



*The mission of the Oregon Medical Board is to protect the health, safety and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.*

## Two New Members Join the Board

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The Oregon Medical Board welcomes two new members. Paul Chavin, MD, and Melissa Peng, PA-C, were sworn in on April 7, 2016.

Dr. Paul Chavin earned his medical degree from Loyola Stritch School of Medicine in Maywood, Illinois, and completed his internship and residency at the Medical College of Wisconsin in Milwaukee. Following his training, Dr. Chavin served as a Lieutenant Commander (LCDR) in the United States Navy.

Since relocating to Oregon, Dr. Chavin has practiced obstetrics and gynecology in the Eugene and Springfield area. He is the former chief of staff of McKenzie Willamette Hospital, past chairman of the board of Pacific Source Health Plans, and past president of the Lane County Medical Society. He has worked with Volunteers in Medicine in Springfield and Bend.

Outside of his medical practice, Dr. Chavin is a member of the International Society of Rotary and enjoys golf, tennis, biking, and

spending time with his wife, children, and grandchildren.

The Physician Assistant seat is new to the Board in 2016 following the successful passage of Senate Bill 905 in 2015. The Board is delighted to welcome Melissa Peng, PA-C, as its first Physician Assistant member.

Ms. Peng works for Providence Medical Group and Coffee Creek Correctional Facility. Ms. Peng received her Masters of Science in Physician Assistant Studies from Pacific University and her Masters of Public Health from Oregon State University.

Ms. Peng is certified by the National Commission on Certification for Physician Assistants. She is a current member of the Oregon Physician Assistant Society and the Oregon Medical Association.

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Paul A. Chavin, MD



Melissa Peng, PA-C

**Statement of Purpose:** *The OMB Report is published to help promote medical excellence by providing current information about laws and issues affecting medical licensure and practice in Oregon.*

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## New Board Members

*(Continued from front page)*

Ms. Peng previously served as a Committee member on the Board's former Physician Assistant Advisory Committee from 2013 - 2015. She has also worked as an independent consultant for the Board.

Ms. Peng is a member of the Mittleman Jewish Community Center where she is on the fitness committee, is active in her children's public schools and volunteers at Friends of Terwilliger and SW Watershed with her family. In her spare time, Ms. Peng enjoys hiking, biking and camping with her family as well as enjoying the culinary scene in the Northwest.

Dr. Chavin succeeds Roger M. McKimmy, MD, who completed two consecutive terms. Dr. McKimmy served as Board Vice Chair in 2012 and as Board Chair in 2013. Dr. McKimmy also chaired the Investigative Committee in 2012. The Board thanks Dr. McKimmy for his six years of dedicated service to the Board. +

## State Emergency Registry of Volunteers

### *You Could Make a Difference*

The State Emergency Registry of Volunteers in Oregon (SERV-OR) is a statewide registry system to help pre-credentialed health care professionals volunteer their services during emergencies. The registry is sponsored by the Oregon Public Health Division in partnership with the Medical Reserve Corps. SERV-OR uses a secure database to register, credential and alert volunteer health providers. The registry meets a critical need and results in significant health impacts in the community.

To be eligible for the registry, healthcare providers must have an active or emeritus license in good standing, complete relevant training and pass a criminal background check. SERV-OR, a service of the Oregon Health Authority, provides training opportunities in areas such as disaster response, advanced and basic life support and radiation response. Interested licensees may sign up for the statewide unit known as the State Managed Volunteer Pool or the county program known as the Medical Reserve Corps.

To register, visit [www.SERV-OR.org](http://www.SERV-OR.org) and choose "Register Now." For additional information, e-mail the systems coordinator at [serv.or@state.or.us](mailto:serv.or@state.or.us) or call 1-877-343-5767. +

Put your skills to use.

Register and train to take part in Oregon's disaster response program.

*FOREWORD: The Board advocates for licensee wellness at every opportunity. Prevention, treatment, and rehabilitation efforts have led to improvements in the Health Professionals' Services Program (HPSP) and the inception of the initiative described below. Dr. Girard has helped the initiative blossom and probed every opportunity and potential resource. The Board is deeply committed to the wellness program but will rely on its partner organizations to establish the program in order to ensure complete confidentiality. Our deepest appreciation goes to those organizations and to Dr. Girard for his unrelenting dedication.*

## The Oregon Physicians' Initiative: The Coalition for Professional Enhancement

*By Donald Girard, MD, Board Vice Chair*

Health care professionals are exposed to and endure some of the most difficult themes life has to offer. That is part of the sacred covenant of medicine. Indeed, physicians share an intimate connection with their patients that is unmatched by any other cohort of professionals in any domain. Those relationships are usually wonderful and add immeasurably to physicians' life experiences. However, they can be difficult, emotionally disruptive, and occasionally destructive. These too are the responsibility of the physician to work through, put into perspective and live with. So what in our formal education affords us the skills to deal with the wonderful and the tragic life events? What in our culture affords us the guidance in navigating these themes?

