Oregon Medical Board

BOARD ACTION REPORT
October 15, 2012

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

Beck, Shoshana , LAc; AC00326; Portland, OR
On October 11, 2012, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's September 6, 2012, Corrective Action Agreement.

*Bost, Dawn Elizabeth, MD; MD16820; Aloha, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and impairment. This Order grants Licensee an active medical license, limits Licensee's work week to 40 hours, places Licensee on probation for 5 years, requires that Licensee practice under the supervision of a proctor at a site pre-approved by the Board's Medical Director, prohibits Licensee from self-prescribing controlled substances, requires Licensee to continue care under her treating physicians, and requires enrollment and compliance in HPSP with drug screening testing at least 24 times per year.

Clark, Thomas Leonard, MD; MD15528; White City, OR
On October 11, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to submit a re-entry to practice plan to the Board's Medical Director to include ongoing mentorship by a pre-approved physician, weekly meetings with mentor physician, and submission of quarterly reports to the Board from mentor physician.
*Clark, Thomas Leonard, MD; MD15528; White City, OR
On October 11, 2012, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's September 3, 2009, Stipulated Order.

Elzinga, Lawrence Wayne, MD; MD13174; Beaverton, OR
On October 11, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to retire his license to practice medicine and to provide a copy of the Corrective Action Agreement to any other state licensing board where he holds or applies for a license.

Farris, Clyde Alan, MD; MD11437; West Linn, OR
On October 11, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a medical documentation course pre-approved by the Board's Medical Director, and to notify the Board of any changes in practice setting.

Gates, Lawrence Keith, Jr., MD; MD23505; Salem, OR
On October 11, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to successfully complete courses on pain management and documentation.

*Graham, Barbara Ann, MD; MD15611; Portland, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross negligence or repeated negligence in the practice of medicine. This Order reprimands Licensee, places Licensee on probation for 5 years, fines Licensee $7,000, requires Licensee to complete a remediation plan through CPEP, requires that Licensee obtain a mentor who is pre-approved by the Board's Medical Director, and subjects Licensee's practice and charts to no notice audits by the Board.

Gregory, Sylvia Jane, PA; PA00264; Eugene, OR
On October 11, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete courses on pain management and professional boundaries, and submit practice agreements to the Board's Medical Director prior to working in a new practice setting.

Griesser, Carl Russell, MD; MD155331; Medford, OR
On September 27, 2012, the Board issued an Order Modifying Consent Agreement. This Order modifies Licensee's November 16, 2011 Consent Agreement. This Order reduces the number of CMEs required to 150, and requires that Licensee obtain board certification.

Gudman, Jonathan Todd, MD; MD14380; Portland, OR
On October 11, 2012, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to remain under the care of a physician pre-approved by the Board's Medical Director.

*Lee, Carma Jane, MD; MD21672; Portland, OR
On October 11, 2012, the Board issued an Order Modifying Stipulated Order. This Order terminates Terms 5.3 and 5.4 of Licensee's October 6, 2011 Stipulated Order.
*Makker, Vishal James, MD; MD23879; Lake Oswego, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; obtaining any fee by fraud or misrepresentation; and repeated negligence in the practice of medicine. In this Order Licensee surrenders his license to practice medicine and is prohibited from re-applying for licensure in the state of Oregon.

*Marjanovic, Danijela Mozina, MD; MD12634; Roseburg, OR
On October 4, 2012, the Board issued an Order of License Suspension to immediately suspend licensee's medical license due to her willfully violating a Board rule, specifically continuing medical competency (education).

*Miller, Gerald Wendall, MD; MD16819; Beaverton, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for gross or repeated acts of negligence. This Order assesses a civil penalty of $2,000, requires pre-approval by the Board's Medical Director for any practice setting, prohibits Licensee from practicing "anti-aging" medicine or endocrinology, and reprimands Licensee.

Polchert, Susan Elizabeth, MD; MD16479; Eugene, OR
On October 11, 2012, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to work under the personal supervision of a board certified psychiatrist for a minimum of three months followed by direct supervision for a minimum of three months.

*Read, Robert Allen, MD; MD21063; Corvallis, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence in the practice of medicine. This Order reprimands Licensee, fines Licensee $3,500, requires that an Oregon licensed surgeon assist Licensee in all complicated surgical procedures performed by Licensee, requires that Licensee's practice location be pre-approved by the Board's Medical Director, and requires that Licensee complete a health assessment at a facility pre-approved by the Board's Medical Director.

*Stull, Carol Grammer, MD; MD21384; Portland, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated negligence. This Order reprimands Licensee, places Licensee on probation for 5 years, requires that Licensee complete a pre-approved course in perinatal medicine, and requires that Licensee obtain a consultation from a pre-approved physician for 10 moderate to high risk deliveries.

Sunderland, Margaret Carol, MD; MD125755; Corvallis, OR
On October 11, 2012, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to submit a re-entry to practice plan to the Board's Medical Director to include ongoing mentorship with a pre-approved physician, weekly meetings with mentor physician, and submission of quarterly reports to the Board from mentor physician.
*Usher, Vernon Howard, MD; MD09413; Portland, OR
On October 8, 2012, Licensee entered into an Interim Stipulated Order in which he agrees to practice only under the supervision of a board certified anesthesiologist 100 percent of the time, pending the completion of the Board's investigation into his ability to safely and competently practice anesthesiology.

*Waters, Harris J, MD; MD15831; Silverton, OR
On October 11, 2012, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order reprimands Licensee, fines Licensee $4,000, requires that Licensee complete a pre-approved course on ultrasound guided line placement, and requires that Licensee use ultrasound to guide and confirm placement of any guided lines placed by him.

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

In the Matter of )
) ) STIPULATED ORDER
DAWN ELIZABETH BOST, MD ) LICENSE NO. MD16820 )
)

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. Dawn Elizabeth Bost, MD (Licensee) is a licensed physician (Inactive) in the state of
Oregon.

2.

2.1 The Board opened an investigation in May 2007 based upon credible information
that Licensee had self medicated with opioids to address her complaints of chronic pain related
to a prior cervical injury, had used marijuana, and was seeing patients while impaired. On or
about July 5, 2007, Licensee was notified that she needed to provide a urine sample, for drug
testing, as part of the on-going investigation. Licensee reported to the collection lab the
following day and was observed attempting to substitute urine contained in tied off condoms,
which was concealed under her outer attire, for her own specimen. Licensee admitted that she
did so to conceal her recent use of marijuana. Licensee subsequently produced a urine sample
under observation, which tested positive for Lorazepam (Ativan, Schedule IV), Oxazepam
(Serax, Schedule IV), Temazepam (Restoril, Schedule IV), Marijuana (Schedule I), and Fentanyl
(Schedule II). At the time of the July 2007 urinalysis, the Licensee was unable to provide the
Board with any medical records from her treating healthcare providers to substantiate her use of
these substances. On July 12, 2007, Licensee voluntarily withdrew from the practice of
medicine pursuant to the terms of an Interim Stipulated Order. In July 2012, after repeated
requests from Board investigators since 2007, Licensee submitted various treatment and
pharmacy records documenting prescriptions of Fentanyl and Lorazepam that she received prior
to the date of the July 2007 urinalysis. Licensee also submitted a copy of her medical marijuana
card with an effective date in November 2007.

