Oregon Medical Board

BOARD ACTION REPORT

September 15, 2019

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between August 16, 2019, and September 15, 2019.

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

Printed copies of the Board Orders not provided with this report are available to the public. To obtain a printed copy of a Board Order not provided in this report, please complete the License Verification and Malpractice Report Request (http://www.oregon.gov/OMB/ombforms1/request-licensee-info-verification.pdf) found under the Forms 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.

Crupper, Michael Lee, AC; Applicant; Portland, OR
On September 5, 2019, Applicant entered into a Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to complete a 400-hour mentorship with a Board-approved clinical supervisor, and complete 60 hours of NCCAOM-approved CEUs.

***Gardner, Marion Lee, Jr., MD; MD17617; North Plains, OR**
On August 28, 2019, Licensee entered into an Interim Stipulated Order to voluntarily cease the initiation of chronic pain treatment with opioids; taper current chronic pain patients to 90 MED or less or transfer care of the patient; limit prescribing for acute pain; and comply with the Oregon Administrative Rules regarding treatment with controlled substances for weight reduction and maintenance of a log for dispensed controlled substances pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

***Laws, Craig Robert, MD; MD171675; Bend, OR**
On August 16, 2019, 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.

***Popowich, Yale Sands, MD; MD26661; Portland, OR**
On September 5, 2019, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 11, 2019, Stipulated Order.

***Rushton, Michael James, DPM; DP00321; Baker City, OR**
On September 5, 2019, the Board issued a Final Order for repeated acts of negligence in the practice of podiatry. This Order reprimands Licensee; places Licensee on probation for a minimum of 10 years; subjects Licensee to periodic chart audits by persons designated by the Board; subjects Licensee to no-notice chart audits and office visits by the Board's designee; requires Licensee to complete a pre-approved course on medical documentation; and assesses costs for the disciplinary proceedings.

Schlindwein, Jaclyn Marie, LAc; AC191087; Portland, OR
On September 4, 2019, Applicant entered into a Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to complete an 80-hour mentorship with a Board-approved clinical supervisor, and complete 15 hours of NCCAOM-approved CEUs.

Shortridge, Terry Wayne, MD; MD16008; Lebanon, OR
On August 30, 2019, the Board issued an Order Terminating Consent Agreement for Re-Entry to Practice. This Order terminates Licensee's February 27, 2019, Consent Agreement for Re-Entry to Practice.

***Zamora, Joanna Magdalena, MD; MD173312; McMinnville, OR**
On August 29, 2019, 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.

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 MARION LEE GARDNER, JR., MD LICENSE NO. MD17617	))))))	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. Marion Lee Gardner, Jr., MD (Licensee) is a licensed physician in the State of Oregon and holds an active medical license.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to certain terms until the investigation is completed.

3.

In order to address the Board's concerns, Licensee and the Board agree to the entry of this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee. This Order will remain in effect while this matter remains under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee must not begin treatment for chronic pain with opioids for any new or existing patient. For the purposes of this Order, chronic pain is defined as pain that persists or progresses over a period of time greater than 30 days.

3.2 Licensee must immediately begin to taper opioid medications for any chronic pain patient whose morphine equivalent dose (MED) is over 90 by at least 10% per month until

patient's MED is 90 or less unless the patient is currently enrolled in hospice or is currently receiving end of life care. If this exception applies, Licensee must certify on the written prescription that the patient is a hospice patient or receiving end of life care. Licensee may elect to transfer the care of any patient with an MED over 90 to another physician.

3.3 Licensee may treat patients for acute pain for no more than 30 days per year, with a maximum MED of 50.

3.4 Licensee must comply with the Oregon Administrative Rules regarding treatment with controlled substances for weight reduction and the maintenance of a log for dispensed or administered controlled substances.

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

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

4.

At the conclusion of the Board's investigation, the Board will decide whether to close the case or to proceed to some form of disciplinary action. If the Board determines, following that review, not to lift the requirements of this Order, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.410, which grants the Board the authority to attach conditions to Licensee's license to practice medicine. These conditions will remain in effect while the Board conducts a complete investigation in order to fully inform itself with respect to the conduct of Licensee. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as

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evidence in any judicial proceeding. However, as a stipulation this Order is a public document and is reportable to the National Practitioner Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 28th day of August, 2019.

[redacted]

MARION LEE GARDNER, JR., MD

IT IS SO ORDERED THIS 30th day of August, 2019.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

JOSEPH J. THALER, MD
Medical Director

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of CRAIG ROBERT LAWS, MD, MPH LICENSE NO. MD171675	)))))	INTERIM 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. Craig Robert Laws, MD, MPH (Licensee) is a licensed physician in the State of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to cease the practice of medicine until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

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

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

3.3 Licensee must notify the Oregon Medical Board within 10 days as to how patients may access or obtain their medical records.

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 Practitioner 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 16 day of August, 2019.

[redacted]

CRAIG ROBERT LAWS, MD, MPH

IT IS SO ORDERED THIS 22 day of August, 2019.

State of Oregon
OREGON MEDICAL BOARD

[redacted]

NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of YALE SANDS POPOWICH, MD LICENSE NO. MD26661	))) ORDER MODIFYING) STIPULATED ORDER)

1.

On April 11, 2019, Yale Sands Popowich, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On July 9, 2019, Licensee submitted a written request asking the Board to modify Term 4.2 of this Order, which reads:

> *4.2 The medical license of Licensee is suspended for a total of 90 days. The dates of suspension are from May 14, 2019 through June 13, 2019; from August 15 through September 15, 2019; and from December 27, 2019 through January 22, 2020.*

2.

Having fully considered Licensee's request, the Board modifies Term 4.2 of the April 11, 2019, Stipulated Order as follows:

> 4.2 The medical license of Licensee is suspended for a total of 90 days. The dates of suspension are from May 14, 2019, through June 13, 2019; and from August 15, 2019, through October 14, 2019.

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This modification becomes effective the date this Order is signed by the Board Chair. All other terms of the April 11, 2019, Stipulated Order are unchanged and remain in full force and effect.

IT IS SO ORDERED this 5th day of September, 2019.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

K. DEAN GUBLER, DO
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

IN THE MATTER OF:	)	
	)	
MICHAEL JAMES RUSHTON, DPM	)	**FINAL ORDER**
LICENSE NO. DP00321	)	
	)	

HISTORY OF THE CASE

On January 28, 2016, the Oregon Medical Board (Board) issued a Complaint & Notice of Proposed Disciplinary Action to Michael James Rushton, DPM.[1] On January 28, 2016, Dr. Rushton requested an administrative hearing. On September 14, 2016, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned the matter to Senior Administrative Law Judge (ALJ) Bernadette Bignon.

On November 9, 2016, ALJ Monica A. Whitaker held a telephone prehearing conference. Senior Assistant Attorney General Warren Foote represented the Board. Attorney Ellen Voss represented Dr. Rushton. The parties agreed to a hearing on April 3 and 4, 2017. Mr. Foote also agreed to set forth, in writing, the Board's proposed sanctions.

On February 2, 2017, the OAH reassigned the matter to ALJ Jennifer H. Rackstraw.

On March 15, 2017, the Board filed a Motion for Qualified Protective Order (motion). Dr. Rushton did not object to the motion.

By letter dated March 16, 2017, Mr. Foote outlined the Board's proposed sanctions against Dr. Rushton (Pleading P12).

On March 21, 2017, ALJ Rackstraw granted the Board's motion and issued a Qualified Protective Order Limiting Use and Disclosure.

On April 3 and 4, 2017, ALJ Rackstraw held a hearing at the Board's office in Portland, Oregon. Mr. Foote represented the Board. Mr. Pitcher represented Dr. Rushton. The following witnesses testified: Dr. Rushton; Eric Brown, Chief Investigator for the Board; Elliot Michael, DPM; Stacey Clarke, DPM; Byron Hutchinson, DPM; Stewart Jones, DPM; and Joseph Thaler, MD, Medical Director for the Board. Also present were Michele Sherwood, the Investigations Coordinator for the Board, and Kim McLain, the court reporter. The evidentiary record closed at the conclusion of the hearing on April 4, 2017.

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[1] Doctor of Podiatric Medicine.

On May 11, 2017, the OAH received the final written transcript of the hearing. The hearing record closed in its entirety on that date, and ALJ Rackstraw took the matter under advisement. ALJ Rackstraw issued a Proposed Order on January 19, 2018.

ISSUES

1. Whether Dr. Rushton engaged in unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), by practicing podiatry[2] in a manner that constituted, or may have constituted, a danger to the health or safety of a patient. *See* ORS 677.190(1)(a).

