September 23, 2011, Patient G’s treating oncologist, Jeffrey
5 Menashe, MD, noted the following with regard to Patient G’s decision not to continue with
6 chemotherapy treatment:
7

8 Clinically, [Patient G] is improved. After much reflection, she prefers not
9 to continue with Velcade for now because of presumed toxicity with initial
10 treatment. * * * * *. If her response to single-agent steroid therapy is
11 suboptimal, we will consider again incorporating Velcade into her
12 treatment regimen.
13

14 Exhibit R188 at 13.
15

16 On September 28, 2011, Patient G had a follow-up visit with Dr. Sachdev. A chart note
17 for the visit states, in part:
18

19 [H]er biological HRT or alternative treatment regimens were modified
20 extensively today. Discussed in great detail. *We also discussed*
21 *chemotherapy regimen, try to go to low to dose Velcade and with the*
22 *prednisone 20 mg p.o. q.d., which she has recently been on may be*
23 *switched to higher dose discussed this with the doctors.*
24

25 Exhibit A46 at 11 (emphasis added). When dictating the italicized portion of the above chart
26 note, Dr. Sachdev had intended for it to reflect that Patient G and/or her husband (Peter) had
27 merely relayed that information to Dr. Sachdev regarding the patient’s oncology regimen, and
28 that Dr. Sachdev told them to discuss it with the oncologist. Transcript at 106. At hearing, Dr.
29 Sachdev explained that she did not have a “discussion” with Patient G and Peter regarding
30 chemotherapy or lowering the patient’s chemotherapy dose. Rather, she simply listened as the
31 patient and/or Peter told her about the chemotherapy treatment that was being recommended by
32 the oncologist. *Id.* at 103-104. Dr. Sachdev flatly denies recommending that Patient G lower her
33 chemotherapy dose. *Id.* at 106-107.
34

35 Dr. Turner admitted at hearing that she could not decipher the meaning of the italicized
36 sentence in the above chart note, and that she could not determine whether Dr. Sachdev was
37 giving Patient G any advice regarding the chemotherapy. The administrative law judge agreed,
38 and the Board agrees, that a plain reading of the sentence does not allow the reader to make a
39 definitive determination as to its meaning. Given Dr. Sachdev’s plausible explanation as to the
40 meaning of the sentence, and given that Dr. Menashe had noted five days prior that Patient G
41 preferred not to continue with Velcade treatment, there would seem to be no reason for Dr.
42 Sachdev to encourage the patient to lower her Velcade dose at that time.
43

44 The Board has not proven, more likely than not, that Dr. Sachdev encouraged Patient G
45 to reduce her dosage of the chemotherapy drug Velcade. Consequently, the Board’s allegation
46

1 that Dr. Sachdev failed to explain the risks of discontinuing chemotherapy to pursue Dr.
2 Sachdev's alternative treatments is without merit.

3
4 Third, the Board alleges that Dr. Sachdev did not engage in or chart any coordination of
5 care with Patient G's treating oncologist.

6
7 Patient G treated with oncologist Dr. Menashe for approximately four to five months in
8 2011. Dr. Sachdev was aware that the patient was under an oncologist's care. Similarly, Dr.
9 Menashe was aware that Patient G was receiving testosterone therapy from Dr. Sachdev, and he
10 had no concerns regarding the patient's use of testosterone during her cancer treatment.

11
12 Dr. Sachdev never communicated with Dr. Menashe regarding Patient G, and she never
13 provided any treatment records to him. She believed it was unnecessary to communicate with
14 the oncologist, because Peter, the patient's husband who was heavily involved in her care, had
15 agreed to do so. At hearing, in response to the question "Did you have any conversation with
16 any of [Patient G's] treating oncologists," Dr. Sachdev replied, in part, "There was no need for
17 me because I actually asked that to [*sic*] the husband. He was such a fabulous person in – in
18 communicating and – and we brought that discussion up. And he said I will go into – and I said
19 fine." Transcript at 5.

20
21 In Dr. Turner's opinion, adequate coordination of care between Dr. Sachdev and Patient
22 G's treating oncologist would have included some type of communication between Dr. Sachdev
23 and the oncologist. The ALJ concluded that Dr. Sachdev's reliance on the patient's husband as a
24 conduit between Dr. Sachdev and the treating oncologist was unreasonable, and a breach of the
25 standard of care. The Board has established violations of ORS 677.190(1)(a) and (13).

26
27 Fourth, the Board alleges that Dr. Sachdev gave Patient G assurances regarding the
28 efficacy of alternative treatments for multiple myeloma, when medical science does not support
29 those assurances. The Board points to a November 2, 2011 chart note as evidence. That chart
30 note states, in part:

31
32 [The patient] is also pursuing alternative treatment regimen, which have
33 been working very well for her upon my recommendations she is very
34 pleased at that and so again a very extensive discussion on her multiple
35 myeloma and how she can prevent it even through alternative treatment
36 regimens.

37
38 Exhibit A46 at 15.

39
40 Dr. Turner testified at hearing that she found the chart note ambiguous and that she did
41 not understand its meaning. She further testified that to the extent Dr. Sachdev was discussing
42 with Patient G how she could prevent her multiple myeloma through alternative treatment, such
43 a discussion is puzzling because one cannot prevent something that has already occurred.
44 Transcript at 1748-1749, 1825.

1 At hearing, Dr. Sachdev stated that she did not intend for the above chart note to convey
2 that she told the patient that alternative treatment regimens could prevent multiple myeloma.
3 Instead, when dictating the chart note, Dr. Sachdev was referring to the prevention and/or
4 treatment of anemia through alternative treatment regimens (*i.e.* testosterone therapy). Transcript
5 at 109-112. When prescribing testosterone to Patient G, Dr. Sachdev had considered an article
6 titled “Low Testosterone Levels and the Risk of Anemia in Older Men and Women.” Exhibit
7 R209. The article states that “low testosterone levels could be a susceptibility factor for anemia
8 that has been generally neglected.” *Id.* at 7. Dr. Sachdev was particularly interested in the
9 following excerpt from the article:

10
11 The mechanism through which testosterone stimulates [red blood cell
12 formation] is unclear. Testosterone enhances the proliferation of erythroid
13 burst-forming units and colony-forming units by stimulating specific
14 nuclear receptors, and this effect is completely abolished by pretreating
15 marrow cells with [antiandrogens], which selectively block androgen
16 binding to nuclear androgen receptors.

17
18 *Id.* at 6. Dr. Sachdev construed the above as suggesting that testosterone is unique in red blood
19 cell formation, and that it could therefore prove beneficial in treating anemia.

20
21 While Dr. Sachdev did admit to discussing with Patient G and Peter an article that Dr.
22 Sachdev believes suggests the possibility that testosterone could affect the outcome of multiple
23 myeloma,⁹⁷ the Board failed to establish that Dr. Sachdev gave Patient G assurances about the
24 efficacy of preventing multiple myeloma through alterative treatment regimens.

25
26 Finally, in its Notice, the Board notes that Dr. Sachdev sold a stock bottle of testosterone
27 to Patient G before the patient moved out of state. However, the Board has not specifically
28 alleged any violation with regard to that conduct.

29
30 In conclusion, the Board failed to establish that Dr. Sachdev prescribed bioidentical
31 hormones treatment to Patient G without charting medical indications, that she encouraged
32 Patient G to reduce her dosage of a chemotherapy drug, and that she gave Patient G scientifically
33 unproven assurances regarding the efficacy of alternative treatments for multiple myeloma. The
34 Board proved, however, that Dr. Sachdev failed to engage in or chart any coordination of care
35 with Patient G’s treating oncologist. This breach of the standard of care constitutes a violation of
36 ORS 677.190(1)(a) and (13).

37
38 *J. Treatment of Patient H*

39
40 In its Notice, the Board alleges that Dr. Sachdev failed to address Patient H’s low
41 potassium level and that she prescribed antibiotics to Patient H that were insufficient to treat a
42 post-operative wound infection.

43
44
45
46 ⁹⁷ “Age-Associated Increased Interleukin-6 Gene Expression, Late-Life Diseases, and Frailty.” Exhibit
R210.

1 On December 12, 2011, Dr. Sachdev performed a tumescent liposuction procedure on
2 Patient H. Prior to the procedure, Patient H did not inform Dr. Sachdev or clinic staff that she
3 had chronic hypokalemia or that she had received a facet joint steroid injection approximately
4 one week prior. As a precaution against infection, Dr. Sachdev prescribed 500 mg of Keflex
5 (cephalexin), to be taken twice per day for 10 days, to Patient H.
6

7 On December 14, 2011, Patient H returned to the clinic for a post-operative check-up,
8 and she complained of pain in the lower abdominal area. Dr. Sachdev observed minimal
9 bruising, and a small area of erythema in the lower abdominal area that was swollen and warm to
10 the touch. Patient H had a temperature of 99.4 degrees. Dr. Sachdev observed no signs of
11 tachycardia or sepsis, and two physicians with whom she consulted opined that it was unlikely
12 that Patient H had a seroma or infection at that time. A third physician, who examined Patient H
13 at Dr. Sachdev's request, determined that Patient H had no signs of tachycardia, sepsis, or
14 necrotizing fasciitis. As an additional precaution, Dr. Sachdev decided to perform a blood test
15 (specifically, a "CBC" and a "chem profile") on Patient H. At 1:30 p.m. on December 14, 2011,
16 Patient H's blood was collected and sent for testing.
17

18 Against Dr. Sachdev's advice, Patient H insisted on flying home to Idaho on December
19 14, 2011. When Patient H left the clinic at approximately 3:00 p.m. that day, Dr. Sachdev did
20 not yet know the patient's blood test results. She decided to administer 250 mg of IM Rocephin
21 (ceftriaxone) to Patient H, which she determined would provide the patient with antibiotic
22 protection for an approximate four to six-hour period—enough time for the patient to fly to
23 Idaho and meet up with her then-boyfriend, Dr. Waters (an orthopedic surgeon). Dr. Sachdev
24 also had Patient H take a dose of Keflex before leaving the clinic.
25

26 On the morning of December 15, 2011, Dr. Sachdev received Patient H's blood test
27 results and learned of the patient's very low potassium level of 2.8. Dr. Sachdev directed Patient
28 C to call Patient H to report the results, but Patient C was unsuccessful in reaching Patient H. On
29 December 15 or 16, 2011, Dr. Sachdev called Dr. Waters to inform him of Patient H's low
30 potassium level. Dr. Waters told Dr. Sachdev that Patient H had a history of hypokalemia, that
31 she was not always compliant in taking her potassium supplements, and that he would inform
32 Patient H's internist about the test results.
33

34 At hearing, Drs. Turner and Thaler both testified that Patient H's medical records did not
35 document sufficient efforts by Dr. Sachdev to address the patient's low potassium level. Had Dr.
36 Sachdev known of the low potassium level prior to Patient H returning to Idaho on December 14,
37 2011, the Board would be correct in asserting that Dr. Sachdev failed to properly address the
38 potassium issue. However, the record establishes, more likely than not, that the patient was not
39 forthright with Dr. Sachdev and failed to disclose her chronic hypokalemia to Dr. Sachdev
40 during the relevant treatment period. The record further establishes that Dr. Sachdev did not
41 learn of the low potassium level results until the day after Patient H returned to Idaho. After so
42 learning, Dr. Sachdev made reasonable (yet unsuccessful) efforts to alert the patient, and
43 ultimately decided to report the results to the patient's surgeon boyfriend. After he assured Dr.
44 Sachdev that Patient H had a history of hypokalemia and that he would inform the patient's
45 internist of the test results, Dr. Sachdev determined that her responsibilities with regard to the
46 patient's low potassium level had ended. The administrative law judge agreed. At that point,

1 Patient H had returned home to Idaho, after disregarding Dr. Sachdev's medical advice to the
2 contrary, and there appears to have been little, if anything, left for Dr. Sachdev to do in regard to
3 treating the patient's chronic low potassium condition. At hearing, Dr. Sachdev credibly testified
4 that if Patient H had not flown back to Idaho, she would have addressed the patient's
5 hypokalemia herself. Moreover, Dr. Sachdev testified that if she had known of Patient H's
6 chronic hypokalemia prior to the December 12, 2011 surgical procedure, she would have
7 checked the patient's potassium level prior to performing the surgery. Drs. Turner and Thaler
8 have not suggested that Dr. Sachdev breached any standard of care by not testing the patient
9 prior to the surgery, when the patient neither disclosed her condition nor presented with any
10 symptoms suggestive of the condition. After consideration of the above factors, the ALJ
11 concluded, and the Board agrees, that Dr. Sachdev did not fail to properly address Patient H's
12 low potassium level.

13
14 The next issue is whether Dr. Sachdev provided antibiotics to Patient H in doses that
15 were insufficient to treat a post-operative wound infection.

16
17 Dr. Thaler opined that the dosage of Keflex that Dr. Sachdev prescribed to Patient H (500
18 mg, two times per day) immediately following the surgery was not sufficient to treat a potential
19 post-operative infection. At hearing, Dr. Sachdev conceded that the typical dose of this
20 antibiotic is 500 mg, four times per day. However, because she had concerns about how the
21 antibiotic might affect Patient H, given the patient's Celiac disease, she instructed the patient to
22 only take it twice per day. During her testimony, Dr. Sachdev also pointed out that some
23 physicians elect not to give antibiotics post-surgery to liposuction patients. Transcript at 3604.

24
25 The Board finds Dr. Sachdev's explanation for the Keflex dosage unpersuasive. She
26 seems to be asserting that the lower dosage of Keflex was appropriate, even though it was only
27 half the typical dosage, given that some physicians would have opted not to prescribe *any*
28 antibiotics to a patient in Patient H's situation. The fact is that Dr. Sachdev *did* elect to provide
29 antibiotics to the patient, and presumably she provided them to effectuate some reasonable
30 medical purpose. The only reasonable purpose would have been to prevent a post-operative
31 infection, and based on Dr. Thaler's credible testimony, the dosage she prescribed was
32 insufficient for that purpose. The Board has therefore proven that Dr. Sachdev provided an
33 inadequate dose of Keflex to Patient H.

34
35 In Dr. Turner's opinion, Dr. Sachdev administered an inadequate dose of Rocephin to
36 Patient H on December 14, 2011. Dr. Turner credibly testified that the standard dose for
37 treatment of a wound infection is one to two grams, and that a 250 mg dose would only be
38 appropriate to treat a condition such as gonorrhea.

39
40 Dr. Sachdev has provided various, and contradictory, explanations for her decision to
41 administer the 250 mg dose of Rocephin to Patient H on December 14, 2011. She informed the
42 Board's Investigative Committee that she administered the Rocephin because Patient H had a
43 UTI. However, the December 16, 2011 chart note does not mention a UTI, or the possibility that
44 Patient H might have such an infection. At hearing, she initially testified that she was concerned
45 about Patient H flying and the risk of infection, given that she doubted the patient's compliance
46 with taking the oral antibiotic. Transcript at 129-130 ("I'm coming to realize that she's not

1 compliant and then she's flying[.]") However, in subsequent testimony, Dr. Sachdev admitted
2 that she only learned of the patient's non-compliance with taking medications after speaking
3 with Dr. Waters on December 15 or 16, 2011. *Id.* at 3625, 3627, 3635-3636 ("That's when he
4 told me she's not compliant" and "[He] at that time made me aware that she's not a very
5 compliant patient." Yet, she later testified, in response to a question regarding the Rocephin and
6 treatment of a potential UTI, that one of the things she considered was that the patient was non-
7 compliant with medication. *Id.* at 3638-3639.⁹⁸ In Dr. Turner's opinion, if Dr. Sachdev believed
8 that Patient H was non-compliant in taking her oral antibiotic, that would provide *even more*
9 reason for Dr. Sachdev to have administered a higher dose of the IM Rocephin on December 14,
10 2011. *Id.* at 1770-1772.

