

Oregon Medical Board
BOARD ACTION REPORT
April 15, 2011

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between March 16, 2011 and April 15, 2011.

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 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](#) 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.

***ALVARADO, Hernan Carlos, MD; MD26272; Greenville, PA**

Licensee entered into a Stipulated Order with the Board on April 7, 2011. In this Order Licensee surrendered his license under investigation effective June 1, 2011. Licensee also agreed to never re-apply for a license to practice medicine in Oregon.

***BENNETT, William Adams, DPM; DP00270; North Bend, OR**

The Board issued an Order Terminating Stipulated Order on April 7, 2011. This Order terminates Licensee's September 28, 2006, Stipulated Order.

***BRAY, Thomas Harry, MD; MD26593; Redondo Beach, CA**

Licensee entered into an Interim Stipulated Order with the Board on March 29, 2011. In this Order Licensee agreed to withdraw from practice pending completion of the Board's investigation into his ability to safely and competently practice medicine. Licensee may only communicate with his patients for the purpose of transferring their care to another health care provider, or to facilitate the delivery of medical records to the patient or another care provider.

DOMST, James Edward, MD; MD25856; Mt Angel, OR

Licensee entered into a Corrective Action Agreement with the Board on April 7, 2011. In this Agreement Licensee agreed to successfully complete coursework on medical charting and documentation that is pre-approved by the Board's Medical Director. This is not a disciplinary action.

***EY, Frederick Sterling, MD; MD14443; Portland, OR**

The Board issued an Order Terminating Interim Stipulated Order on April 7, 2011. This Order terminates Licensee's January 10, 2011, Interim Stipulated Order.

***GUERREIRO, John, Palma, MD; MD26933; Beaverton, OR**

The Board issued an Order Modifying Stipulated Order on April 7, 2011. This Order terminates Term 5.3 of Licensee's April 9, 2009, Stipulated Order. All other terms of the April 9, 2009, Stipulated Order are unchanged and remain in full force and effect.

KELLER, Michael Edgar, LAc; AC00839: Portland, OR

Licensee entered into a Corrective Action Agreement with the Board on April 8, 2011. This Agreement requires Licensee to obtain 20 hours of practice mentorship. This is not a disciplinary action.

***KOLO-CARON, Lucinda Marie, MD; MD23674; Deer Island, OR**

The Board issued an Order Terminating Voluntary Limitation on April 7, 2011. This Order terminates Licensee's July 9, 2009, Voluntary Limitation.

***LEWIS, Todd Jay, MD; MD13887; Corvallis, OR**

Licensee entered into an Interim Stipulated Order with the Board on April 5, 2011. In this Order Licensee agreed to voluntarily and immediately refrain from performing kyphoplasty or vertebroplasty surgeries.

***LIDOR, Yaron Jacob, MD; MD27956; Denver, CO**

Licensee entered into a Stipulated Order with the Board on April 7, 2011. In this Order Licensee agreed to not to practice medicine in the state of Oregon and not to apply in the future to lift this limitation on his medical license. Licensee also agreed to implement and follow the recommendations contained in the Acumen Institute report.

***MAKKER, Vishal James, MD; MD23879; Portland, OR**

Licensee entered into an Interim Stipulated Order with the Board on April 14, 2011. In this Order Licensee agreed to utilize a neurological mentor prior to conducting any operative procedure to assess the appropriateness of any proposed intervention. This limitation will remain in effect until the completion of the Board's investigation.

MATSUMURA, Andrea Loran, MD; MD22819; Portland, OR

Licensee entered into a Corrective Action Agreement with the Board on April 7, 2011. In this Agreement Licensee will complete a pain management course and undergo a minimum of two chart audits of chronic pain patients. Licensee will develop and present three sessions on improvement in opiate therapy to fellow clinicians and provide documentation of these presentations to the Board. Licensee will undergo a practice review by her employer focused on her opiate patients. Licensee will meet monthly with her employers for a minimum of one year, with quarterly reports to the Board.

***MCCLUSKEY, Edward Alan, MD; MD18356; Gresham, OR**

Licensee entered into a Stipulated Order with the Board on April 7, 2011. In this Order Licensee was placed on 10 years of probation with the following terms and conditions: reprimand, effective the date of this Order Licensee will be granted a medical license limited to administrative medicine with conditions to allow for enrolling and completing a training program with Center for Personalized Education for Physicians (CPEP), under no circumstances may Licensee evaluate, treat chronic pain patients, serve as Medical Director for a pain clinic, or otherwise manage the delivery of care to chronic pain patients. Licensee's practice will be subject to no-notice compliance audits by the Board's designee. Licensee must provide a copy of this Order to any current or future employer. Licensee will not supervise physician assistants.

***REDWINE, David Byron, MD; MD09578; Bend, OR**

Licensee entered into a Stipulated Order with the Board on April 7, 2011. In this Order Licensee was reprimanded and fined \$5,000. Licensee's Oregon medical license will be suspended for 30 days effective the date of this Order. Licensee must complete a continuing medical education course on professional boundaries and appropriate prescribing. [REDACTED]

***WEISBERG, Stuart Gordon, MD; MD23402; Portland, OR**

The Board issued a Default Final Order on April 7, 2011. This Order revoked Licensee's Oregon medical license.

***YAZDI, Navid Darius, MD; Applicant; Hillsboro, OR**

Applicant entered into a Stipulated Order with the Board on April 8, 2011. In this Order Applicant was reprimanded and placed on two years of probation with quarterly reports to the Board. Probation begins when an active license is issued. Applicant must immediately inform the Board's Compliance Officer of any change to his current address, phone number, and practice location. Applicant must provide a copy of this Order to any employer where he practices or hospital administrator where he has privileges. [REDACTED]

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.