2.2 Licensee now requests that the Board activate her medical license.

2.3 Pursuant to a Board order, Licensee underwent a physician assessment at UC San
Diego Physician Assessment and Clinical Education (PACE) Program on June 29 – 30, 2011 and
October 3 – 7, 2011. The PACE assessment report reflects that Licensee passed the assessment,
with a minor recommendation that included the need for her to update her knowledge regarding
current medical and screening guidelines.

3.

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

Licensee understands that she has the right to a contested case hearing under the Administrative
Procedures Act (chapter 183), Oregon Revised Statutes 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 stipulates that she engaged in the conduct described in paragraph 2 of
this Order and that this conduct violated ORS 677.190(1)(a) as defined by ORS 677.188(4)(a)
unprofessional or dishonorable conduct and ORS 677.190(7) impairment. Licensee understands
and agrees that this conduct constitutes grounds for the Board to take disciplinary action against
her license and to impose terms of probation pursuant to ORS 677.205. Licensee understands
that this Order is a public record and is a disciplinary action that is reportable to the DataBank
and the Federation of State Medical Boards.

4.

Licensee and the Board agree to resolve this matter by entry of this Stipulated Order to
allow Licensee to reenter the practice of medicine, subject to the following terms and conditions
of probation:

4.1 Licensee is granted an active medical license.

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4.2 Licensee must not work more than a total of 40 hours per week. After six months of full compliance with the terms of this Order, Licensee may submit a written request to modify this limitation.

4.3 Licensee is placed on probation for a minimum of five years, after which time she may submit a written request to terminate the terms of probation, subject to her full compliance with the terms and conditions of this Order and the discretion of the Board. 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.

4.4 Licensee must limit her practice to internal medicine under the supervision of a proctor(s) who is board certified in internal medicine or family medicine and is pre-approved by the Board’s Medical Director. This proctor(s) will provide quarterly reports to the Board on Licensee’s practice of medicine, to include whether she is complying with the terms and conditions of this Order, whether her practice conforms to the standard of care (to include timely and accurate charting), and her ability to safely practice medicine.

4.5 Licensee must practice at a site pre-approved by the Board’s Medical Director, and is prohibited from practicing medicine in a solo setting. There must be another licensed physician present at any location where Licensee is working, serving as her proctor.

4.6 After six months of full compliance with the terms of this Order, Licensee may submit a written request to the Board, accompanied by an endorsement from the practice proctor(s), to modify the requirement that she practice under the supervision of a pre-approved proctor.

4.7 Licensee must not self-prescribe any substance classified as a controlled substance under the Controlled Substances Act, to include marijuana. Licensee must abstain from any substance classified as a controlled substance under the Controlled Substances Act, to include marijuana, except for Schedule II, III, IV and V medications that are prescribed by her treating physician(s), with appropriate prior notification to the Board’s Medical Director or Compliance Officer.
4.8 Licensee must continue under the care of her treating physician(s). Any physician providing care to Licensee must be pre-approved by the Board's Medical Director. Licensee agrees and understands that she must sign all necessary releases to allow for full communication between the Board and her treating physician(s). Licensee's treating physician(s) will provide quarterly written reports on her medical condition and capability to safely practice medicine.

4.9 Licensee will enroll in and remain fully compliant with the Oregon Health Professionals' Services Program (HPSP) for a minimum of five years from the date this Order is signed by the Board Chair. Licensee shall sign any and all release authorizations to facilitate full communication between the Board and the program.

4.10 As part of Licensee's enrollment in HPSP and at her expense, Licensee must submit to random observed drug screening tests a minimum of 24 times a year, to include hair samples up to 4 times a year, as directed by the Board’s Compliance Officer.

4.11 The July 12, 2007 Interim Stipulated Order is terminated upon the approval of this Order by the Board.

4.12 Any violation of the terms of this Order constitutes grounds for immediate suspension and other disciplinary action under ORS 677.190(17).

5.

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

IT IS SO STIPULATED THIS 16th day of September, 2012.

SIGNATURE REDACTED

DAWN ELIZABETH BOST, MD

IT IS SO ORDERED THIS 11th day of October, 2012.

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of
THOMAS LEONARD CLARK, MD
LICENSE NO. MD15528
ORDER TERMINATING STIPULATED ORDER

1.
On September 3, 2009, Thomas Leonard Clark, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee’s Oregon medical license.

2.
The Board terminates the September 3, 2009 Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 11th day of October, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair
BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of

BARRA B ANN GRAHAM, MD
LICENSE NO. MD15611

STIPULATED ORDER

1.

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

2.

In a Complaint and Notice of Proposed Disciplinary Action dated October 7, 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 negligence or repeated negligence in the practice of medicine.

3.

Licensee came under investigation in 2006 for allowing her physician assistants to practice independently without the direction and regular review by a physician and for having 300 to 400 medical charts that needed to be updated. A site visit to her clinic by Board investigators revealed that Licensee relied upon small handwritten “post it” notes inserted into many of her patient charts and that hundreds of charts were months or years in arrears.

Licensee subsequently entered into a Corrective Action Order with the Board with an effective date of May 8, 2007, in which Licensee agreed to various terms, to include enrolling in and completing the Physicians Evaluation Education and Renewal (PEER) program as well as completing a medical documentation course. The Board terminated the Order on July 9,
2009. The Board opened an investigation in 2011 in regard to reports that Licensee was failing to complete medical records for multiple patients in a timely manner. The acts and conduct that violated the Medical Practice Act are:

3.1 The Board’s investigation revealed that Licensee has once again engaged in a pattern of practice in which she has failed to chart her patient encounters in a timely manner. Rather than completing her charts on the same day of a patient visit to her clinic, Licensee customarily failed to dictate or write a chart note. If she received a call in regard to patient care issues, Licensee relied upon her memory and small “post it” notes that she may have placed into the file. Licensee asserts that her intent was to dictate a chart note for each patient encounter later, but a backlog grew and became unmanageable.

3.2 The Board conducted a review of Licensee’s charts for Patients A – D, which revealed a pattern of late chart notes.

3.3 Licensee has failed to respond in a timely manner to requests for patient records from various sources, to include Farmers Insurance Company.