The long held tradition of the physicians' creed is that we do not need help, that we march forward, unaffected by personal failures or professional setbacks. And we are to devote fully to our patients and their needs. The Physician's Oath spells out our responsibilities very clearly: patients first and always first.

However, physicians are human. We should have the support of colleagues and other professionals to help attenuate both celebrations and defeats. We need mentors and more experienced individuals to help guide us through the emotional highs and lows. Just as others, peer support, reflection, and counsel help us moderate and learn from these experiences and prepare us for the next set, the next time. There is no formal part of any

medical school or graduate medical education or continuing medical education curriculum that prepares us for these critical events. And this void in our training is apparent as we observe the impact on physicians in the course of their professional lives. This training void takes us down.

**THE CULTURE:** William Osler, MD, the first Chair of Medicine at Johns Hopkins Hospital and perhaps the most highly reputed physician in the dawn of the twentieth century, in his famous *Aequanimitas*, exhorted the men of medicine to give up their personal lives, to follow the path of caring for the sick. Eugene Stead, Jr., MD, the famous Chair of Medicine at Duke University, apologized to his all male interns that they were on call but every other night and thus would miss half the patients. Michael DeBakey, MD, the Chair of Surgery at Baylor College of Medicine in Houston, and the most highly recognized pioneer of cardiothoracic surgery in the world, structured the surgical ICU rotation for his residents so they would spend all days, nights, and weekends of the three months in the windowless basement of Methodist Hospital in Houston, save for two hours on Sunday noon, when they could visit family in the hospital lobby. Even today, residents are bound to spend 80 hours per week during training, a commitment often scoffed at by the old and established physician. It is often said that the young doctor has not learned enough to enter the

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## The Oregon Physicians' Initiative

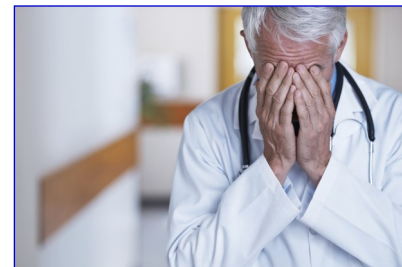
*(Continued from page 3)*

real world of practice, nor is trained to work hard enough to meet peer expectations.

Currently, about 950,000 physicians, allopathic and osteopathic, are practicing in the U.S. The average age at graduation from medical school is 27-29 years. Approximately half are men and half women. The average debt burden per graduate from medical school alone today is roughly \$225,000. The average career length is 29 years. The distribution of physicians is increasingly specialty medicine. Forty years ago, the majority of physicians remained generalists and today less than 20% are generalists. In contrast to 40 years ago, more than half of physicians work for large business networks, have little or no oversight authority, and are purely resources for "patient care output." All employed doctors are required to meet productivity standards for reimbursement. In the early 1970s, the majority of physicians were represented by medical societies, local, regional and national. Through them physicians negotiated with payers, established their codes of ethics, and developed networks where doctors worked together to care for patients. Beginning in the early 1980s the "world of Wall Street" began to realize the capital value of medicine and since that time the profession has become increasingly industrialized. It is now huge business, with buying and selling large healthcare institutions occurring continually to the highest set of bidders, without physicians or other health care professionals in any sense involved in their own destiny.

In sum, the physicians of today are in debt, overcommitted and have little authority in their professional lives. We are made to believe that we are healers with no need for personal healing. Instead, we should follow the path of our mentors where medicine is the only marriage in life.

**THE PROBLEM:** Impairment is the final step of a continuum, the presence of which adversely affects the physician's abilities to carry out the sacred duties of medicine. While many think of impairment as the domain of addiction to drugs, alcohol or other substances, impairment actually comes in many forms and is just as capable in any form of obstructing the physician's work and resulting in patient harm. A disorganized practice, cognitive dysfunction, mental health disorders, falling behind in knowledge or skills, not maintaining professional boundaries, poor interpersonal skills, social isolation, and myriad personal issues, including spousal discord, financial concerns, malpractice threats, family illness and dysfunction are all examples of themes that impair us but are rarely given the attention that comes with the addiction illnesses. Unaddressed, these are often more subtle but just as devastating. But if the sacred covenant among physicians is to first do no harm and ultimately protect those for whom we have care responsibilities, impairment must be prevented, or at the very least identified and treated at its earliest appearance.



