

Oregon Medical Board  
**BOARD ACTION REPORT**  
**July 15, 2012**

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between June 16, 2012 and July 15, 2012.

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 Corrective Action Agreements and Consent Agreement are not posted, as they are not disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report, as they are not final actions by the Board. Both Orders, however, are public and are available upon request.

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

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

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

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**\*Branch, Benjamin Frederick, DO; DO29119; Medford, OR**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order reprimands Licensee, assesses a \$2,000 fine, and requires Licensee to complete a boundaries course approved by the Board's Medical Director.

**\*Calvert, James Francis, Jr., MD; MD18000; Klamath Falls, OR**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; and prescribing a controlled substance without a legitimate medical purpose or following accepted procedures. This Order reprimands Licensee, assesses a \$5,000 fine, places Licensee on probation, and requires Licensee to complete courses on chronic pain treatment and rheumatologic disorders approved by the Board's Medical Director.

**\*Clemons, Ian Marvin, PA; PA00692; Portland, OR**

On July 12, 2012, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's September 1, 2011, Stipulated Order.

**\*Dunkley-Shurts, Karissa Marie, DO; Applicant; Lake Oswego, OR**

On July 12, 2012, the Board issued a Default Order for unprofessional or dishonorable conduct, and willfully violating any rule adopted by the Board, Board order, or failing to comply with a Board request. This Order denies the application to practice medicine and assesses a \$10,000 fine.

**\*Killen, Ronald Hugh, MD; MD15428; Sandy, OR**

On July 5, 2012, 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.

**Laird, Sheri Lee, MD; MD21936; West Linn, OR**

On July 12, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a course on appropriate prescribing, pre-approved by the Board's Medical Director; review chronic pain patient charts with a Board approved mentor twice a month; and continue treatment with her current healthcare provider.

**Matsumura, Andrea Loran, MD; MD22819; Portland, OR**

On July 12, 2012, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's April 7, 2011, Corrective Action Agreement.

**\*Metzger, Mark Steven, MD; MD23691; Gresham, OR**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and conviction of any offense punishable by incarceration in a Department of Corrections institution. This Order surrenders Licensee's medical license while under investigation.

**\*Nielsen, Erik William, MD; MD12909; Portland, OR**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order permanently surrenders Licensee's medical license and prohibits Licensee from applying for a medical license in this, or any other state.

**Ono, Alfred Kazuo, MD; MD08406; Portland, OR**

On July 12, 2012, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 8, 2010, Corrective Action Agreement.

**\*Pozar, John Mark, MD; MD08211; Salem, OR**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board. This Order retires Licensee's medical license while under investigation.

**\*Robinson, Michael Truman, DO; DO10555; Central Point, OR**

On July 12, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete an appropriate prescribing course approved by the Board's Medical Director.

**\*Rodriguez, Hubert Alfredo, Jr., MD; MD27178; Birmingham, AL**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated acts of negligence. This Order reprimands Licensee; places Licensee on probation, however the probation is stayed as long as Licensee does not hold an active license in Oregon; assesses a fine of \$5,000, with \$4,000 stayed; requires Licensee to obtain and complete an educational intervention plan from CPEP prior to applying for an active Oregon medical license; and requires Licensee to complete a course on medical ethics approved by the Board's Medical Director.

**Rosencrantz, David Richard, MD; MD07089; Portland, OR**

On July 12, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a course on professional boundaries within six months, and continue treatment with his current healthcare provider.

**Sharma, Sanjeev Kumar, MD; MD151024; Ashland, OR**

On July 12, 2012, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's April 5, 2012, Corrective Action Agreement.

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

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; and prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order reprimands Licensee; revokes Licensee's medical license, however the revocation is stayed; suspends Licensee's license to practice medicine for 60 days; places Licensee on probation for 10 years; assesses a fine of \$5,000; requires Licensee to complete a boundaries course approved by the Board's Medical Director; and requires Licensee to comply with all terms of his HPSP agreement.

**Stapleton, Joseph Paul, MD; MD13551; Happy Valley, OR**

On July 12, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete courses on medical documentation and the appropriate prescribing of narcotics within one year.

**\*Thomson, Kathryn Mary Donoghue, DO; DO13836; Beaverton, OR**

On July 12, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order retires Licensee's osteopathic license while under investigation, prohibits Licensee from practicing any form of medicine in Oregon and precludes Licensee from re-applying for licensure for two years.

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

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
 BENJAMIN FREDERICK BRANCH, DO ) STIPULATED ORDER  
 LICENSE NO. DO29119 )

1.

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

2.

In a Complaint and Notice of Proposed Disciplinary Action dated April 5, 2012, 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 dishonorable conduct, as defined by ORS 677.188(4)(a).

3.

The acts and conduct alleged to violate the Medical Practice Act follow:

3.1 Licensee is a physical medicine and rehabilitation physician. In 2009, Licensee became acquainted with Patients A and B, a married couple, because they lived in the same neighborhood in Medford, Oregon. Patient B was employed at the same workplace as Licensee. Licensee saw Patient B, an adult female, on two occasions in 2009 as a patient and recommended certain treatments to her. Licensee last saw Patient B as a patient in December 2009. On May 2, 2011, Patient A, an adult male, presented to Licensee with complaints of left sided back pain.

1 Patient A was active in multiple sporting activities and had undergone a prior knee surgery.  
2 Patient A had subsequent office visits with Licensee on June 1, 2011, June 20, 2011, and July 26,  
3 2011. Treatments included recommending physical therapy, an injection of Lidocaine and  
4 Osteopathic Manipulative Treatment (OMT).