3.4 At the Board’s request, Licensee underwent an assessment by the Center for Personalized Education for Physicians (CPEP), which issued an assessment report in December of 2011. The report concluded that Licensee demonstrated medical knowledge that was broad, but had several gaps and was superficial in several areas. The CPEP assessment reported that Licensee’s clinical judgment and reasoning were variable, with concerns regarding her application of knowledge. CPEP also reported concerns regarding the level and extent of Licensee’s supervision for her PA’s. CPEP recommended that Licensee establish a relationship with an experienced educational preceptor in internal medicine.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and
finally waives the right to a contested case hearing and any appeal therefrom by the signing of
and entry of this Order in the Board’s records. Licensee admits that she engaged in the
conduct described in paragraph 3 above, and that this conduct violated ORS 677.190(1)(a)
unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS
677.190(13) gross negligence or repeated negligence in the practice of medicine.
Licensee understands that 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.

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

5.1 Licensee is reprimanded.

5.2 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.

5.3 Licensee must pay a fine of $7,000. This fine may be paid by installment
payments of $1,000 every 3 months, with the first installment payment due 12 months from
the date this Order is signed by the Board Chair.

5.4 Within 24 months, Licensee must successfully complete an education
remediation plan that is designed and administered by the CPEP and that is pre-approved by
the Board’s Medical Director. Licensee is responsible for all costs associated with the CPEP
education activity. Licensee will sign all necessary releases to allow for free communication
between the Board and CPEP. Licensee will cause CPEP to send a copy of the CPEP
Education Plan, all interim progress reports and the final report to the Board. Licensee will
complete a Post Education Evaluation, if recommended by CPEP.

5.5 Licensee must affiliate with a physician mentor pre-approved by the Board’s
Medical Director. This mentor will meet with Licensee on a weekly basis, for the purpose of
reviewing cases and chart documentation to ensure that her medical charts are complete and up to date, to discuss decisions related to those cases, to review specific topics, and to review the adequacy of Licensee’s supervision of her PA’s in their care of patients. The mentor must submit quarterly reports to the Board.

5.6 Licensee’s medical practice and charts are subject to no notice audits by the Board’s designees.

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

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

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

IT IS SO STIPULATED this 16th day of August, 2012.

SIGNATURE REDACTED

BARBARA ANN GRAHAM, M.D.

IT IS SO ORDERED this 11th day of October, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

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

In the Matter of
)
CARMA JANE LEE, MD
ORDER MODIFYING
LICENSE NO. MD21672 STIPULATED ORDER

1. On October 6, 2011, Carma Jane Lee, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On July 10, 2012, and July 23, 2012, Licensee submitted a written request asking the Board to terminate Terms 5.3 and 5.4 of this Order, which read:

5.3 Licensee may only interpret electrocardiograms (ECGs) under the supervision of a cardiologist(s) at Portland Adventist Hospital who is pre-approved by the Board’s Medical Director. This cardiologist(s) must co-sign any ECG interpretation provided by Licensee. Licensee must meet with this cardiologist(s) at Portland Adventist Hospital on a frequent and ongoing basis to read ECG’s under supervision until she is deemed to have reached a level of acceptable competency, at which time the supervising cardiologist(s) may submit a letter to the Board’s Medical Director requesting that the requirement that she read ECG’s under supervision be lifted.

5.4 Licensee may only write new prescriptions for Tramadol (Ultram), psychotropic or Schedule II or III medications by having a physician, pre-approved by the Board’s Medical Director, review and approve each prescription. Licensee must also obtain a preceptor physician that has been pre-approved by the Board’s Medical Director. This preceptor physician will review and approve these prescriptions, as well as any refills, for these medications, within 24 hours.

2. Having fully considered Licensee’s request and compliance with these terms, the Board terminates Terms 5.3 and 5.4 of the October 6, 2011, Stipulated Order effective the date this

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PAGE 1 - ORDER MODIFYING STIPULATED ORDER - Carma Jane Lee, MD
Order is signed by the Board Chair. All other terms of the October 6, 2011 Stipulated Order are unchanged and remain in full force and effect.

IT IS SO ORDERED this \underline{11}th day of \underline{October}, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of
VISHAL JAMES MAKKER, MD
LICENSE NO. MD23879

STIPULATED ORDER

1.
The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Vishal James Makker, MD (Licensee) is a licensed physician in the state of Oregon. Licensee entered into an Interim Stipulated Order on April 14, 2011, which requires Licensee to have a Board-approved neurosurgical mentor assess the appropriateness of any operative procedure prior to commencing surgery.

2.
Licensee is a board-certified neurosurgeon. The Board opened an investigation in February of 2011 after receiving credible information that Licensee may have engaged in unprofessional conduct that included entering inaccurate information into the medical charts of certain patients and fraudulent billing. On June 22, 2012, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Complaint) in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, and assessment of costs, 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), (b) and (c); ORS 677.190(4) obtaining any fee by fraud or misrepresentation; and ORS 677.190(13) gross or repeated
negligence in the practice of medicine. The factual allegations supporting this action are set forth in the Complaint.

3. Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to permanently surrender his license while under investigation, with a stipulation never to reapply, 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 denies but the Board finds that Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a), (b) and (c); ORS 677.190(4) obtaining any fee by fraud or misrepresentation; and ORS 677.190(13) repeated negligence in the practice of medicine. Licensee understands that this document is a public record and is reportable to the DataBank and the Federation of State Medical Boards.

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

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

4.2 Licensee is prohibited from applying for a license to practice medicine in the state of Oregon.

4.3 The signing of this Order by the Board Chair will terminate all other Orders by this Board pertaining to Licensee.
4.4 Licensee stipulates and agrees that any violation of the terms of this Order would be grounds for further disciplinary action under ORS 677.190(17).

IT IS SO STIPULATED this 24th day of September, 2012.

SIGNATURE REDACTED

VISHAL JAMES MAKKER, MD

IT IS SO ORDERED this 11th day of October, 2012.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
BOARD CHAIR
BEFORE THE
OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of

DANIELA MOZINA MARJANOVIC, MD
LICENSE NO. MD12634

ORDER OF LICENSE SUSPENSION

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Danijela Mozina Marjanovic, MD (Licensee) holds a license to practice medicine in the state of Oregon.

2.

The Board now intends to suspend the license of Licensee pursuant to ORS 677.205 for violating the Medical Practice Act, to wit: ORS 677.190(17) willfully violating a Board rule, specifically OAR 847-008-0070, continuing medical competency (education).

3.

FINDINGS OF FACT

On December 19, 2011, Licensee received an audit to provide documentation of 60 hours of continuing medical education obtained during the 2010-2011 biennium. Licensee failed to respond with the required documentation by the deadlines provided in the audit and subsequent notices. Licensee failed to request a hearing.

4.