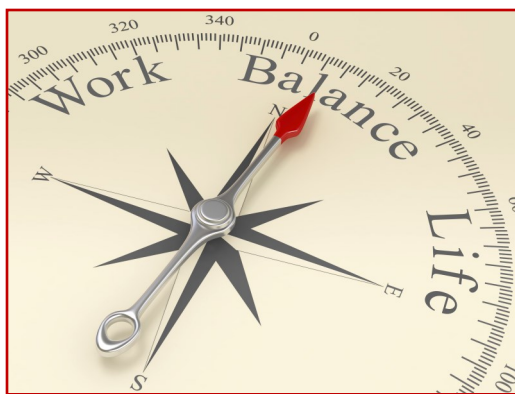
Suicide is the most visibly tragic failure among physicians. More than twice as many physicians, men and women, commit suicide than age- and demographically-matched peer groups. But suicide is only a small part of the tragedies that physicians encounter during their lifetimes. As noted, there are myriad problems in the course of their complex lives which are not addressed in timely manner or at all, which impair their professional roles and which lead to spiraling events that often end careers, families, friends,

self-esteem and early death.

Unhappily, there is no single source for these spiraling tragedies, although they often follow a certain order. Often simple, unresolved challenges gain strength and momentum, when unattended, they lead to the precipitous slide that often has no turning back.

Physicians enter a career that is a calling; one where there is little role for failure. We are programmed to be there for others and put off immediate or even remote personal rewards and needs. That includes the receipt of timely health care and counseling and the myriad learning opportunities that life offers when one asks. Doctors have fewer personal physicians and see fewer health and mental health professionals, instead often opting to treat themselves (badly).

**THE SOLUTION:** Complex problems can often be solved by simple solutions if they are understood. The central challenging issues for physicians are twofold. First, physicians are products of endless support from others and now are expected to be endless support to others. Second, the culture into which they are expected to assimilate discounts – in fact rejects – the role of peer or professional help in addressing life’s challenges. Now is the time for a culture change to reinvigorate a plagued and unhappy profession. Now is the time to establish the balanced work-



life that is critical for personal wellness in today’s complex world.

Let us not forget our

promise in the Physician’s Oath to treat our colleagues as our sisters and brothers. So who

better to facilitate the transition than a group of our peers? By establishing a community of resources that are easily accessible, non-judgmental, and freely used by physicians, we can address the spectrum of issues ranging from personal to professional.

Oregon has the reputation for wellness innovation. The roots of the state’s involvement with physician health goes back more than 30 years when a flurry of suicides among Oregon physicians became the nidus for the formal establishment of a medical association and later a state program. The Health Professionals Program (HPP), established in the late 1980s to intervene on the behalf of physicians with substance abuse disorders, became a notable success. During its tenure, more than 78% of those who entered returned to full-time successful practice after five years. In addition, many of those who succeeded in the program became mentors for those just entering, and the program maintained the confidentiality of the practitioner to a great degree.

In the later part of the first decade of 2000, legislation reassigned participants in the HPP to the Health Professionals’ Services Program (HPSP), which exists to this time. The current program is committed to mirroring the success of the earlier program. Random urine monitoring is the centerpiece of the program. Treatment is available as an adjunct to the program. During the 2013 legislative session, changes were made to the law to allow for treatment arms as well as monitoring. That is good news.

Through organizational partnerships, a Coalition has formed among the Oregon Medical Association, the Oregon Medical Board, the Oregon Psychiatry Association, the Medical Society of Metropolitan Portland, the Lane County Medical Society, and the Oregon Health &

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## The Oregon Physicians' Initiative

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Science University Resident and Faculty Wellness Program. This Coalition has met several times to share experiences in program development. Principles that Coalition members agree are essential to the ultimate success of a program include:

1. Common protocols for entry, evaluation and treatment;
2. Standard qualifications for health care professionals who provide the treatment;
3. Financial support that is provided by umbrella groups rather than the individual health care professional;
4. Supportive peer professionals to provide counseling;
5. Increasingly sophisticated resources for the evaluation of physicians to help with better understanding of challenges and recommendations for their remediation;
6. Ability to address any variety of issues, including personal (relationships, marital discord, children, finances, etc.), professional (organization, charting, malpractice,

interpersonal skills, disruptive behavior, etc.), substance abuse, and mental health; and

7. Core tenets: confidentiality and professionalism in all relationships.

Oregon has the exceptional ability to gather myriad experienced and thoughtful peers, consultants, advanced degrees in social work, psychology, counseling, mental health, addiction medicine, psychiatry, and education and retraining to provide the professional resources necessary. The Coalition will create a network using the individual members' established resources and strengths, building upon the successes of the individual organizations to create a unified program.