2. Whether Dr. Rushton committed gross negligence or repeated acts of negligence in the practice of podiatry. *See* ORS 677.190(13).

3. If one or both violations are proven, whether the Board may impose the proposed sanctions set forth in its March 16, 2017 letter. *See* Pleading P12; *see also* ORS 677.205(1) and (2).

EVIDENTIARY RULINGS

The Board's Exhibits A1 through A13 and Dr. Rushton's Exhibits R1, R2, R6 through R19, R27, R30, and R31 were admitted into the record without objection.[3] Pleadings P1 through P12 were also made a part of the record.

FINDINGS OF FACT

Dr. Rushton's Practice

1. Dr. Rushton has been a licensed podiatric physician[4] for at least 17 years. (Test. of Rushton; Tr. at 29, 274.) His current practice consists of conservative (*i.e.* non-surgical) care only. (*Id.* at 278.) He does not have any hospital privileges. (*Id.* at 30.)

2. Dr. Rushton is the only practicing podiatrist in Baker City, John Day, Ontario, and La Grande. (Test. of Rushton; Tr. at 277.) On Tuesdays, he practices in Baker City, Oregon. Every other Monday, he practices in John Day or Ontario, Oregon. On Wednesdays, he practices in La

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[2] ORS 677.010(15)(a) defines "podiatry" as follows:

> (A) The diagnosis or the medical, physical or surgical treatment of ailments of the human foot, ankle and tendons directly attached to and governing the function of the foot and ankle, except treatment involving the use of a general or spinal anesthetic [*with certain exceptions*]; and
>
> (B) Assisting in the performance of surgery, as provided in ORS 677.814.

[3] Although Dr. Rushton filed additional exhibits prior to the hearing, he elected to offer only those exhibits noted as having been admitted into the record.

[4] A podiatric physician refers to a physician licensed under ORS 677.805 to 677.840 to treat ailments of the human foot, ankle and tendons directly attached to and governing the function of the foot and ankle. ORS 677.010(14).

Grande, Oregon. On Thursdays and Fridays, he serves as the Medical Director of an orthotic laboratory in Utah. (*Id.* at 29-30, 277, 300.) On his practice days, he typically sees around 20 patients per day. (*Id.* at 300; Ex. A9 at 14.)

Neuroma Treatment

3. Neuromas are conditions commonly seen in podiatry practice. (Ex. A9 at 3.) After fasciitis, neuromas are the most common condition Dr. Rushton encounters in his practice. (Test. of Rushton; Tr. at 279.) An interdigital neuroma of the foot is typically referred to as a "Morton's neuroma." (Ex. A11 at 3.) Neuromas most often occur in either the second or third interspace of the forefoot, with up to 90 percent occurring in the third interspace. (Test. of Rushton; Tr. at 33; test. of Michael; Tr. at 85; test. of Hutchinson; Tr. at 242.)

4. Conservative treatment for neuromas includes new footwear, metatarsal padding, strapping, custom orthotics, anti-inflammatory medication, physical therapy, steroid injections, and sclerosing injections. (Exs. R15 at 3, R16 at 1; test. of Michael; Tr. at 65.) Dr. Rushton frequently treats neuromas with the use of orthotics and wide shoes. Less frequently, he administers sclerosing injections, using a 3 cc syringe, proximal to the joint and nerve. (Ex. A9 at 4; Test. of Rushton; Tr. at 36.) The injections are typically made in either the second or third metatarsal space, depending on the location of the patient's symptoms. (Test. of Michael; Tr. at 91.)

5. The established dosage for a sclerosing injection is 1 to 3 cc of 4 percent sclerosis solution. (Test. of Hutchinson; Tr. at 229-230; test. of Jones; Tr. at 447.) Dr. Rushton routinely administered 1 cc of 4.79 percent sclerosing solution to patients, but dosing ranged between 0.5 and 3 cc, depending on the patient. (Test. of Rushton; Tr. at 35-36.)

6. Sclerosing therapy generally consists of between three and seven injections. (Test. of Michael; Tr. at 97; test. of Hutchinson; Tr. at 227; test. of Jones; Tr. at 446.) If a patient shows improvement after the third sclerosing injection, most podiatric experts recommend completing a course of seven injections, and then waiting approximately three months to assess the efficacy of the treatment because the nerve may continue to improve for up to three months after the last injection. (Test. of Rushton; Tr. at 34, 50; test. of Jones; Tr. at 447.) If a patient is not seeing some therapeutic change between the third and fifth sclerosing injection, it is appropriate to discuss with the patient whether to continue with the full series of injections or to move on to some other type of treatment. (Test. of Michael; Tr. at 270.)

7. During a three-year period prior to December 2015, of 19 patients to whom Dr. Rushton administered sclerosing injections to treat neuroma, only one patient (Patient A) completed the entire course of seven recommended injections. Ten of the 19 patients only received one injection. (Ex. A9 at 4-5.) Some of those ten patients experienced "significant" symptom relief with only one injection; others may have experienced side effects or determined that the injection was worse than the symptoms of the condition. (*Id.* at 5, 7.)

8. Sclerosing therapy has a low risk of complications. (Test. of Michael; Tr. at 97; test. of Hutchinson; Tr. at 227; test. of Jones, Tr. at 446.) It is rare for one of Dr. Rushton's patients to require surgical treatment for neuroma. (Test. of Rushton; Tr. at 65-66.)

Charting and Medical Records

9. Patient charts assist in the delivery of quality care to patients. Chart notes substantiate patient diagnoses and treatments. They document what was treated, why it was treated, and the outcome of the treatment. They also act as a communication tool between providers and assist with continuity of care. (Test. of Michael; Tr. at 87-88, 271; test. of Jones; Tr. at 467.)

10. It is important for chart notes to be accurate. A provider is responsible for the accuracy of his or her chart notes. (Test. of Michael; Tr. at 88, 100.) Some patients are poor historians and may be confused regarding aspects of their medical history and past treatment. (Test. of Rushton; Tr. at 31; test. of Jones; Tr. at 470.) A patient chart containing erroneous information could impact future treatment for that patient and potentially lead to patient injury. (Test. of Michael; Tr. at 88-89.)

11. At hearing, the Board's Medical Director, Joseph Thaler, MD,[5] discussed the role of medical records in internal and family medicine as follows:

> [T]he medical record provides the story of a patient's medical problems. And as an internist, I would often take care of complex patients that had a need for specialists in many fields, whether it be their heart or their skin or their feet. And so I could not be expected to know everything about all those specialty areas. So very often, I would depend on the specialist to send me records so that I could understand what the patient was being treated for, how the treatment was going, and whether there were any complications or problems as a result of the treatment. Because the patients often return to their internist or their family doctor to either have things explained them about the treatment they're getting or because the patient's problem — for example, a diabetic patient will have foot problems, but they'll also have problems with their blood sugar, or their blood pressure, or their cholesterol.
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> So the job of most primary care physicians, like family physicians and internists, [is] just to try to integrate the care and understand what's going on for their patient, and to help to decide, well, do you need to see a

[5] Dr. Thaler has been the Medical Director for the Board since approximately 2012. He previously served as a Board consultant, a Board member, and Board chair. He received his medical degree from Case Western Reserve Medical School in Cleveland, Ohio. He completed his residency at Emory University in Atlanta, Georgia. He also completed one year of cardiology training at the University of California, San Francisco. He is board-certified in internal medicine. He practiced internal medicine in Oregon for 29 years. (Test. of Thaler; Tr. at 475-477.) As the Board's Medical Director, he reviews Board complaints and medical records from podiatrists, physician assistants, acupuncturists, doctors of osteopathy, and doctors of allopathic medicine. As an internist, he commonly saw patients who had received podiatric care and he reviewed podiatric records. (*Id.* at 480.)

podiatrist for your foot care or an eye doctor for your diabetic eye care. So it's a way to integrate the entire * * * view of the patient[.]

(Test. of Thaler; Tr. at 481-482.)

12. When a charting error is discovered, the provider should correct it and note the correction, or add an addendum to the chart that notes the correction. (Test. of Michael; Tr. at 88, 100; Test. of Hutchinson; Tr. at 243-244.) If a physician has a series of errors in his or her chart notes, the physician has an obligation to place an addendum in the notes to identify the errors. (Test. of Jones; Tr. at 472.)

13. The standard of care for podiatric physicians includes maintaining adequate chart notes. (Test. of Michael; Tr. at 87; Test. of Jones; Tr. at 467-468.) Stewart Jones, DPM, MS,[6] believes that physicians have an ethical obligation to maintain accurate chart notes. (Test. of Jones; Tr. at 472.)