CONCLUSIONS OF LAW

Licensee’s failure to provide documentation of 60 continuing medical education credit hours of American Medical Association Category 1 or American Osteopathic Association Category 1-A or 2-A for the 2010-2011 biennium by the audit deadline violates ORS 677.190(17) willfully violating a Board rule, specifically OAR 847-008-0070.
5.

The Board therefore suspends Licensee’s license to practice medicine effective immediately pursuant to ORS 677.205 for a minimum of 90 days. Licensee must notify the Board within 10 days as to how patients may access or obtain their medical records.

IT IS SO ORDERED this 4th day of October, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of:
GERALD WENDALL MILLER, MD
LICENSE NO. MD16819

STIPULATED ORDER

1.
The Oregon Medical Board (Board) is the state agency responsible for licensing,
regulating and disciplining certain health care providers, including physicians, in the State of
Oregon. Gerald Wendall Miller, MD (Licensee) is a licensed physician in the State of Oregon.

2.
In an Amended Complaint and Notice of Proposed Disciplinary Action dated January 27,
2012, 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(13) gross or repeated acts of
negligence.

3.
Licensee is a general practitioner and formerly practiced in Beaverton, Oregon, where he
represented that he practiced "anti-aging" medicine and specialized in nutrition and dietary
counseling. Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 The Board opened an investigation that included a review of Licensee's
medical records for Patients A - G that revealed a pattern of minimal documentation, in which
Licensee failed to record new patient historical data or patient examinations for most patient
visits. The Board's review revealed that Licensee failed to document his medical decision-
making, often merely providing a list of diagnoses and nurse obtained vital signs, but without
supporting observations and findings. Licensee's diagnoses are often non-specific, such as
“adrenal fatigue” or “borderline low adrenal reserve,” which lack a well recognized diagnostic
criterion and provide little information to other clinicians. Licensee frequently ordered
laboratory studies that are not commonly used in clinical practice, to include rT3, insulin
levels, pregnenolone levels, and occasionally leptin and adiponectin levels. Licensee failed to
address reported TSH levels, and often continued to prescribe thyroid medication in the face
of lab studies and symptoms that indicated thyrotoxicosis. The Board’s review revealed that
Licensee failed to utilize appropriate endocrine testing to diagnose hypothyroidism and to
monitor patient response to treatment. Licensee frequently subjected his patients to excessive
thyroid hormone dosing despite the lack of any objective medical findings that would support
a diagnosis of thyroid disease. Licensee’s chart notes failed to explain his medical reasoning and
failed to articulate the clinical basis for diagnosing and treating hypothyroidism. Licensee
continued to prescribe thyroid hormone, often increasing the dosage, in the face of blood tests
and patient responses that indicated excessive dosing.

3.2 Specific descriptions of Licensee’s care and treatment of patients that constitutes
gross or repeated acts of negligence follow:

a. Patient A, a 58 year old female, presented to Licensee on May 27, 2009
complaining of recent weight gain. Her history included bipolar disorder,
hypertension, biliary cirrhosis and long term lithium treatment. The chart reflects
Patient A’s height as 63 inches, her weight 166 pounds, with a body mass index of
29.4. Licensee conducted various lab studies and hormone testing. Without setting
forth the supporting medical indications in the chart, Licensee’s diagnosed “borderline
low adrenal reserve” and “hormone imbalance.” A lab study that was collected on
July 13, 2009, reflected a TSH\(^1\) of 1.23 \(\mu\)IU/mL, a free T4 of 1.26 ng/dL, and a free

\(^1\) Thyroid Stimulating Hormone (TSH) assay is a widely used screening test for hyperthyroidism and
hypothyroidism. The Medical Guidelines for Clinical Practice for the Evaluation and Treatment of Hyperthyroidism
and Hypothyroidism, published by the American Association of Clinical Endocrinologists (AACE), 2006 amended
version, p. 463, state that “[a]ppropriate laboratory evaluation is critical to establish the diagnosis and cause of
hypothyroidism in the most cost-effective way. The most valuable test is a sensitive measurement of TSH level.”
The Guidelines, at p. 465, state that “treatment is indicated in patients with TSH levels > 10 \(\mu\)IU/mL or in patients
T3 of 2.7 pg/mL—values which were in the normal range. Nevertheless, on August 11, 2009, Licensee diagnosed “sub-optimal B12,” “hypothyroidism,” and “elevated blood sugar not specifically diabetic.” Licensee did not set forth findings to support the diagnosis of hypothyroidism, but prescribed Synthroid (Levothyroxine) 50 mcg #30 tablets, 1 p.o. (by mouth) daily. A lab study that was collected on October 20, 2009, reflects a TSH level of 0.10, free T4 of 1.98, and free T3 of 3.5. On January 25, 2010, Licensee increased Patient A’s dosage on Levothyroxine to 75 mcg per day, and added Cytomel (Liothyronine, 5 mcg every other day) without explanation. On January 27, 2010, Patient A complained that she was not losing weight. Without a sound basis in medical science, Licensee advised her that this was due in part to her thyroid issues. On April 1, 2010, Licensee increased the dosage of Levothyroxine to 100 mcg per day, despite lab studies indicating excessive dosing. On May 24, 2010, Patient A complained of a near syncopal event at home. Patient A came to Licensee’s clinic where her blood sugar was tested and found to be elevated at 158. Based on a single elevated blood sugar test, Patient A was told that she had “at least insulin resistance if not diabetes” and was diagnosed with “diabetes mellitus”. Licensee failed to set forth the medical indications to support his diagnosis in the chart. Licensee examined Patient A on June 10, 2010, diagnosed hypothyroidism and abnormal weight gain, and ordered a lab study. That study reflected a TSH of <0.01, free T3 of 5.2, and a free T4 of 2.66. Although these values did not support his diagnosis and indicated possible hyperthyroidism, Licensee did not change Patient A’s diagnosis or modify the dosage of thyroid medication. On June 14, 2010, Patient A presented to Providence Hospital with nausea and vomiting. After an initial assessment, she was admitted. Her calcium level was found to be elevated at 11.3. During her workup, she was found to be excessively hyperthyroid with a suppressed TSH

with TSH levels between 5 and 10 μIU/mL in conjunction with goiter or positive anti-thyroid peroxidase antibodies (or both)." "The target TSH level should be between 0.3 and 3.0 μIU/mL."
that was less than .01. Her diagnosis was determined to include dehydration, hypercalcemia, and hyperthyroidism. Patient A was treated with IV fluid hydration and the thyroid medications that she had been taking (Levothyroxine and Cytomel) were withheld. Patient A’s calcium level fell to 10.3, her free T4 dropped from 2.66 to 1.89 and her free T3 declined from 5.2 to 3.7. Patient A’s symptoms of nausea and vomiting resolved. She was discharged from the hospital on June 16, 2010. Licensee’s diagnosis and treatment of hypothyroidism was not medically indicated and his ongoing treatment of Patient A with thyroid medication exposed her to the risk of harm.