**ENVISIONING THE ULTIMATE PROGRAM:** Entry to the program is confidential but carries no stigma because the services offered are vast and entry is open to all, both those needing help and those wanting to serve. The individual physician bears no costs; those are underwritten by the partner organizations and the health care systems in which the physicians work. These health care

### *The Physician's Oath (Declaration of Geneva)*

I solemnly pledge to consecrate my life to the service of humanity;  
 I will give to my teachers the respect and gratitude that is their due;  
 I will practise my profession with conscience and dignity;  
 The health of my patient will be my first consideration;  
 I will respect the secrets that are confided in me, even after the patient has died;  
 I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;  
 My colleagues will be my sisters and brothers;  
 I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;  
 I will maintain the utmost respect for human life;  
 I will not use my medical knowledge to violate human rights and civil liberties, even under threat;  
 I make these promises solemnly, freely and upon my honour.





systems provide critical support and understand that healthy healthcare providers are key to best practices and outcomes.

The Oregon Coalition leaders believe that physicians have long been denied the access to and learning from the vast curricula of opportunities available to the general population that affords improved coping skills and resilience and markedly diminishes the risks of burnout, career loss, and most

tragically suicide. The long standing belief that physicians are a singular professional group who can “march through” the personal tragedies of their own and their patients is just not reality. We need at least the same if not more help, advice, and resilience training in dealing with the inordinate stresses of the profession than perhaps any other group. To leave these treatable concerns unaddressed and untreated is not acceptable to our health care professionals or the patients they serve. +



Licensee health and wellness is a critical component in achieving the Oregon Medical Board’s mission of protecting patients while promoting access to quality care.

The Oregon Medical Board’s website has a Topics of Interest page with information on wellness programs and other resources.

Visit [www.oregon.gov/OMB](http://www.oregon.gov/OMB) and click on ‘Wellness’ under the Topics of Interest heading.

## *Father Palladino, Priest and Calligrapher, Remembered*

Pause for a moment today and look at your license certificate hanging on the wall. Is it written in hand calligraphy? In the 1980s and 1990s they all were, and Father Robert Palladino was the man behind the script. Fr. Palladino was the Board’s calligrapher before the Board moved to electronically printed licenses. His death on February 26, 2016, provides an opportunity to reflect on his fascinating life as well as this era in the Board’s history.

Fr. Palladino joined the Trappist Order of the Roman Catholic Church shortly after graduating from high school in 1950 and was ordained as a Catholic priest soon after. He left the priesthood in 1968, was married, and had a son. For the next 15 years, he taught calligraphy at Reed College in Portland, with one of his students being future Apple Computers co-founder Steve Jobs. After the passing of his wife, he provided his calligraphy

talents to the OMB. He was later reinstated into the priesthood, becoming Oregon’s first formerly married Catholic priest. He served parishes in Welches and Estacada.

Fr. Palladino led a remarkable life and leaves a legacy of beautiful work. His calligraphed Hippocratic Oath hangs in the Board’s library and remains a focal point of the Board’s meetings. The difficult decision to cease calligraphy on licenses was made in order to issue licenses quicker and more efficiently. If you have one of these licenses in your office, we hope you’ll cherish this piece of Board history. +



## Statement of Philosophy: *Pain Management*

The OMB urges the skillful use of effective pain control for all patients. Providers are encouraged to treat pain within the scope of their practice and refer patients to the appropriate specialists when indicated. In all cases of pain management, practitioners should maintain records to track prescriptions and coordinate care with other treating practitioners. Health care providers are encouraged to use the Oregon Prescription Drug Monitoring Program (PDMP), a division of the Oregon Health Authority, to help guide treatment plans. The PDMP is a database that allows prescribers of controlled substances to access a patient's name, the controlled substance prescribed, the dosage, and the name and contact information of the prescriber.

The National Transportation Safety Board recommends that health care providers discuss with patients the effect their medical condition and medication may have on their ability to safely operate a vehicle in any mode of transportation.

It is important for providers to be well-informed on relevant pain management techniques and hone their skills for the optimal treatment of their patients, taking into account the etiology of the pain. Types of pain include, but are not limited to, acute, post-operative or traumatic pain, chronic non-cancer pain, chronic pain caused by malignancies and pain associated with terminal illness.

### ACUTE PAIN

Effective treatment of acute pain promotes recovery and return to normal function. The potential for addiction is low when short courses of opioids are used to treat acute pain and discontinued as the patient recovers. Inadequately managed acute pain may result in chronic pain. Patients who are not recovering as expected must be carefully assessed. Skillful pain management techniques including oral, parenteral and, when available, regional pain management techniques, can achieve maximum patient comfort and may reduce the need for opioids.