14. In the opinion of Elliot Michael, DPM,[7] professional standards regarding charting and recordkeeping do not differ within geographic regions of Oregon, and they do not differ with regard to whether a podiatrist provides surgical versus non-surgical (*i.e.* more conservative) treatment. (Test. of Michael; Tr. at 119-121.) Although he recognizes that the community in which a podiatrist practices may affect whether he or she keeps electronic versus handwritten charts, Dr. Michael believes that "charting is charting," and the general standards for record keeping do not change based on where a podiatrist practices or whether a treatment provided is surgical versus conservative. (*Id.* at 271, 119-123.) He believes there are certain recordkeeping standards that are universal no matter where a person practices. (*Id.* at 120.)

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[6] Dr. Jones received a Master's of Science degree in 1995 and a podiatric medicine degree in 1997 from Barry University School of Biomedical Sciences in Miami Shores, Florida. He completed his residency in 1999 and a fellowship in 2000 at Kern Hospital and Medical Center in Warren, Michigan. He has been certified in foot and ankle surgery by the American Board of Podiatric Surgery since 2006. He has practiced podiatry in a group setting in Boise, Idaho for the past 16 years. He has treated all types of podiatric ankle and foot maladies. He has served on the Idaho State Board of Podiatry for the past four years. In that position, as well as his own practice, he has had the opportunity to see medical records from other podiatrists. (Ex. R7 at 1; test. of Jones; Tr. at 438-442.)

[7] Dr. Michael received his podiatric medicine degree from Scholl College of Podiatric Medicine, in Chicago, Illinois in 1986. He completed his residency at Medical Center Hospital, in Portland, Oregon in 1987. He is board-certified in foot and ankle surgery, rear foot and reconstructive ankle surgery, podiatric orthopedic medicine, and primary podiatric medicine. He is a Fellow in the American College of Foot and Ankle Surgery and in the American College of Foot & Ankle Orthopedics. He is a Member of the American Podiatric Medical Association, the Oregon Podiatric Medical Association, and the American Diabetes Association. From 1989 to 2007, he was the Residency Director at Legacy Portland Hospitals. From 1992 to 2007, he was a Graduate Medical Education Member at Legacy Portland Hospitals. From 2008 to 2014, he was a member of the Joint Residency Review Committee, and his responsibilities included review and accreditation of residency programs in podiatric medicine and surgery. From 2003 to the present, he has served as a Peer Reviewer at Legacy Portland Hospitals.[7] From 2015 to the present, he has been the Medical Director at Tuality Wound Clinic. (Ex. A12 at 1; test. of Michael; Tr. at 83-84.)

15. In the opinion of Byron Hutchinson, DPM,[8] there is a lower standard of care for recordkeeping in rural communities than in big cities such as Portland or Seattle because a private practitioner working in a small community is unlikely to have the type of recordkeeping technology (*e.g.* Epic, an electronic recordkeeping system) available to a practitioner working for a health care system in a major city. He also believes that there is a lower standard of care for recordkeeping with conservative care (such as the provision of orthotics) than with surgical care due to the "entirely different risk profile" for the two types of treatment. (Test. of Hutchinson; Tr. at 244-246.) He distinguishes between treating a patient with orthotics — which in his opinion does not pose a risk of harm to a patient — versus treating a patient surgically — which has associated risks and potential complications. (*Id.* at 246-247.)

16. During the time period relevant to this matter, Dr. Rushton utilized a "face sheet that contained billing information, and occasionally handwritten notes, for each patient encounter. (*See, e.g.*, Ex. A10 at 25-34; Test. of Rushton; Tr. at 54-55.) The "face sheets" were kept in the patient's file with the chart notes. (Test. of Rushton; Tr. at 55, 288.) The handwritten notations on the "face sheets" also appeared in the corresponding chart notes for each patient. (*Id.* at 288-290.)

17. In the medical records for Patients A through F, Dr. Rushton had the following recurring entry:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine.[9] This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness.

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[8] Dr. Hutchinson received his podiatric medicine degree from the California College of Podiatric Medicine in 1982. In 1984, he completed a residency in reconstructive foot and ankle surgery through the Waldo Podiatric Residency Program and Fifth Avenue Hospital, in Seattle, Washington. He is licensed in the state of Washington and certified by the American Board of Podiatric Surgery. Since 1987, he has been a staff physician at Highline Community Hospital; since 1994, he has been a staff physician at St. Francis Hospital (Franciscan Health System); and since 1997, he has been a staff physician at Swedish Medical Center. His current appointments include the following: Medical Director, Franciscan Foot & Ankle Institute; Medical Director, Foot and Ankle Services (Franciscan Health System); Trustee, Professional Affairs & Quality Committee (Franciscan Health System); Board of Directors, American College of Foot & Ankle Surgeons; Director of Surgical Missions and Member of the Board of Trustees, Waldo Medical Foundation; Member of Board of Trustees, International Foot and Ankle Foundation; Editorial Advisor, Ankle Surgery, Foot & Ankle Quarterly; and Credentials Committee, Franciscan Health System. His previous appointments include the following: President, Vice-President, Oral Examiner, and Board of Trustees Member of the American Board of Podiatric Surgery; Director of Residency Training at the Green River Surgery Center; Residency Director at Northwest Podiatric Residency at Providence Hospital; Member of the Joint Residency Review Committee for the American Podiatric Medical Association; and a Podiatric Consultant for the Washington State Department of Labor & Industry. He has authored 19 publications, and presented extensively on podiatric issues since 1982.[8] (Ex. R6 at 1-75; test. of Hutchinson; Tr. at 219-221.)

[9] Sometimes the chart note would indicate an injection number, such as "Injection #7." (*See, e.g.*, Ex. A3 at 16.)

(*See, e.g.*, Exs. A3 at 16, 18, 20; A4 at 2, 6; A5 at 2, 4, 6, 8; A6 at 2, 8; A7 at 2, 4, 8; A8 at 6, 8, 10.) Dr. Rushton actually administered between .5 cc and 3 cc of 4.79 percent sclerosing solution to Patients A through F. He would fill a 3 cc syringe all the way and then use the amount he deemed appropriate for the particular patient at the time. He did not document in any of the patients' charts whether he actually used .5 cc, or 3 cc, or an amount in between those two values. (Test. of Rushton; Tr. at 35-37; Ex. A1 at 2.) He did not place an addendum in any of the notes to identify the errors. (*See* Exs. A3 through A8, R8 through R13.)

Patient A

18. In April 2009, Dr. Stacey Clark, DPM, began treating Patient A for foot and toe pain. (*See* Exs. A2 at 104-105, R14 at 2-3; Test. of Clarke; Tr. at 174.) On May 13, 2010, Patient A presented to Dr. Clarke with complaints of pain in the left heel and left great toe. (Exs. A2 at 91, R14 at 4.) Dr. Clarke performed a chemical matrixectomy (*i.e.* permanent removal) of Patient A's left great toenail and diagnosed plantar fasciitis of the left foot. (Exs. A2 at 91-94, R14 at 4-5.) On August 29, 2011, Patient A presented to Dr. Clarke for a diabetes check-up and routine foot care. (Exs. A2 at 88, R14 at 7.) On April 5, 2012, Patient A presented to Dr. Clarke with bilateral heel pain. (Exs. A2 at 87, R14 at 8.)

19. On May 7, 2014, at the age of 64, Patient A presented to Dr. Rushton for evaluation of diabetic neuropathy and neuroma. (Ex. A3 at 29.) She complained of "burning, tingling and occasionally shooting" pain in her feet. (*Id.*) Dr. Rushton discussed oral treatment for neuropathy, encouraged the patient to follow up with her primary care provider or endocrinologist for diabetes management, discussed various treatments for neuromas (including rest, wide shoes, ice, injections, and orthotics), directed the patient to decrease or discontinue smoking, and fitted orthotics for her feet. (*Id.* at 30; *see also* Ex. R8 at 49.) Although Patient A informed Dr. Rushton that she had previously treated with another podiatrist for neuroma, without relief, Dr. Rushton never saw Dr. Clarke's chart notes. (Ex. A9 at 2.)

20. On May 14, 2014, Patient A presented for treatment of neuroma. Dr. Rushton noted in her chart that "[t]ouch, pin, vibratory and proprioception sensations are normal with exception to affected digits." (Ex. A3 at 27.) He also noted "pain with palpation to affected interspace with a positive Moulders and Sullivans [*sic*] sign." (*Id.*) He checked her orthotics for proper fit, noted that metatarsal splay was increased, and administered the first of seven recommended injections. The chart note for the visit states, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. This is injection #1.[10] I explained the

[10] *See also* Exhibit R8 at 48.

> likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision.

(*Id.* at 28.)