11
12 When weighing Dr. Turner's consistent, credible testimony regarding the inadequacy of
13 the Rocephin dose against Dr. Sachdev's contradictory and rather confusing explanations for her
14 decision to administer that amount of the medication, the Board accords greater weight to Dr.
15 Turner's testimony. The evidence establishes, more likely than not, that Dr. Sachdev provided
16 an inadequate dose of Rocephin to Patient H.

17
18 Dr. Sachdev's conduct in prescribing inadequate dosages of antibiotics to Patient H falls
19 below the standard of care for a medical professional and constitutes gross negligence. Thus, the
20 Board has proven a violation of ORS 677.190(13).

21
22 *K. Prescribing Vicodin, Ambien, Xanax, Soma, and Adderall to Patient I*

23
24 It is undisputed that, as of 2011, Dr. Sachdev was prescribing Vicodin, Ambien, Xanax,
25 Soma, and Adderall to Patient I. The Board alleges that this medication regimen was not
26 medically indicated, and that the regimen was excessive and posed a significant danger of
27 harmful drug interaction.

28
29 Dr. Sachdev contends that there is documentation showing medical indications for each
30 of the medications at issue. She further contends that the regimen was not excessive and that it
31 did not pose a significant risk to the patient because most of the medications were prescribed on
32

33 ⁹⁸ At hearing, in response to the question, "[D]id you provide [the IM antibiotic] for a urinary tract
34 infection," Dr. Sachdev responded, in part:

35
36 I – one of the things I do is, again, this is my cautiousness. It's always – well,
37 she has a fever. * * * * *. The dipstick showed that she didn't have a urinary
38 tract infection, but then I always think, okay, again, functionalism. What if she
39 had less than 100,000 bacteria to declare an infection? What if she's budding
40 and then she's going to be going to the airport. She's going to be dehydrated.
41 Oh, good, perfect. [Rocephin] will cover that, too. * * *. 250 [mg] will cover
42 the wound infection. She's not compliant with her medication. I can cover her
43 urinary tract infection. So all that stuff is going in my mind and I thought it was
44 a perfect thing to give. * * *. In view of the fact that I also was cautious about
45 the dose because she's got Celiac disease. I'm not going to get her now the
46 diarrhea and a flare-up with that. * * *. So that's my thinking.

(Tr. at 3638-3639.)

1 merely an as-needed basis, she had good communication with the patient, the patient had been
2 taking the medications for a significant period of time, and the patient understood the risks of the
3 medications and how to properly take them.
4

5 Documentation of Medical Indications 6

7 Patient I has been treating with Dr. Sachdev for more than a decade. The patient has seen
8 numerous specialists and providers throughout the years for her multiple physical and mental
9 health conditions. Her medication history is rather convoluted and unclear. While the evidence
10 establishes that she was prescribed one or more of the medications at issue by providers other
11 than Dr. Sachdev, it is not evident when she was taking those medications, which medications
12 they were and in what dosages, and whether she had stopped the medications prior to Dr.
13 Sachdev beginning to prescribe them to her.
14

15 In Dr. Turner's opinion, if Patient I was taking medication[s] prescribed by another
16 physician while treating with Dr. Sachdev, Dr. Sachdev should have documented that
17 information in the patient's chart, and done a complete history and physical to understand when
18 the problems (for which she is taking the medications) started, what alternative medications she
19 had taken, and what prior consultations she had received. She should also have evaluated the use
20 of the medication[s] to determine efficacy, and made a long-term plan for continuation,
21 discontinuation, or modification of the medication[s]. Patient I's medical records do not contain
22 documentation that Dr. Sachdev followed these steps with regard to any of the five medications
23 at issue.
24

25 A Patient Medication List for Patient I is the earliest documentation of her medication
26 regimen with Dr. Sachdev, and it shows that, as of at least August 9, 2010, Dr. Sachdev was
27 prescribing Vicodin, Ambien, Soma, and Adderall to the patient.
28

29 1. Vicodin 30

31 Patient I's medical records do not reference when Dr. Sachdev first began prescribing
32 Vicodin to Patient I, but Patient I's testimony suggests that it was prescribed initially for back
33 pain resulting from a 2005 or 2006 car accident. Electronic prescription records show that Dr.
34 Sachdev prescribed Vicodin to Patient I thirteen times from December 24, 2010 to December 27,
35 2011.
36

37 Contrary to the Board's allegation, several chart notes provide medical indications for
38 prescribing Vicodin for Patient I. For example, a January 3, 2011 chart note states, in part:
39

40 [H]er other issue, which is also most important, is her right shoulder. I
41 have looked at the x-rays. It showed calcific tendonitis.⁹⁹ This is an
42 extremely painful condition. On top of that, she has a history of
43 fibromyalgia and chronic back pain issues. She is having much more back
44 pain[.] * * * * *. I am also going to recommend some alternative
45

46 ⁹⁹ Dr. Sachdev referred Patient I for an orthopedic consultation and, on January 21, 2011, an orthopedist confirmed the diagnosis of calcific tendonitis.

1 treatment regimens for the muscle tightness that she is having over the
2 neck area[.] * * * * *. The patient is under so much pain right now that
3 we have to amend the chronic pain management contract I am going to
4 have with her as she is going through about one and a half tablets of
5 Vicodin twice a day. Until she gets her depression under control[], gets
6 her evaluation done and gets her calcific tendonitis resolved, I am going to
7 * * * prescribe her 3 Vicodin tablets a day and we will give it on a weekly
8 basis of about 21 tablets in a week and there will be no other prescribing
9 doctor[]. * * *. If for some reason the medicines need to be changed she
10 can let me know and I can discuss that with the specialist that she will be
11 [seeing.]
12

13 Exhibit A58 at 130.

14
15 A May 26, 2011 chart note states, in part:

16
17 The patient is having acute neck pain exacerbation again along the
18 scapular strain along with pain in her upper back area. * * * * *. The only
19 thing that she has been on is pain management contract, but she is very
20 uncomfortable. She has been doing about four Vicodin a day, but there is
21 no Tylenol to that, so I am going to try to lower her dose of Tylenol and I
22 will just do more hydrocodone, probably switch her to Vicodin 7.5 mg
23 tablets and we will see how she does with three tablets a day. * * *. I
24 have also recommended [an] alternative treatment regimen, which really
25 works well for her as well. Combined with these two treatments, the
26 patient tends to do a lot better.
27

28 * * * * *

29
30 A/P: Acute fasciitis/neck pain/scapular pain/myositis/myalgias. The
31 patient also signed a chronic pain management contract * * * and will
32 follow up over the next 8 to 10 weeks.
33

34 Exhibit A58 at 127.

35
36 A July 26, 2011 chart note states that Patient I continued to experience chronic back pain
37 and intermittent chronic neck pain. An October 10, 2011 chart note states that Patient I was
38 experiencing an exacerbation of chronic neck and back pain, for which Dr. Sachdev continued
39 prescribing Vicodin and recommended meditation and relaxation techniques.
40

41 The ALJ concluded that Dr. Sachdev adequately charted the medical indications for
42 prescribing Vicodin to Patient I in 2011.
43

44 2. Ambien
45
46

1 Patient I's medical records do not reference when Dr. Sachdev first began prescribing
2 Ambien to Patient I, but electronic prescription records show that she did so eight times from
3 May 13, 2011 to January 12, 2012.
4

5 At hearing, Dr. Sachdev testified that she prescribed Ambien because of Patient I's
6 insomnia and fibromyalgia issues. Transcript at 154-155, 2111, 3310.
7

8 An MSQ dated January 3, 2011 indicates that Patient I was experiencing frequent non-
9 severe insomnia. A chart note dated January 3, 2011 states, in part:
10

11 [S]he she has a history of fibromyalgia[.] * * * * *. I am also going to
12 recommend some alternative treatment regimens for the muscle tightness
13 that she is having over the neck area[.] There are [a] lot of trigger points
14 that are positive for fibromyalgia[.]
15

16 Exhibit A58 at 130.
17

18 An MSQ dated July 26, 2011 indicates that Patient I was experiencing occasional severe
19 insomnia.
20

21 An October 10, 2011 chart note states, in part:
22

23 The patient is * * * under tremendous amount of stress. * * * * *. She
24 cannot sleep. Her fibromyalgia symptoms have flared up. * * *. She is
25 having insomnia[.]
26

27 * * * * *

28
29 Neurologic: As mentioned * * * insomnia issues[.]
30

31 * * * * *

32
33 Psychiatry: Poor memory. Poor concentration. Feelings of depression,
34 anxiety, insomnia, irritability, or panic attacks.
35

36 *Id.* at 118.
37

38 The ALJ concluded that Dr. Sachdev adequately charted the medical indications for
39 prescribing Ambien to Patient I in 2011.
40

41 3. Xanax 42

43 Electronic prescription records show that Dr. Sachdev prescribed Xanax to Patient I five
44 times from September 9, 2011 to approximately December 27, 2011.
45
46

1 On October 10, 2011, Patient I treated with Dr. Sachdev and one of her chief complaints
2 was anxiety. The chart note for that visit states, in part:

3
4 HPI: The patient is * * * under tremendous amount of stress. * * * * *.
5 She is starting to feel again emotional mood swings, anxiety and panic
6 attacks. She actually had to go when I was out of [town] to see another
7 doctor just to get a few tablets of Xanax. Her situation is really, really
8 bad. We had a lengthy discussion with regard to that.

9
10 * * * * *

11
12 Psychiatry: Poor memory. Poor concentration. Feelings of depression,
13 anxiety, insomnia, irritability, or panic attacks.

14
15 * * * * *

16
17 2. Panic attacks. Secondary to financial distress. I am going to give her
18 Xanax 0.25 mg p.o. b.i.d. on a p.r.n. basis[.]

19
20 Exhibit A58 at 118-119.

21
22 The above chart note suggests that Dr. Sachdev first prescribed Xanax to Patient I as of
23 that office visit, October 10, 2011. However, a prescription authorization request form shows
24 that prescriber "Naina Sachdev" wrote a prescription for Xanax to Patient I on September 9,
25 2011, which Patient I filled on September 11, 2011. The same form shows a refill request dated
26 September 28, 2011, which was approved on September 29, 2011.

27
28 Patient I's medical records do not contain any chart notes or progress notes that document
29 or discuss the September 2011 Xanax prescriptions, and Dr. Sachdev has not offered any
30 explanation for that lack of documentation.

31
32 Nonetheless, Dr. Sachdev did adequately chart the medical indication for prescribing
33 Xanax to Patient I on October 10, 2011.

34
35 4. Soma

36
37 Dr. Sachdev prescribed Soma, a muscle relaxant, for Patient I's muscular pain and
38 spasms. Patient I's medical records do not reference when Dr. Sachdev first began prescribing
39 the medication, but electronic prescription records show that Dr. Sachdev prescribed it to Patient
40 I five times from September 27, 2010 to December 2, 2011.

41
42 Several chart notes provide medical indications for prescribing Soma for Patient I. For
43 example, a January 3, 2011 chart note states, in part:

44
45 [S]he has a history of fibromyalgia and chronic back pain issues. She is
46 having much more back pain[.] * * * * *. I am also going to recommend

1 some alternative treatment regimens for the muscle tightness that she is
2 having over the neck area[.]

3
4 Exhibit A58 at 130.

5
6 A May 26, 2011 chart note states, in part:

7
8 The patient is having acute neck pain exacerbation again along the
9 scapular strain along with pain in her upper back area. * * * * *. The only
10 thing that she has been on is pain management contract, but she is very
11 uncomfortable. * * * * *. I have also recommended [an] alternative
12 treatment regimen, which really works well for her as well[.]

13
14 * * * * *

15
16 A/P: Acute fasciitis/neck pain/scapular pain/myositis/myalgias[.]

17
18 *Id.* at 127.

19
20 An October 10, 2011 chart note states that Patient I was experiencing an exacerbation of
21 chronic neck and back pain, for which Dr. Sachdev recommended, among other things,
22 meditation and relaxation techniques.

23
24 The ALJ concluded that Dr. Sachdev adequately charted the medical indications for
25 prescribing Soma to Patient I in 2011.

26
27 5. Adderall

28
29 Patient I's medical records do not indicate when Dr. Sachdev first began prescribing
30 Adderall to Patient I. At hearing, when explaining her basis for prescribing the medication, Dr.
31 Sachdev testified that the patient had a "history of ADD" and a "history of Adderall use."
32 Transcript at 170-171. However, Patient I's medical records contain no documentation to
33 support those assertions. Moreover, at hearing, in response to the question, "[W]hen did you
34 first start getting prescribed Adderall and who was the prescriber," Patient I replied that it was
35 Dr. Sachdev who initially recommended the medication and prescribed it for her. Patient I
36 specifically testified:

37
38 Initially, Dr. Sachdev recommended it and wanted me to go get a test
39 through a psychiatrist or to go get actually tested for it, for ADD. * * *.
40 So she recommended, and I said I would set up an appointment. And in
41 the meantime she did prescribe it to make sure that, you know, I got
42 started right away because I was having such difficulties.

43
44 *Id.* at 2104-2105.

45
46 A January 3, 2011 chart note states, in part:

1
2 The patient is having several issues. Firstly is that of her ongoing ADD
3 issues. She definitely needs to be on Adderall. There have been financial
4 issues that she is having to face. This has caused her [a] tremendous
5 amount of stress in her life and pretty much in how she is dealing * * * she
6 is starting to feel depressed.
7

8 Exhibit A58 at 130. A January 3, 2011 Nutraceutical Protocol form lists Adderall under the
9 protocol section.

10
11 An October 10, 2011 MSQ indicates that Patient I was experiencing occasional insomnia,
12 anxiety, and irritability of a severe nature; poor memory and poor concentration of a non-severe
13 nature; and frequent depression and mood swings of a non-severe nature. An October 10, 2011
14 chart note states, in part:

15
16 [T]he patient is * * * under [a] tremendous amount of stress. * * * * *
17 She cannot sleep. * * * * *. She feels that sometimes she cannot focus.
18 She is starting to feel again emotional mood swings, anxiety and panic
19 attacks. * * *. Her situation is really, really bad[.]

20
21 * * * * *

22
23 Psychiatry: Poor memory. Poor concentration. Feelings of depression,
24 anxiety, insomnia, irritability, or panic attacks.

25
26 * * * * *

27
28 CURRENT MEDICATIONS: * * *. Adderall, she is taking 30 mg * * *
29 twice a day[.]
30

31 *Id.* at 118.