b. Patient B, a 61 year old female and breast cancer survivor, initially presented to Licensee on February 7, 2008, with a history of osteoporosis and symptoms associated with menopause. On February 21, 2008, without medical justification, Licensee’s diagnosis list included hypothyroidism. Licensee prescribed Armour Thyroid 60 mg b.i.d. 5 refills. On March 13, 2008, Licensee added SRT3, 20 mcg, and SRT4, 80 mcg, b.i.d., 5 refills. In subsequent clinical visits, Licensee continued to list hypothyroidism as a diagnosis and continued to prescribed SRT3 and SRT4 in varying dosages. Licensee did not conduct lab studies to determine Patient B’s TSH level, either as a baseline or to follow Patient B’s response to his medication regimen; neither did he set forth clinical findings to support his diagnosis. On October 8, 2009, Patient B reported “moodiness and irritability (bitchy) and have wondered if there would be any possible adjustment to hormone cream.” Licensee did not consider these symptoms as an indication of mismanagement of her thyroid medication and continued to diagnose and treat hypothyroidism. Throughout 2009 and 2010, Licensee continued to list a diagnosis of “hypothyroidism” or “acquired hypothyroidism” without reporting supporting TSH levels or clinical findings. Patient B went to St. Vincent hospital on October 3, 2010, where she complained of extremely poor balance, and reported that she feels like she was “losing it entirely and gets frustrated easily.” Her TSH was tested and determined to be 0.01μIU/mL. This test and her reported symptoms indicated possible iatrogenic
thyrotoxicosis. On October 6, 2010, there is a chart note that acknowledges that Patient B went to the hospital “like you told her to… found out her thyroid levels are high.” There is no indication in the chart that Licensee reevaluated or modified his diagnosis or treatment plan. Instead, on November 10, 2010, Licensee’s chart note states that “she presented with hypothyroidism.” Licensee did not address the reported high thyroid levels or even acknowledge her recent hospitalization, but instead, listed her vital signs and basal temperature, noted “acquired hypothyroidism” as a diagnosis, and prescribed SRT3, 18.5 mcg, and SRT4, 13.5 mcg, 60 tablets, b.i.d., 3 refills. Licensee’s diagnosis and treatment of hypothyroidism was not medically indicated and his ongoing treatment of Patient B with thyroid medication exposed her to the risk of harm.

c. Patient C, a 57 year old male, initially presented to Licensee on March 24, 2010 with a history of Hepatitis C. A lab study drawn on April 12, 2010, reflected a TSH of 1.30 μIU/mL, free T3 pg/mL of 3.8, and a free T4 of 0.7 ng/dL, values which were all in the normal range. On May 6, 2010, Licensee listed hypothyroidism among his various diagnoses without stating his clinical findings or discussing the previous lab study and prescribed Synthroid, 50 mcg, 1 p.o. daily a.c. (before meals) with 2 refills. This medication was not medically indicated. On June 7, 2010, Licensee prescribed Levothyroxine, 50 mcg #30 1 p.o. daily with 3 refills. On August 3, 2010, Licensee noted “acquired hypothyroidism” as a diagnosis and prescribed Levothyroxine 75 mcg, 1 tablet p.o., daily 1 hr a.c., 30 days, 1 refill, for a total of 30, “start on November 26, 2010, and end on January 24, 2011.” On September 8, 2010, Licensee continued to list “acquired hypothyroidism” as a diagnosis. A lab study collected on October 1, 2010, reflected a TSH of .08, free T3 of 3.6, and a free T4 of 0.8. Once again, Licensee’s chart notes do not address this study. Licensee’s diagnosis and treatment of hypothyroidism was not medically indicated and his ongoing treatment of Patient C with thyroid medication was unnecessary and exposed him to the risk of harm.

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d. Patient D, a 51 year old woman, initially presented to Licensee in December 2008. A lab study dated December 9, 2008, reflected a TSH of 1.65 μIU/mL, free T3 of 2.9 pg/mL, and free T4 of 0.7 ng/dL. All the values were within the normal range. Nevertheless, Licensee prescribed SRT3 and SRT4, 4/40 mcg, 60 tablets, b.i.d., a.c., 5 refills. A lab study dated February 16, 2009, reflected a TSH of 0.24 μIU/mL, free T3 of 314 pg/dL, and free T4 of 1.3 ng/dL. On March 2, 2009, Licensee increased the prescription to SRT3 and SRT4, 5/55 mcg, 60 tablets, b.i.d., 4 refills, without explanation. A note dated June 10, 2010, lists “acquired hypothyroidism” as a diagnosis without explanation. A review of the chart revealed that Licensee ordered several successive thyroid studies in the months to come, and continued to prescribe thyroid medication that was not medically indicated. A lab study collected on September 7, 2010, reflected a TSH of 0.94 μIU/mL, free T3 of 268 pg/dL, and free T4 of 1.0 ng/dL. On September 21, 2010, Licensee prescribed SRT4 90 mcg, 30 tablets, daily, 3 refills. Licensee’s diagnosis and treatment of hypothyroidism was not medically indicated and his ongoing treatment of Patient D with thyroid medication exposed her to the risk of harm.

e. Patient E, a 41 year old female, has been a patient of Licensee for more than ten years. A lab study collected on October 10, 2007, reflects a TSH of 1.56 μIU/mL, free T3 of 3.2 pg/mL, a free T4 of 1.0 ng/dL, all values in the normal range. On April 8, 2010, Licensee’s chart note states that Patient E “notes some ongoing concerns of her weight management and is requesting to go on the HCG [Human Chorionic Gonadotropin] diet.” At the time, Patient E was noted to weigh 199 pounds, was 58 inches tall, with a body mass index of 39.7. On April 12, 2010, Licensee prescribed 1.25cc HCG 1000 IU/vial in 10cc of diluent, a non-FDA approved HCG protocol for weight loss. On April 29, 2010, Licensee noted that Patient E had received the HCG and that Licensee would show her “how to prepare her HCG for injection.” Her recommended dosage was 0.125 cc daily IM (125 IU). On May 28, 2010, a lab study
reflects a TSH of 1.13 μIU/mL, free T3 of 2.7 pg/mL, and a free T4 of 1.26 ng/dL, all values in the normal range. On July 4, 2010, without explanation or medical indication, Licensee prescribed Levoxyl (Levothyroxine) 75 mcg #30 tablets, daily, 3 refills. On July 14, 2010, Licensee’s diagnosis list included “abnormal weight gain” and “acquired hypothyroidism.” A lab study collected on September 2, 2010, reflected a TSH of .06 μIU/mL, free T3 of 2.8 pg/mL, and a free T4 of 1.45 ng/dL. On September 28, 2010, Licensee ignored the lab study that indicated iatrogenic thyrotoxicosis and Licensee prescribed Synthroid (Levothyroxine) 100 mcg #30 tablets, 1 hr. a.c., daily, 2 refills, and listed in his chart note a diagnosis of “acquired hypothyroidism.” Licensee’s diagnosis and treatment of hypothyroidism was not medically indicated and his ongoing treatment of Patient F with thyroid medication exposed her to the risk of harm.