1 out in severe discomfort, while blood extruded from the penis. Patient A's adult son, who was
2 present in the hospital room watching the procedure, asked that pain medication be provided for
3 his father. The attending nurse offered to get the analgesics. Licensee ignored the request and
4 the nurse's offer and informed them that inserting a catheter is not a painful procedure. Patient A
5 continued to moan in pain. Licensee was observed trying to force the catheter up the penis, only
6 causing more cries of distress from Patient A. Finally, Licensee pulled the catheter out from the
7 bloody penis, threw the catheter and his surgical gloves onto Patient A's abdomen, stated: "I've
8 had it—I'm done with this" (or words to that effect). He subsequently exclaimed: "Do it
9 yourself" to Patient A's son and left the hospital room. Licensee continues to deny that Patient
10 A's cries of pain were attributable to his efforts to insert the catheter.

11 3.2 Patient B, a 67-year-old male, was diagnosed with a bladder tumor on December
12 13, 2007. Patient B was referred by the diagnosing physician to Licensee for treatment. Patient
13 B met with Licensee in early January 2007 and was subsequently scheduled for surgery. On
14 January 24, 2008, Licensee performed a transurethral resection of the bladder tumor on Patient
15 B. The pathology report was positive for cancer—reflecting an invasive flat urothelial
16 carcinoma, high grade, with background urothelial carcinoma in situ. The carcinoma was seen
17 invading into fragments of smooth muscle tissue. Instead of immediately scheduling Patient B
18 for additional biopsies and ordering studies to stage the cancer, Licensee waited until March 10,
19 2008, to have Patient B undergo a CT scan of the pelvis with contrast. The CT scan indicated
20 that the bladder carcinoma was advancing. Licensee took additional biopsies on March 20,
21 2008, resulting in a final diagnosis of invasive, flat urothelial carcinoma, high grade, with
22 invasion into the muscularis propria. Patient B subsequently went to Oregon Health Science
23 University for treatment. Licensee's two month delay to re-biopsy and restage Patient B, who
24 had an aggressive, high grade tumor, did not conform to the standard of care and subjected this
25 patient to the risk of harm and to the cancer progressing.

26 3.3 Patient C, a 39-year-old male, presented to Licensee on December 16, 2007, for
27 an outpatient vasectomy. Licensee administered a local anesthetic by injections prior to

1 conducting the procedure. Patient C complained of acute pain, but Licensee dismissed Patient
2 C's complaints and proceeded with the procedure. Licensee's conduct is considered
3 inappropriate and insensitive towards a patient's pain.

4 3.4 Patient D, a 70-year-old female, underwent a computed tomography (CT) scan of
5 the abdomen and pelvis on May 9, 2007 that showed a left renal pelvic mass. Patient D
6 presented to Licensee on May 27, 2007, for follow up. Licensee reviewed the CT scan and
7 found that it showed a centrally located round mass in the middle of the left renal pelvis,
8 suspicious for transitional cell carcinoma (TCCa). On June 15, 2007, Licensee performed a
9 cystoscopy and left ureteroscopy on Patient D that confirmed the finding of a renal pelvic mass
10 (bleeding), which was suspicious for a TCCa, although a biopsy was not obtained. On July 13,
11 2007, Licensee performed a left radical nephrectomy (removal of the left kidney) on Patient D
12 using a midline surgical approach. The pathology revealed a TCCa. Licensee did not attempt to
13 remove the left ureter in its entirety. Patient D was discharged on postoperative day five.
14 Licensee saw Patient D in follow up on July 19 and August 21, 2007. Patient D underwent a CT
15 scan of the abdomen on November 21, 2007. Licensee subsequently saw Patient D on
16 November 28, 2007, and informed her that he planned to see her again in six months. Patient
17 D's understanding was that she had been "cured." Patient D was seen by another urologist in
18 June 2009 and underwent a diagnostic cystoscopy. This revealed numerous focal papillary
19 recurrences of transitional cell tumor in her bladder as well as gross tumor spilling out of her left
20 ureteral orifice, which had not been resected by Licensee at her initial surgery in 2007. Patient D
21 underwent a complete left urectectomy and resection and fulguration of her bladder recurrences
22 in August of 2009. A subsequent bone scan indicated that the TCCa had spread to her bones.
23 She was treated with radiation therapy. Licensee's failure to remove the entire ureter at the time
24 he removed the left kidney in the face of TCCa of the renal pelvis and his failure to closely
25 monitor Patient D postoperatively for signs of recurrence with surveillance cystoscopy and
26 ureteroscopy was grossly negligent and exposed this patient to the risk of harm.

27 ///

1 Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a
2 contested case hearing and any appeal therefrom by the signing of and entry of this Order in the
3 Board's records. Licensee understands that this document is a public record and is reportable to
4 the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank and the
5 Federation of State Medical Boards.

6 5.

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

9 5.1 Licensee surrenders his license to practice medicine while under investigation.
10 This surrender of license becomes effective June 1, 2011. As of that date, Licensee shall cease
11 practicing medicine entirely.

12 5.2 Licensee agrees to never re-apply for a license to practice medicine in Oregon.

13 5.3 Licensee stipulates and agrees that any violation of the terms of this Order would
14 be grounds for further disciplinary action under ORS 677.190(17).

15
16 IT IS SO STIPULATED this 22 day of FEBRUARY, 2011.