32
33 According to the DSM-IV-TR, an ADHD diagnosis requires that a person have at least
34 six of nine listed symptoms for at least six months to a degree that is maladaptive or inconsistent
35 with developmental level, with impairment from the symptoms present in two or more settings
36 (*e.g.* work, home, or school).
37

38 In Dr. Turner's opinion, an adequate clinical evaluation for ADD/ADHD should include
39 consideration of the patient's functioning in different spheres of life, how the patient's symptoms
40 affect that functioning, historical information regarding the patient's functioning in school,
41 whether the patient received an ADD/ADHD diagnosis during childhood (and, if so, on what
42 basis), what medications the patient may have previously taken for ADD/ADHD, and whether
43 the patient has any comorbid conditions (*e.g.* anxiety, depression). Dr. Turner's opinion is
44 consistent with the DSM-IV-TR criteria and a 2009 article in *Primary Psychiatry*, titled "ADHD
45 in Adults: Update for Clinicians on Diagnosis and Assessment," which states, in part:
46

1 The clinical evaluation and interview are essential to the diagnosis of
2 ADHD in adults. This includes discussion regarding patient recall of any
3 childhood symptoms of ADHD. Current symptoms and their impact on
4 work, home, and social functioning should also be explored. Clinicians
5 should assess the patient's family history and observable impairments of
6 family members, including disorganization, job/financial instability, and
7 alcohol/substance use disorders. Rating scales * * * can be useful in
8 gathering information from patients regarding childhood and current
9 symptoms[.]

10
11 Exhibit R157 at 3, 9. The article goes on to state that assessment of ADD/ADHD symptoms can
12 be complicated by the nonspecific nature of the symptoms, and by their resemblance to
13 impairments that occur in other disorders. For example, inattentive symptoms associated with
14 ADD/ADHD might resemble concentration impairments that occur in PTSD, anxiety, or major
15 depressive disorder.

16
17 Patient I's medical records contain no evidence that Dr. Sachdev performed *any* clinical
18 evaluation before determining that Patient I had "ADD issues"¹⁰⁰ that warranted treatment with
19 Adderall. Although some of Patient I's MSQs and chart notes reference symptoms that could be
20 indicative of ADD/ADHD (e.g. poor memory, poor concentration, inability to focus), those
21 symptoms could also be indicative of numerous other diagnoses. There is no documentation to
22 show that Patient I met the ADD/ADHD diagnostic criteria, as set forth in the DSM-IV-TR, to
23 justify Adderall treatment. The fact that psychotherapist Scott Losk informed Patient I on
24 December 26, 2010, after a two-hour interview to assess her for participation in a depression-
25 related study, that he agreed with Dr. Sachdev's treatment protocol does not make up for Dr.
26 Sachdev's lack of an adequate clinical evaluation. Moreover, there are no records to show how
27 Dr. Losk arrived at his opinion.

28
29 The evidence persuasively establishes that Dr. Sachdev prescribed Adderall to Patient I
30 without documenting the medical indications for the treatment. This conduct is a breach of the
31 standard of care, and therefore violates ORS 677.190(1)(a) and (13).

32
33 Medication Regimen – Whether Excessive and Dangerous

34
35 In Dr. Boyko's opinion, Patient I's prescribed medication regimen was not excessive, and
36 any concerns he might have about such a complex regimen are minimized if the patient was
37 following up with the prescribing physician at least two to four times per year. At hearing, he
38 testified, in part:

39
40 [P]hysicians often find that patients have multiple medical conditions
41 which require multiple treatments, which will increase the possibility of
42 interaction. And if a patient is followed by his or her provider to guard
43 against harmful interactions, then my concern is minimized in that case.

44
45 Transcript at 2431-2432.

46

¹⁰⁰ See Exhibit A58 at 130.

1
2 At hearing, Dr. Thaler expressed concern that although Patient I was on a complex
3 medication regimen, she went nearly one year without an office visit with Dr. Sachdev.
4 Transcript at 2451. The evidence establishes, however, that Patient I treated with Dr. Sachdev
5 on August 9, 2010, August 18, 2010, January 3, 2011, May 26, 2011, July 26, 2011, October 10,
6 2011, and January 13, 2012. See Exhibit A58 at 1, 96, 131-132. Thus, during the relevant time
7 period,¹⁰¹ the longest that Patient I went without an office visit with Dr. Sachdev, according to
8 her patient file, was approximately four months (*i.e.* January 3 to May 26).
9

10 At hearing, Dr. Turner testified that the standard of care dictates that when a patient
11 begins taking prescribed controlled substances, the physician should have one or more follow-up
12 visits with the patient in short intervals. However, once the patient is on a stable medication
13 regimen, it is reasonable for the physician to have clinical follow-up visits approximately every
14 six months. Transcript at 1817. The frequency with which Patient I followed up with Dr.
15 Sachdev while on the medication regimen at issue satisfies that particular standard of care.
16

17 However, Dr. Sachdev did not satisfy the standard of care pertaining to the substance and
18 charting of a clinical follow-up. An adequate clinical follow-up requires documentation of how
19 the patient is responding to each medication and whether the patient is experiencing any side
20 effects. Where, as here, a patient is on a complex medication regimen that carries a significant
21 risk for adverse drug interaction, a thorough evaluation of that regimen and appropriate charting
22 is likely even more critical. Patient I's medical records lack sufficient documentation to show
23 that Dr. Sachdev conducted the appropriate evaluations with regard to the five medications at
24 issue. The ALJ therefore concluded that Dr. Sachdev did not conduct adequate clinical follow-
25 up visits with Patient I in 2011. Given Patient I's complex medication regimen, the lack of
26 adequate clinical follow-up constitutes gross negligence. The Board has established a violation
27 of ORS 677.190(1)(13).
28

29 *L. Prescribing Testosterone to Patients B and D*

30

31 In its Notice, the Board contends that Dr. Sachdev treated Patient B with topical and
32 injectable testosterone and Patient D with topical testosterone without chart notes that document
33 the medical indications for the treatment. The Board further alleges that there is no
34 documentation that Dr. Sachdev provided the patients with warnings regarding the potential side
35 effects of testosterone.
36

37 Medical Indications for Patient B

38

39 On November 15, 2004, Patient B began treating with Dr. Sachdev. The patient's
40 medical records show a history of irregular menstrual periods. In September 2006, Patient B had
41 an extremely high free testosterone level of 25. A September 22, 2006 chart note states that Dr.
42 Sachdev started Patient B on Yasmin oral contraceptive pills (OCPs). A July 21, 2008 chart note
43 states that Patient B's dysmenorrhea had resolved with the continued use of OCPs. An October
44 23, 2009 chart note stated that Patient B was again experiencing dysmenorrhea, despite her
45 continued use of the OCPs.
46

¹⁰¹ The Board's Notice references Patient I's medication regimen as of 2011.

1
2 On or about March 7, 2011, Dr. Sachdev started Patient B on progesterone. June 29,
3 2011 lab results showed that Patient B had low levels of DHEA sulfate (117.6), free testosterone
4 (< 0.04), and total testosterone (10), and high levels of sex hormone-binding globulin (> 200).
5 The record contains no chart notes that discuss the June 29, 2011 lab results. In approximately
6 July 2011, Patient B informed Dr. Sachdev that she had low libido and that it was affecting her
7 relationship with her significant other.
8

9 On July 21, 2011, Dr. Sachdev began prescribing topical testosterone to Patient B. The
10 only document in the record that notes this prescription is a Nutraceutical Protocol dated July 21,
11 2011. Patient B's medical records contain no chart notes or progress notes that discuss Dr.
12 Sachdev's rationale for prescribing the topical testosterone.
13

14 November 22, 2011 lab results showed that Patient B still had low free testosterone
15 (< 0.08) and total testosterone (23), and high levels of sex hormone-binding globulin (> 200).
16 Dr. Sachdev determined that the topical testosterone was not effective in increasing Patient B's
17 testosterone levels. However, Patient B's medical records contain no chart notes or progress
18 notes that reference the ineffectiveness of the topical testosterone.
19

20 In late 2011, Dr. Sachdev gave Patient B a test dose response of 10 mg of injectable
21 testosterone. Because the patient did not have a strong, positive response, Dr. Sachdev elected
22 not to continue the injections. However, when the patient was "still not doing well" in January
23 2012, Dr. Sachdev administered another test dose response on January 27, 2012. Transcript at
24 3574. Patient B's medical records contain no chart notes or progress notes that discuss the test
25 dose responses of testosterone, including why Dr. Sachdev chose to administer another test dose
26 in January 2012 despite the lack of a strong, positive response in late 2011.
27

28 In conclusion, Dr. Sachdev failed to chart the medical indications for prescribing topical
29 and IM testosterone for Patient B, and she failed to document the efficacy of either treatment.
30 This conduct breached the standard of care, and the Board has therefore established a violation of
31 ORS 677.190(1)(a).
32

33 Medical Indications for Patient D

34 On March 1, 2011, Patient D began treating with Dr. Sachdev. On a handwritten
35 progress note, Dr. Sachdev noted the patient's family history, menstrual history, and a review of
36 the systems. She diagnosed Patient D with fatigue and menstrual disorder, and ordered lab tests.
37
38

39 A March 11, 2011 chart note states, in part:

40
41 HPI: The patient is here for follow[]up of her blood work and fatigue. As
42 per last visit mentioned, every other period[] she has been having horrible
43 cramps 33 to 36 days apart which was never the case and then she is also
44 having really fatigue issues. She is here for follow[]up of her test results.
45 She is a poor T4 to T3 converter and low normal vitamin D levels. She
46 also has had _____.

1 Exhibit A32 at 4. The dictated chart note ends abruptly, with no mention of the blood work
2 results, a review of symptoms, or an assessment/plan. On a Nutraceutical Protocol form dated
3 March 11, 2011, Dr. Sachdev listed testosterone cream, along with the recommended dosage and
4 instructions for use, under the protocol section.
5

6 The evidence establishes that Dr. Sachdev prescribed topical testosterone to Patient D
7 from at least March 11, 2011 through November 21, 2011. However, Patient D's medical
8 records are devoid of any chart notes or progress notes that discuss the indications for
9 prescribing topical testosterone to the patient. This conduct breached the standard of care, and
10 the Board has therefore established a violation of ORS 677.190(1)(a).
11

12 Warnings of Side Effects / Informed Consent for Patients B and D

13

14 At hearing, when the Board's counsel asked Dr. Sachdev whether she told female
15 patients receiving testosterone treatment that the treatment was not FDA approved, Dr. Sachdev
16 replied, "Yeah. There is actually informed consent so I have – I don't know if you've been able
17 to look at the exhibits. In the informed consent, if you read that, it states that and absolutely the
18 patients know that." Transcript at 43.
19

20 Dr. Sachdev customarily required patients to sign an "Informed Consent" form prior to
21 receiving bioidentical hormone treatment (including testosterone). Contrary to Dr. Sachdev's
22 hearing assertion, the "Informed Consent" form does not mention testosterone by name, and it
23 does not contain any information regarding off-label use of testosterone or a lack of FDA
24 approval for its general use in women. The form also does not mention the specific risks
25 associated with topical testosterone and IM testosterone. Thus, Dr. Sachdev's reliance on that
26 form as evidence that she discussed the potential risks of testosterone with female patients who
27 signed the form is misplaced.¹⁰²
28

29 Dr. Sachdev also testified at hearing that she would verbally inform patients of the risks
30 for off-label use of testosterone. Transcript at 73, 75, 118-119. However, there is no
31 documentation in the medical records of either Patient B or D that references such a discussion.
32 In contrast, an August 26, 2011 chart note for Patient G states, in part, "we are going to initiate
33 bioidentical hormone replacement therapy regimen, informed consent was given, RBS [risks,
34 benefits, and side effects] was [*sic*] discussed[.]" Exhibit A46 at 8-9. Dr. Sachdev has not
35 provided any explanation for why she would chart having had a discussion of the risks, benefits,
36 and side effects of testosterone treatment with one patient, but not with others.
37

38 ORS 677.097 sets forth the procedure by which a physician obtains informed consent
39 from a patient, and provides:
40

41 (1) In order to obtain the informed consent of a patient, a physician or
42 physician assistant shall explain the following:
43

44 (a) In general terms the procedure or treatment to be undertaken;
45

46 ¹⁰² It is also concerning that Dr. Sachdev may misunderstand, or be unaware of, the specific content of that form.

1
2 (b) That there may be alternative procedures or methods of treatment, if
3 any; and
4

5 (c) That there are risks, if any, to the procedure or treatment.
6

7 (2) After giving the explanation specified in subsection (1) of this section,
8 the physician or physician assistant shall ask the patient if the patient
9 wants a more detailed explanation. If the patient requests further
10 explanation, the physician or physician assistant shall disclose in
11 substantial detail the procedure, the viable alternatives and the material
12 risks unless to do so would be materially detrimental to the patient. In
13 determining that further explanation would be materially detrimental the
14 physician or physician assistant shall give due consideration to the
15 standards of practice of reasonable medical or podiatric practitioners in the
16 same or a similar community under the same or similar circumstances.
17

18 While the above statute does not expressly require charting or documentation of informed
19 consent, there must be sufficient indicia of reliability to support a contention that a physician has
20 complied with the statutory requirements. Here, given Dr. Sachdev's misstatements regarding
21 the substance of her informed consent form, and her multiple inconsistent and contradictory
22 statements at hearing, the ALJ was not persuaded, more likely than not, that she informed
23 Patients B and D of the risks and side effects associated with testosterone treatment, or that she
24 discussed the off-label use of the medication. This conduct violates ORS 677.097, and is a
25 breach of the standard of care. The Board has therefore established violations of ORS
26 677.190(1)(a) and (13).
27

28 *M. Prescribing Adderall to Patients B, C, E, and J*
29

30 As previously discussed, the DSM-IV-TR sets forth the clinical criteria for an
31 ADD/ADHD diagnosis. The evidence establishes that although ADD/ADHD screening forms
32 can provide valuable information to a clinician who suspects that an adult may have
33 ADD/ADHD, an adequate clinical evaluation requires more than mere symptom assessment.
34 Indeed, the previously referenced article "ADHD in Adults: Update for Clinicians on Diagnosis
35 and Assessment" states that "[d]uring clinical evaluation, symptoms assessment is essential but
36 not sufficient to diagnose this disorder. The chronicity and pervasiveness of ADHD symptoms,
37 as well as impairment due to ADHD symptoms, are critical to the correct diagnosis of ADHD in
38 adults. Exhibit R157 at 9.
39

40 The record establishes that an adequate ADD/ADHD diagnostic evaluation must include
41 consideration of the patient's functioning in different spheres of life, how the patient's symptoms
42 affect that functioning, historical information regarding the patient's functioning in school,
43 whether the patient received an ADD/ADHD diagnosis during childhood (and, if so, on what
44 basis), what medications the patient may have previously taken for ADD/ADHD, and whether
45 the patient has any comorbid conditions. Prescribing Adderall to a patient without an adequate
46 clinical evaluation falls below the standard of care for a physician.