21. On May 21, 2014, Patient A presented to Dr. Rushton for continued treatment of neuroma. (Ex. A3 at 25-26.) Dr. Rushton noted that Patient A's lower extremity skin temperature was "warm to cool, proximal to distal;" her touch, pin, vibratory, and proprioception sensations were normal except for the affected digits; her deep tendon reflexes and muscle tone were normal; she had good coordination; and she had "pain with palpation to affected interspace with a positive Moulders and Sullivans sign [*sic*]." (*Id.* at 25.) Dr. Rushton also noted that he checked the patient's orthotics "for proper fit and wear patterns," he observed that her metatarsal splay was increased, and he instructed her to continue the orthotics use. (*Id.*) The chart note also contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. This is injection #2.[11] I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision.

(*Id.* at 26.) Neither the May 21, 2014 chart note nor the May 21, 2014 "face sheet" indicate whether Patient A experienced any improvement, reactions, or side effects from the first injection administered on May 14, 2014. (*See id.* at 25-26; *see* Ex. R8 at 47.)

22. On May 28, 2014, Patient A presented to Dr. Rushton for continued treatment of neuroma. (Ex. A3 at 23-24.) Dr. Rushton noted, "Patient states she can move her toes." (*Id.* at 23; *see also* Ex. R8 at 46 ("I can move my toes!").) He also noted that he checked the patient's orthotics "for proper fit and wear patterns," he observed that her metatarsal splay was increased,

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[11] The only difference between this chart note excerpt and the one that Dr. Rushton included in the May 14, 2014 chart note is that the May 14, 2014 excerpt referenced "injection #1" instead of "injection #2." (*See* Ex. A3 at 26, 28.)

and he instructed her to continue the orthotics use. (Ex. A3 at 24.) The chart note also contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. (Injection #3) This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision.

(*Id.*)

23. On June 4, 2014, Patient A presented to Dr. Rushton for continued treatment of neuroma. (Ex. A3 at 21-22.) Dr. Rushton noted that he checked the patient's orthotics "for proper fit and wear patterns," he observed that her metatarsal splay was increased, and he instructed her to continue the orthotics use. (*Id.*) The chart note also contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision. Return to clinic in one week.

(*Id.* at 22.) Neither the June 4, 2014 chart note nor the June 4, 2014 "face sheet" indicate how Patient A responded to the previous three injections (*i.e.* whether she experienced any improvement, reactions, or side effects from the injections).[12] (*See id.* at 21-22; *see* Ex. R8 at 45.)

[12] At hearing, however, Dr. Rushton testified that Patient A showed some improvement after receiving her first three injections, so he followed standard protocol and proceeded to continue with the fourth, fifth, sixth, and seventh injections. (Test. of Rushton; Tr. at 55.)

24. On June 11, 2014, Patient A presented to Dr. Rushton for continued treatment of neuroma. (Ex. A3 at 19-20.) Dr. Rushton noted that "[t]his will be her fifth injection." (*Id.* at 19.) He also noted that he checked the patient's orthotics "for proper fit and wear patterns," he observed that her metatarsal splay was increased, and he instructed her to continue the orthotics use. (*Id.* at 20.) The chart note also contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision. Return to clinic in one week.[13]

(*Id.* at 20.) Neither the June 11, 2014 chart note nor the June 11, 2014 "face sheet" indicate how Patient A responded to the previous four injections. (*See id.* at 19-20; *see* Ex. R8 at 44.)

25. On June 18, 2014, Patient A presented to Dr. Rushton for continued treatment of neuroma. (Ex. A3 at 17-18.) Dr. Rushton noted that he checked the patient's orthotics "for proper fit and wear patterns," he observed that her metatarsal splay was increased, and he instructed her to continue the orthotics use. (*Id.* at 18.) The chart note also contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. Injection #6. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision. Return to clinic in one week.

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[13] This excerpt is identical to the one in the June 4, 2014 chart note. (*See* Ex. A3 at 20, 22.)

(*Id.*) Neither the June 18, 2014 chart note nor the June 18, 2014 "face sheet" indicate how Patient A responded to the previous five injections. (*See id.* at 17-18; *see* Ex. R8 at 43.)

26. On June 25, 2014, Patient A presented to Dr. Rushton for continued treatment of neuroma. (Ex. A3 at 15-16.) Dr. Rushton noted that he checked the patient's orthotics "for proper fit and wear patterns," he observed that her metatarsal splay was increased, and he instructed her to continue the orthotics use. (*Id.* at 16.) The chart note also contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. Injection #7. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics; all of which we have or are trying at present, failure of this treatment possibly could result in surgical excision.
>
> Patient will return to clinic in 1 week.

(*Id.*) Neither the June 25, 2014 chart note nor the June 25, 2014 "face sheet" indicate how Patient A responded to the previous six injections. (*See id.* at 15-16; *see* Ex. R8 at 42.)

27. On July 30, 2014, Patient A again presented to Dr. Rushton with "symptoms consistent with a neuroma." (Ex. A3 at 13.) Dr. Rushton noted that the patient "states her condition is 70% better since the injections." (*Id.*; *see also* Ex. R8 at 41.) He also noted that Patient A's touch, pin, vibratory, and proprioception sensations were "normal," her epicritic sensations were "intact," and "Tinels sign, Mulder's sign and Valleix phenomenon [were] absent." (Ex. A3 at 13.) He recommended that Patient A follow up in two weeks, or as needed. (*Id.* at 14.)

28. On August 6, 2014, Patient A presented to Dr. Rushton with a new complaint — arch pain that extended up the leg. (Ex. A3 at 11-12.) Dr. Rushton noted that Patient A's Achilles reflex was 2/4 on the right and 2/4 on the left. Upon examination, he also noted the following:

> 15 degrees dorsiflexion with knee extended. Pain with palpation to the navicular at the insertion of the posterior tibial tendon. Also painful with palpation of the posterior tibial tendon behind the malleolus and up until it becomes the posterior tibial muscle. No other pain on palpation[.]

(*Id.*) Based on those findings, Dr. Rushton diagnosed Patient A with "[p]osterior tibial tendonitis." (*Id.* at 12; test. of Rushton; Tr. at 58.) He noted on a "face sheet" dated August 6, 2014, "Extensor tendon – possible rupture." (Ex. R8 at 40.) He explained to Patient A the etiology of posterior tibial tendonitis, as well as the various treatments for the condition—including rest, ice, analgesics, night splints, orthotics, steroid injections, physical therapy, and immobilization. He strapped the patient's second and third toes together,[14] fitted her for orthotics, and recommended "[i]buprofin 800 mg po Tid with food for inflammation." (Ex. A3 at 12.) After explaining the risks and benefits of administering an injection to the affected area, Patient A declined an injection. Under a section of the chart note titled "Discuss RX," it states "Physical Therapy evaluation and treatment for achilles [*sic*] tendonitis." (*Id.*; test. of Rushton; Tr. at 59-60.) Dr. Rushton recommended that Patient A follow up in two weeks, or as needed. (Ex. A3 at 12.)

29. On August 13, 2014, Patient A presented to Dr. Rushton with continued complaints of arch pain extending up the leg. (Ex. A3 at 9-10.) Dr. Rushton's findings upon examination were the same as those noted in the patient's August 6, 2014 chart note. (*See id.* at 9, 11-12.) He ordered an x-ray, re-strapped the patient's second and third toes together,[15] and recommended more ibuprofen for inflammation. The patient again declined an injection to the affected area. Under a section of the chart note titled "Discuss RX," it states "Physical Therapy evaluation and treatment for achilles [*sic*] tendonitis." (*Id.* at 10.) Dr. Rushton recommended that Patient A follow up in two weeks, or as needed. (*Id.*)

30. On August 20, 2014, Patient A presented to Dr. Rushton with continued complaints of arch pain extending up the leg. (Ex. A3 at 5-6.) Dr. Rushton noted that the pain had been ongoing for several months and that there was no initial event or trauma associated with the onset. (*Id.* at 5.) Dr. Rushton's findings upon examination were the same as those noted in the patient's August 6 and 13, 2014 chart notes. (*See id.* at 5, 9, 11-12.) He re-strapped the patient's toes,[16] recommended more ibuprofen for inflammation, and discussed proper shoes and the use of a night splint. The patient once again declined an injection to the affected area. Dr. Rushton fitted Patient A for a third pair of orthotics. (*See id.* at 6.) The chart notes do not contain an explanation or justification for the fitting. (*See id.* at 5-6.) Under a section of the chart note titled "Discuss RX," it states "Physical Therapy evaluation and treatment for achilles [*sic*] tendonitis." (*Id.* at 6.) Dr. Rushton recommended that Patient A follow up in two weeks, or as needed. (*Id.*)

31. On September 3, 2014, Patient A followed up with Dr. Rushton for arch pain extending up the leg. (Ex. A3 at 3-4.) Dr. Rushton's findings upon examination were the same as those noted in the patient's August 6, 13, and 20, 2014 chart notes. (*See id.* at 3, 5, 9, 11-12.) The patient again declined an injection to the affected area. Under a section of the chart note titled "Discuss RX," it states "Physical Therapy evaluation and treatment for achilles [*sic*]

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[14] *See also* Exhibit R8 at 40.