5 3.2 In June and July of 2011, Licensee and Patient B made a number of personal  
6 phone calls and text messaging between each other. On July 23, 2011, while Patient A was out  
7 of town, Patient B went out to dinner with Licensee. After dinner, they proceeded to go to  
8 Licensee's home where they engaged in inappropriate intimate conduct. After Patient A's  
9 appointment with Licensee on July 26<sup>th</sup>, Patient A became suspicious of a secret liaison between  
10 Licensee and Patient B; he had become aware that multiple cell phone calls had occurred  
11 between Licensee and Patient B. This culminated in a series of confrontations between Patient A  
12 and Licensee. Licensee violated his ethical obligation by engaging in inappropriate intimate  
13 conduct with a former patient who was also the spouse of another patient.

14 4.

15 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.  
16 Licensee understands that he has the right to a contested case hearing under the Administrative  
17 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the  
18 right to a contested case hearing and any appeal therefrom by the signing of and entry of this  
19 Order in the Board's records. Licensee admits that he engaged in the conduct described in  
20 paragraph 3, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable  
21 conduct, as defined by ORS 677.188(4)(a). Licensee understands that this Order is a public  
22 record and is a disciplinary action that is reportable to the National Practitioner Data Bank, the  
23 Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

24 5.

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

27 5.1 Licensee is reprimanded.





1 started Patient A on morphine sulfate (Schedule II), 30 mg twice a day (bid), and oxycodone  
2 (Schedule II) 5 mg bid. In December, 2008, Licensee tentatively diagnosed rheumatoid arthritis  
3 and increased Patient A's prescription of morphine sulfate to 30 mgs three times a day (tid) and  
4 started her on hydroxychloroquine (Plaquenil). Subsequent laboratory studies did not support an  
5 inflammatory condition. In February, 2009, Licensee diagnosed seronegative rheumatoid  
6 arthritis and started Patient A on methotrexate and low dose prednisone. In March of 2009,  
7 Licensee authorized a medical marijuana card. In October of 2010, a consulting rheumatologist  
8 saw Patient A but did not agree with the diagnosis of rheumatoid arthritis. In November, 2010,  
9 Patient A was stopped by the police for careless driving due to driver's impairment. Licensee  
10 signed and attested on January 20, 2011 that: "There is no impairing condition" on a driver  
11 medical report for the Oregon Division of Motor Vehicles (DMV). This report also reflected  
12 Patient A's self-report of "severe arthritis in hips, back and knees, inability to control muscle  
13 movements and use of prescribed medications including morphine, marijuana and hydrocodone  
14 caused dangerous driving 11/03/10." In January, 2011, a urine drug screen was positive for  
15 methamphetamine, marijuana and benzodiazepines, as well as her prescribed narcotics.  
16 Licensee's approach was to require her to submit a "clean" urine drug sample before he would  
17 reauthorize scheduled medications. Licensee ceased prescribing for Patient A on September 9,  
18 2011, after Patient A refused to produce a urine drug screening sample. Review of the chart  
19 reveals that Licensee failed to establish a diagnosis of rheumatoid arthritis, yet persisted in  
20 treating this condition without supporting medical indications. In addition, Licensee persisted in  
21 prescribing narcotic medications in the face of substantial evidence of impairment and substance  
22 abuse, and certified that Patient A was not impaired to the DMV in the face of strong evidence to  
23 the contrary. Licensee also authorized marijuana without medical justification when Patient A  
24 was on a course of narcotic medication.

25           3.2     The Board conducted a review of Licensee's charts for Patients B - E, which  
26 revealed the following pattern of substandard practice: Poor patient selection for chronic pain  
27 medications; being too willing to accept his patients' attribution of pain to medical conditions

1 amenable to prescribing as opposed to complex life circumstances and deficient coping skills;  
2 prescribing multiple medications with co-morbidities and high potential for abuse to satisfy  
3 patient demands for increased medications; readily prescribing opioid medication to address  
4 complaints of migraine headaches for patients with a history of substance abuse; failing to  
5 recognize and address “red flags” that indicate patient addiction, to include requests for early  
6 refills and increased dosages, missed appointments, or complaints of medication losses; failing to  
7 take appropriate action when presented with evidence of abuse or dependence; failing to  
8 effectively monitor patient compliance with the treatment plan; and failing to support his  
9 diagnoses with clinical findings, failing to obtain appropriate consultations when patients do not  
10 progress; and failing to hold his patients accountable for noncompliance with the treatment plan.  
11 Specific patient care concerns follow:

12           a.       Patient B, a 47 year old female, was seen by Licensee on a recurrent basis  
13 over a period of multiple years. Between August 8, 2007, and May 19, 2011, Licensee treated  
14 Patient B’s complaints of chronic migraine headaches with a series of IM injections of  
15 meperidine (Demerol, Schedule II) 150 - 200 mg, with phenergan (Promethazine) 25 mg,  
16 varying in frequency from twice to four times a month. Patient B also used “medical marijuana”  
17 for the ostensible purpose of treating her migraine headaches. Licensee diagnosed Patient B with  
18 migraine headaches, bipolar disorder and “possibly some parkinsonian side effects.” Over the  
19 course of time, Licensee also prescribed a combination of narcotics and benzodiazepines to  
20 address Patient B’s complaints, to include methadone (Schedule II) 5 mg qid,  
21 hydrocodone/acetaminophen (Schedule III), 10/325mg tid, Xanax (alprazolam, Schedule IV), 1  
22 mg, tid, Effexor XR 75 mg, and clonazepam (Klonopin, Schedule IV) 1 mg, tid. Patient B  
23 developed a dependence on prescribed opioid medication. On March 3, 2010, Patient B suffered  
24 an overdose on narcotics and benzodiazepines and was hospitalized. On April 22, 2010,  
25 Licensee counseled Patient B that she “is probably still really in withdrawal” and increased her  
26 prescription of Effexor XR from 75 to 150 mg. Licensee also prescribed clonazepam (Klonopin,  
27 Schedule IV) 1 – 3 mg, tid, and Clonidine, and noted that “the patient’s headaches have