17
18 Signature Redacted

19
20 HERNAN CARLOS ALVARADO, MD

21 IT IS SO ORDERED this 7th day of April, 2011.

22 OREGON MEDICAL BOARD
23 State of Oregon

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25 Signature Redacted

26 RALPH A. YATES, DO
27 BOARD CHAIR

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CERTIFICATE OF MAILING

On February 15, 2011, Jenny Pedersen, Investigations Coordinator, mailed the foregoing Stipulated Order to the following parties:

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 70081300000050894005

Hernan Carlos Alvarado, MD
University of Pittsburgh Medical Center
90 Shenango Street
Greenville, PA 16125

Certified Mail Receipt # 70081300000050894012

David Landis, JD
1515 SW Fifth # 844
Portland, OR 9704

By: UPS GROUND

Warren Foote
Department of Justice
1162 Court St NE
Salem OR 97301

Jenny Pedersen
Jenny Pedersen
Investigations Coordinator
Oregon Medical Board

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of:)
WILLIAM ADAMS BENNETT, DPM) ORDER TERMINATING
LICENSE NO. DP00270) STIPULATED ORDER

1.

On September 28, 2006, William Adams Bennett, DPM (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon podiatric medical license. On December 28, 2010, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of the Order, the Board does hereby order that the September 28, 2006 Stipulated Order be terminated effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7th day of April, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

~~RALPH A. YATES, DO~~
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
THOMAS HARRY BRAY, MD) INTERIM STIPULATED ORDER
LICENSE NO. MD26593)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Thomas Henry Bray, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The Board received 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 cease the practice of medicine until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

3.1 Licensee voluntarily withdraws from the practice of medicine and his license, which is inactive, will remain inactive pending the completion of the Board’s investigation into his ability to safely and competently practice medicine.

3.2 Licensee may only communicate with his patients for the purpose of transferring their care to another health care provider or to facilitate the delivery of medical records to the patient or another care provider.

3.4 Licensee understands that violating any term of this Order will be grounds for

1 disciplinary action under ORS 677.190(17).

2 4.

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

7 5.

8 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
9 of protecting the public, and making a complete investigation in order to fully inform itself with
10 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
11 competently practice medicine. Pursuant to ORS 677.425(1), Board investigative materials are
12 confidential and shall not be subject to public disclosure, nor shall they be admissible as
13 evidence in any judicial proceeding. However, as a stipulation this Order is a public document
14 and is reportable to the National Practitioners Data Bank and the Health Insurance Portability
15 and Accountability Date Bank (HIPDB) and the Federation of State Medical Boards.

16 6.

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

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19 IT IS SO STIPULATED THIS 29 day of March, 2011.

20 SIGNATURE REDACTED
21 THOMAS HENRY BRAY, MD

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24 IT IS SO ORDERED THIS 4 day of April, 2011.

25 State of Oregon
26 SIGNATURE REDACTED
27 KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the matter of,)
LUCINDA MARIE KOLO-CARON, MD) ORDER TERMINATING
LICENSE NO. MD23674) VOLUNTARY LIMITATION

1.

On July 9, 2009, Lucinda Marie Kolo-Caron, MD (Licensee) entered into a Voluntary Limitation with the Oregon Medical Board (Board). This Order put conditions on Licensee's Oregon medical license. On February 22, 2011, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and her successful compliance with the terms of this Order, the Board does hereby order that the July 9, 2009 Voluntary Limitation be terminated effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7th day of April, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

RALPH A. VATES, DO
BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
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TODD JAY LEWIS, MD) INTERIM STIPULATED ORDER
LICENSE No. MD13887)
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1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Todd Jay Lewis, MD, (Licensee) is a licensed physician in the state of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. 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 immediately limit his practice until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following practice limitation and conditions, effective the date this Order is signed by Licensee:

3.1 Licensee voluntarily and immediately refrains from performing kyphoplasty, or vertebroplasty surgeries.

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

4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. Following that review, if the Board decides not to terminate this Order,

///

1 Licensee may request a hearing to contest that decision.

2 5.

3 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
4 of protecting the public, and making a complete investigation in order to fully inform itself with
5 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
6 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are
7 confidential and shall not be subject to public disclosure, nor shall they be admissible as
8 evidence in any judicial proceeding. However, as a stipulation this Order is a public document
9 and reportable to the National Practitioner Data Bank and the Health Insurance Portability and
10 Accountability Data Bank.

11 6.

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

13
14 IT IS SO STIPULATED THIS 5th day of April, 2011.

15 Signature Redacted

16 ~~Signature Redacted~~

17
18 IT IS SO ORDERED THIS 6th day of April, 2011.

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20 State of Oregon
21 OREGON MEDICAL BOARD

22 Signature Redacted

23 KATHLEEN HALEY, JD
24 EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
VISHAL JAMES MAKKER, MD) INTERIM STIPULATED ORDER
LICENSE NO. MD23879)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Vishal James Makker (Licensee) is a licensed physician in the state of Oregon.

2.

The Board received credible information regarding Licensee on January 24, 2011, February 24, 2011, March 10, 2011 and April 5, 2011 involving four different patients 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 take the below outlined steps until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

3.1 Licensee will utilize a neurosurgical mentor prior to conducting any operative procedure to assess the appropriateness of any proposed intervention. The mentor must be pre-approved by the Board's Medical Director. This voluntary limitation will maintain in effect pending the completion of the Board's investigation.

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

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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 unlimited 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, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document.

IT IS SO STIPULATED THIS 14 day of April, 2011.

SIGNATURE REDACTED

VISHAL JAMES MAKKER, MD

IT IS SO ORDERED THIS 14th day of April, 2011.

State of Oregon
OREGON MEDICAL BOARD

SIGNATURE REDACTED

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

JAMES PECK, MD
MEDICAL DIRECTOR

MAR 04 2011

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
EDWARD ALAN McCLUSKEY, MD) STIPULATED ORDER
LICENSE NO. MD18356)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Edward Alan McCluskey, MD (Licensee) is a licensed physician in the state of Oregon.