1
2 Patient B
3

4 The Board alleges that Dr. Sachdev prescribed Adderall to Patient B without
5 corresponding chart notes to support an ADD/ADHD diagnosis, without documenting informed
6 consent, and without documenting how the patient responded to the Adderall treatment.
7

8 A November 15, 2004 progress note states that Patient B was experiencing, among other
9 things, an inability to think clearly and concentrate.
10

11 A September 9, 2007 chart note states that Dr. Sachdev prescribed Lexapro for Patient B
12 after diagnosing the patient with headaches, dizziness, anxiety, panic attacks, generalized
13 anxiety, and mild depression. An October 8, 2007 chart note states that Patient B had improved
14 on Lexapro, and specifically noted:
15

16 She is not having the highs and lows in terms of her mood. She is more
17 upbeat. She has been able to go to school and is feeling more motivated.
18 * * *. She is less emotional about everything. So, definitely the Lexapro
19 seems to be working well for her. * * * * *. She has had no headaches,
20 no palpitations, no chest pain, no shortness of breath, and no belly pain.
21

22 Exhibit A19 at 27.¹⁰³
23

24 A July 21, 2008 chart notes states that Patient B was no longer taking Lexapro and that
25 she was doing well off the medication.
26

27 A September 1, 2010 chart note states that Patient B was experiencing, among other
28 things, a significant amount of stress, as well as fatigue and sluggishness. An MSQ dated
29 September 1, 2010 indicates that Patient B was experiencing frequent severe insomnia, fatigue,
30 and sluggishness and occasional severe anxiety, fear, and/or nervousness.
31

32 An MSQ dated November 29, 2010 indicates that Patient B was experiencing frequent
33 severe fatigue, sluggishness, apathy, lethargy, restlessness, and weakness/tiredness; frequent
34 non-severe anxiety, fear, and/or nervousness; and occasional severe mood swings. When asked
35 at hearing to identify any indicators of ADD/ADHD on Patient B's November 29, 2010 MSQ,
36 Dr. Sachdev replied, "Well, difficulty making decisions, restlessness. A lot of time ADHD
37 people may also say they feel fatigued. It's kind of paradoxical, but that is sometimes an issue
38 with them." Transcript at 3555.
39

40 A November 29, 2010 progress note states that Patient B complained of fatigue,
41 insomnia, palpitations, and mood swings. The record does not contain a transcribed chart note
42 for November 29, 2010. When asked at hearing whether she had charted any indications for
43 Patient B's Adderall use, Dr. Sachdev answered in the affirmative and then referenced the
44

45
46 ¹⁰³ As discussed in Footnote 31, it is unknown whether Patient B had actually switched over to Zoloft at
the time of that office visit.

1 November 29, 2010 progress note and stated “fatigue, early am, insomnia, palpitations, IBS,
2 mood swings,” *Id.* at 3553-3554.
3

4 A March 8, 2011 progress note indicates that Patient B complained of fatigue and lack of
5 energy. Dr. Sachdev admitted at hearing that fatigue and lack of energy are not bases for
6 prescribing Adderall. *Id.* at 57. However, paradoxically, when asked at hearing how Patient B
7 responded to the Adderall treatment, Dr. Sachdev responded, “The patient continued – the
8 patient continued to have issues with fatigue. She never got better. She continued to feel tired,
9 exhausted no matter what multiple doctors did[.]” *Id.* at 77. Dr. Sachdev’s hearing response is
10 strong evidence that she did, in fact, prescribe Adderall to treat the patient’s fatigue symptoms.
11

12 On March 23, 2011, Patient B filled out the Adult Self-Report Scale and the Adult
13 ADHD-RS-IV with Adult Prompts. The Adult ADHD-RS-IV with Adult Prompts shows that
14 Patient B had severe issues with the following: difficulty sustaining attention in activities;
15 doesn’t listen; can’t organize; easily distractible; forgetful in daily activities; on the go, “driven
16 by a motor;” and intrudes/interrupts others. Dr. Sachdev began prescribing Adderall to Patient B
17 on March 23, 2011. The record does not contain a progress note, a transcribed note, or an MSQ
18 for an office visit on that date.
19

20 Dr. Sachdev testified at hearing that she prescribed Adderall to Patient B based on the
21 patient’s history, the patient’s responses on the MSQ, and the results of the ADD/ADHD
22 screens. *Id.* at 76-77. Dr. Sachdev further testified:
23

24 [E]arly on I did think that she probably had something because I saw her
25 working. She had some issues. But I’m not – I’m going to treat her other
26 comorbid conditions. So I was more interested in like seeing if she’s –
27 maybe anemia might be the cause. Maybe is she depressed? In the past, I
28 did treat her with antidepressants. She was a very complex patient.
29 Always tired.
30

31 *Id.* at 3556.
32

33 Dr. Sachdev had successfully treated Patient B with antidepressant medication (*i.e.*
34 Lexapro and/or Zoloft) in the past. It is unclear from the medical documentation whether Patient
35 B’s symptoms in March 2011 differed from her previous symptoms of anxiety, panic, mild
36 depression, mood fluctuations, and lack of motivation, which had responded well to the previous
37 antidepressant treatment. *See* Exhibit A19 at 24-25, 27. If Patient B was experiencing different
38 symptoms in 2011, that might explain Dr. Sachdev’s decision not to prescribe antidepressant
39 therapy again for the patient. However, the medical records do not assist in that determination.
40

41 At hearing, Dr. Sachdev testified that the two areas of Patient B’s life where she was
42 functioning poorly were at work and in her relationship with her significant other. Transcript at
43 76-77. However, Patient B’s medical records do not mention poor functioning with regard to the
44 patient’s work or her personal relationship. Dr. Sachdev testified at hearing that in July 2011,
45 Patient B complained that her low libido was causing problems with her significant other. But
46 that complaint occurred after Dr. Sachdev started prescribing Adderall, the complaint is not

1 reflected in the patient's medical records, and there is no evidence that poor relationship
2 functioning caused by low libido is an indication for an ADD/ADHD diagnosis.
3

4 Dr. Sachdev prescribed Adderall to Patient B from March 23, 2011 to at least September
5 2011. Patient B's medical records fail to demonstrate that Dr. Sachdev conducted an adequate
6 diagnostic evaluation, and the records do not support an ADD/ADHD diagnosis. Furthermore,
7 there is no documentation to support that Dr. Sachdev obtained informed consent from Patient B,
8 and the medical records contain no documentation as to how the patient responded to the
9 Adderall treatment. These failings constitute a breach of the standard of care. The Board has
10 therefore proven that Dr. Sachdev violated ORS 677.190(1)(a) and (13).
11

12 Patient C
13

14 In its Notice, the Board alleges that Dr. Sachdev prescribed Adderall to Patient C without
15 documenting the medical indications to support the treatment, and without documenting how the
16 patient responded to the treatment.
17

18 On July 8, 2010, Patient C began treating with Dr. Sachdev. In the corresponding chart
19 note, Dr. Sachdev discusses the patient's extensive medical history and notes that the patient had
20 multiple surgical procedures a few years prior. With regard to those surgical procedures, the
21 chart note states:
22

23 She was in the hospital for 35 days and then was finally discharged in a
24 stable condition after being on multiple antibiotics and heavy duty pain
25 medications[.] She then at that point had to deal with getting off
26 painkillers. Obviously, she developed [an] addiction to that and so she has
27 slowly weaned herself off, which she did over the next course of about
28 two and a half weeks.
29

30 Exhibit R217 at 2.
31

32 On an Adrenal Fatigue Quick Check form dated July 8, 2010, Patient C indicated that she
33 had significant difficulty getting up in the morning, that she had to keep moving or else she
34 would get tired, and that she would get a second wind in the evening and stay up late. On an
35 MSQ form dated July 8, 2010, Patient C indicated that she experienced, among other things,
36 frequent non-severe hyperactivity and occasional severe restlessness. On an MSQ form dated
37 August 5, 2010, Patient C indicated that she experienced, among other things, frequent non-
38 severe restlessness and occasional non-severe hyperactivity and fatigue.
39

40 The record is unclear as to when Dr. Sachdev first prescribed Adderall to Patient C. Dr.
41 Sachdev contends that she began prescribing the medication in May 2011. At hearing, she
42 testified that Patient C's medical file should contain a handwritten chart note for May 2011 that
43 discusses Patient C having significant personal issues, including difficulties with her husband's
44
45
46

1 alcoholism.¹⁰⁴ Transcript at 3682-3683. Dr. Sachdev further testified that during the May 2011
2 office visit, Patient C disclosed that she had a history of ADD/ADHD. Patient C's medical
3 records do not contain any progress note or chart note for May 2011.
4

5 A Patient Medication List for Patient C indicates that she was taking Adderall on April
6 25, 2011, October 26, 2011, and November 17, 2011. At hearing, Dr. Sachdev contended that
7 the document had been altered, and she insisted that she only prescribed Adderall twice for
8 Patient C—on May 13, 2011 and July 8, 2011. *Id.* at 81-82, 3686, 3689, 3691-3692; *see* Exhibit
9 A14 at 11-12. However, Dr. Sachdev's hearing testimony conflicts with a previous statement
10 she gave to an LOPD officer during an investigation involving Patient C. When presented with
11 copies of Adderall prescriptions for Patient C dated March 23, 2011, May 13, 2011, July 8, 2011,
12 August 29, 2011, and November 15, 2011, Dr. Sachdev informed the officer that only the
13 November 15, 2011 prescription did not bear her authentic signature. By contrast, at hearing, Dr.
14 Sachdev testified that the signatures on the March 23, 2011 and August 29, 2011 prescriptions
15 were not hers. Transcript at 3691-3693.
16

17 Patient C's medical file contains an undated ASRS-V1.1 Screener filled out by Patient C,
18 as well as an undated Adult ADHD-RS-IV with Adult Prompts questionnaire that indicates the
19 patient has severe issues with regard to 16 of the 18 ADHD symptoms listed therein. Dr.
20 Sachdev's hearing testimony suggests that Patient C filled out the ADD/ADHD forms prior to or
21 during a May 2011 office visit. Transcript at 3694 ("We charted * * * on May 2011, I talked
22 about personal issues, all of that. And then she'd done the ADD screen[.]"). However, there are
23 no documents in the record to support that Patient C treated with Dr. Sachdev in May 2011, and
24 given Dr. Sachdev's inconsistent statements with regard to when she began prescribing Adderall
25 to the patient, her testimony as to the date the ADD/ADHD forms were completed is not reliable.
26

27 The record contains no chart notes or progress notes that document when or why Dr.
28 Sachdev prescribed Adderall to Patient C. A November 17, 2011 chart note is the only
29 document in Patient C's medical records that mentions an ADHD diagnosis for the patient, and it
30 contains no information about the diagnosis. There are no medical records to show that Dr.
31 Sachdev conducted an adequate ADD/ADHD diagnostic evaluation prior to prescribing Adderall
32 to Patient C, and no progress notes or chart notes that document how the patient responded to the
33 treatment.
34

35 The evidence establishes, more likely than not, that Dr. Sachdev prescribed Adderall to
36 Patient C without explanation in her chart, and without documenting medical indications for the
37 treatment or how the patient responded to the treatment. This conduct breached the standard of
38 care, and the Board has therefore established violations of ORS 677.190(1)(a) and (13).
39

40 Patient E
41
42
43
44

45 ¹⁰⁴ At hearing, Dr. Sachdev stated that she did not dictate the note because Patient C, who was also a
46 clinic employee, was concerned about other employees learning of her personal issues. (Tr. at 3682-
3683.)

1 In its Notice, the Board contends that Dr. Sachdev failed to document the medical
2 indication for prescribing Adderall to Patient E, and that she also failed to document how the
3 patient responded to the treatment.
4

5 1. Documentation of Medical Indication
6

7 At hearing, Dr. Turner admitted that she had no concerns regarding Dr. Sachdev's
8 decision to prescribe Adderall to treat Patient E's orthostatic edema. Transcript at 1439-1440,
9 1447. As set forth below, multiple chart notes reference Patient E's edema, a pediatric
10 rheumatologist confirmed the patient's edema, and Dr. Sachdev's July 18, 2011 chart note
11 specifically sets out her rationale for prescribing Adderall to treat what she opined was likely
12 orthostatic edema.
13

14 A December 1, 2010 chart note states, in part:

15 The patient is not feeling good. The Armour Thyroid actually * * *
16 was making her feel bloated. * * * * *. She is having puffy facies [*i.e.* a
17 puffy face] after we have gone off the higher dose of the T3. * * * * *. I
18 think the underlying issue is still adrenal fatigue[.]
19
20

21 Exhibit A35 at 5.
22

23 A December 29, 2010 chart note mentions that a physical examination revealed that
24 Patient E had no edema in the extremities at that time. However, a February 18, 2011 chart note
25 states, in part:
26

27 Her thyroid is still not optimally balanced[.] * * * * *. [Patient E's
28 mother] is also complaining that [Patient E] has generalized puffiness and
29 edema. This is very unusual for a young girl and even the lymphatic
30 massage therapist has noticed that.
31

32 *Id.* at 8.
33

34 A March 2, 2011 chart note states that when Dr. Sachdev changed Patient E's thyroid
35 medication, the patient became puffier and experienced weight gain issues. An April 11, 2011
36 chart note states that Patient E's puffiness issues had improved. On May 28, 2011, Patient E
37 began an hCG weight-loss regimen. The regimen was not successful, and Dr. Sachdev
38 discontinued it after approximately one month. According to Patient E's mother, the hCG
39 regimen required that Patient E consume large quantities of water and Patient E "ballooned up
40 ten to 15 pounds in a week [and] * * * her knees and ankles were absolutely non-existent."
41 Transcript at 1338, 1363. A June 29, 2011 chart note states that Patient E continued to complain
42 of generalized edema around her abdominal area, her hands, face is swollen and her knees.
43

44 On July 14, 2011, Patient E treated with a pediatric rheumatologist, who discussed the
45 patient's edema in a chart note that states, in part:
46

1 Cannot comment on specific etiology for her edema. I would like to be
2 sure that she is not hypoproteinemic or hyponatremic for any reason, as I
3 did not see a comprehensive metabolic panel in her recent laboratory
4 studies. I have seen edema associated with dermatomyositis, but this is
5 associated with active disease. * * * * *. I have heard of edema
6 associated with hypothyroidism, so she may benefit from a closer look at
7 her thyroid issues[.]
8

9 Exhibit A40 11-12.

10
11 Dr. Sachdev and Patient E's mother researched the issue of idiopathic orthostatic edema,
12 and they reviewed a 2005 article published in *Pediatrics Review* that discussed treatment of
13 orthostatic edema in adolescents with dextroamphetamine (*i.e.* amphetamine salts/Adderall).
14 Patient E's mother asked Dr. Sachdev about the possibility of treating Patient E's edema with
15 Adderall. On July 18, 2011, Dr. Sachdev prescribed Adderall to Patient E. A July 18, 2011
16 chart note states, in part:

17
18 [S]o now we are actually dealing with perhaps orthostatic edema in
19 adolescents, the issue is really is [*sic*] that there is abnormal vasodilation
20 that increases capillary permeability and increases venous return to the
21 heart. So things that will reduce the capillary permeability and would also
22 constrict at the capillary level and increase[] venous return would be very
23 beneficial, one of them is Adderall and so I am going to initiate that
24 treatment[.]
25

26 Exhibit A35 at 14.

27
28 The evidence establishes that Dr. Sachdev adequately documented the indication for
29 prescribing Adderall for Patient E. There is clear documentation that the patient had recurring
30 issues with edema, and her condition was confirmed by a pediatric rheumatologist. In a July 18,
31 2011 chart note, Dr. Sachdev states that she is prescribing Adderall to treat what she strongly
32 suspects is orthostatic edema, and she explains the mechanism by which she believes the
33 medication will work for Patient E. The Board has not established a standard of care violation
34 with regard to Dr. Sachdev's documentation of the medical indication for prescribing Adderall.
35

36 2. Documentation of Patient's Response to Treatment

37

38 The Board contends that Dr. Sachdev failed to document how Patient E responded to the
39 Adderall treatment, including whether the medication was effective and whether she experienced
40 any side effects.
41

42 Only two chart notes discuss Patient E's edema after Dr. Sachdev initiated the Adderall
43 treatment. First, an August 11, 2011 chart note indicates that Patient E continued to have
44 generalized edema and states, in part:
45
46

1 [W]e discussed the idiopathic orthostatic edema as leading to all her
2 generalized edema issues. * * * * *. [I] looked * * * to see if there was
3 any correlation between optimizing her thyroid function and her
4 generalized edema issues and there seems to be a definite correlation,
5 when we lowered the dose, she felt definitely much more fatigued.
6