f. Patient F, a 33 year old female, presented as a new patient on September 14, 2010, with a reported history of hypothyroidism. A lab study collected on September 17, 2010, reflected a TSH of 2.33 μIU/mL, free T3 of 2.3 pg/mL, and a free T4 of 1.43 ng/dL (all in the normal range). Licensee accepted the diagnosis of hypothyroidism, noted patient complaints of “existing problems with hypothyroidism” and continued Patient F on Synthroid, 75 mcg daily. On November 1, 2010, Licensee prescribed Synthroid 88 mcg, 1 tablet, p.o., daily 1 hr. a.c., 90 days, 3 refills, for a total of 90, “start on November 04, 2010 and end on October 29, 2011.” A lab study collected on December 20, 2010, reflected a TSH of 0.298 μIU/mL and a free T4 of 1.20 ng/dL. Licensee did not address these findings or modify the treatment regimen. In a letter dated January 3, 2011, Patient F informed Licensee that she had repeatedly called his office to complain of problems that she was having with her thyroid medication, to include palpitations, “runs of tachycardia,” and severe itching episodes, but his office had failed to respond. Licensee responded to her inquiry on January 6, 2011. Licensee’s decision to accept the diagnosis and treat hypothyroidism was not medically indicated and his ongoing treatment of Patient F with thyroid medication exposed her to the risk of harm.
g. Patient G, a 51 year old adult female, initially presented to Licensee on October 6, 2003 "with some hormone questions." On March 15, 2006, Licensee diagnosed "hypothyroidism" without explanation or supporting clinical findings. Licensee charted: "I have recommended that she double her dose of Liquid Iodine to get 300 mcg of Iodine per day for the time being and will also assigned (sic) a prescription currently SRT 20 mcg, we will change this to 25 mcg (60) 1 p.o. b.i.d. 1 hour a.c."\(^2\) A lab study collected on February 21, 2006 reflected a TSH of 1.65 μIU/mL, free T3 of 262 pg/dL, and a free T4 of 0.8 ng/dL. All of these values were within the normal range and did not support a diagnosis of hypothyroidism. Licensee increased the dosage of SRT3 to 25 mcg 1 p.o. b.i.d. on April 17, 2006. Licensee failed to address a lab study collected on May 22, 2006, which reflected a TSH of 0.02 μIU/mL (subnormal), free T3 of 6.9 pg/mL, and a free T4 of 0.8 ng/dL. Rather than address the issue of possible hyperthyroidism, Licensee continued to prescribe thyroid medication for Patient G over the following years without clinical justification, and failed to address successive lab reports with TSH levels that indicated subclinical hyperthyroidism. A lab study collected on April 28, 2011, reflected a TSH < 0.01 μIU/mL, free T3 of 4.2 pg/mL, and a free T4 of 1.5 ng/dL. Licensee also failed to address the possible connection between the abnormal TSH lab reports and Patient G’s complaints of various symptoms that suggested possible hyperthyroidism, to include a complaint of tachycardia on March 5, 2007, excessive hair loss on June 7, 2007, reported difficulty walking up stairs and drooling while talking on March 31, 2008, and reports of tremors and swelling on April 9, 2008. Licensee charted on April 17, 2008, that he instructed Patient G to stop taking thyroid medications for several weeks, and she reported feeling better. A lab study collected on April 9, 2008, reflected a TSH of 0.02 μIU/mL (depressed), free T3 of 18.6 pg/mL, and a free T4 of 5.8 ng/dL. Nevertheless, on May 27, 2008, Licensee had Patient G resume taking

\(^2\) This indicates that Licensee was already treating Patient G with thyroid medication prior to diagnosing her with hypothyroidism.
SRT3/SRT4 5/65 mcg one p.o.b.i.d. On July 24, 2008, Patient G reported hot flashes and a three inch loss of height since her youth. Throughout the course of her treatment, Licensee did not order a bone density study or discuss with Patient G the risk factor of osteoporosis that is associated with subclinical hyperthyroidism (which is characterized by a serum TSH level < 0.1 μIU/mL and normal free T4 and T3 estimates.) A lab study collected on July 30, 2008, reflected a TSH of 0.02 μIU/mL, free T3 of 3.7 pg/mL, and a free T4 of 1.78 ng/dL. A lab study collected on July 28, 2009, reflected a TSH of 0.01 μIU/mL, free T3 of 3.0 pg/mL, and a free T4 of 1.2 ng/dL. A lab study collected on January 19, 2010, reflected a TSH of < 0.01 μIU/mL, free T3 of 4.1 pg/mL, and a free T4 of 1.19 ng/dL. On May 23, 2011, Patient G presented at the Urgent Care Center at Providence Tanasbourne with complaints of “fast and flipping” heart rate, rapid breathing, difficulty concentrating, swelling, and the inability to put words together. Her whole body was twitching. A lab study collected that day reflected a TSH < 0.01 μIU/mL, T3 > 800 ng/dL, and a free T4 > 12.0 ng/dL. The diagnosis was iatrogenic hyperthyroidism. Licensee’s diagnosis and treatment of hypothyroidism was not medically indicated and his ongoing treatment of Patient G with thyroid medication exposed her to the risk of harm.

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

Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee understands that all open Board investigations into his conduct will be closed with the signing of this Order by the Board Chair. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s records. Licensee admits that he engaged in the conduct described in paragraph 3, and that this conduct violated: ORS 677.190(13) gross or repeated acts of negligence. Licensee understands that this Order is a
public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

5.

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

5.1 Licensee must pay a civil penalty of $2,000, payable in two equal installments of $1,000, within 90 days and 180 days from the signing of this Order by the Board Chair.

5.2 Licensee may only work as a physician at a practice setting that is approved in advance by the Board’s Medical Director. Licensee must submit any practice setting to the Board’s Medical Director for review and approval prior to beginning work as a physician at the proposed position.

5.3 Licensee must not practice “anti-aging” medicine or endocrinology. This limitation on the license of Licensee prohibits Licensee from treating or diagnosing endocrine disorders, to include diabetes, in all of its forms, and the diseases of thyroid, parathyroid, adrenal glands, pituitary and gonads. Licensee must make arrangements to provide coverage and referrals for endocrine disorder patients. This limitation on license prohibits Licensee from treating any patient with thyroid medication, human growth hormones or testosterone.