### CHRONIC PAIN

Patients with chronic pain require complex care and treatment decisions for multi-faceted problems. Providers have a responsibility to diagnose and manage chronic pain while maximizing the benefits and minimizing the potential adverse effects of treatment. Opioids are not always required or effective for the treatment of chronic pain, and they should be discontinued if the patient's pain control or function does not improve with their use.

Pain management treatment must be evidence-based and individualized to the patient. Oregon statute protects providers from disciplinary action by the Board when prescribing or administering controlled substances as part of a treatment plan for pain with the goal of controlling the patient's pain for the duration of the pain. However, prescribing controlled substances without a legitimate medical purpose is prohibited.





Patient safety should be a key factor in determining a treatment plan for pain management. When the provider prescribes opioids as part of the treatment plan, the provider must consider drug safety, efficacy and treatment goals for the patient. Safe opioid prescribing requires knowledge of the pharmacology of various opioid classes, and of potential drug interactions. Opioids are most likely to be successful in reducing pain and restoring function when they are combined with other pain management approaches such as physical therapy and psychological techniques.

When prescribing opioids for chronic pain, Oregon law requires practitioners to provide careful assessment and documentation of the medical condition causing pain as well as co-morbid medical and mental health conditions. Goals for treatment should be established with the patient before prescribing opioids. The provider's assessment, diagnosis and discussion must be documented in the patient record. The diagnosis, drugs used, goals, alternatives, and side effects must be included in a signed document demonstrating consent and understanding of the treatment plan and its risks. A sample document may be found at [www.oregon.gov/OMB/pdfforms/materialrisknotice.pdf](http://www.oregon.gov/OMB/pdfforms/materialrisknotice.pdf). In addition to the signed informed consent document, a written patient-provider agreement is recommended for patients requiring opioids for chronic pain.

### TERMINAL ILLNESS

The OMB believes that physicians should make every effort to relieve the pain and suffering of their terminally ill patients. Patients nearing the end of their lives should receive sufficient opioid dosages to produce comfort. The physician should acknowledge that the natural dying process usually involves declining blood pressures, decreasing respirations and altered levels of consciousness. Opioids should not be withheld on the basis of physiologic parameters when patients continue to experience pain.

Some physicians express concerns that the use of opioids in these patients may hasten death through pneumonia or respiratory depression. For these reasons, at times physicians may have limited the use of opioids in dying patients out of fear that they may be investigated for inappropriate prescribing or allegations of euthanasia.

### **Surgery and Opioids**

Post-op patients are prescribed more opioids after elective surgery today compared to five years ago. The reason is not clear.

Some of those medications are not used by the patient for post-op pain. Excess opioids become part of Oregon's opioid abuse epidemic when they are obtained by adolescents and others for non-medical purposes.

Carefully consider the number of opioid tablets you routinely prescribe after elective surgery.

Caution patients to destroy unused prescription opioids.

The OMB is concerned that such fear on the part of physicians may result in inadequate pain control and unnecessary suffering in terminally ill patients. The OMB encourages physicians to employ skillful and compassionate pain control for patients near the end of life and believes that relief from suffering remains the physician's primary obligation to these patients. +

- Adopted January 15, 1993
- Amended April 16, 1999
- Amended July 9, 2004
- Amended April 8, 2011
- Amended January 10, 2013
- Amended April 8, 2016

## BOARD ACTIONS

January 9, 2016 to April 8, 2016

*Many licensees have similar names. When reviewing Board Action details, please review the record carefully to ensure that it is the intended licensee.*

### INTERIM STIPULATED ORDERS

*These actions are not disciplinary because they are not final orders, but are reportable to the national data banks.\**

**BUCKLER, Robert E., MD; MD13443**

**Woodburn, OR**

On April 7, 2016, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**CALCAGNO, John A., MD; MD14823**

**Gresham, OR**

On January 21, 2016, Licensee entered into an Interim Stipulated Order in which he agreed to not accept new ADD or ADHD patients and agreed to limitations on his prescribing of psycho-active medications pending the completion of the Board's investigation.

**HAMILTON, Anthony M., PA; PA01072**

**Klamath Falls, OR**

On February 26, 2016, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**KAHN, Heather A., MD; MD22858**

**Grants Pass, OR**

On January 29, 2016, Licensee entered into an Interim Stipulated Order to voluntarily restrict her prescribing of scheduled controlled substances for chronic pain patients pending

the completion of the Board's investigation into her ability to safely and competently practice medicine.

**LE, Christian T., MD; MD153577**

**Portland, OR**

On April 6, 2016, Licensee entered into an Interim Stipulated Order to voluntarily cease prescribing all controlled substances pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**REDFERN, Craig C., DO; DO14108**

**Portland, OR**

On February 19, 2016, Licensee entered into an Interim Stipulated Order to voluntarily cease prescribing all scheduled controlled substances within 60 days pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**RUSSELL, Jill R., DO; DO17341**

**Hillsboro, OR**

On March 15, 2016, Licensee entered into an Interim Stipulated Order to voluntarily limit her prescribing of controlled substances for chronic pain pending the completion of the Board's investigation into her ability to safely and competently practice medicine.