2.

In an Amended Complaint and Notice of Proposed Disciplinary Action, dated November 17, 2010, 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), (b) and (c) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

3.

Licensee is a board certified anesthesiologist, and is the Medical Director for Pain Relief Specialists Northwest (clinic), which provides treatment for patients with complaints of chronic pain. On February 29, 2008, Licensee and the Board entered into a Stipulated Order in which it imposed disciplinary sanctions and terms of probation. Following the February 29, 2008, Stipulated Order, the Board received several additional complaints and opened investigations based upon these complaints. Licensee and the Board subsequently entered into an Interim Stipulated Order on March 4, 2010. Pursuant to Licensee's request, Licensee and the Board subsequently entered into an Order Modifying the Interim Stipulated Order, dated March 22, 2010. Licensee submitted a request on April 27, 2010 to restore his legal authority to practice

1 pain management. The Board considered Licensee's request and issued a Second Amended
2 Interim Stipulated Order on June 22, 2010. The acts and conduct alleged to violate the Medical
3 Practice Act are set forth below:

4 3.1 Patient A, a 63-year-old female, had a history that included multiple spine
5 surgeries and spine injections and chronic low back pain. She was initially evaluated by
6 Licensee in May 2002. Patient A was followed primarily by clinic personnel, to include
7 registered nurses, physician assistants and nurse practitioners. Patient A was initially treated
8 with a series of cervical steroid injections and, later, with narcotic pain medications. In 2005,
9 Patient A underwent a series of radiofrequency ablation procedures to treat her chronic pain,
10 about once every three months. The medical indication for the frequency of these treatments was
11 not documented. In February of 2006, a spinal stimulator was implanted but was not effective.
12 Patient A experienced a series of falls as her dosages of narcotic medications increased to
13 address her chronic pain. In January 2007, Patient A fell and broke her nose. In October and
14 November of 2007, Patient A complained of frequently falling, and blamed the events on her
15 oral pain medications. On February 28, 2008, Licensee performed a bilateral vertebroplasty on
16 Patient A, but failed to document the findings from a medical examination or his rationale to
17 support this surgery. Based on the chart notes and Patient A's documented complaint of an old
18 non-acute fracture, this procedure was not medically indicated. From March through November
19 2008, chart notes reflect that Patient A was hospitalized on multiple occasions for analgesic
20 overdose and suffered several falls, one of which resulted in an ankle fracture, as well as multiple
21 notations of depression. Patient A returned to the clinic on multiple occasions for follow-up by
22 clinic staff. The chart notes do not reflect whether Licensee met with Patient A after performing
23 the vertebroplasty to evaluate her or to review her treatment plan and medication regimen in light
24 of Patient A's frequent life threatening complications. These complications included loss of
25 consciousness, respiratory distress, and frequent falls attributed to the medication regimen.

26 3.2 Licensee assumed the chronic pain care of Patient B, a 78-year-old adult female,
27 in December 2005, to include managing her pain pump refills. There is no chart note to indicate

1 that Licensee performed a detailed physical examination of Patient B, although Licensee did
2 evaluate Patient B immediately prior to surgery on March 8, 2007. Licensee did not personally
3 evaluate Patient B post-operatively until June 11, 2007 at which time he did bilateral lumbar
4 facet injections. Patient B had been seen by a medical assistant for her first post-op visit on
5 March 22, 2007. Patient B's phone call on March 30, 2007, regarding swelling around the
6 incision was handled by a medical assistant who advised her to take oral diphenhydramine.
7 Other postoperative visits were with mid-level providers. On July 8, 2008, Patient B underwent a
8 right upper quadrant scar and seroma revision by Licensee. A physician assistant saw Patient B
9 at her first post-operative visit on July 22, 2008. The physician assistant noted the development
10 of a seroma at the surgical site. On July 25, 2008, Licensee aspirated the seroma. The
11 examination and consent form for this procedure were inadequate in that they lacked any
12 information indicating Licensee actually physically examined Patient B, or participated in a
13 Procedure, Alternatives, Risks, and Questions (PARQ) conference with the patient. A nurse
14 practitioner saw Patient B post-operatively on August 8, 2008, and noted the recurrence of an
15 infected seroma with cellulitis. On August 11, 2008, antibiotics were prescribed by a provider
16 outside of Licensee's clinic for Patient B. She underwent another aspiration performed by
17 Licensee on August 14, 2008. The examination related to this aspiration does not include any
18 comments regarding the area of interest. Patient B was seen by a nurse practitioner on
19 September 3, 2008, for medication review and refills. Patient B was not seen by Licensee until
20 October 8, 2008, at which time Licensee surgically resected the seroma, which now was a wound
21 hematoma. The first post-operative visit on October 24, 2008 was with a registered nurse who
22 removed the staples. As the operating surgeon, Licensee failed to carry out his primary
23 responsibility to provide post-operative care for Patient B.