7 Exhibit A35 at 16.
8

9 Second, an August 26, 2011 chart note states, in part:

10
11 The patient has had remarkable improvement with the adjustment of the
12 thyroid medications. We initially thought she might have orthostatic
13 edema, but she lost about 10 pounds and the edema is now resolved just be
14 making adjustments in her alternative treatment regimen and optimizing
15 the thyroid function. This is so dramatic[.]
16

17 *Id.* A35 at 19. Upon physical examination, Dr. Sachdev noted no generalized or peripheral
18 edema at that time.
19

20 Neither chart note mentions how Patient E was tolerating the Adderall treatment and
21 whether she was experiencing any side effects from it. The August 26, 2011 chart note states
22 that Patient E's edema was resolved, and it attributes the resolution of the edema to adjustments
23 in her alternative treatment regimen and the optimization of her thyroid function. The chart note
24 does not state whether and to what extent the Adderall played a role in resolving the edema issue.
25 Nonetheless, Dr. Sachdev continued to prescribe Adderall to the patient, without documenting
26 any justification for continuing the treatment. By failing to document how Patient E responded
27 to the Adderall, and thereby failing to document any justification to continue the treatment, Dr.
28 Sachdev breached the standard of care. The Board has established a violation of ORS
29 677.190(1)(a).
30

31 Patient J 32

33 In its Notice, the Board alleges that Dr. Sachdev prescribed Adderall to Patient J for the
34 treatment of ADD/ADHD without charting the medical indications for the treatment, or how the
35 patient responded to the treatment.
36

37 1. Documentation of Medical Indication 38

39 Patient J began treating with Dr. Sachdev on October 19, 2010, when she was 15 years
40 old. On an Adrenal Fatigue Checklist, Patient J indicated that she was experiencing severe
41 problems with getting up in the morning, lethargy, low mood, poor memory, afternoon lows,
42 continuing fatigue, less enjoyment or happiness in life, brain fog/loss of focus, decreased
43 tolerance for stress/noise/disorder, and feeling overwhelmed by all that needs to be done. In an
44 October 19, 2010 chart note, Dr. Sachdev discussed several significant events that had
45 contributed to the patient's stress and other symptoms, including the divorce of her parents, her
46

1 best friend's death, an abusive relationship, and changes at school. The chart notes states, in
2 part:

3
4 [S]he is now feeling depressed[.] * * * * *. [F]atigue is an issue she is
5 having along with mood swings and just feeling of depression and
6 frequent illness, urgent urination, significant adrenal fatigue issues. So, at
7 this point, the patient is feeling depressed. We had a lengthy discussion
8 with her mom and getting her into psychotherapy. Most probably, I can
9 put her on short-term depression medication. It is serious major
10 depression, as I have discussed with her, I am not comfortable without
11 having the patient go on something. They will closely monitor with me.
12

13 * * * * *. Initially, because she is suffering from depression, I really want
14 to refer her to a psychotherapist, doing to the [sic] neurotransmitter test,
15 which will more accurately help me prescribe the optimum medication for
16 her rather than simply starting her just on a medication. She [ha]s
17 managed for this long. I have asked her if she wants me to initiate
18 medication. Her father prefers her not to start on medication without a
19 proper evaluation, so we will start with a psychotherapist, proper
20 evaluation, neurotransmitter test and then that will effectively help us to
21 optimize her medication regimen as well.
22

23 Exhibit A61 at 43-44, 55-56.
24

25 At hearing, Dr. Sachdev testified that upon her first visit with Patient J, she “knew that
26 [Patient J] probably had ADD issues,” but she looked for comorbid conditions such as
27 depression and anxiety and chose to focus on those conditions before focusing on any ADD
28 issues. Transcript at 3111. A November 10, 2010 chart note states, in part:
29

30 [T]he patient has been having a lot of issues of anxiety and depression and
31 at this point what I want to address is her neurotransmitter imbalance. * *
32 * * *. At this point what I want to do is really address her focus issues,
33 which is a huge issue for her. We are going to start her [on] Pristiq[.]
34

35 A/P
36

37 1. Metabolic dysfunction/depression/vitamin D deficiency/adrenal
38 fatigue. At this point, I am going to initiate Rx of Pristiq 50 mg p.o. q.d.
39 and alternative treatment regimen initiated, vitamin D3 replacement
40 therapy initiated. RTC in four weeks[.]
41

42 Exhibit A61 at 42, 53.
43

44 On May 3, 2011, Patient J completed the ASRS-V1.1 screening form, as well as the
45 Adult ADHD-RS-IV with Adult Prompts. She scored a 51 on the latter form, which signifies
46 severe symptomology. A May 3, 2011 chart note states, in part:

1
2 The patient is acutely here. * * * * *. When her mom left * * * the room,
3 she explained to me * * * how she really wants to have [a] relationship
4 with her mother. She is stressing internally a great deal. She is barely
5 going to school. She cannot focus. She cannot get up. She feels tired.
6 The Pristiq did not help her at all. So she went off the antidepressant. She
7 has been doing the same since the time that she saw me, which has been
8 several months. * * * * *. She is having fatigue issues, headaches, binge
9 eating and excessive weight[.] * * * * *. After her mother left [the room],
10 I also discussed with the patient further on how she feels. A lot of her
11 issues are more focus related. Her mother has ADD and so I am starting
12 to suspect that she may have ADD issues and that may be very significant
13 for her. So this is a serious issue that we have to deal with[.]

14
15 * * * * *

16
17 2. Depression. I really do not think is [*sic*] more than depression, it is a
18 lack of focus and all of that. I think we did an ADHD screening along
19 with the DSM 18-point scale for ADHD symptoms and she ca[me] back
20 high for both [of] those. So I am going to initiate Adderall. * * * * *. I
21 will see her back in about two to three weeks, because there is so much
22 going on with her[.]

23
24 3. ADHD. Initiate Adderall.

25
26 *Id.* at 50-51.

27
28 At hearing, Dr. Sachdev testified as follows regarding her decision to prescribe Adderall
29 to Patient J, and Patient J's results on that medication:

30
31 This is a * * * patient that was actually functioning very well. She was in
32 high school very, very well. And then suddenly I guess perhaps her
33 parents go through a divorce * * * and she stops functioning. She can't go
34 out of the house. She's gaining weight. She now starts to flunk school
35 where she's done extremely, extremely well. * * * * *.

36
37 So I said, "Let's have her see a counselor and then let's – she probably
38 needs to be on antidepressant[s]." And * * * then antidepressants were
39 tried. Nothing affected her. She went to counseling. [I] mentioned she
40 see a psychiatrist. I think [the family] was limited by * * * money[.]
41 * * *. So there were all of those dynamics going on. And so several
42 months I think went by. [I] think the patient definitely saw counselors but
43 I don't know if she saw them regularly.¹⁰⁵ That's what I don't know. So
44 she didn't do well. No matter what we * * * [tried.]

45
46 ¹⁰⁵ At hearing, when asked whether Dr. Sachdev ever communicated with Patient J's counselor[s], Dr. Sachdev replied, in relevant part:

1
2 [I] tried, of course, my integrative methods and all, and I was really
3 surprised. I said something should have worked here. And then I started
4 asking her a few questions. I said, "Do you get distracted?" I just started
5 asking her a few of the ADD screening [questions]. I said, "Let me have
6 you take [the] ADD screen." She took it and I said, "Let's just see for a
7 month. Let's – we're going to prescribe her Adderall." * * * * *

8
9 So after I did the screen – and I was so happy. I thought. "Oh my gosh. I
10 bet you she's got – she probably has ADD." And so I said, "Okay. Let's
11 [try Adderall] for a month[.]"

12
13 So we tried Adderall; very great results. She had fabulous results. This
14 lady went to functioning. She went back to school, started getting A's.
15 * * *. I mean, she was functional, totally functional.

16
17 Transcript at 174-176.

18
19 Patient J's medical file contains no documentation to establish that Patient J was
20 evaluated for ADD/ADHD by a psychologist or psychiatrist. Her medical file contains no
21 evidence that she was engaged in mental health therapy or counseling. Her medical file contains
22 no evidence that she tried antidepressant medications other than Pristiq.

23
24 In the opinions of Drs. Turner and Thaler, Dr. Sachdev failed to conduct and document
25 an adequate clinical evaluation to establish a diagnosis of ADD/ADHD for Patient J.

26
27 At hearing, Dr. Turner testified extensively with regard to what constitutes an adequate
28 ADD/ADHD diagnostic evaluation. For example, the evaluation must include consideration of
29 the patient's functioning in various life spheres (*i.e.* work, home, relationships), how the patient's
30 symptoms affect that functioning, and historical information regarding the patient's functioning
31 in school. In Dr. Turner's opinion, Dr. Sachdev based her diagnosis of Patient J's condition
32 merely on the ADD/ADHD screening forms, and on her determination that Patient J's issues
33 were primarily "focus related." See Exhibit A61 at 50.

34
35 In Dr. Thaler's opinion, Dr. Sachdev should have more thoroughly evaluated the patient's
36 school functioning and attention history to determine if she had long-term symptoms of

37
38 I – I communicated via the mom. I mean, I'm fine with that. I've mentioned it
39 before. [I]t's my art of practice. It goes with the art of medicine. [I] I feel
40 comfortable that I have a patient that I'm able to – that I know what's going on,
41 that I want to treat – I did a neurotransmitter test. I really wanted to – I thought I
42 could get a good understanding from the neurotransmitter test how she would do
43 * * * what I could put her on. And I know that she's seeing a counselor. I didn't
44 * * * necessarily expect her to see a psychiatrist. I threw it out there, but I was
45 comfortable after I got the blood work back.

46
(Tr. at 3768-3769.)

1 ADD/ADHD. Dr. Thaler explained at hearing that “attention deficit [dis]order in adolescents
2 should be diagnosed from the time they first appear in school, in kindergarten and elementary
3 school when they have trouble, not at the age of 18. So there should have been a long history of
4 this.” Transcript at 2452.
5

6 In contrast, Dr. Boyko opined at hearing that Patient J’s medical records support the
7 Adderall treatment regimen and that they contain documentation as to how the patient responded
8 to the treatment. Dr. Boyko did not, however, explain the basis for his opinions.
9

10 The administrative law judge accorded greater weight to the opinions of Drs. Turner and
11 Thaler because their opinions are well-explained and well-reasoned. Dr. Boyko’s unexplained
12 medical opinion is simply not as persuasive.
13

14 The only documentation in Patient J’s medical records that might go towards establishing
15 an ADD/ADHD diagnosis includes the following: an undated Adrenal Fatigue Checklist,
16 indicating that Patient J had severe problems with getting up in the morning, brain fog/loss of
17 focus, and a feeling of being overwhelmed by all that needs to be done; a November 10, 2010
18 chart note that references the patient’s “focus issues” (Ex. A61 at 42); the ADD/ADHD
19 screening forms; and the May 3, 2011 chart note that states, in part, “She cannot focus” and “A
20 lot of her issues are more focus related. Her mother has ADD and so I am starting to suspect that
21 she may have ADD issues and that may be very significant for her.” (*Id.* at 50.)
22

23 Patient J’s medical records do not establish, more likely than not, that Dr. Sachdev
24 conducted an appropriate diagnostic evaluation of Patient J prior to initiating Adderall treatment.
25 The May 3, 2011 chart note does not, for example, explain how the patient meets the
26 ADD/ADHD diagnostic criteria. Dr. Sachdev merely relies on the assessment screening forms,
27 the fact that she believes the patient’s mother has ADD, and the fact that the patient has “focus
28 related” issues.
29

30 The evidence persuasively establishes that Dr. Sachdev prescribed Adderall to Patient J
31 without documenting medical indications that support the treatment. This conduct is a breach of
32 the standard of care, and therefore violates ORS 677.190(1)(a) and (13).
33

34 2. Documentation of Patient’s Response to Treatment 35

36 As previously discussed, when a patient begins a new medication regimen involving
37 controlled substances, the patient should have one or more clinical follow-up visits within short
38 intervals. However, once the patient is on a stable medication regimen, the clinical follow-up
39 visits may occur as infrequently as every six months.
40

41 Patient J’s first follow-up visit with Dr. Sachdev after starting Adderall was one week
42 later—on May 10, 2011. In the chart note for that visit, Dr. Sachdev notes significant
43 improvement in Patient J’s previous symptoms of fatigue, lack of focus, lack of energy, and
44 mood. The chart note states, in part:
45
46

1 The patient is here really to get her Pap done, but I was also concerned
2 from the last visit. She is already doing much, much better in terms of her
3 fatigue, lack of focus issues and a lot of issues that she had. The Adderall
4 is working really well for her. * * *. She is actually doing about 10 mg
5 twice a day with significant improvement in her symptoms. She has
6 already taken control of just her focus, her energy and just her mood and
7 has already significantly improved.

8
9 * * * * *

10
11 [A]DD. The patient is doing really well on the Adderall 10 mg p.o. b.i.d.
12 dosing and she is doing great.

13
14 Exhibit A61 at 48.

15
16 Of the four symptoms that Dr. Sachdev noted had improved, only lack of focus could
17 reasonably be considered a symptom of ADD/ADHD. Moreover, Dr. Sachdev does not
18 document in the May 10, 2011 chart note whether Patient J was experiencing any side effects
19 from the Adderall.

20
21 Between May 10, 2011 and March 9, 2012, Patient J had no follow-up visits with Dr.
22 Sachdev, even though Dr. Sachdev continued to prescribe Adderall to the patient during that time
23 period. It is unreasonable to conclude that Patient J was on a stable Adderall regimen just one
24 week after starting the medication. Thus, the 10-month interval between the May 10, 2011 and
25 March 9, 2012 office demonstrates a lack of adequate clinical follow-up. Moreover, while a
26 March 9, 2012 progress note states that the purpose of the office visit was to reassess for
27 Adderall, there is no dictated chart note in the patient's file for that visit.

28
29 In conclusion, there is not adequate documentation in Patient J's medical records to
30 establish that Dr. Sachdev conducted adequate follow-up with regard to the patient's Adderall
31 treatment. This conduct is a breach of the standard of care, and therefore violates ORS
32 677.190(1)(a).