1 improved greatly since she got off her pain medicine.” On April 14, 2011, Patient B complained  
2 that her “pain is intolerable” and that she was: “using a lot of marijuana to try to make her pain  
3 go away....” Licensee started her on hydrocodone (Norco, Schedule III) 10 mg, 1 qid, to treat  
4 her complaints of generalized pain from fibromyalgia. On May 12, 2011, Licensee started  
5 Patient B on methadone, 2.5 mg, qid for pain control. On May 20, 2011, Patient B was admitted  
6 to a hospital with somnolence, flat affect, and depressed respirations due to her medications.  
7 Licensee last saw Patient B on May 26, 2011, when she denied taking too much methadone, and  
8 claimed that she was just treating her “headache.” Licensee started her on sertraline (Zoloft),  
9 25 mg, and continued the methadone. Patient B was found dead at home on June 19, 2011.  
10 Licensee placed Patient B on a dangerous combination of narcotics and benzodiazepines and  
11 resumed prescribing narcotic medication when it was not medically indicated. Licensee failed to  
12 recognize that Patient B was not a safe candidate for opioid medication and failed to effectively  
13 address her symptoms of dependence prior to her death.

14           b.       Patient C, a 55 year old woman, presented to Licensee on September 29,  
15 2008, for a routine follow up visit, with a medical history that included “failed back syndrome,”  
16 fibromyalgia, fibromyositis, depression, chronic hepatitis C infection, and recurrent anemia.  
17 Licensee treated her complaint of joint pain with a 40 mg IM injection of Kenalog and 6 mL of  
18 Marcaine. In successive clinical visits, Patient C continued to complain of back pain. Licensee  
19 diagnosed “low back syndrome” based on history, but without supporting clinical findings. A  
20 review of Licensee’s medication log sheet reflects that on April 30, 2009, Licensee started  
21 Patient C on a course of methadone (Schedule II), 10 mg, #420, Roxicet (oxycodone &  
22 acetaminophen, Schedule II) #60, and methylphenidate (Ritalin, Schedule II) #60. Licensee did  
23 not establish clinical findings or diagnoses to support these medications. In his chart notes,  
24 Licensee makes reference to a history of back surgeries and states that she had been on a long  
25 course of chronic opioid therapy. On October 29, 2009, Licensee renewed the prescriptions even  
26 though she had missed two previous appointments. She still complained that her back hurt—but  
27 Licensee did not record an examination or make clinical findings. On November 17, 2009,

1 Licensee continued the prescriptions, and charted that: "Her back hurts but things go okay as  
2 long as she has her pain medications." On November 18, 2010, Licensee listed Attention Deficit  
3 Disorder as a diagnosis, but did not provide supporting clinical findings. On February 17, 2011,  
4 Licensee authorized an early refill of methadone due to Patient C's complaint that her: "back was  
5 bothering her more than it ever has." There are no clinical findings. On June 21, 2011, Licensee  
6 observes that Patient C "looks pale. She is shaky. She is very tachycardiac with a heart rate of  
7 about 130. Her blood pressure is 96/70." Licensee also noted that Patient C: "is in a little bit of  
8 withdrawal, since she has been low on her medicine the last couple of days, so she cannot really  
9 talk to me about too much." Licensee's plan was to give her "medicines for next 3 months."  
10 Licensee inappropriately responded to Patient C's withdrawal symptoms and her deviations from  
11 her treatment plan by prescribing a three month supply of controlled substances. Patient C was  
12 admitted to the hospital in August of 2011 to reverse a possible narcotic overdose.

13 4.

14 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.  
15 Licensee understands that he has the right to a contested case hearing under the Administrative  
16 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the  
17 right to a contested case hearing and any appeal therefrom by the signing of and entry of this  
18 Order in the Board's records. Licensee admits that he engaged in the conduct described in  
19 paragraph 3, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable  
20 conduct, as defined by ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or repeated  
21 negligence in the practice of medicine; and ORS 677.190(24) prescribing a controlled substance  
22 without a legitimate medical purpose or following accepted procedures. Licensee understands  
23 that this Order is a public record and is a disciplinary action that is reportable to the National  
24 Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and the Federation of  
25 State Medical Boards.

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5.

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

5.1 Licensee is reprimanded.

5.2 Licensee must pay a fine of \$5,000, payable in full within 60 days from the signing of this Order by the Board Chair.

5.3 Licensee must promptly enroll in and successfully complete courses on the treatment of chronic pain (including prescribing) and rheumatologic disorders, which are pre-approved by the Board's Medical Director within one year of the date this Order is signed by the Board Chair.

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

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

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

IT IS SO STIPULATED THIS 19 day of June, 2012.

**SIGNATURE REDACTED**

JAMES FRANCIS CALVERT, JR., MD

IT IS SO ORDERED THIS 12<sup>th</sup> day of July, 2012.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

W. KENT WILLIAMSON, MD  
BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
IAN MARVIN CLEMONS, PA ) ORDER TERMINATING  
LICENSE NO. PA00692 ) STIPULATED ORDER  
)

1.

On September 1, 2011, Ian Marvin Clemons, PA (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon physician assistant license. On May 11, 2012, 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 September 1, 2011 Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 12<sup>th</sup> day of July, 2012.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

W. Kent Williamson  
W. KENT WILLIAMSON, MD  
Board Chair



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

3 3.

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

6 FINDINGS OF FACT

7 3.1 Applicant submitted an application for an active license to practice medicine in  
8 Oregon on February 8, 2011. Applicant disclosed in her application that on July 1, 2009, she  
9 entered a neurological surgery residency at John H. Stroger Hospital of Cook County, Illinois.  
10 On May 14, 2010, Applicant resigned from this residency program.