24 3.3 Patient C, a 38-year-old male, was referred to Licensee as a potential candidate
25 for a possible spinal cord stimulator or pain pump. Patient C presented with lumbar post-
26 laminectomy syndrome. Patient C was evaluated at Licensee's clinic on February 3, 2008, by a
27 physician assistant. Patient C informed the physician assistant during this evaluation that he had

1 a medical marijuana card that had been authorized by his referring primary care physician. The
2 physician assistant noted in the electronic record Patient C's use of marijuana. Licensee charted
3 that he had a "Face to Face evaluation with direct formulation of treatment plan." Patient C was
4 seen by a psychologist on March 26, 2008, and disclosed that he had a medical marijuana card.
5 The letter from the psychologist to Licensee indicates Patient C told the psychologist that he had
6 a medical marijuana card, "but seldom smoked marijuana." Patient C underwent a spinal cord
7 stimulator trial on July 15, 2008, and underwent a spinal infusion pump implantation on August
8 1, 2008, performed by Licensee. Licensee did not see Patient C post operatively. Patient C
9 returned to the clinic periodically for pump refills, when he was seen by licensed clinic staff.
10 Patient C initially reported some improvement in his chronic pain. As a result, his primary care
11 physician began to reduce the amount of oral narcotic medications being prescribed. On January
12 23, 2009, Patient C was seen by a physician assistant and signed a narcotic pain control contract
13 prepared by the clinic that included a clause stating: "Though Marijuana has some sanctioned
14 medical uses in Oregon, use combined with opioids may be harmful or dangerous. I understand
15 that its use is a violation of this contract." This clause was followed by a handwritten addendum
16 in which it was specifically noted that Patient C had a medical marijuana card through his
17 primary care physician and that "Pt signs this document under the disclaimer that he has a
18 medical marijuana card and is going to continue to use it." Licensee signed the office note for
19 this visit on January 24, 2009. This contract was entered into the patient chart without comment
20 or objection by Licensee or his staff. A serum drug screen in February 2009 was positive for
21 THC. Patient C was seen by a physician assistant at Licensee's clinic on April 15, 2009, and self
22 reported a 50 – 60% reduction in his pain due to the overall regimen. Licensee reviewed the
23 physician assistant's chart note later in April and noticed for the first time that Patient C was
24 using medical marijuana. As a result, Licensee ordered the removal of narcotic medicine from
25 Patient C's pump on a gradual basis, and to use non-narcotic medication instead. Licensee made
26 this decision without first discussing this with Patient C or his primary care physician, without
27 examining Patient C, and in violation of the existing pain contract.

1 3.4 Patient D underwent a psychological evaluation related to the appropriateness of
2 implantation of a pain pump in December of 2007. The psychological evaluation identified
3 concerns, which made the appropriateness of the pump questionable. The psychologist offered
4 suggestions for action to be taken prior to making a decision on implantation of the pump.
5 Licensee conducted a pump implant procedure on Patient D, a 36-year-old female, on April 14,
6 2008. Licensee did not see Patient D for postoperative visits. Patient D was seen by medical
7 assistants for wound checks, and by registered nurses for pump refills. On May 28, 2008, a chart
8 note indicates partial wound dehiscence after a difficult pump refill. The pump was removed on
9 June 2, 2008, and purulent drainage was noted. The chart note reflects that Patient D returned to
10 the clinic on June 19, 2008 where she was seen by a medical assistant. The antibiotic was
11 discontinued at that time. Patient D returned for wound care visits six times between June 19
12 and August 5, 2008 and was seen by a medical assistant. Patient D complained of foul smelling
13 drainage from the wound. Patient D was again seen by a medical assistant on August 25, 2008.
14 Patient D was seen by a nurse practitioner on September 4, 2008, and plans were made to re-
15 implant the pump, which was performed on September 12, 2008. Licensee failed to adequately
16 follow Patient D's post-operative intrathecal catheter complications and recovery.

17 3.5 The Board also reviewed Patients E-G, and that review, together with Patients A-
18 D, revealed a pattern of poor documentation, substandard medical care and poor clinical
19 decision-making, to include the following: (1) failing to document an adequate history or
20 physical examination and lack of objective findings; (2) failing to document his medical
21 decision-making and post-operative follow-up to include: not documenting whether a procedure
22 helped the patient, or not; (3) telling patients of the need for them to come in for a urine screen
23 test a day or more in advance of the test date, which in the Board's view reduces the
24 effectiveness of a random drug screen; (4) failing to document the presence of who was present
25 and provided care at each patient visit; (5) failing to document that Licensee participated in the
26 discussion with each surgical patient that he operated on to obtain their informed consent; (6)
27 failing to clearly document who is providing medical services at any particular point in time; (7)

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 neither admits or denies, but the Board finds, that he
3 engaged in the conduct described in paragraph 3 and that this conduct violated ORS
4 677.190(1)(a), (b) and (c) unprofessional or dishonorable conduct, as defined by ORS
5 677.188(4)(a) and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

6 5.

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

9 5.1 Licensee is reprimanded.

10 5.2 Licensee is placed on probation for a minimum period of ten years and will report
11 in person to the Board at each of its quarterly meetings at the scheduled times for a probation
12 interview, unless otherwise directed by the Board's Compliance Officer or its Investigative
13 Committee.

14 5.3 Beginning on the effective date of this Order, Licensee will be granted a medical
15 license limited to administrative medicine in the state of Oregon. At such time that Licensee
16 enrolls into a training program with Center for Personalized Education for Physicians (CPEP),
17 the Board will add conditions allowing Licensee to complete the Education Program
18 recommended by the CPEP, including practice supervision as recommended by CPEP with the
19 intent to protect the public. Licensee may continue to practice administrative medicine, provided
20 he submits a job description, work location, and work schedule to the Board's Medical Director,
21 requesting his review and approval.

22 5.4 Under no circumstances may Licensee evaluate, treat chronic pain patients, serve
23 as a Medical Director for a pain clinic, or otherwise manage the delivery of care to chronic pain
24 patients.

25 5.5 Within 30 days from the approval of this Order, Licensee shall sign an agreement
26 with CPEP to undergo a full CPEP evaluation and assessment and subsequently complete the

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1 5.6 CPEP Education Program at Licensee's expense, which must be pre-approved by
2 the Board's Medical Director before it goes into effect.