[15] *See also* Exhibit R8 at 39.

[16] *See also* Exhibit R8 at 38.

tendonitis." (*Id.* at 4.) Dr. Rushton recommended that Patient A follow up in two weeks, or as needed. (*Id.*)

32. On October 1, 2014, Patient A followed up with Dr. Rushton for arch pain extending up the leg. (Ex. A3 at 1-2.) Dr. Rushton noted that Patient A "has symptoms consistent with a neuroma." (*Id.* at 1.) His findings upon examination were the same as those noted in the patient's August 6, 13, and 20 and September 3, 2014 chart notes. (*See id.* at 1, 3, 5, 9, 11-12.) The chart note for the visit includes diagnoses of posterior tibial tendonitis and Morton's neuroma. (*Id.* at 1.) The chart note does not include clinical findings for Morton's neuroma, or the location of the diagnosed conditions. (*See id.* at 1-2.) Dr. Rushton administered a steroid injection (2.5 cc of lidocaine and .5 cc of kenalog) into Patient A's foot, to the "point of maximum tenderness." (*Id.* at 2; *see also* Ex. R8 at 36.) With regard to the injection, he noted the following:

> I explained the risks and benefits of an injection to the area. All the patient[']s questions were answered to their [*sic*] satisfaction. The patient agreed to an injection[.]

(*Id.*) Under a section of the chart note titled "Discuss RX," it states "Physical Therapy evaluation and treatment for achilles [*sic*] tendonitis." (*Id.* at 2.) Dr. Rushton recommended that Patient A follow up in two weeks, or as needed. (*Id.*)

33. On October 15, 2014, Patient A presented to Dr. Clarke with complaints of pain in the second and third toes of her left foot. As reported by the patient, Dr. Clark noted that the patient had been seeing Dr. Rushton for foot pain, he administered a series of shots for seven weeks, in August the patient's left second and third toes "separated," and she thereafter was unable to place weight on her left foot. (Exs. A2 at 40, R14 at 14.) Upon examination, Dr. Clark noted, in part:

> Splaying toe 2, 3 L. foot. They do not purchase the floor with standing.
>
> * * * * *
>
> Any attempt to exam the 2nd or the 3rd MTP elicits tear-inducing, severe pain L. foot.
>
> * * * * *
>
> Impression / Diagnosis: Plantar plate rupture with dislocation of the 2nd MTP and medial collateral ligament 3rd MTP with subsequent metatarsalgia and splay toes. This is all likely due to too many injections to the 2nd interspace.

(Exs. A2 at 40, R14 at 14.) Dr. Clarke informed the patient that she would likely require surgery, and she instructed Patient A to tape her toes down daily for four weeks and use an

insert. Dr. Clarke wrote in the chart note, "NO more injections to her foot." (Exs. A2 at 41, R14 at 15.)

34. On October 20, 2014, Dr. Clarke provided Dr. Rushton's office with a "Release of Medical Information" signed by Patient A, and requested all chart notes for Patient A. (Ex. A2 at 48.)

35. On November 12, 2014, Patient A presented to Dr. Clarke with continued complaints of pain in the second and third toes of her left foot. (Exs. A2 at 37-38, R14 at 17-18.) Dr. Clarke noted that the patient's pain was between an eight and a ten (with ten being the most painful), she had experienced no improvement since the October 15, 2014 visit, and she had additional pain in the ball of the left foot. Dr. Clarke noted the same physical findings as on October 15, 2014, provided the same impression/diagnosis, and recommended surgical intervention (specifically, "PIPJ arthrodesis of toes 2,3 and capsulotomy and stabilization of the MTPs with K-wire pinning"). (Exs. A2 at 37, R14 at 17-18.) She again noted "NO more injections" to Patient A's foot. (*See* Ex. R14 at 19.)

36. In a treatment note dated January 15, 2015, Dr. Clarke noted, in part, the following:

> The patient sustained plantar plate disruption of the second and third metatarsals related to multiple cortisone and sclerosing alcohol injections to the second and third interspaces. The toes are dislocating at the second and third MTP. There is extreme pain. Conservative options have been exhausted * * *. She * * * is willing to pursue surgical intervention to achieve pain relief and stability of the toes.

(Ex. R27 at 4; all caps omitted.)

37. On January 29, 2015, Dr. Clark performed the following surgical procedures on Patient A:

1. Arthrodesis of PIPJ of 2nd left toe.
2. Arthroplasty 4th left toe.
3. Capsulorrhaphy of 2nd MTP, 3rd MTP left foot.
4. Extensor digitorum tendon lengthening 3rd left toe.

(Exs. A2 at 15, 21; R27 at 9-10.)

38. At a post-operative visit with Dr. Clarke on June 15, 2015 (20 weeks post-operative), Patient A was discouraged that she "still can't make a regular step." (Exs. A2 at 3, R14 at 61.) Dr. Clarke noted that the patient walks with a limp, going down stairs and standing remained painful, she continued to have soreness in her toes and ball of the foot, and her pain was a five out of ten. (Exs. A2 at 3, R14 at 61.)

39. At follow-up visits on July 27, 2015 and September 28, 2015, Patient A reported to Dr. Clarke that her pain level was the same as prior to the surgery, yet it felt "different." (Ex.

R14 at 65, 73.) Dr. Clarke noted that Patient A was still limping and still keeping her second and third toes bandaged. (*Id.*) On September 28, 2015, Dr. Clark recommended additional surgery and discussed "full reconstruction with repair of medial col[l]ateral ligaments to the 3rd MTPJ and hemi arthroplasty to the 2nd MTPJ vs resection arthroplasty of the 2nd MTPJ." (*Id.* at 73.)

40. On November 12, 2015, Dr. Clarke performed a partial 2nd metatarsal head excision on Patient A's left foot. (*See* Ex. R14 at 84-85.) In a post-operative treatment note dated January 25, 2016, Dr. Clarke wrote that Patient A reported "90% improvement overall." (*Id.* at 91.)

Patient B

41. On July 8, 2014, Patient B was a 64-year-old female who presented to Dr. Rushton for treatment of neuroma. (Ex. A4 at 5-6.) Dr. Rushton noted in her chart that "[t]ouch, pin, vibratory and proprioception sensations are normal with exception to affected digits." (*Id.* at 5.) He also noted "pain with palpation to affected interspace with a positive Moulders and Sullivans sign [*sic*]." (*Id.*) He diagnosed Patient B with Morton's Neuroma, checked her orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and recommended that she ice the affected area and take ibuprofen for pain. (*Id.* at 5-6.) The chart note for that visit states, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections[.]

(*Id.* at 6.) Dr. Rushton directed the patient to return in two weeks. (*Id.*) A "face sheet" dated July 8, 2014 indicates that Patient B was a new patient for Dr. Rushton and that she received an injection on July 8, 2014. (Ex. R9 at 22.)

42. On July 22, 2014, Patient B presented for treatment of neuroma. Dr. Rushton noted in her chart that "[p]atient states it feels like [her] socks are rolled up underneath ball of foot." (Ex. A4 at 3.) He also noted that touch, pin, vibratory, and proprioception sensations were "normal," epicritic sensations were "intact," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient had pain "with evaluation and palpation of [the] affected interspace." (*Id.*) The chart note for the visit states, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or tow [*sic*] of the toes is a common symptom. As the nerve swells, it

> can be felt as a popping sensation when walking. Pain is intermittent and aggravated by anything that compresses the nerve. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and orthotics. Each of these modalities was discussed in detail with the patient. PARQ. Appropriate sized blanks in both width and length were selected for the patient. They were heated to the proper molding temperature in a convection oven. The orthotics were fitted to the patient's feet in a relaxed calcaneal stance position. The orthotics were checked for proper fit and set in a cold water bath. Instruct patient to take 600 mg ibuprofen[.]

(*Id.* at 3-4.) The chart note does not state whether Patient B received the second of the course of seven recommended injections.[17] (*See id.*) The July 22, 2014 "face sheet" shows that Patient B was fitted for a custom molded orthotic; it does not indicate that Patient B received an injection on July 22, 2014. (*See* Ex. R9 at 21.)