11 3.2 Subsequent to her resignation, Applicant has not taken any continuing medical  
12 education courses and does not engage in a medical self-study program.

13 3.3 Applicant answered "yes" to the following question of the application (Category  
14 I, Question #2): "Have you ever failed a licensing examination, or any portion of a licensing  
15 examination, for a medical license (USMLE, NBME, NBOME, FLEX, ECFMG) or for any other  
16 health professional license? If you ever failed a portion of a licensing examination you must  
17 answer "yes" even if you later passed the examination." Applicant answered "yes" and disclosed  
18 that she had failed "Step 1 COMLEX." In fact, Applicant had also failed Level 2 of the  
19 Comprehensive Osteopathic Medical Licensing Examination-USA (COMLEX).

20 3.4 In a letter from the Board, dated June 10, 2011, the recommendation was made to  
21 Applicant to provide proof of current Continuing Medical Education (CME) certificates and that  
22 Applicant take and pass the Special Purpose Examination (SPEX). Upon review by the Medical  
23 Board, Applicant was also asked, in a letter dated July 8, 2011, in accordance with current  
24 policy, to obtain 50 hours of Category I, American Medical Association CME in her current  
25 specialty. At this time Applicant's application was turned over to the Board Investigations  
26 Department to facilitate an interview before the Investigative Committee (IC).

27 ///

1           3.5     After no response to two telephone messages, contact was made with Applicant  
2 by email. Applicant was told of the IC meeting date and Applicant's mailing address was  
3 confirmed. A letter was sent requesting additional information about Applicant's resignation  
4 from the neurological surgery residency program at John H. Stroger Hospital. A certified letter  
5 was sent August 2, 2011, inviting Applicant to the September 1, 2011, IC meeting for an  
6 interview, no response was received from Applicant.

7           3.6     From August 18, 2011, through August 26, 2011, attempts were made to contact  
8 Applicant by telephone and email. The certified letter had been returned as unclaimed on August  
9 26, 2011. In an email received on August 29, 2011, Applicant stated she felt adequate answers  
10 to the Board's questions had been provided and that she would appear at the September 1, 2011,  
11 IC Interview. Applicant did appear at the September 1, 2011, IC meeting and was interviewed.

12          3.7     In a letter from a Board Investigator, dated September 6, 2011, Applicant was  
13 directed to successfully complete the Special Purpose Examination (SPEX) in order to be  
14 granted an Oregon medical license. Procedures for taking the examination were included in the  
15 letter. Applicant failed to respond to this letter. In a letter sent both certified and first class mail,  
16 dated November 7, 2011, a Board Investigator informed Applicant that the Board's Investigative  
17 Committee had reviewed the information from her interview and determined that she must  
18 successfully complete SPEX in order to receive a license. A deadline of December 16, 2011 was  
19 set. Applicant failed to respond or comply and the certified letter was returned on December 1,  
20 2011 as "Refused." On December 16, 2011, an email was sent asking Applicant if she had  
21 received the November 7th letter. In a return email, dated December 17, 2011, the Applicant  
22 declined to take the SPEX examination. OAR 847-020-0183 provides that if an applicant has  
23 ceased the practice of medicine for a period of 12 or more consecutive months immediately  
24 preceding the application for licensure, the applicant may be required to demonstrate clinical  
25 competency, and may be required to pass SPEX.

26          3.8     On January 18, 2012, Applicant was sent another letter by certified mail, first  
27 class mail and encrypted email attachment explaining her application was to be reviewed at the

1 February 2, 2012 IC meeting. Applicant was specifically asked if she wished to withdraw her  
2 application and was advised, in the absence of a withdrawal, the Board may issue a public order  
3 denying her license. The letter closed reminding Applicant she could still submit proof of  
4 enrollment for the SPEX examination before the February IC meeting. Notice of attempted  
5 delivery was left at Applicant's address on January 21, 2012. No response was received from the  
6 applicant nor have any CME certificates been received.

7 4.

8 CONCLUSIONS OF LAW

9 Applicant's conduct, as described above, breached well recognized standards of practice  
10 and ethics of the medical profession. The Board concludes that Applicant's conduct violated  
11 ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a)  
12 and ORS 677.190(17) willfully violating any rule adopted by the Board, Board order, or failing  
13 to comply with a Board request pursuant to ORS 677.320. Based upon its examination of the  
14 record in this case, the Board finds that each alleged violation of the Medical Practice Act is  
15 supported by reliable, probative and substantial evidence.

16 5.

17 **ORDER**

18 IT IS HEREBY ORDERED THAT the application of Karissa Marie Dunkley-Shurts,  
19 DO, to practice medicine is denied and she is assessed a \$10,000 fine.

20  
21 DATED this 12<sup>th</sup> day of July, 2012.

22  
23 OREGON MEDICAL BOARD  
24 State of Oregon

25 **SIGNATURE REDACTED**

26 W. KENT WILLIAMSON, MD  
27 BOARD CHAIR



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4.

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

5.

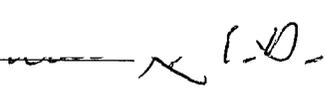
This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure. However, as a stipulation this Order is a public document and is reportable to the National Practitioners Data Bank and the Health Insurance Portability and Accountability Data Bank (HIPDB) and the Federation of State Medical Boards.

6.

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

IT IS SO STIPULATED THIS 5<sup>th</sup> day of July, 2012.

**SIGNATURE REDACTED**

RONALD HUGH KILLEN, MD 

IT IS SO ORDERED THIS 6<sup>th</sup> day of July, 2012.

State of Oregon  
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 )  
MARK STEVEN METZGER, MD ) STIPULATED ORDER  
LICENSE NO. MD23691 )

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. Mark Steven Metzger, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board is prepared 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(6) conviction of any offense punishable by incarceration in a Department of Corrections institution.