3 5.7 Licensee must timely and successfully complete the recommended CPEP
4 Education Program, including any "Post-Education Evaluation," within 18 months from the date
5 the CPEP Education Program is approved by the Board's Medical Director.

6 5.8 Licensee must also sign all necessary releases to authorize full ongoing
7 communication between the Board and CPEP, and Licensee will ensure that periodic progress
8 reports, interim reports and the final written evaluation report from CPEP are provided promptly
9 to the Board.

10 5.9 Licensee must provide the Board with written proof from CPEP upon successful
11 completion of the recommended Education program, including successful completion of the
12 Post-Education Evaluation, as defined above.

13 5.10 Throughout Licensee's probation, Licensee stipulates that all work settings in the
14 health care field must be approved in advance by the Board's Medical Director.

15 5.11 All recommendations and instructions issued by CPEP will constitute terms of
16 this Order. Licensee must comply with all CPEP recommendations and instructions within the
17 time periods set out by CPEP or the Board.

18 5.12 Reports by CPEP of late compliance or non-compliance with the terms of the
19 Education Plan will constitute grounds for discipline and may provide a basis for immediate
20 license suspension.

21 5.13 At the conclusion of the CPEP Education Program, Licensee shall cause CPEP to
22 submit a final written evaluation report to the Board. This report shall include recommendations
23 concerning Licensee's medical knowledge, medical judgment, his progress in addressing his
24 identified deficiencies, and his ability and willingness to practice safely and competently. At
25 such time, Licensee may apply for an unlimited license at which time the Board will review and
26 consider CPEP's recommendations prior to making a decision on whether to grant an unlimited
27 license.

1 5.14 At no expense to the Board, for two years following Licensee’s successful
2 completion of the CPEP Objectives and Post-Education Evaluation (“Quality Review Period”), a
3 “quality reviewer” must monitor Licensee’s practice. CPEP will nominate, in writing, a
4 proposed quality reviewer for the Board’s approval. The nominee must be a physician board
5 certified in anesthesia who is licensed and currently practicing in Oregon. The nominee must
6 have no financial interest in Licensee’s practice of medicine.

7 5.15 The Board approved CPEP quality reviewer will perform the following:

- 8 a. Each month, for the first three months of the Quality Review Period, the
9 quality reviewer must review at least ten patient charts maintained by
10 Licensee. The quality reviewer must review charts from all work settings in
11 which Licensee practices. The quality reviewer must make reasonable efforts
12 to ensure randomized review such that Licensee has no notice of which charts
13 will be selected for review. The quality reviewer is authorized to review, and
14 Licensee must make available, such other medical records maintained by
15 Licensee as the quality reviewer deems appropriate.
- 16 b. After the first three months of the Quality Review Period, the quality review
17 will review charts on a quarterly basis. Each quarter, the quality reviewer
18 must review at least ten charts maintained by Licensee. The quality reviewer
19 must make reasonable efforts to review charts from all of Licensee’s work
20 settings. The quality review will make reasonable effort to ensure randomized
21 review such that Licensee has no notice of which charts will be selected for
22 review. The quality reviewer is authorized to review, and Licensee will make
23 available, such other medical records maintained by Licensee as the quality
24 reviewer deems appropriate.
- 25 c. The quality reviewer must submit such reviews to CPEP and, in turn, CPEP
26 will submit quarterly written reports to the Board that will include the
27 following: (1) a description of each of the cases reviewed; and (2) in regard to

1 each case reviewed, CPEP's opinion whether Licensee is practicing medicine
2 in accordance with generally accepted standards of medical practice.

3 5.16 If at any time CPEP or the quality reviewer believes Licensee is not in compliance
4 with this Order, is unable to practice with skill and safety to patients, or has otherwise committed
5 unprofessional or dishonorable conduct or gross or repeated negligence, CPEP or the quality
6 reviewer must inform the Board immediately.

7 5.17 If the quality reviewer is unable to carry out or complete the assigned duties, the
8 Board has the discretion to allow CPEP to arrange for a new quality reviewer.

9 5.18 It is the responsibility of Licensee to fully cooperate with CPEP and the quality
10 reviewer. Failure of the quality reviewer to perform the duties set forth above may result in a
11 notice from the Board requiring the nomination of a new quality reviewer. Upon such
12 notification, CPEP will nominate a new quality reviewer according to the procedure set forth
13 above. CPEP will nominate the new quality reviewer within 30 days of such notice.

14 5.19 Licensee's practice, to include his charts at any medical facility, will be subject to
15 no-notice compliance audits by the Board's designee.

16 5.20 Licensee must provide a copy of this Order to any current or future employer in
17 the health care field.

18 5.21 Licensee will not supervise physician assistants.

19 5.22 Licensee must obey all federal and Oregon State laws and regulations pertaining
20 to the practice of medicine.

21 5.23 Upon signature of the Board Chair, all previous Interim Stipulated Orders,
22 Stipulated Orders and Orders Modifying Board Orders will be terminated and the current
23 Stipulated Order will remain in full force and effect.

24 5.24 Licensee stipulates and agrees that any violation of the terms of this Order shall
25 be grounds for further disciplinary action under ORS 677.190(17).

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6.

Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards. This Order becomes effective the date it is signed by the Board Chair.

IT IS SO STIPULATED this 2nd day of March, 2011.

Signature Redacted

EDWARD ALAN MCCLUSKEY, MD

IT IS SO ORDERED this 7th day of April, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

RALPH A. YATES, DO
Board Chair

1 dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated
2 acts of negligence. Licensee acknowledges that the American College of Obstetrics and
3 Gynecologists has opined that sexual contact or a romantic relationship between a physician and
4 a current patient is always unethical. Licensee understands that this Order is a public record and
5 is a disciplinary action that is reportable to the National Practitioner Data Bank, Healthcare
6 Integrity and Protection Data Bank and the Federation of State Medical Boards.