43. On June 9, 2015, Patient B presented to Dr. Rushton for treatment of neuroma. (Ex. A4 at 1-2.) Dr. Rushton noted in her chart that "[t]ouch, pin, vibratory and proprioception sensations are normal with exception to affected digits." (*Id.* at 1.) He also noted "pain with palpation to affected interspace with a positive Moulders and Sullivans sign [*sic*]." (*Id.*) He diagnosed Patient B with Morton's Neuroma, checked her orthotics for proper fit, noted that metatarsal splay was increased, and recommended that she ice the affected area and take ibuprofen for pain. (*Id.*) The chart note for that visit states, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections.

(*Id.* at 2.) A "face sheet" dated June 9, 2015 indicates that Patient B received an injection on that date.[18] (Ex. R9 at 18.) Neither the June 9, 2015 chart note nor the June 9, 2015 "face sheet" indicate whether, and to what extent, Patient B received past injections for neuroma. The medical records also do not indicate how Patient B responded to any such past treatment.[19] (*See* Exs. A4 at 1-2, R9 at 18.)

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[17] Dr. Rushton confirmed at hearing that Patient B did not receive a sclerosing injection on this date. (Test. of Rushton; Tr. at 67.)

[18] At hearing, Dr. Rushton confirmed that this was the patient's second injection (with the first having been almost one year prior). (Test. of Rushton; Tr. at 69; *see* Ex. A4 at 6.)

[19] At hearing, Dr. Rushton testified that Patient B "came back a year later because the injection she received a year earlier worked wonders. She came and she wanted a second one[.]" (Test. of Rushton; Tr. at 69.)

Patient C

44. On September 29, 2010, Patient C was a 68-year-old female who presented to Dr. Rushton "for evaluation for symptoms consistent with a neuroma." (Ex. R10 at 21.) The chart note for the visit states, in part:

> This has been going on for several months and has continued to get worse. It is aggravated by tight fitting shoes and activity, and sometimes aches even at rest. * * *. Patient states she had a shot last year by Dr. Kopp[.]

(*Id.*) Dr. Rushton also noted that touch, pin, vibratory, and proprioception sensations were "normal," "epicritic sensations were "intact," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient had pain "with evaluation and palpation of the affected interspace." (*Id.* at 21-22.) He diagnosed Patient C with Morton's neuroma and applied a "low dye type strapping" to the left foot "to encourage excellent biomechanical control." (*Id.* at 22.) The chart note states, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or two of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. Pain is intermittent and can be aggravated by anything that compresses the nerve. I explained the likely mechanical etiology of the discomfort and that the treatment consists of rest, wide shoes, ice, steroid or sclerosing injections, accommodative padding and/or orthotics. Each of these modalities was discussed in detail with the patient. PARQ.

(*Id.*) Dr. Rushton instructed the patient to take 600 mg of ibuprofen and return to the office in two weeks. (*Id.*) A "face sheet" for Patient C, dated September 29, 2010, notes that she was a new patient, that she received a shot by Dr. Kopp more than a year prior, and that she received a strapping on the left ankle or foot from Dr. Rushton on September 29, 2010. (*Id.* at 34.) The "face sheet" does not indicate that Patient C received any injections on that date. (*See id.*)

45. On October 13, 2010, Patient C returned to Dr. Rushton for "evaluation of a neuroma." (Ex. R10 at 19.) Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and the patient had pain "with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (*Id.*) He checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and recommended that she ice the affected area and take ibuprofen for pain. (*Id.* at 20.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in

> one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. Total number of injections 7. * * *. Return to the office in 1 week as that is the recommend[ed] period between injections, or as needed or directed differently. #2.

(*Id.*) An October 13, 2010 "face sheet" indicates that Patient C received injection "#2" on that date.[20] (*Id.* at 33.)

46. On October 20, 2010, Patient C presented to Dr. Rushton for evaluation of a neuroma. Dr. Rushton noted that the patient was "[s]till complaining of cramps." (Ex. R10 at 17.) He also noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and the patient had pain "with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (*Id.*) He checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and recommended that she ice the affected area and take ibuprofen for pain. (*Id.* at 18.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. Total number of injections 7. * * *. Discussed stretching and diet changes for cramps. Return to the office in 1 week as that is the recommended period between injections, or as needed or directed differently. #3.

(*Id.*) Neither the October 20, 2010 chart note nor the October 20, 2010 "face sheet" indicate how Patient C responded to her previous injection[s]. (*See id.* at 17-18, 32.)

47. On October 27, 2010, Dr. Rushton administered the fourth injection to Patient C. (Ex. R10 at 15-16, 31.) On November 3, 2010, he administered the fifth injection to Patient C. (*Id.* at 13-14, 30.) On November 10, 2010, he administered the sixth injection to Patient C. (*Id.* at 11-12, 29.) On November 17, 2010, he administered the seventh injection to Patient C. (*Id.* at 9-10, 28.) The chart notes for each of those four visits are nearly identical.[21] (*See id.* at 9-16.) None of the chart notes or "face sheets" for those visits state how Patient C responded to her previous injections. (*See id.* at 9-16, 28-31.)

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[20] It is possible that Dr. Rushton considered injection #1 to be the shot that Dr. Kopp reportedly administered to Patient C in 2009. (*See* Ex.R10 at 21.)

[21] One difference, however, was that the November 17, 2010 chart note, unlike the others, states that the injection administered on that date was the "7th and final shot." (*See* Ex. R10 at 10.)

48. On December 12, 2012, Patient C presented to Dr. Rushton for evaluation of a neuroma. (Ex. R10 at 7-8.) The chart note for the visit is nearly identical to the chart notes from October 27, 2010 and November 3, 10, and 17, 2010.[22] (*See id.* at 7-16.) The December 12, 2012 chart note contains the following excerpt:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 2.5 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine.[23] This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. Total number of injections 7. * * *. Return to the office in 1 week as that is the recommended period between injections, or as needed or directed differently.

(*Id.* at 8.) The December 12, 2012 "face sheet" notes that Patient C was "last seen [in] 2010." (*Id.* at 27.) Neither the chart note nor the "face sheet" for the December 12, 2012 visit indicates that Dr. Rushton had previously treated the patient for neuroma and previously administered a course of injections for that condition. (*See id.* at 7-8, 27.)

49. On January 23, 2013, Patient C presented to Dr. Rushton for evaluation of a neuroma and received an injection. (Ex. R10 at 5-6, 26.) The chart note for that visit is nearly identical to the December 12, 2012 chart note. (*See id.* at 5-8.) Neither the January 23, 2013 chart note nor the corresponding "face sheet" indicate how Patient C responded to her previous injection on December 12, 2012. (*See id.* at 5-6, 26.)

50. On September 4 and 18, 2013, Patient C presented to Dr. Rushton for evaluation of a neuroma and received an injection at each visit. (Ex. R10 at 1-4, 37-38.) The chart notes for those visits are nearly identical to the patient's previous 2012 and 2013 chart notes. (*See id.* at 1-8.) The chart notes for both visits indicate that the patient received an injection at each visit, and that the total number of recommended injections is seven. Neither the chart notes nor "face sheets" for the visits indicate what number (out of seven) those injections represent. (*See id.* at 1-4, 37-38.) The chart notes and "face sheets" for those visits do not indicate how Patient C responded to her previous injections. (*See id.*)

51. At hearing, in response to the question, "How did the patient respond to the first injection?" Dr. Rushton responded, in part:

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[22] One difference is that the December 12, 2012 chart note, unlike the others, states that Dr. Rushton administered "2.5 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine." (*See* Ex. R10 at 8.) The other chart notes reference "3 cc." (*See id.* at 10, 12, 14, 16.)

[23] *See also* Exhibit R10 at 27.

> We went on to a second and a third injection, which tells me there — she was receiving no benefit or she was receiving some benefit. Because she went to all seven injections, that tells me that after the third injection, she was somewhat better. When she concluded her seven injections, she went on a year later to have two more injections, which tells me that the first series of seven had helped her for I think over a year before she came back[.]

(Test. of Rushton; Tr. at 71.)

Patient D

52. On December 4, 2013, Patient D was a 55-year-old female who presented to Dr. Rushton with a chief complaint of pain in the forefoot, which Dr. Rushton noted as a "deep, dull pain * * * made worse while walking barefoot." (Ex. R11 at 11.) Upon examination, he noted that the patient had "[h]yperkeratotic tissue in the forefoot of the affected side" and that she had "pain with palpation to the metatarsal heads of the affected side." (*Id.*) Dr. Rushton diagnosed metatarsalgia and callosities. (*Id.*) He informed her of various treatment options, including rest, ice, extra depth shoes, accommodative padding, lesion debridement, splinting, analgesics, NSAIDs, custom-heat molded orthotics, physical therapy, and steroid injections. He performed a sharp debridement of callouses, instructed Patient D to take 600 mg of ibuprofen, and recommended that she return to the office as needed. (*Id.* at 12.)