5.4 Licensee is reprimanded.

5.5 Licensee’s Interim Stipulated Order of August 13, 2011 is terminated.

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

5.7 Licensee must obey all federal and Oregon State laws and regulations pertaining to the practice of medicine.
5.8 Licensee stipulates and agrees that any violation of the terms of this Order constitutes grounds for further disciplinary action under ORS 677.190(17).

IT IS SO STIPULATED THIS 27th day of Sept, 2012.

SIGNATURE REDACTED

GERALD WENDALL MILLER, MD

IT IS SO ORDERED THIS 17th day of October, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

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

In the Matter of

ROBERT ALLEN READ, MD
LICENSE NO. MD21063

STIPULATED ORDER

1.

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

2.

Licensee is a general surgeon and has practiced medicine in Corvallis, Oregon since
1998. The Board opened an investigation into Licensee’s performance as a surgeon after
receiving a report that Licensee made a serious error in judgment and technique in 2006 when he
accidently entered a patient’s uterus and caused major complications while attempting to perform
a laparoscopic appendectomy on a patient who was in her third trimester. The Board’s
investigation included a review of five other cases where patients experienced serious
complications between 2000 and 2009. On January 6, 2011, the Board issued a Complaint and
Notice of Proposed Disciplinary Action, in which 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 by ORS 677.188(4)(a)(b)
and (e), and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

3.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order.
Licensee understands that he has the right to a contested case hearing under the Administrative
Procedures Act (chapter 183). Licensee fully and finally waives the right to a contested case
hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s
records. Licensee neither admits or denies, but the Board finds, that Licensee engaged in the
conduct described in paragraph 2 and that this conduct violated ORS 677.190(1)(a)
unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a)(b) and (c), and ORS
677.190(13) gross or repeated negligence in the practice of medicine. Licensee understands that
this Order is a public record and is a disciplinary action that is reportable to the Data Bank and
the Federation of State Medical Boards.

4.
Licensee and the Board agree that the Board will close the investigation and resolve this
matter by entry of this Stipulated Order, subject to all of the following conditions:
4.1 Licensee is reprimanded.
4.2 Licensee is fined $3,500, which is payable within 60 days from the date this Order
is signed by the Board Chair.
4.3 Licensee must have a surgeon who will scrub in and assist Licensee for the
entirety of all complicated surgical procedures as defined by the Board’s Medical Director. The
assisting surgeon cannot be a physician assistant or nurse practitioner, and must be board-
certified in surgery. After six months from the date this order is signed by the Board’s Chair,
Licensee may request in writing to have this term modified. This assisting surgeon must also
report in a timely manner to the Board’s Medical Director if serious complications occur.
4.4 Licensee must allow for communication between the Board’s Medical Director
and any medical facility where he will be operating to discuss these complicated surgical cases,
4.5 Licensee’s practice location must be pre-approved by the Board’s Medical
Director.
4.6 Licensee must establish and maintain care with healthcare providers pre-approved
by the Board’s Medical Director and sign appropriate releases of information to allow for
communication between the providers and Board’s Medical Director.
4.7 Licensee must complete a health assessment at a medical facility that is pre-approved by the Board's Medical Director within one year from the signing of this Order by the Board Chair. Licensee must sign any releases to allow full communication between the evaluators and the Board. Licensee must cover all expenses associated with the assessment, to include travel, lodging, and testing.

4.8 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).

5.

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

IT IS SO STIPULATED this 2nd day of September 2012.

SIGNATURE REDACTED

ROBERT ALLEN READ, MD

IT IS SO ORDERED this 11th day of October 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

W. KENT WILLIAMSON, MD
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
CAROL GRAMMER STULL, MD)
LICENSE NO. MD21384)

) STIPULATED ORDER)

1.
The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Carol Grammer Stull, MD (Licensee) is a licensed physician in the state of Oregon.

2.
On April 24, 2012, the Board issued a Complaint and Notice of Proposed Disciplinary Action, in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a $10,000 fine, and assessment of costs, pursuant to ORS 677.205, 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 negligence.

3.
Licensee practices obstetrics and gynecology (OB-GYN) at Women’s Healthcare Associates in Portland, Oregon. Licensee’s acts and conduct that violated the Medical Practice Act follow:

3.1 Patient A, a 32 year old, gravida 0 (her first pregnancy) at 37 weeks gestation with a history of smoking and first trimester bleeding, was seen by Licensee on July 31, 2009 at Women’s Healthcare Associates. Licensee was substituting for Patient A’s primary prenatal care provider, who was out of town. During the examination, Licensee states that she confirmed normal fetal movement. However, a urine dip for protein revealed a 2+ protein. The blood
pressure was 134/72. During Patient A’s previous appointment on July 23, 2009, she first had a
2+ protein with a blood pressure of 120/78. Licensee also ordered a pregnancy induced
hypertension (PIH) panel. Licensee was not on call that weekend, and returned to work on
August 4, 2009. She did not ask the on-call physician to follow up on the time sensitive lab
work as would be expected. When she reviewed the laboratory report four days later, she noted
that Patient A’s uric acid level was 7.0 mg/dL. Licensee’s chart note was signed at 11:32 p.m.
on August 4, 2009. She had left a message for her assistant to call Patient A to inform her that
“soft signs of emerging PIH are seen in her labs” and that she “would prefer she discontinue
work and rest” and that Patient A “needs follow up testing this week.” The assistant called
Patient A at 2:31 p.m. on August 6, 2009. Patient A revealed the presence of headaches for two
days and was equivocal in terms of feeling fetal movement. Patient A was encouraged to
immediately come to the hospital, where no fetal heart tones were obtained. Labor was induced
and Patient A delivered a still born infant on August 7, 2009. Licensee failed to diagnose and
appropriately manage preeclampsia during the outpatient visit on July 31, 2009. Licensee failed
to order a 24 hour urine during this visit. She did not check out this patient to one of her
colleagues so that in follow up of the labs, the patient’s abnormal labs would have come to a
provider’s attention in a timely manner and appropriate management instituted which may have
prevented the fetal demise. In fact, she did not review the PIH lab work until four plus days
later. At that time she communicated indirectly and then relied on an office assistant, in whom
she lacked confidence, to give information of an urgent nature to Patient A. Her actions reflect a
lack of clinical recognition of a potentially serious pregnancy complication which needed to be
acted upon urgently.

3.2 The Board reviewed Licensee’s medical charts for Patients B – E, and had
additional concerns which are outlined in the Complaint & Notice of Disciplinary Action issued
April 24, 2012.

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4. Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s records. Licensee neither admits or denies, but the Board finds, that Licensee engaged in the conduct described in paragraph 3, and that this conduct violated 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 negligence. Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the DataBank and the Federation of State Medical Boards.