7 5.

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

10 5.1 Licensee is reprimanded.

11 5.2 The license of Licensee to practice medicine is suspended for 30 days, effective
12 the date this Order is signed by the Board Chair.

13 5.3 Licensee must notify the Oregon Medical Board within 10 days of the suspension
14 of how patients may access or obtain their medical records.

15 5.4 Licensee is fined \$5,000 payable within 60 days from the date this Order is signed
16 by the Board Chair

17 5.5 Within 180 days from the date this Order is signed by the Board Chair, Licensee
18 must complete a continuing medical education course on professional boundaries and
19 appropriate prescribing, as pre-approved by the Board's Medical Director.

20 5.6 Licensee must obtain psychotherapy from a psychotherapist pre-approved by the
21 Board's Medical Director. Licensee must meet with this psychotherapist on at least a weekly
22 basis. After one year, Licensee may, with the recommendation of his approved psychotherapist,
23 request permission of the Board's Medical Director to meet on a less frequent basis. The
24 psychotherapist shall provide quarterly written reports to the Board. Licensee shall sign all
25 releases to allow the psychotherapist to communicate directly with the Board. In the event of an
26 anticipated absence, Licensee may submit a written request to the Board's Medical Director for
27 permission to miss a psychotherapy meeting.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
STUART GORDON WEISBERG, MD)
LICENSE NO. MD 23402) 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. Stuart Gordon Weisberg, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On June 24, 2010, the Board issued an Order of Emergency Suspension against the medical license of Licensee while the Board continued its investigation into reports of personal behavior and manner of practice that called into serious question his ability to practice medicine safely and competently. On July 9, 2010, Licensee requested a contested case hearing. On November 4, 2010, the Board issued a Complaint and Notice of Proposed Disciplinary Action. This Notice designated the Board's file on this matter as the record for purposes of a default order and granted Licensee an opportunity for a hearing, if requested in writing within 21 days of service of the Notice. This Notice was sent by Certified Mail on November 8, 2010 to Licensee at the address provided by Licensee. In a letter received by the Board on February 7, 2011, Licensee wrote the following: "I wish to withdraw my request for a contested case hearing and proceed to judgment. Thank you." As a result, Licensee has waived his right to request a hearing and now stands in default. The Board elects in this case to designate the record of proceeding to date, which consists of Licensee's file with the Board, as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

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1 3.

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

4 FINDINGS OF FACT

5 In the Complaint and Notice of Proposed Disciplinary Action dated November 4, 2010,
6 the Board informed Licensee that it intended to take disciplinary action against him based upon
7 violations of the Medical Practice Act, as follows: ORS 677.190(1)(a) unprofessional or
8 dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7) impairment; ORS
9 677.190(13), gross or repeated negligence; and ORS 677.190(17) willfully violate a Board order
10 or regulation. This notice was based upon the following conduct:

11 3.1 Licensee has been in private (solo) practice since June 1, 2004 after resigning
12 from his four year residency at Oregon Health Science University six weeks prior to graduation.
13 Licensee was previously disciplined by the Board and was placed on probation for five years
14 consistent with the terms of a Stipulated Order, dated July 13, 2006, for violations of the Medical
15 Practice Act, to wit ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in
16 ORS 677.188(4)(a) and ORS 677.190(13), gross negligence or repeated acts of negligence in the
17 practice of medicine; and ORS 677.190(24) prescribing controlled substances without a
18 legitimate medical purpose, without following accepted procedures for record keeping and
19 without giving the notice required under ORS 677.485. Consistent the terms of his
20 probation, Licensee completed the Oregon Physicians Education Renewal Program (PEER) on
21 June 17, 2008.

22 3.2 The Board subsequently opened a new investigation, which was resolved with
23 Licensee undergoing an evaluation by the Physician Assessment and Clinical Education Program
24 (PACE). On April 24, 2009, Licensee successfully completed a 40 hour intensive training
25 program in psychiatry that was designed for him by PACE. Licensee entered into a Corrective
26 Action Order (CAO) that was approved by the Board on June 9, 2009, which required Licensee

1 to practice with the benefit of a practice mentor pre-approved by the Board's Medical Director
2 and to meet with this mentor at least twice a month to conduct chart review and to discuss
3 ongoing patient care issues. One year later, in a letter dated June 14, 2010, Licensee informed
4 the Board that his practice mentor no longer supported his ideas pertaining to practice and
5 regarding this practice mentor, Licensee requested "removal from his services." Licensee ceased
6 meeting with his Board approved practice mentor shortly after this. In a subsequent letter dated
7 June 18, 2010, Licensee presented the Board with a form purporting to modify his CAO of 2009
8 that would eliminate the term requiring a practice mentor and, apparently in replacement, offered
9 to meet with a Board member periodically. He also stated that his "practice as a psychiatrist is
10 full." The sum of the information gathered by the Board, to include information that both
11 preceded and followed the Licensee's two letters mentioned above, prompted the Board to issue
12 an Order of Emergency Suspension on June 24, 2010. Licensee's unilateral decision to cease
13 meeting with his Board approved practice mentor violated the terms of the CAO.

14 3.3 Prior to Licensee's unauthorized attempt to void the CAO, Licensee's practice
15 mentor reviewed a case in which Patient A, a 68-year-old female presented to Licensee with
16 complaints of melancholic depression. Licensee tried multiple antidepressants without apparent
17 beneficial effect. Licensee subsequently augmented this treatment with various medications, to
18 include escitalopram (Lexapro), alprazolam (Xanax, Schedule IV) and a trial of Ketamine
19 (Schedule III). Licensee also recommended electroconvulsive therapy. Licensee's off label
20 treatment with Ketamine was not medically indicated and exposed Patient A to the unnecessary
21 risk of harm.