33
34 **5. Sanction**

35
36 ORS 677.205 authorizes the Board to sanction a licensee for violations of the Medical
37 Practice Act as follows:

38
39 (1) The Oregon Medical Board may discipline as provided in this section
40 any person licensed, registered or certified under this chapter who has:

41
42 * * * * *

43
44 (b) Been found to be in violation of one or more of the grounds for
45 disciplinary action of a licensee as set forth in this chapter;

1 testosterone to a family member without conducting an examination of the patient, documenting
2 the medical indications, and conducting any follow up to determine how the patient was
3 responding to the treatment.
4

5 At hearing, Dr. Sachdev was loathe to admit to any mistakes or deficiencies in her
6 medical practice, and she frequently had convoluted, contradictory, or downright puzzling
7 explanations for her conduct. For example, when asked whether she considered it important to
8 document that a patient had stopped taking her Phentermine medication, she explained that when
9 she charts, she is really only concerned with things that are dangerous to a patient, and because
10 she was focusing on other issues with this particular patient she did not feel it was important to
11 chart the patient's non-life-threatening discontinuation of the medication. This was just one of
12 several troubling justifications she provided at hearing for conduct that failed to meet standards
13 of care.
14

15 Ultimately, the Board must determine whether, in light of Dr. Sachdev's demonstrated
16 practice deficiencies, she can nonetheless modify her conduct to meet the standards of care in the
17 future. During the investigatory phase of this case, Dr. Sachdev entered into a stipulated
18 agreement with the Board, wherein she agreed to refrain from the practice of medicine pending
19 resolution of the matter. She, unfortunately, breached that agreement. In so doing, she
20 demonstrated that she was unwilling to cooperate with the Board for a finite period of time. This
21 casts serious doubt on her willingness and ability to comply with the Board on a long-term basis.
22

23 **EXCEPTIONS**

24

25 On August 18, 2014, the Board received a 326 page document entitled Exceptions to
26 Proposed Order, with 121 enumerated exceptions, and multiple attachments. One of those
27 attachments is entitled: "DECLARATION OF KENNETH WELKER." This individual was
28 included on Dr. Sachdev's list of witnesses for the hearing, but was never called to testify. The
29 submitted declaration constitutes new evidence. The evidentiary record closed at the conclusion
30 of the hearing on October 25, 2013. The Board concludes that the submitted declaration by Dr.
31 Welker constitutes new evidence that may not be considered by this Board at this time. Dr.
32 Sachdev has failed to show or make an offer of proof that this witness was not reasonably
33 available at the time of the original hearing. Dr. Sachdev's counsel failed to request a subpoena
34 from the ALJ to compel this witness to appear and otherwise failed to raise this matter as an
35 issue before the ALJ during the two week hearing. The Board will not consider the submitted
36 declaration.
37

38 The Board has reviewed the submitted Exceptions, and will comment on selected
39 exceptions.
40

41 In exception no. 1, counsel for Dr. Sachdev is critical of the ALJ's statement of issue on
42 page 3 as to whether Dr. Sachdev violated the terms of the Interim Stipulated Order (ISO) by
43 engaging in the practice of medicine in violation of ORS 677.190(17) and ORS 677.085.
44 Counsel contends that the Board failed to identify and cite ORS 677.085 in its Complaint and
45 Notice of Proposed Disciplinary Action (hereinafter Notice). The Board's Notice alleged that
46 Licensee violated the ISO "by engaging in the active practice of medicine after the ISO went into

1 effect.” Under the terms of the ISO, Licensee voluntarily withdrew from the practice of medicine
2 on June 7, 2012.

3
4 Counsel contends that the Board’s Notice failed to identify and cite sections that Dr.
5 Sachdev violated, and cites *Drayton v. Department of Transportation*, 186 Or. App. 1 (2003);
6 *Villanueva v. Board of Psychologist Examiners*, 175 Or. App. 345 (2001); and *Villanueva v.*
7 *Board of Psychologist Examiners*, 179 Or. App. 134 (2002). The Board disagrees, and affirms
8 the findings and conclusions of the ALJ.

9
10 The Board’s notice meets the requirement of ORS 183.415. The appropriate statutory
11 violation was identified in the Notice—ORS 677.190(17), which refers to willfully violating a
12 board order. The ALJ’s reference to ORS 677.085 on page 3 is explained on page 84, where the
13 ALJ quotes the statutory definition of what constitutes the practice of medicine. The ALJ
14 concluded that Dr. Sachdev engaged in the practice of medicine, as defined in ORS 677.085(4)
15 after she signed the ISO. Therefore, she willfully violated the ISO, and that “the Board has
16 proven multiple violations of ORS 677.190(17).” This exception lacks merit.

17
18 In exception no. 3, counsel takes issue with the ALJ’s finding of fact in regard to Dr.
19 Sachdev’s website at paragraph 53. The Board’s Notice alleged that Sachdev violated the terms
20 of the ISO by engaging in the active practice of medicine. At page 92, the ALJ found that while
21 the website demonstrated that Dr. Sachdev continued to hold herself out to the public as a
22 practicing physician, the Board failed to meet its burden to prove that Dr. Sachdev had willfully
23 breached the terms of ISO, in violation of ORS 677.190(17). Therefore, this exception is moot.

24
25 Exception no. 5 takes issue with the finding in regard to the ALJ’s finding at page 62,
26 paragraph 256, that in Dr. Turner’s opinion, Dr. Sachdev should have communicated with
27 Patient G’s treating oncologist. Counsel contends that because Dr. Turner practices internal
28 medicine, she is not qualified to offer an opinion in regard to Dr. Sachdev’s medical practice,
29 which Sachdev described as integrative (or functional) medicine. Therefore, counsel asserts that
30 the Board should disregard Dr. Turner’s opinion. This exception lacks merit.

31
32 The Board recognizes that the use of alternative medicine does not by itself constitute
33 unprofessional conduct provided the requirements of ORS 677.190(1)(b) (A) are satisfied, which
34 defines “alternative treatment” to mean:

- 35
36 (i) A treatment that the treating physician, based on the treating physician’s
37 professional experience, has an objective basis to believe has a reasonable
38 probability for effectiveness in its intended use even if the treatment is outside
39 recognized scientific guidelines, is unproven, is no longer used as a generally
40 recognized or standard treatment or lacks the approval of the Food and Drug
41 Administration;
- 42 (ii) A treatment that is supported for specific usages or outcomes by at least one other
43 physician licensed by the Oregon Medical Board; and
- 44 (iii) A treatment that poses no greater risk to a patient than the generally recognized or
45 standard treatment.
- 46

1 The ALJ accurately addressed this issue at Page 97-98. The Board agrees with her
2 analysis. Dr. Sachdev failed to articulate an objective basis to believe her manner of treatment
3 would be effective, failed to provide testimony by another Oregon physician that supported her
4 treatments for specific usages and outcomes, and on some occasions, provided treatment that
5 posed an increased risk of harm to the public. Therefore, the defense that Dr. Sachdev was
6 practicing alternative medicine, and therefore, cannot be sanctioned for unprofessional or
7 dishonorable conduct, is not available to her. The ALJ also correctly found that Dr. Sachdev's
8 treatment involved conventional medications (such as Adderall) that were being used to treat
9 conventional health conditions (such as ADD and ADHD). And that such treatments fall within
10 the ambit of internal medicine. Furthermore, the obligation to coordinate care with another
11 treatment provider, particularly in regard to patient receiving treatment for cancer, goes to the
12 fundamentals of competent medical care, which Dr. Turner was well qualified to address.

13
14 In addition, the Board notes that the practice of alternative medicine is not a pathway to
15 avoid the necessity of maintaining coherent patient charts, coordinating care with other health
16 care providers, and observing the fundamental tenants of ethical practice, to include "first, do no
17 harm."

18
19 Exception no. 6 takes issue with the finding at page 79, paragraph 327, in regard to the
20 testimony of Dr. Turner and Dr. Thaler that Dr. Sachdev failed to conduct an adequate clinical
21 evaluation to establish a diagnosis of ADD/ADHD. For the reasons stated for exception no. 5,
22 this exception also lacks merit. The Board has reviewed her medical records and the testimony,
23 and agrees with the expert opinions of Dr. Turner and Dr. Thaler.

24
25 Exception no. 7 takes issue with the ALJ's finding on page 80, paragraph 328 that Dr.
26 Sachdev failed to comply with the standard of care in regard to Patient J's Adderall treatment.
27 Once again, Dr. Sachdev's claim that she practices alternative (Dr. Sachdev frequently referred
28 to her practice as "integrative" or "functional medicine") does not exempt her from conducting
29 an adequate evaluation, charting, and follow-up while prescribing a controlled substance. The
30 exception lacks merit.

31
32 Exception no. 13 relies upon information not presented at hearing. Counsel takes issue
33 with the ALJ's conclusion at page 97-98. Counsel has failed to show that this new evidence was
34 not reasonably available at the time of hearing. This exception is, therefore, unsupported by
35 evidence that is part of the record and lacks merit.

36
37 Exception no. 14 takes issue with the ALJ's reference at page 97 to ORS 677.265(1)(c),
38 which discusses the powers of the Board in the context of determining whether to discipline a
39 licensee for a standard of care violation. Counsel contends that the Board failed to provide
40 adequate notice as to alleging violations of the standard of care. The Board met its notice
41 requirement by providing a short and plain statement of the matters asserted or charged with a
42 reference to the particular sections of the statutes and rules involved, *see* ORS 183.425. In this
43 regard, to grounds for taking discipline action are set forth in ORS 677.190, which are alleged in
44 the Board's Notice. *See Spray v. Board of Medical Examiners*, 50 Or. App. 311, 316 (1981).
45 This exception lacks merit.
46

1 Exception no. 16 contends that the ALJ erred by concluding at page 100 that Dr. Sachdev
2 violated the standard of care by keeping medications for “office stock” and transferring
3 medications from one patient to another. The ALJ’s conclusion was supported by the findings of
4 fact at paragraph 118. The Board may rely upon the expert testimony of its witnesses to
5 determine whether a physician under review conformed their conduct to the standard of care.
6 *See Spray*, at 319, *citing Megdal v. Board of Dental Examiners*, 288 Or. 293 (1980). This
7 exception lacks merit.
8

9 Exception no. 18 contends that the Board’s Notice is deficient when it alleged that Dr.
10 Sachdev engaged in a pattern of conduct in which she has received a series of self-prescribed
11 testosterone injections (Schedule III) at her office. The ALJ notes on page 102-103 that Dr.
12 Sachdev did not dispute that she self- prescribed IM testosterone, and failed to maintain chart
13 notes or progress notes for herself. This conduct violated ORS 677.190(1)(a) and ORS
14 677.190(13), as alleged in the Notice. This exception lacks merit.
15

16 Exception no. 20 contends that the Board’s Notice is deficient by failing to cite OAR
17 847-015-0010 and therefore, there should be no adverse findings in regard to Patients D and F.
18 The ALJ concluded at pages 103-106 that Dr. Sachdev treated Patients D and E with
19 Phentermine, without explanation in their charts, without documenting medical indications for
20 the treatment and how the patients responded to the treatment, which was specifically alleged in
21 the Board’s Notice. As a result, the ALJ concluded that Dr. Sachdev engaged in unprofessional
22 conduct as well as gross or repeated acts of negligence. The Notice complied with the
23 requirements of ORS 183.415(3) and this exception lacks merit.
24

25 Exception no. 23 contends that the Board’s Notice failed to specifically allege that Dr.
26 Sachdev inadequately prescribed Keflex. In fact, the Board’s Notice stated that Patient H “was
27 placed on cephalexin 500 mg twice a day.” The Notice also stated “Patient H was allowed to fly
28 back to her home in Idaho after receiving an injection of ceftriaxone (Rocephin) 250 mg IM.”
29 The Notice also stated that “the antibiotics that were given were insufficient to treat a post-
30 operative wound infection.” Cephalexin and ceftriaxone are antibiotics. Another name for
31 cephalexin is Keflex. The Board’s Notice is sufficient, and the findings and conclusions of the
32 ALJ at pages 114 – 116 are well supported. This exception is without merit.
33

34 Exception no. 42 relies upon new unsupported allegations from counsel that will not be
35 considered concerning an affidavit that he attempted to submit to the Board with information that
36 was reasonably available to counsel as the time of the hearing. In addition, counsel asserts that
37 Dr. Edward Boyko’s name does not appear in the list of witnesses that testified at the hearing on
38 behalf of Dr. Sachdev. Counsel has correctly identified a deficiency in the proposed order. The
39 Board will modify the order to include the name of Edward Boyko, MD, as a witness that
40 testified at the hearing.
41

42 Exception no. 43 repeats counsel’s attack against Board Investigator Bitonti, who came to
43 the Board with many years of law enforcement experience, as being unqualified and untrained to
44 conduct Board investigations. This exception is without merit.
45
46

1 Exception no. 44 is critical of the ALJ's statement on page 30 that "In Oregon,
2 Phentermine use is restricted to patients with body mass indexes (BMIs) greater than 27." This
3 exception has merit in that the ALJ's statement is unclear. The Board will revise this sentence to
4 conform it to the Board's regulation, which the ALJ cited: "In Oregon, a physician may initiate
5 treatment with Phentermine for the purpose of weight reduction if one of the following
6 conditions exist: (1) Patient's body mass index exceeds 30 Kg/M sq for patients with a body mass
7 index (BMIs) greater than 27; or (2) Patient's body mass index exceeds 27 Kg/M sq and the
8 excess weight represents a threat to the patient's health (as with hypertension, diabetes, or
9 hypercholesterolemia.)"

10
11 Exception no. 52 asserts that the ALJ's statement on page 19 is in error when she stated
12 that Mr. Bitonti suspected that the phentermine prescriptions might be fraudulent, so he reported
13 the information to the Lake Oswego Police Department (LOPD). Counsel's assertion that Dr.
14 Sachdev reported the same information to the LOPD does not negate the fact that Mr. Bitonti
15 made a similar report.

16
17 Exception no. 55 takes issue with the ALJ's statement at page 21 that "[t]here is a general
18 maxim among physicians that "[I]f it is not in the chart, it didn't happen." The Board affirms the
19 ALJ's finding at paragraph 64. This exception lacks merit.

20
21 Exception no. 56 is critical of the ALJ's findings on page 28, paragraph 89 regarding the
22 standard of care. The ALJ properly relied upon the testimony of Dr. Turner. This Board must
23 make its determination on a case by case basis as to whether a physician under review conformed
24 their practice to the standard of care based upon the expert testimony of physicians that are called
25 to testify. See *Spray v. Board of Medical Examiners*, 50 Or. App. at 318. This exception lacks
26 merit.

27
28 Exception no. 67 asserts that the ALJ's finding on page 40, paragraph 160 erroneously
29 states that there are no chart notes that discuss the June 29, 2011 lab results. Counsel identifies a
30 lab report at A21, 23, which reflect abnormal levels of DHEA-Sulfate, free testosterone, and sex
31 hormone bind globulin. Counsel points to repeat blood tests and asserts that testosterone
32 treatment was discontinued, but failed to identify any discussion in Dr. Sachdev's progress notes
33 that addressed the significance of the abnormal lab results. The ALJ is correct, the record does
34 not contain any progress notes or any other chart note that discusses the June 29, 2011 lab
35 results. This exception is without merit.

36
37 Exception no. 68 takes issue with the ALJ's finding on page 41, paragraph 163 that the
38 only document in the record that notes the prescription of topical testosterone is a Nutraceutical
39 Protocol at Ex. A19, 92. Counsel contends that a progress note at A19, 48, which contains check
40 marks (but no narrative explanation) in regard to the patient's testosterone levels on 6/28/11, was
41 an indicator of Patient B's progress (or lack thereof) from the testosterone therapy. He then
42 points to A19, 92, to show that Dr. Sachdev made a change to medications on 7/21/11. (Once
43 again, this medication change was made without a stated rationale in the chart.) Counsel then
44 asserts that Dr. Sachdev provided oral explanations to the patient. Counsel's comments do not
45 alter the accuracy of the ALJ's finding. This exception is without merit.

1 Exception no. 69 is critical of the ALJ's finding at page 41, paragraph 165, that the
2 record does not contain any chart notes or progress notes that reference the ineffectiveness of the
3 topical testosterone. In his exception, counsel points to check marks on a progress note at A19,
4 48, which does not contain a narrative explanation of any findings, a lab report that reflected a
5 low testosterone value, and once again makes reference to verbal discussions between physician
6 and patient. These assertions by counsel do not impact the accuracy of the ALJ's finding. Dr.
7 Sachdev consistently failed to provide any narrative explanation of her medical reasoning or
8 patient response to treatment in her medical charts. When pressed for an explanation at hearing,
9 she would point to a lab report, a check mark on a progress note, and oral discussions she
10 recalled having with her patients to provide a post hoc rationale for her treatment decisions. This
11 exception is without merit.