53. On December 18, 2013, Patient D followed up with Dr. Rushton with regard to her forefoot pain. (Ex. R11 at 9.) Dr. Rushton's findings upon examination were the same as noted in the December 4, 2013 chart note. (*See id.* at 9, 11.) He again diagnosed metatarsalgia and callosities, discussed various treatment options, performed a sharp debridement of callouses, instructed the patient to take 600 mg of ibuprofen, and recommended that she return to the office as needed. (*Id.* at 9-10.)

54. A "face sheet," dated January 22, 2014, indicates that Patient D received an injection on that date. (Ex. R11 at 51.) The record contains no chart note for a visit on January 22, 2014,[24] and it is unknown what type of injection Patient D received on that date. (*See id.* at 1-72, 51.)

55. On January 29, 2014, Patient D presented to Dr. Rushton for evaluation of a neuroma. In the chart note for the visit, Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and the patient had pain "with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (Ex. R11 at 7.) He diagnosed Morton's neuroma, at the third interspace on the left. He checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and recommended that she ice the affected area and take ibuprofen for pain. (*Id.* at 8.) He also noted, in part:

[24] The January 22, 2014 "face sheet" includes the handwritten notation, "missing chart note." (*See* Ex. R11 at 51.) The author of the notation is unknown.

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. * * *. Return to the office in 1 week as that is the recommended period between injections, or as needed or directed differently.

(*Id.*) A "face sheet" dated January 29, 2014 indicates that Patient D received an injection in the third interspace on the left on that date. (*Id.* at 50.)

56. On February 5, 2014, Patient D presented to Dr. Rushton for evaluation of symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the patient had been experiencing symptoms for several months and they were continuing to worsen. He also noted that the symptoms are aggravated by tight-fitting shoes and activity, and that the patient feels as though a sock is rolled under her foot. (Ex. R11 at 5.) Upon examination, he noted that touch, pin, vibratory, and proprioception sensations were "normal," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient experienced pain "with evaluation and palpation of [the] affected interspace." (*Id.* at 5-6.) According to the chart note, he diagnosed Morton's neuroma, fitted the patient for orthotics, placed "low dye type strapping" to the patient's right foot, instructed the patient to take ibuprofen, and recommended a return to the office in two weeks. (*Id.* at 6.) There is no indication in either the chart note or the February 5, 2014 "face sheet" that Patient D received an injection on that date. (*See id.* at 5-6, 49.)

57. On February 19, 2014, Patient D followed up with Dr. Rushton for symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the patient "states her condition is better and it even feels better when she walks barefoot." (Ex. R11 at 3.) He recommended that she purchase wide, stiff shoes. (*Id.*) Upon examination, he noted that touch, pin, vibratory, and proprioception sensations were "normal," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient experienced pain "with evaluation and palpation of [the] affected interspace." (*Id.* at 3-4.) According to the chart note, he diagnosed Morton's neuroma, fitted the patient for orthotics, placed "low dye type strapping" to the patient's right foot, instructed the patient to take ibuprofen, and recommended a return to the office in two weeks. (*Id.* at 4.) There is no indication in either the chart note or the February 19, 2014 "face sheet" that Patient D received an injection on that date. (*See id.* at 3-4, 48.) There is no indication on the February 19, 2014 "face sheet" that Dr. Rushton applied strapping to the patient's foot on that date. (*See id.* at 48.)

58. On March 18, 2015, Patient D presented to Dr. Rushton for treatment of a neuroma. On the chart note for the visit, Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and that the patient experienced "pain with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]."

(Ex. R11 at 1.) According to the chart note, he diagnosed Morton's neuroma, checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and instructed the patient to ice the affected area and take ibuprofen for pain. (*Id.* at 1.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. * * *.
>
> Patient would like a referra[l] to Dr. Marshall to have cartilage removed from a previous surgery that he performed on her left foot[.]
>
> Patient will return to office in 2 weeks.

(*Id.* at 2.) A "face sheet" dated March 18, 2015 indicates that Patient D received an injection on that date. (*Id.* at 47.)

59. At hearing, in response to the question, "How many total injections did this patient receive?" Dr. Rushmore answered "Two. They were about a year apart, very common." (Test. of Rushton; Tr. at 74.)

Patient E

60. On August 21, 2012, Patient E was an 81-year-old female who presented to Dr. Rushton for an initial evaluation of joint pain, which she described as dull and achy, with frequent swelling and occasional redness to the area. (Ex. R12 at 14.) Dr. Rushton diagnosed degenerative joint disease and bilateral tarsometatarsal joint. In the chart note for the visit, Dr. Rushton noted that he discussed arthritis and osteoarthritis with the patient, he encouraged the patient to rest and utilize ice, compression, and elevation principles, he recommended ibuprofen for pain and inflammation, he injected her left foot with "2.5 cc of Marcaine w/ epi and .5 cc of Kenalog," and he instructed her to return to the office in two weeks. (*Id.* at 15.)

61. On September 4, 2012, Patient E followed up with Dr. Rushton with regard to her joint pain. She reported feeling "much better," but with some pain in the right foot and a corn on the right second toe. (Ex. R12 at 11.) Dr. Rushton diagnosed degenerative joint disease, bilateral tarsometatarsal joint, and corn pain. (*Id.* at 12.) He debrided the "skin partial thickness to a level of tolerance for [the] patient," he encouraged the patient to rest and utilize ice, compression, and elevation principles, and he recommended ibuprofen. (*Id.* at 13.)

62. When asked at hearing how Patient E responded to the cortisone injection she received on August 21, 2012, Dr. Rushton testified as follows:

> We didn't repeat the injection so she must have been doing much better. Generally speaking, cortisone injections are given in series of threes in this type of situation. Most subsequently providing practitioners would know that so the fact that she didn't get another injection says that she was doing much better.
>
> And it says in the top of the chart note, "Patient states she is doing much better[.]"

(Test. of Rushton; Tr. at 75.)

63. On January 22, 2013, Patient E presented to Dr. Rushton for evaluation of symptoms consistent with tendonitis. According to the chart note for the visit, the patient reported that for several months she had been experiencing pain in the lateral aspect of the midfoot after periods of activity and standing. (Ex. R12 at 9.) Dr. Rushton diagnosed peroneal tendonitis, and he recommended the continued use of orthotics, rest, ice to the affected area, elevation of the area, physical therapy at home, and ibuprofen. He instructed the patient to return to the office in two weeks. (*Id.* at 10.)

64. On February 5, 2013, Patient E presented to Dr. Rushton for evaluation of a neuroma. On the chart note for the visit, Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and that the patient experienced "pain with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (Ex. R12 at 7.) According to the chart note, he diagnosed Morton's neuroma, checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and instructed the patient to ice the affected area and take ibuprofen for pain. (*Id.* at 7-8.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. * * *. Return to the office in 1 week as that is the recommended period between injections, or as needed or directed differently.

(*Id.* at 8.) A "face sheet" dated February 5, 2013 indicates that Patient E received an injection on that date. (*Id.* at 24.)

65. On February 19, 2013, Patient E presented to Dr. Rushton for evaluation of symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the patient had been experiencing symptoms for several months and the symptoms were worsening. He also noted that the symptoms are aggravated by tight-fitting shoes and activity, and that the patient feels as though a sock is rolled under her foot. (Ex. R12 at 5.) Upon examination, he noted that touch, pin, vibratory, and proprioception sensations were "normal," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient experienced pain "with evaluation and palpation of [the] affected interspace." (*Id.* at 5-6.) According to the chart note, he diagnosed Morton's neuroma, checked the patient's orthotics for proper fit and wear patterns, added appropriate accommodation and wedging to the orthotic, instructed the patient to take ibuprofen, and recommended a return to the office in two weeks. (*Id.* at 6.) There is no indication in either the chart note or the February 19, 2013 "face sheet" that Patient E received an injection on that date. (*See id.* at 5-6, 23.)

66. On October 1, 2013, Patient E presented to Dr. Rushton for evaluation of a neuroma. On the chart note for the visit, Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and that the patient experienced "pain with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (Ex. R12 at 3.) According to the chart note, he diagnosed Morton's neuroma, checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and instructed the patient to ice the affected area and take ibuprofen for pain. (*Id.* at 3-4.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. * * *. Return to the office in 1 week as that is the recommended period between injections, or as needed or directed differently.