3.

Licensee entered into an Interim Stipulated Order with the Board on March 17, 2010, in which he agreed to voluntarily withdraw from the active practice of medicine. Licensee's medical license was automatically suspended on September 2, 2010, pursuant to ORS 677.225(1)(b), because Licensee was an inmate in a penal institution. Licensee was released from prison on November 10, 2011, and placed on 42 months of post-prison supervision. Licensee's acts and conduct that violated the Medical Practice Act are:

3.1 Licensee was convicted pursuant to his plea of guilty in Multnomah County Circuit Court of one count of Attempted Sexual Abuse in the First Degree (Class C felony).

1 The criminal investigation revealed that Licensee had attempted acts of sexual abuse against a  
2 12 year old child, these acts occurred outside Licensee's medial practice. On August 31, 2010,  
3 Licensee was sentenced to 18 months of confinement by the Oregon Department of  
4 Corrections. Licensee's sentence included 42 months of post-prison supervision. Licensee  
5 has completed his term of confinement and is now under post-prison supervision.

6 3.2 On various occasions between May 2002 and September 2009, Licensee self-  
7 prescribed various medications, to include paroxetine (Paxil), trazodone, alprazolam (Xanax,  
8 Schedule IV), and busiprone.

9 4.

10 Licensee and the Board agree to close this investigation with this Stipulated Order in  
11 which Licensee agrees to surrender his license while under investigation, consistent with the  
12 terms of this Order. Licensee understands that he has the right to a contested case hearing  
13 under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully  
14 and finally waives the right to a contested case hearing and any appeal therefrom by the  
15 signing of and entry of this Order in the Board's records. Licensee stipulates that he engaged  
16 in the conduct described in paragraph 3 above and that this conduct violated the Medical  
17 Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined  
18 by ORS 677.188(4)(a); and ORS 677.190(6) conviction of any offense punishable by  
19 incarceration in a Department of Corrections institution. Licensee understands that this  
20 document is a public record and is reportable to the National Practitioners Data Bank, the  
21 Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

22 5.

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

25 5.1 Licensee surrenders his license to practice medicine while under investigation.  
26 This surrender of license becomes effective the date the Board Chair signs this Order.



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
ERIK WILLIAM NIELSEN, MD ) STIPULATED ORDER  
LICENSE NO. MD12909 )

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. Erik William Nielsen, MD (Licensee) is a licensed physician in the State of Oregon.

2.

Licensee is a board certified anesthesiologist. The Board opened an investigation after receiving credible information that Licensee was engaging in unprofessional conduct. On July 7, 2011, Licensee signed an Interim Stipulated Order in which he voluntarily and immediately withdrew from the practice of medicine and his license was placed in Inactive status until the Board completed the investigation.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to surrender his license while under investigation, consistent with the terms of this Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies he engaged in the conduct described in paragraph 2 above, but the Board concludes that Licensee engaged in unprofessional or dishonorable conduct, in violation of ORS 677.190(1)(a), as defined in ORS 677.188(4)(a). Licensee understands that this document is a

1 public record and is reportable to the National Practitioner Data Bank, the Healthcare  
2 Integrity and Protection Data Bank and the Federation of State Medical Boards.

3 4.

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

6 4.1 Licensee permanently surrenders his license to practice medicine while under  
7 investigation. Licensee further agrees that he will never apply for a license to practice  
8 medicine in this state or any other state. This surrender of license becomes effective the date  
9 the Board Chair signs this Order.

10 4.2 Licensee must pay a fine of \$2,500, to be paid within 30 days from the date  
11 this Order is signed by the Board Chair.

12 4.3 Licensee stipulates and agrees that any violation of the terms of this Order  
13 would be grounds for further disciplinary action under ORS 677.190(17).

14

15 IT IS SO STIPULATED this 6<sup>th</sup> day of July, 2012.

16

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**SIGNATURE REDACTED**

18

ERIK WILLIAM NIELSEN, M.D.

19

20 IT IS SO ORDERED this 12<sup>th</sup> day of July, 2012.

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OREGON MEDICAL BOARD  
State of Oregon

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**SIGNATURE REDACTED**

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W. KENT WILLIAMSON, MD  
BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
JOHN MARK POZAR, MD ) STIPULATED ORDER  
LICENSE NO. MD08211 )

1.

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

2.

On December 27, 2011, the Board opened an investigation after receiving a complaint related to Licensee's prescription of controlled and non-controlled substances to a friend without maintaining adequate records or obtaining necessary testing or monitoring.

3.

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

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1 4.

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

4 4.1 Licensee retires his license to practice medicine while under investigation. This  
5 retirement of license becomes effective the date the Board Chair signs this Order.

6 4.2 Throughout the time that the medical license of Licensee remains in a retired  
7 status, Licensee is prohibited from practicing any form of medicine.

8 4.3 In the event Licensee should submit an application for reactivation of his  
9 medical license, Licensee understands that the Board will reopen this investigation.

10 4.4 Licensee stipulates and agrees that any violation of the terms of this Order  
11 would be grounds for further disciplinary action under ORS 677.190(17).

12  
13 IT IS SO STIPULATED this 26<sup>th</sup> day of June, 2012.

14 POZAR, John Mark, MD  
15 Legal File

16 (JOHN MARK POZAR, MD

17 IT IS SO ORDERED this 12<sup>th</sup> day of July, 2012.

18 OREGON MEDICAL BOARD  
19 State of Oregon

20 **SIGNATURE REDACTED**

21 W. KENT WILLIAMSON, MD  
22 BOARD CHAIR  
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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
MICHAEL TRUMAN ROBINSON, DO )  
LICENSE NO. DO10555 ) CORRECTIVE ACTION AGREEMENT

1.

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

2.