5. Licensee and the Board agree 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 is placed on probation for 5 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. In the event that Licensee discontinues her practice in the state of Oregon, this term shall be held in abeyance until such time that Licensee returns to practicing in Oregon.

5.3 Within 18 months from the signing of this Order by the Board Chair, Licensee must successfully complete an American College of Obstetricians and Gynecologists (ACOG) post graduate course in perinatal medicine that is pre-approved by the Board’s Medical Director.

5.4 Licensee must obtain a consultation with a board certified, fellowship trained Maternal Fetal Medicine physician pre-approved by the Board’s Medical Director for the next ten moderate to high risk deliveries that Licensee is scheduled to perform.
5.5 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

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

5.7 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 5th day of September, 2012.

SIGNATURE REDACTED

CAROL GRAMMER STULL, MD

IT IS SO ORDERED THIS 11th day of October, 2012.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

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

In the Matter of

VERNON HOWARD USHER, MD
LICENSE No. MD09413

INTERIM STIPULATED ORDER

1.
The Oregon Medical Board (Board) is the state agency responsible for licensing,
regulating and disciplining certain health care providers, including physicians, in the state of
Oregon. Vernon Howard Usher, 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 Board believes it necessary that Licensee agree to immediately to
comply with all of the terms of this Order until the Board completes its investigation.

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 each of the
following conditions, effective the date this Order is signed by Licensee:

3.1 Licensee must practice only under the personal supervision of a board-certified
anesthesiologist, who is licensed by this Board. The supervising anesthesiologist shall be pre-
approved by the Board’s Medical Director in writing.

3.2 The personal supervision must entail 100 percent of Licensee’s practice. The
supervising anesthesiologist must be personally present at all times when Licensee is delivering
anesthesia services to a patient.

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Page -1  INTERIM STIPULATED ORDER – Vernon Howard Usher, MD
3.3 The supervising anesthesiologist must notify the Board in a timely manner about complications involving any patient for whom Licensee has provided care. The supervising anesthesiologist shall make the notification by contacting the Board's Medical Director, or the Chief Investigator, if the Medical Director is unavailable.

3.4 Licensee must provide a copy of this Order to any medical facility where Licensee is practicing or shall be practicing at.

3.5 Licensee understands that violating any term of this Order will be grounds for disciplinary action under ORS 677.190(17) and a possible emergency suspension of his license.

4.

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

5.

This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure. However, as a stipulation this Order is a public document and is reportable to the national Data Bank and the Federation of State Medical Boards.
6.

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

IT IS SO STIPULATED THIS \underline{38th} day of \underline{Oct}, 2012.

SIGNATURE REDACTED

VERNON HOWARD USHER, MD

IT IS SO ORDERED THIS \underline{9th} day of \underline{October}, 2012.

State of Oregon
OREGON MEDICAL BOARD

SIGNATURE REDACTED

EXECUTIVE DIRECTOR
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of: 
HARRIS J. WATERS, MD
LICENSE NO. MD15831

STIPULATED ORDER

1.
The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. Harris J. Waters, MD (Licensee) is a licensed physician in the State of Oregon.

2.
In a Second Amended Complaint and Notice of Proposed Disciplinary Action dated July 5, 2012, 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 a board certified general surgeon. Licensee’s acts and conduct that violated the Medical Practice Act follow:

3.1 On July 13, 2009, Licensee attempted to repair a large ventral incisional hernia on Patient A, a 60 year old female, at Silverton Hospital. Licensee reports that due to dense adhesions from her previous surgery, he had to perform a significant lysis of adhesions. During that procedure, Licensee made an enterotomy in the small bowel, which he repaired. Due to the risk of infection, Licensee did not place a mesh at this time, but washed out her abdomen and put her on antibiotics. The Licensee placed a central line in the subclavian vein for total parenteral

PAGE 1 – STIPULATED ORDER - Harris J. Waters, MD
nutrition (TPN). Licensee sutured the catheter in place. Licensee was handed a 30 cm central line, instead of a 16 cm line that he was accustomed to using. Licensee did not notice this, and did not request a different central line. Licensee subsequently ordered a stat chest x-ray. (The purpose of this x-ray after catheter placement is to check for possible complications and to confirm that the catheter is in a safe position—typically above the heart in the superior vena cava.) The x-ray report included the following finding: “A central line tip probably lies within the right atrium. No pneumothorax is apparent.” The location of this line put Patient A’s heart at risk of perforation. Licensee never asked to see the x-ray, and did not read the x-ray report. Nevertheless, Licensee gave his approval to use the catheter. The radiologist at Silverton Hospital did not call Licensee to alert him of the catheter position.

3.2 Licensee returned Patient A to surgery on July 15, 2009 for hernia repair with mesh. Licensee did not review the placement of the central line. Licensee continued Patient A on antibiotics and TPN post-operatively. Unfortunately, the tip of the central line was within the heart and was never checked or adjusted. Patient A initially appeared to progress well post-operatively and was ambulating on July 17th. Patient A was scheduled for discharge on July 18, 2009. On the morning of July 18th, Patient A went into cardiac arrest requiring a full code. The attending health care team assumed that Patient A had suffered a myocardial infarction, but was unable to resuscitate Patient A. The autopsy report reflects that the cause of death was: “surgical repair of a ventral hernia with multiple postoperative complications.”

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

Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee and the Board agree that all currently open Board investigations into his conduct will be closed with the signing of this Order by the Board Chair. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s records. Licensee admits that he engaged in the conduct described in paragraph 3, and that this conduct violated:
ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a).

Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the national DataBank and the Federation of State Medical Boards.

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:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a fine of $4,000, payable in full within 60 days from the signing of this Order by the Board Chair.

5.3 Licensee must successfully complete a course on ultrasound guided line placement that is pre-approved by the Board’s Medical Director.

5.4 For the placement of any guided line, Licensee must use ultrasound to guide and confirm the placement of the line into a patient. Licensee must affirmatively verify the placement of any guided line (and confirmed placement of the line) in the chart within 24 hours of the procedure. The Board makes this requirement to provide real time confirmation of guided line placement in order to enhance patient safety.

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

5.6 Licensee must obey all federal and Oregon State laws and regulations pertaining to the practice of medicine.
5.7 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 17\textsuperscript{th} day of August, 2012.

\textbf{SIGNATURE REDACTED}

\textsc{HARRIS J. WATERS, MD}

IT IS SO ORDERED THIS 11\textsuperscript{th} day of October, 2012.

\textsc{OREGON MEDICAL BOARD}
\textsc{State of Oregon}

\textbf{SIGNATURE REDACTED}

\textsc{W. KENT WILLIAMSON, MD}
\textsc{BOARD CHAIR}