**RYSENGA, Juliet C., MD; MD18740**

**Ontario, OR**

On February 10, 2016, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from performing cataract surgery pending the completion of the Board's investigation into her ability to safely and competently practice medicine.

**TOMPKIN, Jane E., MD; MD18337**

**Portland, OR**

On February 8, 2016, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place her license in Inactive status pending the completion of

the Board's investigation into her ability to safely and competently practice medicine.

**YOON, Justin K., MD; MD162038**

**Pendleton, OR**

On January 15, 2016, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

## DISCIPLINARY ACTIONS

*These actions are reportable to the national data banks.\**

**BARNWELL, Stanley L., MD; MD17155**

**Portland, OR**

On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and violation of the federal Controlled Substances Act. This Order retires Licensee's medical license while under investigation.

**BOOHER, Benjamin W., DO; DO22832**

**Hermiston, OR**

On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross negligence or repeated negligence in the practice of medicine; willfully violating any provision of the Medical Practice Act or any rule adopted by the Board, or failing to comply

with a Board request; and prescribing controlled substances without a legitimate medical purpose, without following accepted procedures for examination of patients, or without following accepted procedures for record keeping. This Order surrenders Licensee's medical license while under investigation.

**CRAIGG, Gerald B.R., MD; MD22708**

**Walla Walla, WA**

On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional conduct and disciplinary action by another state of a license to practice medicine. This Order requires that Licensee comply with all prescribing restrictions imposed by the state of Washington in the state of Oregon.

**MIAN, Burhan A., MD; PG172422**

**Portland, OR**

On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; failure to report official action within 10 days; and failure to report a felony arrest. This Order surrenders Licensee's medical license while under investigation.

**WYMER, Todd A., LAc; AC165723**

**Portland, OR**

On April 7, 2016, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of a Board order or regulation. This Order reprimands Licensee; requires Licensee to provide a chaperone for all female patients over the age of 14; requires Board pre-approval of all practice sites; requires that Licensee complete a pre-approved course on professional boundaries; allows for no-notice site visits by the Board; restricts Licensee's use

### ATTENTION!

Dishonesty in any form on a license application or renewal is a violation of the Medical Practice Act. Therefore, the Board issues fines, or "civil penalties," for omissions or false, misleading or deceptive statements or information on an application for initial licensure or renewal.

Serious acts of dishonesty on an application are grounds for discipline.

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of social media with patients and former patients; and requires that Licensee chart every patient encounter.

## **PRIOR ORDERS AND AGREEMENTS MODIFIED OR TERMINATED**

**ANDREWS, David A., MD; MD09145**

**Hillsboro, OR**

On April 7, 2016, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 3, 2014, Stipulated Order.

**HSU, Monica, MD; MD155319**

**Tulsa, OK**

On April 7, 2016, the Board issued an Order Modifying Corrective Action Agreement. This Order modifies Licensee's April 3, 2014, Corrective Action Agreement.

**KORT, Daniel D., MD; MD18043**

**Salem, OR**

On April 7, 2016, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 2, 2015, Stipulated Order.

## **NON-DISCIPLINARY BOARD ACTIONS**

January 9, 2016 to April 8, 2016

### **CORRECTIVE ACTION AGREEMENTS**

*These agreements are **not disciplinary** orders and are not reportable to the national data banks\* **unless** they relate to the delivery of health care services or contain a negative finding of fact or conclusion of law. They are public agreements with the goal of remediating problems in the Licensees' individual practices.*

**MARATH, Aubyn, MD; MD21604**

**Sisters, OR**

On April 7, 2016, Licensee entered into a

Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course in documentation; to continue using the Prescription Drug Monitoring Program when prescribing controlled substances; and to consult with the primary care provider of any minor when authorizing a medical marijuana card.

**SARVER, Patrick J., MD; MD25942**

**Medford, OR**

On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved documentation and prescribing courses and open his practice to review by the Board of his charting and prescribing practices.

**WINDER, Donald E., Jr., PA; PA156714**

**Salem, OR**

On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on pain management; to write a paper on the contraindications to spinal injections for the treatment of pain; to shadow a board-certified pain specialist for 16 hours; and to provide a copy of the Corrective Action Agreement to all supervising physicians.

**WONG, Charles M., MD; MD14849**

**Portland, OR**

On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses on pediatric urgent care and medical documentation.