12
13 Exception no. 71 identifies a scrivener's error on page 43, paragraph 175, which makes
14 reference to the date "November 4, 2000." The year is incorrect and will be modified to reflect
15 the year 2010.

16
17 Exception no. 98 once again addresses counsel's viewpoint on alternative medicine, and
18 makes reference to an affidavit that constitutes new evidence, which as previously explained will
19 not be considered by the Board. This exception lacks merit.

20
21 Exception no. 100 takes issue with the ALJ's conclusions at page 98. The ALJ provided
22 definitions for "gross negligence" and "negligence." He also argues that the reference to the duty
23 of care in ORS 677.095 only applies to medical malpractice claims and may not be relied upon
24 by the Board, citing *Spray* for support. The court in *Spray* at 316 stated that ORS 677.095 does
25 not purport to be a separate ground for suspension or revocation of a medical license. ORS
26 677.190 provides the specific grounds for disciplinary action. *Spray* does not stand for the
27 proposition advocated by counsel. ORS 677.190(13) uses the well-recognized legal terms of
28 gross negligence and repeated acts of negligence. The ALJ was well within her discretion to
29 provide legal definitions for these terms in the proposed order. This exception is without merit.

30
31 Exception no. 102 contends that the Board had incomplete patient records and that the
32 ALJ should have endorsed Dr. Sachdev's assertion that the charts were manipulated and
33 incomplete. The Board observes that Investigator Bitonti sent investigative requests for
34 production of complete medical records pertaining to specific patients (see Exhibit A1, A3, and
35 A5). Dr. Sachdev was obligated to provide the Board with a complete copy of patient records
36 and did submit records to the Board pursuant to the investigative demand. But at hearing and
37 now, she argues that the medical records that she submitted were incomplete, and blamed her
38 staff for the failure. Dr. Sachdev had a duty to provide complete records. The Board affirms that
39 findings of the ALJ on page 98-199 and notes that Dr. Sachdev's charting practices were so
40 scattered and disorganized that even her own staff had difficulty using and finding needed
41 information in her charts.

42
43 Exception no. 106 takes issue with the ALJ's finding on page 105 in regard to Dr.
44 Sachdev's treatment of Patients D and E with phentermine, arguing that her treatment was not
45 for weight loss, but to prevent weight gain, therefore, the Board's regulation did not apply. Dr.
46

1 Sachdev's reliance upon a lack of chart notes, and then providing *post hoc* rationalizations at
2 hearing as to her medical thinking is disingenuous. The ALJ's conclusions are affirmed.
3

4 Exception no. 107 takes issue with the ALJ's findings on page 112-113. The ALJ made a
5 number of findings in favor of Dr. Sachdev in regard to Patient G, but did find that Dr. Sachdev
6 never charted any coordination of care with Patient G's treating oncologist. The chart notes do
7 not reflect a notation by Dr. Sachdev that she contacted the treating oncologist and discussed her
8 treatment plan with him. The ALJ's conclusions are affirmed.
9

10 Exception no. 118 takes issue with the ALJ's conclusions on page 138-140. Counsel
11 points to various items in the chart and the opinions of defense witnesses that supported Dr.
12 Sachdev's treatment of Patient J. This exception illustrates Dr. Sachdev's manner of defense, to
13 point to various chart entries that support her diagnostic conclusion and treatment, and provide
14 an oral explanation as to her medical reasoning and deflect criticism by asserting that this is a
15 matter of integrative medicine, even though she was diagnosing and treating ADD/ADHD.
16 Conducting adequate clinical evaluations, articulating a diagnosis that is supported by data that
17 can be followed by other clinicians, setting forth a treatment plan and providing follow up with
18 ongoing assessment of patient response to treatment are intrinsic to the practice of medicine. Dr.
19 Sachdev's *post hoc* attempt to point to different data entries and documents in her charts and
20 provide commentary that is not articulated in the chart is not persuasive. The ALJ's conclusions
21 are affirmed.
22

23 In an Exception entitled "Procedural Errors that the Proposed Order does not address,"
24 Counsel alleges that Board investigators are untrained and characterized them as "allopathic
25 investigators." A quick survey of the Board's organic statute (ORS 677.010 – 677.900) reveals
26 that the Board has jurisdiction over many categories of health care professionals, to include
27 allopathic, osteopathic and podiatric physicians, as well as physician assistants and
28 acupuncturists. And the practice of alternative medicine is nothing new to the state of Oregon
29 and the Board. The remainder of his allegations and arguments are not supported by the record.
30 The Board specifically notes that the record demonstrates that Dr. Sachdev's presence in her
31 clinic after she entered the ISO went beyond serving as clinic manager to directing medical care.
32 The ALJ set forth her finding in the Order at pages 14-19, which are supported by a
33 preponderance of the evidence.
34

35 The Board has reviewed all the exceptions and finds those to which the Board has not
36 heretofore addressed to be without merit.
37

38 CONCLUSION

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40 In her proposed order, ALJ Rackstraw concluded that the Board has established sufficient
41 grounds to revoke Dr. Sachdev's license, and that the sanction is appropriate under the
42 circumstances. Moreover, ALJ Rackstraw concluded that it is within the scope of the Board's
43 authority to assess a \$10,000 civil penalty and the costs of the proceeding against Dr. Sachdev.
44 ALJ Rackstraw also opined that in light of the number of serious violations, and Dr. Sachdev's
45 failure to abide by the terms of her stipulated agreement with the Board, those penalties are also
46 appropriate.

1
2 The Board adopts ALJ Rackstraw's Proposed Order with minor, non-substantive
3 modifications previously identified in the discussion of the exceptions.
4

5 **ORDER**

6
7 The Oregon Medical Board issues the following order:
8

- 9 1. The medical license of Naina Sachdev, MD, is revoked.
10
11 2. Naina Sachdev, MD, is assessed the costs associated with these proceedings. Costs shall
12 be due within 90 days from the date the Board issues its Bill of Costs.
13
14 3. Naina Sachdev, MD, must pay a civil penalty of \$10,000, which is payable in full within
15 90 days from the date this Order is signed by the Board Chair, or 10 days after this Order
16 becomes final by operation of law, whichever is later.
17
18 4. The Interim Stipulated Order of June 7, 2012, terminates upon the effective date of this
19 Order.
20
21

22
23 DATED this 2nd day of October, 2014.
24

25 OREGON MEDICAL BOARD
26 State of Oregon
27

28 **SIGNATURE REDACTED**
29

30 _____
31 DONALD GIRARD, MD
32 Board Chair
33
34

35 **APPEAL**

36
37 If you wish to appeal the final order, you must file a petition for review with the Oregon
38 Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 et
39 seq.
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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
DAVID WILLIAM SELBY, DO) ORDER TERMINATING
LICENSE NO. DO14260) STIPULATED ORDER
)

1.

On March 1, 2012, David William Selby, DO (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On June 25, 2014, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the March 1, 2012, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

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

1.

On July 12, 2012, Shawn Michael Sills, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On March 26, 2014, Licensee submitted a written request asking the Board to modify certain terms of this Order. Term 5.7 reads:

5.7 Licensee must continue participation in and fully comply with the Health Professionals Services Program (HPSP).

2.

Having fully considered Licensee's request, the Board terminates Term 5.7 of the July 12, 2012, Stipulated Order effective the date this Order is signed by the Board Chair. All other terms of the July 12, 2012, Stipulated Order which have not previously been modified, are unchanged and remain in full force and effect.

IT IS SO ORDERED this 2nd day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

DONALD E. GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
STANLEY BRUCE TEPLICK, MD) ORDER TERMINATING
LICENSE NO. MD19317) STIPULATED ORDER
)

1.

On January 12, 2012, Stanley Bruce Teplick, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On June 24, 2014, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the January 12, 2012, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7th day of October, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
HAROLD ANDREW THOMAS JR., MD) INTERIM STIPULATED ORDER
LICENSE NO. MD14766)
)

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. Harold Andrew Thomas, Jr., MD (Licensee) is a licensed physician in the state of Oregon and holds an active license.

2.

Licensee is an emergency medicine physician. The Board received credible information regarding Licensee that resulted in the Board initiating an investigation.

3.

Licensee voluntarily agrees to enter into this Interim Stipulated Order with the Board, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following terms effective the date this Order is signed by the Licensee:

- 3.1 Licensee voluntarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.
- 3.2 Licensee understands that violating any term of this Order may be grounds for disciplinary action under ORS 677.190(17), willfully violating Board order.

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4.

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

5.

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

IT IS SO STIPULATED THIS 25 day of SEPTEMBER, 2014.

SIGNATURE REDACTED
HAROLD ANDREW THOMAS, JR., MD

IT IS SO ORDERED THIS 26th day of September, 2014.

OREGON MEDICAL BOARD

SIGNATURE REDACTED
KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
STEVEN GARY TILLET, DPM)
LICENSE NO. DP00300) CORRECTIVE ACTION AGREEMENT

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including podiatric physicians, in the state of Oregon. Steven Gary Tillett, DPM (Licensee) is a licensed podiatric physician in the state of Oregon.

2.

Licensee is a podiatric physician practicing in Portland, Oregon. The Board opened an investigation after receiving a report that Licensee had prescribed controlled substances for himself and family.

3.

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

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4.

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

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

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

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

IT IS SO AGREED this 25th day of SEPTEMBER, 2014.

SIGNATURE REDACTED

STEVEN GARY TILLET, DPM

IT IS SO AGREED this 2nd day of October, 2014.

SIGNATURE REDACTED

DONALD GIRARD, MD
Board Chair

1 is signed by the Board Chair. All other terms of the July 11, 2013, Stipulated Order are
2 unchanged and remain in full force and effect.

3 IT IS SO ORDERED this 2nd day of October, 2014.

4 OREGON MEDICAL BOARD
5 State of Oregon

6 **SIGNATURE REDACTED**

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8 DONALD GIRARD, MD
9 Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
KENNETH JAY WELKER, MD)
LICENSE NO. MD 22731) DEFAULT FINAL 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. Kenneth Jay Welker, MD (Licensee) is a licensed physician in the state of Oregon.

2.

2.1 This case has a lengthy procedural history as a result of an ongoing investigation, which brought to light numerous violations of the Medical Practice Act throughout the course of the investigation. The Board issued a Complaint and Notice of Proposed Disciplinary Action on August 5, 2012. Licensee requested a hearing. On June 17, 2013, Licensee signed an Interim Stipulated Order, in which he agreed to certain terms and conditions affecting his practice. On September 18, 2013, Licensee signed another Interim Stipulated Order, in which he agreed to immediately cease performing or providing Adipose Derived Mesenteric Cell Harvesting and Transfer (stem cell) therapy for any patient. After additional evidence of professional misconduct came to the Board's attention, the Board issued an Order of Emergency Suspension on January 9, 2014. On April 8, 2014, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action. On July 11, 2014, the Board issued the Second Amended Complaint and Notice of Proposed Disciplinary Action, in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or

1 dishonorable conduct, as defined by ORS 677.188(4)(a)(b) and (c); ORS 677.190(9) making
2 statements that licensee knows, or should know, are false or misleading regarding skill or the
3 efficacy or value of the medicine or remedy prescribed or administered by the licensee or at
4 the direction of the licensee in the treatment of any disease or condition of the human body;
5 and ORS 677.190(13) gross or repeated acts of negligence.

6 2.2 On July 9, 2014, the Board received a letter from Licensee stating that he had
7 “fired his attorney” and that he had the “right to rescind the request for a contested case
8 hearing previously agreed to and I am doing so now.” On July 11, 2014, the Board
9 subsequently issued the Second Amended Complaint and Notice of Proposed Disciplinary
10 Action. Licensee submitted another letter, which the Board received on July 25, 2014. In this
11 letter, Licensee acknowledged receiving the Board’s correspondence dated July 11, 2014,
12 which contained the Second Amended Complaint and Notice of Proposed Disciplinary
13 Action. In this letter, Licensee made reference to previous correspondence, stating: “I noted
14 the Board acknowledged and agreed to my request to rescind the contested case hearing
15 which my former attorney arranged for me without explaining to me the legal ramifications.”
16 Licensee went on to state that he was “again renewing my right to rescind same....” The
17 Board replied to this letter on July 25, 2014, which Licensee received on July 28, 2014. In
18 this letter, the Board reiterated that it would not provide suggestions or legal advice, but stated
19 the following: “At this time the Board does not have a request for a hearing from you on this
20 matter. Failure to request a hearing by **August 1, 2014**, waives your right to a hearing and
21 will result in the Board issuing a default order.” Licensee did not submit a request for hearing
22 by that specified deadline. On August 29, 2014, the Board received a letter from Licensee in
23 which he reiterated his request to waive his right to an administrative hearing. The Board
24 finds that Licensee has expressly waived his right to a contested case hearing and stands in
25 default.

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

4 FINDINGS OF FACT

5 Licensee is a board certified surgeon, but has ceased practicing as a surgeon, and up
6 until the Order of Emergency Suspension, practiced medicine at a clinic called Optimal
7 Health, in Eugene, Oregon. Licensee states that he is a Diplomat of the American Academy
8 of Anti-Aging Regeneration and Functional Medicine. This organization is not recognized by
9 the American Board of Medical Specialties or the American Osteopathic Association.

10 Licensee engaged in acts and conduct that violated the Medical Practice Act, as follows:

11 3.1 Patient A, a 56-year-old female, presented to Licensee on November 19, 2010,
12 with complaints of a non-healing ulcer on her left calf. Patient A was morbidly obese with
13 underlying insulin dependent adult onset diabetes with renal insufficiency and a history of
14 congestive heart failure, and chronic obstructive pulmonary disease. Licensee estimated her
15 weight to be between 350 and 400 pounds. Licensee noted that Patient A was interested in
16 hydrogen peroxide intravenous (IV) therapy and that she did not want her conventional
17 medicine providers to know that she was receiving other forms of therapy. Licensee initiated
18 a course of IV hydrogen peroxide therapy that was to be done twice a week while she
19 continued with ongoing conventional medical treatment from her primary care provider
20 (PCP). Licensee failed to explain (or document that he explained) the risks, alternatives and
21 side effects associated with this type of treatment, and whether the patient had any questions
22 regarding the treatment. Patient A returned to the clinic on November 22, 2010 for a repeat
23 treatment, received hydrogen peroxide IV therapy from another provider, and experienced
24 unexpected adverse side effects during the initial treatment.