Licensee practices family medicine in Central Point, Oregon. The Board opened an investigation in regard to Licensee's medical practice in April 2011.

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; but it is not a disciplinary action. This document is reportable to the National Practitioner Data Bank (NPDB), but is not reportable to the Healthcare Integrity and Protection Data Bank (HIPDB).

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:



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
HUBERT ALFREDO RODRIGUEZ, JR., MD ) STIPULATED ORDER  
LICENSE NO. MD27178 )  
)

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. Hubert Alfredo Rodriguez, Jr., MD (Licensee) is a physician licensed (inactive) to practice medicine in the state of Oregon.

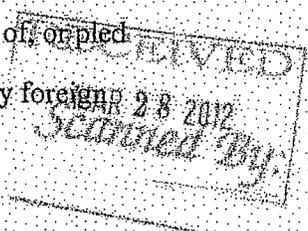
2.

In a Complaint and Notice of Proposed Disciplinary Action issued on April 25, 2011, the Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee is an anesthesiologist. Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 Licensee was arrested on March 9, 2009, for three counts of domestic violence related offenses. Licensee entered into a Diversion Agreement on April 20, 2009, in which he offered a plea of guilty to Assault in the 4<sup>th</sup> degree. On November 9, 2009, Licensee submitted his application for the 2010-2011 biennium license renewal with the Board. Question 5, Category I of the renewal application asked: "Have you been arrested, convicted of, or pled guilty or 'nolo contendere' to ANY offense in any state in the United States or any foreign



1 country, other than minor traffic violations, or a substance use related offense which has been  
2 evaluated by the Oregon Health Professionals Program and you are in compliance with their  
3 recommendations?" Licensee answered "No." Licensee's answer was not true.

4 3.2 The Board opened an investigation into Licensee's delivery of care to patients at the  
5 Mid-Columbia Medical Center (MCMC) in The Dalles, Oregon. On February 25, 2010, Licensee  
6 reported to the Board that he voluntarily resigned from the medical staff at MCMC on January 28,  
7 2010. The Board's investigation revealed a pattern of poor charting, inadequate preoperative  
8 assessment, failure to effectively communicate with the surgeon and hospital staff, which  
9 contributed to his failure to effectively manage postoperative respiratory distress and related  
10 complications, as described below:

11 a. Licensee provided anesthesia to two adult, unrelated patients (Patients A and B),  
12 who underwent cataract surgery on March 12, 2009. Licensee failed to document their vital signs  
13 in the charts.

14 b. Licensee provided anesthesia to Patient C, a 72-year-old male with a history of  
15 hypertension, who underwent cataract extraction surgery on June 10, 2009. The surgeon requested  
16 that the patient remain alert and responsive. Nevertheless, Licensee administered 2 mgs  
17 Midazolam (Versed, Schedule IV), 2 ccs Fentanyl (Schedule II), and 30 mgs Diprivan (Propofol)  
18 prior to administering a peri-bulbar block. As a result, Patient C became somnolent with his  
19 oxygen saturation rates dropping into the 80's. Furthermore, Patient C was not able to respond to  
20 the surgeon's directions in the operating room. Licensee administered a dose of Romazicon, a  
21 reversal agent for Versed. Licensee may also have administered Narcan, a reversal agent for  
22 Fentanyl, but this is not documented in the chart. Licensee failed to document Patient C's vital  
23 signs, placement of an oral airway, and his rationale for administering reversal agents. Because  
24 Licensee over-sedated Patient C, contrary to the surgical plan, the surgeon cancelled the procedure  
25 and rescheduled Patient C for another day.

26 c. Patient D, a diabetic adult female, underwent elective laparoscopic ventral hernia  
27 repair surgery on June 22, 2009. Licensee provided anesthesia for this patient. Licensee did not

1 check Patient D's glucose level during the surgery. Licensee extubated the patient after surgery,  
2 but did not document his respiratory criteria for extubation of the patient in the chart or the data  
3 that supported his decision. A few minutes later, Patient D experienced respiratory distress in the  
4 recovery room. She was unresponsive, with oxygen saturation rates dropping into the 60s. Patient  
5 D was reintubated and she stabilized. Licensee checked her blood sugar level and found that she  
6 was hyperglycemic and required insulin.

7 d. Patient E, a 62-year-old male with acute appendicitis, underwent a laparoscopic  
8 appendectomy on July 6, 2009. After surgery, Licensee noted that Patient E's oxygen saturation  
9 rates had dropped into the 70s. Licensee states that he was concerned about intraoperative  
10 aspiration and ordered that Patient E be suctioned and, at 0155 hrs, ordered a chest X-ray.  
11 Licensee did not notify the surgeon of Patient E's condition or ask for assistance from the  
12 hospitalist. Licensee states that he did not see infiltrate, but did observe a small amount of red-  
13 tinged sputum after Patient E was suctioned again. Licensee states that he completed his care of  
14 Patient E at about 0210 hrs. Patient E was sent to a regular surgical floor despite concerns about  
15 respiratory distress. The surgeon was not notified of Patient E's condition by the nursing staff  
16 until about 0300 hrs, when Patient E was noted to have visible difficulty breathing with a decrease  
17 in oxygen saturation and coarse crackles throughout both lungs. The surgeon ordered Patient E's  
18 transfer from the post-anesthesia care unit (PACU) to telemetry, where he was placed on Bi-PAP  
19 (Bi-level Positive Airway Pressure). Licensee failed to inform the surgeon of Patient E's post  
20 surgical complications and failed to adequately address Patient E's respiratory distress.