**ZIELINSKI, Leann A., DO; DO157231**

**Portland, OR**

On April 7, 2016, Licensee entered into a Corrective Action Agreement with the Board.

In this Agreement, Licensee agreed to complete pre-approved courses on professional boundaries and professionalism.

## CONSENT AGREEMENTS

*These actions are not disciplinary and are not reportable to the national data banks.\**

### **GRUCELLA, Christina M., MD; MD173835 Oregon City, OR**

On April 8, 2016, Applicant entered into a Consent Agreement with the Board. In this Agreement, Applicant agreed to obtain 76 hours of continuing medical education and obtain recertification from her specialty board.

### **SHIRAI, Kumiko, LAc; AC01219 Portland, OR**

On March 2, 2016, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to complete a 20-hour mentorship with a Board-approved clinical supervisor.

### **WILLIAMS, Kalaiselvi B., MD; PG175775 Portland, OR**

On January 20, 2016, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to practice under the supervision of pre-approved mentors, to include the submission of reports to the Board by the mentors.

*Current and past public Board Orders are available on the OMB website: <http://omb.oregon.gov/boardactions>. +*

*\*National Practitioner Data Bank (NPDB) and Federation of State Medical Boards (FSMB).*

## Acupuncture Renewals are Underway

Current acupuncture licenses expire June 30, 2016. A license not renewed by June 30 will lapse, and the licensee may not practice. To renew or check the status of a submitted renewal, visit <http://omb.oregon.gov/login>.

Submit your renewal by June 1, 2016, to ensure Board staff have time to review and process it.

For more information regarding renewals, renewal fees and continuing education audits, visit [www.oregon.gov/omb/licensing/Pages/RenewLicense.aspx](http://www.oregon.gov/omb/licensing/Pages/RenewLicense.aspx).

## OMB RESOURCES

All phone inquiries: 971-673-2700

Fax: 971-673-2670

Website: [www.oregon.gov/OMB](http://www.oregon.gov/OMB)

E-mail: [omb.info@state.or.us](mailto:omb.info@state.or.us)

### **Board Action Report:**

<http://omb.oregon.gov/boardactions>

### **Licensee Search:** <http://omb.oregon.gov/verify>

### **Complaint Form and Information:**

<http://omb.oregon.gov/complaint>

**E-mail:** [complaint.OMB.officer@state.or.us](mailto:complaint.OMB.officer@state.or.us)

### **Investigations Information:**

<http://omb.oregon.gov/investigations>

### **Statements of Philosophy:**

<http://omb.oregon.gov/philosophy>

### **Topics of Interest:**

<http://omb.oregon.gov/topics>

For more OMB resources, see back page.

# Oregon Administrative Rules

*Rules proposed and adopted by the Oregon Medical Board.*

The Oregon Medical Board and other state agencies operate under a system of administrative rules to ensure fairness and consistency in procedures and decisions. Periodically, these Oregon Administrative Rules (OARs) must be amended in response to evolving standards and circumstances. OARs are written and amended within the agency's statutory authority granted by the Legislature.

Rules go through a First and Final Review before being permanently adopted. Temporary rules are effective after First Review, but they expire in 180 days unless permanently adopted after a Final Review. Official notice of rulemaking is provided in the Secretary of State *Bulletin*. The full text of the OARs under review and the procedure for submitting comments can be found at: <http://omb.oregon.gov/rules>.

## Proposed Rules

*First Review*

### All Licensees

**OAR 847-015-0005; 847-015-0010; 847-015-0030: Prescribers of Controlled Substances**

The proposed rule amendments replace "physician" with "licensee" or "health care professional" to reflect that other health care professionals, specifically physician assistants and podiatric physicians, are authorized to prescribe controlled substances.

### Emergency Medical Services (EMS)

**OAR 847-035-0011: EMS Advisory Committee**

The proposed rule amendment requires that the physician members of the EMS Committee have at least two years of experience actively

practicing as Oregon EMS supervising physicians.

## Did You Know?



Members of the public are invited to provide comment on proposed administrative rules.

Public comments are accepted for **21** days after the notice is published in the Secretary of State *Bulletin*.

To access recent editions of the *Bulletin*, visit the Secretary of State website at

<http://arcweb.sos.state.or.us/pages/rules/bulletin/past.html>.