25 3.2 Patient B, a 77-year-old adult male, presented to Licensee on November 30,
26 2011, with complaints of fatigue, joint pain, sleep deprivation, and benign prostate
27 hypertrophy. Licensee examined Patient B, noted an elevated blood pressure of 163/91 and

1 ordered both conventional and unorthodox laboratory studies, but did not conduct a digital
2 rectal examination (DRE) or check Patient B's prostate-specific antigen (PSA), which was
3 last checked in 2005, when Patient B's PSA level was 10, which is elevated. Licensee
4 diagnosed Patient B with hypercholesterolemia, hypertension, and fatigue due to "heavy metal
5 burden chronic toxicity." Licensee's chart note for this initial visit lists thirty eight (38)
6 distinct diagnoses. Licensee started Patient B on a course of medications and supplements, to
7 include clonazepam (Schedule IV), Pregnenolone, hydrochlorothiazide, and ultimately 29
8 dietary supplements. Patient B underwent a test infusion of disodium ethylene diamine tetra-
9 acetic acid (EDTA) on December 2, 2011 as well as heavy metal testing and other studies.
10 Patient B's testosterone level was 396 (within the normal range) and his thyroid stimulating
11 hormone (TSH) level was 2.99 (also within the normal range). On December 19, 2011,
12 Licensee reviewed the recent lab studies with Patient B and decided to treat Patient B with 10
13 sessions of IV chelation, and prescribed an additional one half grain of thyroid and began
14 treating Patient B with injections of 0.5 mL of testosterone (200 mg/ml) per week along with
15 anastrozole (Arimidex) (a medication normally used for breast cancer prophylaxis for women)
16 1 mg per week. Licensee told Patient B that his testosterone level should be in an optimal
17 range of 850 to 950. Licensee did not check Patient B's PSA level or conduct a DRE.
18 Licensee did not advise Patient B of the risks and possible side effects associated with the
19 regimen of medications and supplements that he was taking. On January 13, 2012, Patient B
20 came in for chelation treatment, and complained that his arthritic right knee had caused him to
21 stop playing basketball. Licensee injected his right knee with "1 mm" (sic) aqueous
22 testosterone and 6 mL of prolotherapy. Patient B returned for repeated treatments of aqueous
23 testosterone and prolotherapy. Although Patient B had a history of hypertension, Licensee did
24 not record a blood pressure reading at the January 13th visit. On February 24, 2012, Patient
25 B's blood pressure was noted to be 178/101, and on February 29th, Patient B collapsed at his
26 chiropractor's office. Later that day, his blood pressure readings at Licensee's office were
27 196/109 and 178/126. Licensee failed to address the issue of hypertension in his progress

1 notes. On March 4, 2012, Patient B was seen at the Sacred Heart Emergency Department
2 (ED), with a blood pressure of 168/108, a normal computed tomography scan, normal
3 magnetic resonance angiogram and unchanged electrocardiogram (EKG). Patient B was
4 discharged from the ED with a diagnosis of Transient Ischemic Attack (TIA). On March 12,
5 2012, Patient B informed Licensee that he had an MRI that documented multiple small
6 strokes in the left basal area and right frontal lobe, and that he had been placed on a statin
7 drug and clopidogrel (Plavix), which reduces the risk of strokes by reducing platelet
8 aggregation in the blood. On March 13, 2012, Patient B was again seen at Sacred Heart
9 Emergency Department and diagnosed with a TIA. Licensee spoke by phone with Patient B
10 while he was being seen at Sacred Heart and prescribed losartan 25 mg BID without
11 coordination with the emergency department physicians. Patient B returned to see Licensee
12 on March 19 for EDTA chelation, and informed Licensee that he had been hospitalized for
13 two days the previous week due to a small stroke, and was having trouble with his peripheral
14 vision and understanding the radio. On April 6, 2012, Patient B's testosterone level was 717,
15 blood sugar of 124, A1C of 5.8, and cholesterol/HDL ratio of 6.2. Patient B presented to
16 Licensee on April 9, 2012, for EDTA chelation (#12) treatment. He complained of being
17 irritable and had a large ecchymosis on his left buttocks. Licensee informed Patient B that his
18 ecchymosis may be a hemorrhage at his testosterone injection site caused by his Plavix.
19 Licensee told Patient B to stop taking Plavix. Licensee did not consult with Patient B's PCP,
20 and did not advise Patient B of the risks associated with discontinuing this medication,
21 particularly in the context of his recent history of cerebrovascular disease. Licensee charted
22 that he thought Patient B was "well covered to reduce his risk of stroke particularly on EDTA
23 chelation." During this time, Patient B experienced difficulty urinating and asked Licensee if
24 his symptoms could be attributed to the medications and supplements that Licensee had
25 prescribed or recommended. Licensee rejected the idea, but on April 20, 2012, did prescribe
26 tamsulosin (Flomax) 0.4 mg 30 tablets. On April 23, 2012, Patient B's PCP noted that Patient
27 B did not understand the importance of taking Plavix as well as his statin medication and

1 recommended that Patient B and the Licensee not alter any of his allopathic medications.
2 Patient B continued to experience urination problems, and on May 23, 2012, presented to his
3 PCP with complaints of incomplete voiding. Patient B received a consultation with Oregon
4 Urology Institute, where he presented on May 30, 2012, with complaints associated with urine
5 retention. Patient B was found to have a PSA of 17.6 (elevated) and an enlarged prostate.
6 Patient B declined a transurethral resection of the prostate and elected to discontinue
7 testosterone and to continue taking Flomax. Patient B's symptoms gradually resolved.
8 Licensee failed to inform Patient B of the health risks associated with his treatment plan,
9 recommended unnecessary treatments to address his health condition, to include treatment
10 with thyroid and testosterone, jeopardized Patient B's health by recommending that he
11 discontinue Plavix without medical justification, did not inform the PCP of his intervention
12 into the treatment plan, which included the prescribing of Plavix, and failed to effectively
13 address Patient B's cerebrovascular disease while providing misleading information that
14 chelation therapy is an effective treatment for cerebrovascular disease.

15 3.3 A review of the charts for Patients C – F revealed an ongoing pattern of
16 conduct in which Licensee breached the standard of care by prescribing testosterone for men
17 over the age of 60 that was not medically indicated and without checking their PSA or
18 conducting a DRE. Patients C - F ranged in ages from 61 to 65, and presented to Licensee
19 with various complaints of fatigue. Licensee tested the patients' testosterone level, informed
20 these patients that their testosterone was low (although their test results were in the normal
21 range), recommended that they take various supplements and began treating them with
22 testosterone. Licensee put Patients C – F on a course of Arimidex (1 mg, 1 tablet twice a
23 week) and intra muscular injections of testosterone (200mg/mL at 0.5 mL) that was not
24 medically indicated. In addition, during the course of treatment, Licensee did not monitor
25 PSA levels and did not conduct a DRE prior to initiating testosterone therapy and for three to
26 six months after initiating therapy.

27 ///

1 3.4 Licensee treated Patients G – H with hydrogen peroxide therapy without
2 documenting in the patients' charts that he explained the potential side effects, alternatives,
3 risks, or answered his patients' questions.

4 3.5 Patient I, a 44-year-old adult male, presented to Licensee on October 13, 2009
5 with a history of chronic fatigue, fibromyalgia, insomnia, and complained about numbness
6 and tingling in the hands, with progressive clumsiness and weakness. Licensee examined
7 Patient I and noted for the cardiovascular examination: "RRR [regular rate rhythm], No
8 murmur." Licensee tested for heavy metals and initiated therapy with tramadol (Ultram). On
9 October 26th, Patient I called Licensee to report that he was experiencing "a worsening in his
10 irregular heartbeat and chest discomfort" as well as nausea, headaches and feeling of
11 weakness. Patient I presented to Licensee on October 29, 2009, and reported an increase in
12 his irregular heartbeats with an addition of racing heart and chest discomfort. Patient I
13 attributed his symptoms of diarrhea, nausea, headaches and faintness to his increase of
14 ProtoClear (a nutritional supplement). Licensee's assessment and plan follows: "Due to
15 slight loss in lean body mass, will increase calorie intake to 1600 calories. Begin use of
16 Chasteberry Plus to assist with symptoms of racing heart and thermo regulation." Licensee
17 did not document that he conducted a cardiovascular examination, did not record Patient I's
18 heart rate or blood pressure, did not order an EKG, check enzyme levels, obtain a consult with
19 a cardiologist or contact Patient I's PCP. Licensee failed to document whether he recognized
20 the significance of Patient I's potentially life threatening symptoms, and failed to follow up by
21 examination, laboratory work or referral. By so doing, Licensee unnecessarily exposed
22 Patient I to risk of harm.

23 3.6 The Board reviewed the medical records for Patients J – N, and found that
24 Licensee conducted certain procedures on these patients that were not FDA approved (to
25 include what the Licensee called stem cell and adipose cell transfer procedures) that were
26 described by Licensee as "experimental and investigational." Licensee did not establish any
27 Institutional Review Board for oversight of any experimental or investigational treatment that

1 he provided, and failed to do the following: document any subject selection criteria,
2 document the investigational protocol, establish validated instruments to follow results
3 objectively, describe a data collection and analysis system, establish a protocol for reporting
4 adverse events, and disclosing to patients any potential conflict of interest, financial or
5 otherwise, in asking them to participate in his study. Specific concerns pertaining to patient
6 care follow:

7 a. Patient J, a 62-year-old female, initially presented to Licensee on January 28,
8 2013 with complaints of dizziness, ataxia, and a body mass index of 20. She had previously
9 been diagnosed with multiple sclerosis, and a chiropractor had documented a finding of “lead
10 heavy metal toxicity issues” after an April 2012 post provocative urine test. A November
11 2011 blood test reported normal lead and copper levels. Licensee discussed with Patient J the
12 possibility of “fat transfer with respect to getting cells fat for the purposes of her first rating
13 (sic) her neurological growth.” Licensee noted a plan to “pursue a detox case of lead” via
14 EDTA chelation. Patient J subsequently underwent a series of 20 IV calcium EDTA chelation
15 treatments at Licensee’s clinic. On May 14, 2013, Patient J signed an informed consent form
16 to undergo a “Fat Transfer.” This form states that this procedure is not FDA approved, is
17 usually not covered by health insurance, and that there are “inherent risks.” On that same day,
18 Licensee performed a “stem cell transfer” procedure on Patient J, by removing 80 mL of fluid
19 and fat from the patient’s abdomen through liposuction as well as 120 mL of blood, and
20 processing it. Licensee subsequently injected 8 mLs of the processed solution into the
21 patient’s spinal fluid by lumbar puncture, while the remainder was injected intravenously into
22 Patient J. Within 5 minutes, Patient J complained of tingling in her body and both legs.
23 Licensee noted that she had a high respiratory rate and elevated blood pressure with a lot of
24 perspiration that lasted about 45 minutes. Licensee was surprised by the reaction and could
25 not offer an explanation for the adverse reaction. Licensee did not report this adverse reaction
26 to the Stem Cell therapy to any appropriate entity. Licensee discharged her home in stable
27 condition with a normal blood pressure of 121/73. Patient J returned to the clinic two days

1 later and appeared to be stable, albeit with a mild amount of abdominal pain. Licensee's
2 clinic records for this patient included two (2) different versions of her Vital Signs log for the
3 period of 1/28/2013 through 6/11/2013. The first version has three (3) log entries for vital
4 signs taken during the May 14, 2013, stem cell therapy, the second version of this log does
5 not include any vital signs for this date. Licensee subjected Patient J to a series of EDTA
6 chelation treatments that were not medically indicated and "stem cell transfer" that were not
7 medically indicated and subjected her to an unnecessary risk of harm.

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

23 c. The Board also reviewed other cases where Licensee provided stem cell IV
24 infusion treatments in 2013, pertaining to Patients L – N. Patient L was a 39-year-old female
25 with a history of rheumatoid arthritis who first saw Licensee in July 2010. Patient L returned
26 to Licensee's clinic on July 15, 2013 after an absence of over one year. On July 22, 2013,
27 Licensee administered injections of autologous processed fat and blood into the right knee,

1 left and right wrist, right hip and right shoulder of Patient L. Excess fat was processed and
2 injected into each breast for this patient. On January 10, 2013, Patient M, a 71-year-old male
3 and former marathon runner, presented with complaints of knee pain and left medial knee
4 arthropathy. This patient was seeking an alternative to knee replacement surgery. Licensee's
5 note for the initial visit indicates the Patient "...is probably a good candidate to undergo fat
6 transplant gets cartilage growth going (sic)" and "He understands this is an experimental
7 investigational procedure". Patient M's labs in January 2013 reflect normal TSH level and an
8 elevated total testosterone of 916, even though the patient was not on supplemental
9 testosterone. On January 22, 2013, Licensee performed a "mini liposculpture and
10 venipuncture for his platelet rich plasma." Licensee processed the extracted fat and blood and
11 injected it into Patient M's left knee. Licensee wrapped Patient M's abdomen, prescribed him
12 20 tablets of Oxycodone (Schedule II) and discharged him. Licensee also started Patient M
13 on DHEA, 50 mg, increased his Thyroid medication and failed to investigate the elevated
14 testosterone level. Repeat labs for Patient M continued to reflect normal TSH values and
15 elevated testosterone levels. Patient N, a 39-year-old male, initially presented to Licensee
16 complaining of a tear in his left patellar ligament that he sustained from playing basketball.
17 Licensee referred him to an orthopedic surgeon. At the initial visit on January 29, 2013,
18 Licensee discussed stem cell therapy with Patient N, to include information that the procedure
19 was experimental and investigational and performed a mini liposculpture, processed the
20 extracted fat and blood, and injected it into Patient N's left knee in the patellar tendon and
21 into the right knee. On February 28, 2013, Licensee injected platelet rich plasma into Patient
22 N's left knee. These procedures were not medically indicated and subjected these patients to
23 an unnecessary risk of harm. Licensee describes the stem cell therapy to patients as
24 "experimental and investigational" but did not establish any Institutional Review Board for
25 oversight of any experimental or investigational treatment that he provided. Licensee failed
26 to document appropriate investigational protocol such as: patient selection criteria, data
27

1 collection and analysis, appropriate outcome evaluation, or adverse event reporting, among
2 others.

3 4.

4 CONCLUSIONS OF LAW

5 4.1 Licensee's conduct, as described above, breached well recognized standards of
6 practice and ethics of the medical profession. It is difficult to provide a summary of
7 Licensee's acts of misconduct in view of their scope and the risk of harm that they presented
8 to the public. Suffice it to say that Licensee engaged in multiple acts that placed his patients
9 at serious risk of harm and made false and misleading statements to his patients regarding his
10 skill and the efficacy of certain medications or therapies that he offered. He also engaged in
11 multiple acts of unethical conduct. Licensee treated patients with forms of therapy that are
12 not efficacious and exposed patients to the risk of adverse side effects without obtaining their
13 informed consent. Licensee also advised a patient to cease taking medication prescribed by
14 that patient's primary care physician (PCP) without prior coordination with the PCP medical
15 practice or advising the patient of the risks associated with discontinuing the medication, and
16 thereby unnecessarily exposed this patient to the risk of harm. Licensee prescribed
17 testosterone to patients that were not medically indicated. Licensee treated with hydrogen
18 peroxide without appropriate documentation and without adequate support in the chart.
19 Licensee also failed to recognize life threatening health conditions while pursuing his
20 quackery, and subjected his patients to forms of treatment that were not FDA approved under
21 the guise of participating in a "study" that was potentially harmful.

22 4.2 The Board concludes that Licensee's conduct violated ORS 677.190(1)(a)
23 unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), (b), and (c); ORS
24 677.190(9) making statements that licensee knows or should know are false or misleading
25 regarding skill or the efficacy or value of medicine or remedy prescribed or administered by
26 the licensee or at the direction of the licensee in the treatment of any disease or condition of
27 the human body; and ORS 677.190(13) gross or repeated acts of negligence.

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APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after this default final order is served upon you. *See* ORS 183.480 et seq.

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CERTIFICATE OF MAILING

On, October 8, 2014, I mailed the foregoing Default Final Order regarding Kenneth Jay Welker, MD, to the following parties:

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 7014 1200 0000 8349 9217

Kenneth Jay Welker, MD
501 Elk Drive
Cottage Grove, OR 97424

By: UPS GROUND

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

Beverly Loder
Beverly Loder
Investigations Secretary
Oregon Medical Board