21 e. Patient F, a 75-year-old female, with a history of hypertension and chronic  
22 obstructive pulmonary disease (COPD) underwent lumbar surgery on September 2, 2009.  
23 Preoperatively, Patient F's oxygen saturation level was 86% and she was wheezing. Nevertheless,  
24 Licensee allowed the surgeon to proceed. Postoperatively, Patient F developed respiratory distress  
25 with an oxygen saturation level of 70%. Patient F was tachypneic, tachycardiac, and had  
26 substantial wheezing. Licensee interpreted these symptoms as "classic" for congestive heart  
27 failure. Licensee ordered oxygen and furosemide (Lasix), as well as placement of a Foley catheter

1 and a chest X-ray. When Patient F did not respond favorably, Licensee consulted with the  
2 surgeon, who recommended that a hospitalist see the patient. The hospitalist noted that Patient F  
3 did not have a known history of coronary artery disease and put her on Bi-PAP and low flow  
4 oxygen. Patient F rapidly recovered. Licensee failed to correctly assess Patient F's condition  
5 preoperatively and consider cancellation of the surgical procedure. He then unnecessarily delayed  
6 seeking postoperative assistance from either the surgeon or hospitalist.

7 f. On October 11, 2009, Patient G was evacuated by helicopter after a motor vehicle  
8 accident near Hermiston. En route to a Level One Trauma Center in Portland, Patient G had a  
9 cardiac arrest. The helicopter diverted to MCMC. A surgeon was informed at 1825 hrs, and was  
10 in the emergency room before the patient arrived at 1840 hrs. Licensee was on call. He was  
11 initially called at 1830 hrs, and subsequently was called twice more. Each time, Licensee replied  
12 that he was "on the way." Licensee never arrived at the emergency department. The surgeon did  
13 an anterior lateral thoracotomy without Licensee's presence or assistance in an attempt to save the  
14 patient's life, but Patient F died at 1902 hrs. Licensee was required by MCMC to have no more  
15 than a 30-minute response time when on call. Licensee failed to respond in a timely manner.

16 4.

17 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.  
18 Licensee understands that he has the right to a contested case hearing under the Administrative  
19 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the  
20 right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order  
21 in the Board's records. Licensee neither admits nor denies, however the Board finds, that he  
22 engaged in the conduct described in paragraph 3, and that this conduct violated ORS 677.190(1)(a)  
23 unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13)  
24 gross or repeated acts of negligence. Licensee understands that this Order is a public record and is  
25 a disciplinary action that is reportable to the National Practitioner Data Bank, the Healthcare  
26 Integrity and Protection Data Bank and the Federation of State Medical Boards.

27 ///

1 5.

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

5 5.1 Licensee is reprimanded.

6 5.2 Licensee is placed on probation. Licensee must report in person to the Board at  
7 each of its quarterly meetings at the scheduled times for a probation interview, unless otherwise  
8 directed by the Board's Compliance Officer or its Investigative Committee. The terms of  
9 probation, however, are stayed as long as Licensee does not hold an active license or registers for  
10 a locum tenens license to practice medicine in the state of Oregon.

11 5.3 Licensee must pay a fine of \$5,000, with \$4,000 of this fine stayed until Licensee  
12 applies for an active license in Oregon. The remaining \$1,000 must be paid within 10 days from  
13 the date this Order is signed by the Board Chair. The full amount will be payable in full upon  
14 demand in the event Licensee breaches any of the terms of this Stipulated Order.

15 5.4 Prior to applying to the Board for an active medical license, Licensee must ask the  
16 Center for Personalized Education for Physicians (CPEP) to develop, at Licensee's expense, an  
17 educational intervention plan that addresses the educational recommendations that were  
18 identified in his CPEP Assessment Report, dated April 27-28, 2011. A CPEP Associate Director  
19 will actively monitor progress and compliance with this plan, and will submit a report to the  
20 Board after Licensee successfully completes this plan. Licensee must submit the CPEP  
21 educational plan to the Board's Medical Director for review, comment, and approval prior to  
22 implementation.

23 5.5 Licensee must successfully complete the Board approved CPEP education plan  
24 before the Board will process his application for an active license or locum tenens registration.

25 5.6 Licensee must also sign all necessary releases to authorize full ongoing  
26 communication between the Board and CPEP.

27 ///





1 opiate medications increased in February of 2008, and that he diverted controlled substances  
2 from his patients and his medical clinic in April and May of 2008. His drug of choice during this  
3 time was Dilaudid (Hydromorphone) and Fentanyl, both Schedule II medications.

4 Licensee underwent another medical detoxification in May of 2008 and entered into inpatient  
5 treatment between August and October of 2008. Licensee asserts that he is now clean and sober.

6 3.2 Licensee engaged in professional boundary violations while providing medical  
7 care on repeated occasions to Patient A, an adult female and former employee of Licensee at the  
8 Pain Specialists of Southern Oregon clinic in Medford. Patient A was hired to work at the clinic  
9 in the spring of 2006. Licensee admits to developing an infatuation with her in 2007. Beginning  
10 in the winter of 2007, Licensee occasionally placed medications (to include Fentanyl) into  
11 Patient A's cup of tea at her work station to address her complaints of flu like symptoms.

12 Licensee would tell Patient A that he had made her "a special cup of tea." Licensee failed to  
13 obtain Patient A's informed consent for these "treatments" and did not examine her. Licensee  
14 failed to chart the medications dispensed or administered to Patient A. On one occasion in mid  
15 May of 2007, Licensee went to Patient A's home after she complained of flu like symptoms and  
16 started an IV to "help me relax." Licensee relates that during this home visit, he learned that she  
17 really was not suffering from flu like symptoms, but that she was emotionally distraught over a  
18 recent nonconsensual sexual encounter that she had with her husband. Licensee offered to  
19 conduct an examination due to the nature of her altercation with her husband, but she declined.