## Physician Assistants (PA)

**OAR 847-050-0010; 847-050-0027; 847-050-0036; 847-050-0037; 847-050-0040: Supervising Physician Organizations**

The proposed new OAR 847-050-0036 is a collective rule for all requirements for establishing and maintaining a supervising physician organization. The rule amendments (1) remove substantive provisions regarding agents, supervising physician organizations and supervision from the definitions rule; (2) add a definition for primary supervising physician; (3) clarify that a supervising physician must be available for synchronous communication with the physician assistant; (4) require each supervising physician who is a member of a supervising physician organization to be approved by the Board as a supervising physician; (5) remove the requirement for the primary supervising physician of a supervising physician organization to attest that all member supervising physicians have reviewed the statutes and rules on PAs because all member physicians will have done this through the



supervising physician application process; (6) require the Board to reduce the supervising physician application fee for physicians who volunteer in free or non-profit clinics; (7) clarify that the rules on supervision apply equally to supervising physician organizations, not just individual supervising physician-physician assistant teams; (8) require practice settings rather than locations to be listed in the practice agreement; (9) allow the supervising physicians within a supervising physician organization to collectively provide the 8 hours of on-site supervision and chart review; (10) outline statutory requirements for appropriate delegation of medical services to a physician assistant; and (11) provide the statutory

language that requires the supervising physician or supervising physician organization to ensure competent practice of the physician assistant. The rule amendments also contain general grammar and housekeeping updates.

## Adopted Rules

*Final Review*

### Medical and Osteopathic Physicians (MD/DO)

#### **OAR 847-023-0005: Qualifications for Volunteer Emeritus Licensure**

The rule amendments clarify that applicants for a Volunteer Emeritus license must be able to demonstrate competency to qualify for licensure like any other Oregon Medical Board applicant. Volunteer Emeritus applicants are required to demonstrate competency if they have not completed postgraduate training or been certified or recertified by an accepted specialty board within the past ten years or if the applicant has ceased the practice of medicine for 12 or more months. If the applicant has ceased the practice of medicine for 24 or more months, the applicant is required to complete a re-entry plan approved by the Board.

### Podiatric Physicians (DPM)

#### **OAR 847-008-0070; 847-017-0003; 847-017-0015; 847-017-0020; 847-080-0010; 847-080-0018; 847-080-0021; 847-080-0022; 847-080-0035: American Board of Foot and Ankle Surgery and the Council on Podiatric Medical Education**

The rule amendments update the name of the American Board of Podiatric Surgery (ABPS) to its current name, American Board of Foot and Ankle Surgery (ABFAS). The rules also update the name of the American Podiatric Medical Association Council on Podiatry Education to the Council on Podiatric Medical Education.

*For more information on OARs and the full text of the rules above, visit the Oregon Medical Board website at <http://omb.oregon.gov/rules> or call 971-673-2700. +*

## Speaker's Bureau

The Board offers in-person presentations to your group, which allows direct and open communication in an intimate setting about topics that affect you.

The Board provides a number of standard presentations on topics such as re-entry to practice, the investigative process and complaints, the licensure process, and physician assistant practice. Board staff can also create a specialized presentation to address your specific needs.

To request a presentation from the Board, e-mail the Board at [OMB.info@state.or.us](mailto:OMB.info@state.or.us), or call the Board at 971-673-2700.



**Oregon Medical Board**  
1500 SW 1st Ave, Suite 620  
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971-673-2700  
[www.oregon.gov/OMB](http://www.oregon.gov/OMB)

The OMB Office is open to  
the public Monday - Friday,  
8 am to 12 pm and  
1 pm to 5 pm

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**Acupuncture Renewals are Underway!**

*See page 13 for more information.*

### **UPCOMING MEETINGS**

June 2, 7:30 a.m.

#### **Investigative Committee**

June 3, 12 noon

#### **Acupuncture Advisory Committee**

June 8, 5 p.m.

#### **Administrative Affairs Committee**

July 7 - 8, 8 a.m.

#### **Board Meeting**

### **OFFICE CLOSURES**

Memorial Day

*Monday, May 30*

Independence Day

*Monday, July 4*

Labor Day

*Monday, September 5*

**Applicant/Licensee Services** (*new applications and renewals, address updates, practice agreements and supervising physician applications*):

<http://omb.oregon.gov/login>

#### **Licensing Call Center:**

9 am to 12 pm and 1 pm to 3 pm

Phone: 971-673-2700

E-mail: [omb.appdocuments@state.or.us](mailto:omb.appdocuments@state.or.us)

#### **Sign Up to Receive E-mail Notices:**

##### **Administrative Rules:**

<http://omb.oregon.gov/subscribe-rules>

##### **Board Action Reports:**

<http://omb.oregon.gov/subscribe-actions>

##### **EMS Interested Parties:**

<http://omb.oregon.gov/subscribe-ems>

##### **OMB Report** (*quarterly newsletter*):

<http://omb.oregon.gov/subscribe-newsletter>

##### **Public Meeting Notice:**

<http://omb.oregon.gov/subscribe-meetings>

##### **Quarterly Malpractice Report:**

<http://omb.oregon.gov/subscribe-malpractice>