22 3.4 Licensee's practice mentor also reviewed a case involving Patient B, a 54-year-
23 old female that presented to Licensee with complaints associated with a long history of bipolar
24 disorder with rapid cycles and delusions, chronic pain, substance dependence, and some
25 symptoms of bipolar hypomania. Licensee signed a marijuana card for Patient B in what he
26 described as an effort to engage in "harm reduction," which exposed Patient B to the unnecessary

1 risk of harm. Licensee's chart notes fail to state why medical marijuana for this patient was
2 medically indicated.

3 3.5 During the spring, summer and fall of 2010, Licensee engaged in a pattern of
4 erratic behavior that culminated in his hospitalization in October 2010. The Board concludes
5 based on this behavior that Licensee lacks the capacity to practice with reasonable competence
6 and safety.

7 4.

8 CONCLUSIONS OF LAW

9 Licensee's conduct, as described above, breached well recognized standards of practice
10 and ethics of the medical profession. By failing to meet with Licensee's practice mentor and
11 trying to unilaterally modify and terminate his Corrective Action Order, Licensee violated the
12 terms of a Board order. Furthermore, Licensee's manner of practice in regard to Patient A and
13 Patient B constituted repeated acts of negligence and exposed these patients to the unnecessary
14 risk of harm. In addition, Licensee's personal and professional conduct in 2010 demonstrates a
15 pattern of erratic behavior that leads the Board to the conclusion that Licensee lacks the mental
16 and emotional capacity to safely and competently practice medicine. The Board, therefore,
17 concludes that Licensee's conduct as described above violated the following: ORS 677.190(1)(a)
18 unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7)
19 impairment; ORS 677.190(13), gross or repeated negligence; and ORS 677.190(17) willfully
20 violate a Board order or regulation. Based upon its examination of the record in this case, the
21 Board finds that each alleged violation of the Medical Practice Act is supported by reliable,
22 probative and substantial evidence.

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ORDER

IT IS HEREBY ORDERED THAT the license of Stuart Gordon Weisberg, MD, to practice medicine is revoked.

DATED this 8th day of April, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

~~MAUREN TATES, DO~~
BOARD CHAIR

Right to Judicial Review

NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.482. If this Order was personally delivered to you, the date of service is the day it was mailed, not the day you received it. If you do not file a petition for judicial review within the 60 days time period, you will lose your right to appeal.

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
NAVID DARIUS YAZDI, MD) STIPULATED ORDER
APPLICANT)

1.
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. Navid Darius Yazdi, MD (Applicant) is a physician who has applied for a license to practice medicine in the state of Oregon.

2.

Applicant is licensed to practice medicine in Nebraska with a specialty in obstetrics and gynecology. On January 25, 2010, Applicant entered a no contest plea and was found guilty to a criminal charge of soliciting prostitution, a Class I misdemeanor in Hall County, Nebraska. He was sentenced to a fine of \$1,000. As a result, the Nebraska Department of Health and Human Services Division of Public Health (Department) opened an investigation and determined that Applicant engaged in unprofessional conduct by repeatedly attempting to hire an adult female patient to have sex with a third party and by taking photographs of this patient in his clinic. Licensee also gave this patient money. On June 28, 2010, the Department issued an Amended Petition for Disciplinary Action that listed the alleged misconduct stemming from the criminal case. On July 7, 2010, Applicant's Agreed Settlement was approved by the Department, in which Applicant admitted to the allegations set forth in the Amended Petition for Disciplinary Action and agreed to receive a censure, to pay a civil penalty of \$5,000, and to a 60-day suspension of his Nebraska medical license. Applicant's license was also placed on probation for 18 months, with various specified terms and conditions of probation, to include undergoing weekly mental health sessions.

1 3.

2 Applicant and the Board desire to settle this matter by the entry of this Stipulated Order.
3 Applicant understands that he has the right to a contested case hearing under the Administrative
4 Procedures Act (chapter 183). Applicant fully and finally waives the right to a contested case
5 hearing and any appeal therefrom by the signing of and entry of this Order in the Board's
6 records. Applicant admits and the Board finds that he engaged in the conduct described in
7 paragraph 2 and that this conduct violated ORS 677.190(1)(a), unprofessional or dishonorable
8 conduct, as defined in ORS 677.188(4)(a); ORS 677.190(6) conviction of any offense punishable
9 by incarceration in a Department of Corrections institution; and ORS 677.190(15) disciplinary
10 action by another state of a license to practice. Applicant understands that this Order is a public
11 record and is a disciplinary action that is reportable to the National Practitioner Data Bank,
12 Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

13 4.

14 Applicant and the Board agree that the Board will close this investigation and resolve this
15 matter by entry of this Stipulated Order, subject to the following terms and conditions of
16 probation:

17 4.1 Applicant is reprimanded.

18 4.2 The license of Applicant to practice medicine in Oregon is placed on probation
19 for two years, effective the date that Applicant is granted an active license to practice medicine
20 in Oregon. Applicant will report in person to the Board at each of its regularly scheduled
21 quarterly meetings at the scheduled times for a probationer interview unless otherwise directed
22 by the Board, or by the Board's agents.

23 4.3 In the event Applicant does not practice medicine in the state of Oregon for a
24 period of 90 days or more, the terms of his probation will be stayed until he resumes an active
25 practice in Oregon.

26 4.4 Applicant must immediately inform the Board's Compliance Officer of any
27 change to his current address, phone number, and practice location.