20 In the late summer or early fall of 2007, Licensee invited Patient A to enter into an intimate  
21 relationship with him. Patient A avoided answering him. Licensee also gave multiple cash gifts  
22 (usually gifts of about \$100) to Patient A, to include one gift of \$5,000 in the spring of 2008  
23 when Patient A and her husband were separating. Licensee wrote at least two prescriptions for  
24 her to receive a "cold pack" to address her complaints of flu like symptoms. Licensee engaged  
25 in other inappropriate conduct in regard to Patient A, to include placing a "sex toy" in her car in  
26 the workplace parking lot. In about December of 2008, Licensee invited Patient A to see his  
27 condo (Licensee was now divorced). Patient A states that she felt pressured to accept. Licensee

1 gave her a "tour" of his condo, to include showing her his bedroom and inviting Patient A to  
2 enter into an intimate relationship with him. Patient A states that although she felt that her job  
3 was in jeopardy during this time, she declined the relationship. Licensee told her that she should  
4 find work elsewhere.

5 3.3 Patient B, a 33 year old male, with a history of 13 previous back operations, came  
6 under Licensee's care in July of 2005 for chronic back pain. Licensee managed Patient B's  
7 complaints of chronic pain with a medication regimen that included Lortab (Hydrocodone &  
8 Acetaminophen, Schedule III), Percocet (Oxycodone & Acetaminophen, Schedule II), Duragesic  
9 (Fentanyl, Schedule II), Kadian (Morphine, Schedule II) and Oxycontin (Oxycodone, Schedule  
10 II). Patient B underwent surgery in January 2006 for extension and revision of his back fusion,  
11 but experienced persistent post surgical pain and a new onset of meralgia paresthetica. In early  
12 2008, Patient B underwent additional surgery to revise his back fusion, and suffered post-  
13 operative complications that led to more surgeries and the need for pain management. Patient B  
14 began to request injectable Demerol (Meperidine, Schedule II) instead of Dilaudid to address his  
15 pain. On one occasion, Licensee went to Patient B's home and administered narcotic analgesic  
16 by IV without access to monitoring or resuscitation equipment. Licensee provided care to  
17 Patient B, to include giving Patient B a series of intramuscular injections of Meperidine  
18 (Demerol, Schedule II) at the clinic and at Patient B's home that was not timely or appropriately  
19 charted. Licensee often would merely "drop off" narcotic injections at Patient B's home, and on  
20 other occasions, would make social visits and stay for dinner with Patient B and his wife. Patient  
21 B's last visit to Licensee's clinic occurred on December 30, 2008, when he expressed  
22 dissatisfaction with Licensee's care. Licensee wrote him a final prescription for a 90 day supply  
23 of Norco (Hydrocodone bitartrate and Acetaminophen, Schedule III).

24 4.

25 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.  
26 Licensee understands that he has the right to a contested case hearing under the Administrative  
27 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the

1 right to a contested case hearing and any appeal therefrom by the signing of and entry of this  
2 Order in the Board's records. Licensee admits that he engaged in the conduct described in  
3 paragraph 3, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable  
4 conduct, as defined by ORS 677.188(4)(a), ORS 677.190(13) gross or repeated negligence in the  
5 practice of medicine, and ORS 677.190(24) prescribing controlled substances without a  
6 legitimate medical purpose, or prescribing controlled substances without following accepted  
7 procedures for examination of patients, or prescribing controlled substances without following  
8 accepted procedures for record keeping. Licensee understands that this Order is a public record  
9 and is a disciplinary action that is reportable to the National Practitioner Data Bank, the  
10 Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

11 5.

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

14 5.1 Licensee is reprimanded.

15 5.2 The license of Licensee to practice medicine is revoked, but the revocation is  
16 stayed.

17 5.3 The license of Licensee to practice medicine is suspended for 60 days, which will  
18 be served by Licensee in two equal parts. The first 30 days of the suspension will go into effect  
19 on September 1, 2012. The second 30 days of the suspension will go into effect on December 1,  
20 2012.

21 5.4 Licensee is placed on probation for ten years. Licensee must report in person to  
22 the Board at each of its quarterly meetings at the scheduled times for a probation interview,  
23 unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.

24 5.5 Licensee must pay a fine of \$5,000, payable in full within 60 days from the  
25 signing of this Order by the Board Chair.

26 5.6 Licensee must successfully complete a boundaries course that is pre-approved by  
27 the Board's Medical Director.





1 Order in the Board's records. Licensee neither admits or denies but the Board finds that she  
2 engaged in the conduct described in paragraph 2 and that this conduct violated ORS  
3 677.190(1)(a) unprofessional or dishonorable conduct as defined in ORS 677.188(4)(a).

4 4.

5 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order  
6 in which she retires her medical license subject to the following conditions:

7 4.1 Licensee retires her license to practice medicine while under investigation. Her  
8 retirement becomes effective when this Order is signed by the Board Chair.

9 4.2 Licensee will not practice any form of medicine in Oregon, whether paid or  
10 volunteer, to include writing prescriptions for anyone, to include patients, friends or relatives,  
11 seeing patients in any setting or conducting chart reviews for any organization.

12 4.3 Licensee understands that she is precluded from applying for licensure for a  
13 minimum of two years.

14 4.4 Should Licensee re-apply for an Oregon license in the future, the concerns raised  
15 during the Board's investigation will be reviewed and a new investigation will be opened.

16 4.5 Licensee shall obey all federal and Oregon State laws and regulations pertaining  
17 to the practice of medicine.

18 4.6 Licensee stipulates and agrees that any violation of the terms of this Order shall  
19 be grounds for further disciplinary action under ORS 677.190(17).

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Licensee understands that this document is a public record and is reportable to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

IT IS SO STIPULATED this 16 day of July, 2012.

 **SIGNATURE REDACTED**  
KATHRYN MARY DONOGHUE THOMSON, DO



IT IS SO ORDERED this 12<sup>th</sup> day of July, 2012.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

W. KENT WILLIAMSON, MD  
Board Chair