(*Id.* at 4.) A "face sheet" dated October 1, 2013 indicates that Patient E received an injection on that date. (*Id.* at 22.)

67. On February 18, 2014, Patient E presented to Dr. Rushton for evaluation of a neuroma. On the chart note for the visit, Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and that the patient experienced "pain with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (Ex. R12 at 1.) According to the chart note, he diagnosed Morton's neuroma, checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and instructed the patient to ice the affected area and take ibuprofen for pain. (*Id.* at 1-2.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. * * *. Return to the office in 2 weeks as that is the recommended period between injections, or as needed or directed differently.

(*Id.* at 2.) A "face sheet" dated February 18, 2014 indicates that Patient E received an injection on that date. (*Id.* at 19.) Neither the February 18, 2014 chart note nor the corresponding "face sheet" indicate how Patient E responded to her previous injections. (*See id.* at 1-2, 19.)

Patient F

68. On September 3, 2013, Patient F was a 71-year-old female who presented to Dr. Rushton for evaluation of a neuroma.[25] On the chart note for the visit, Dr. Rushton noted that touch, pin, vibratory, and proprioception sensations were "normal" except for the affected digits, and that the patient experienced "pain with palpation to [the] affected interspace with a positive Moulders and Sullivans sign [*sic*]." (Ex. R13 at 9.) According to the chart note, he diagnosed "Morton's Neuroma. Left," checked the patient's orthotics for proper fit and wear patterns, noted that metatarsal splay was increased, and instructed the patient to ice the affected area and take ibuprofen for pain. (*Id.* at 9-10.) He also noted, in part:

> The most common site for a neuroma is on the ball of the foot. A small nerve passes between the spaces of the metatarsals into the toes and can often be enlarged due to irritation. Burning pain, tingling and numbness in one or more of the toes is a common symptom. As the nerve swells, it can be felt as a popping sensation when walking. This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine. This was done to destroy the peripheral nerve to the area, this may lead to a permanent numbness. This should be done in concert with 6 other injections. * * *. Return to the office in 2 weeks as that is the recommended period between injections, or as needed or directed differently.

(*Id.* at 10.) A "face sheet" dated February 18, 2014 indicates that Patient F received an injection on the left on that date, and that she would receive one on the right at her next visit. (*Id.* at 36.) Neither the February 18, 2014 chart note nor the corresponding "face sheet" specify the location of the injection (*i.e.* which interspace). (*See id.* at 9-10, 36.)

[25] Dr. Rushton had previously treated Patient F for neuroma in 2011. (*See* Ex. R13 at 11-19, 37-39.) His charting with regard to the 2011 treatment is not at issue in the present matter.

69. On September 17, 2013, Patient F followed up with Dr. Rushton with regard to her neuroma. (Ex. R13 at 7-8.) The chart note for that visit is nearly identical to the chart note from September 3, 2013. The only material difference is that the September 17, 2013 chart note lists a diagnosis of "Morton's Neuroma. Right." (*See id.* at 7-10.) The September 17, 2013 "face sheet" indicates that the patient received an injection on the right on that date. (*Id.* at 35.) As with the September 3, 2013 chart note, the September 17, 2013 chart note states that the patient's nerve "was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine" and that it " should be done in concert with 6 other injections." (*See id.* at 8, 10.) Neither the September 17, 2013 chart note nor the corresponding "face sheet" indicate how Patient F responded to her previous injection. (*See id.* at 7-8, 35.)

70. On October 1, 2013, Patient F followed up with Dr. Rushton with regard to her neuroma. (Ex. R13 at 5-6.) The chart note for that visit is nearly identical to the chart notes from September 3 and 17, 2013. The only material difference is that the October 1, 2013 chart note lists a diagnosis of "Morton's Neuroma. Left 3rd Interspace." (*See id.* at 5-10.) The October 1, 2013 "face sheet" indicates that the patient received an injection in the left third interspace on that date. (*Id.* at 32.) As with the September 3 and 17, 2013 chart notes, the October 1, 2013 chart note states that the patient's nerve "was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% Marcaine with epinephrine" and that it " should be done in concert with 6 other injections." (*See id.* at 6, 8, 10.) Neither the October 1, 2013 chart note nor the corresponding "face sheet" indicate how Patient F responded to her previous injections. (*See id.* at 5-6, 32.)

71. On October 22, 2013, Patient F followed up with Dr. Rushton regarding symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the patient had been experiencing symptoms for several months and the symptoms were worsening. He also noted that the symptoms are aggravated by tight-fitting shoes and activity, and that the patient feels as though a sock is rolled under her foot. (Ex. R13 at 3.) Upon examination, he noted that touch, pin, vibratory, and proprioception sensations were "normal," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient experienced pain "with evaluation and palpation of [the] affected interspace." (*Id.* at 3-4.) According to the chart note, he diagnosed Morton's neuroma,[26] checked the patient's custom fitted orthotic, observed increased metatarsal splay on the left, instructed the patient to take ibuprofen, and recommended a return to the office in two weeks. (*Id.* at 4.) There is no indication in either the chart note or the October 22, 2013 "face sheet" that Patient F received an injection on that date. (*See id.* at 3-4, 31.)

72. On November 12, 2013, Patient F followed up with Dr. Rushton regarding symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the "[p]atient states she is doing great!" (Ex. R13 at 1; *see also id.* at 30.) Upon examination, he noted that touch, pin, vibratory, and proprioception sensations were "normal," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient experienced pain "with evaluation and palpation of [the] affected interspace." (*Id.* at 1-2.) According to the chart note, he diagnosed

[26] The chart note does not specify the affected interspace and whether it was the right or left foot. (*See* Ex. R13 at 3-4.)

Morton's neuroma,[27] checked the patient's custom fitted orthotic, instructed the patient to take ibuprofen, and recommended a return to the office as needed. (*Id.* at 2.) There is no indication in either the chart note or the November 12, 2013 "face sheet" that Patient F received an injection on that date. (*See id.* at 1-2, 30.)

Board Investigation

73. By letter dated June 3, 2015, Board Investigator Randy Day notified Dr. Rushton that the Board had received a complaint and opened an investigation regarding Dr. Rushton's care of Patient A.[28] According to the letter, the Board was investigating whether Dr. Rushton failed to properly treat Patient A's neuroma and tendonitis, resulting in the need for surgery. Investigator Day requested that, by June 25, 2015, Dr. Rushton provide the Board's Investigative Committee with a summary report on the matter, including a written response to the complaint, and a legible copy of "all patient records" maintained on Patient A, including "Progress Notes, Consultations, Diagnostic Studies, Medication Flow Sheets, Telephone Logs, and other Provider records maintained in your chart." (Ex. R1 at 4.)

74. By letter submitted to the Board and dated June 17, 2015, Dr. Rushton responded to the Board's complaint regarding Patient A. (Ex. A1 at 1-2.) His letter states, in part:

> The patient was well aware that my practice is not surgically oriented and that if she chose a surgical option it would be elsewhere[.] I offered to refer her to a qualified surgeon if, and when she so desired.
>
> The patient requested her medical records be transferred to Dr. Stacey Clarke, DPM on 11/26/14.
>
> [2] errors were noted on my template while reviewing these charts. The first, in each note from 8/6/14 to 10/1/14, it states in the last paragraph "evaluation and treatment for Achilles Tendonitis[.]" This should read "Extensor Tendonitis[.]" [A]lso each injection is reported as ["]3 cc of 5% Absolute Alcohol." [T]his should read "1 cc of 5% Absolute Alcohol from a 3 cc syringe[.]" Although other studies have used higher concentrations and/or volume of sclerosing alcohol, the most commonly used and most effective treatment in the podiatric literature use ½ to 1 cc of 4% Absolute Alcohol[.]
>
> In answer to the allegation to [*sic*] my care resulted in surgery, [Patient A] had a long[-]standing painful condition in her foot that had been treated unsuccessfully by another podiatrist and exacerbated by her diabetes with neurological and circulatory issues compounded by her tobacco use. [A]s a conservative podiatrist I treated her with a standard of care which included rest, wide shoes, ice, s[cl]erosing injections, accommodative

[27] The chart note does not specify the affected interspace and whether it was the right or left. (*See* Ex. R13 at 1-2.)

[28] Mr. Day has since retired from his employment with the Board. (Test. of Brown; Tr. at 262.)

padding and orthotics. These were designed to avoid or minimize the possibility of surgery[;] although they never have, nor ever will, eliminate the need for surgery.

* * * * *

Although the patient did not seek a surgical referral through my office, she presumably had her neuroma removed with possible digital surgery to increase function in the area. Although frustrated, she did not seem angry at our last appointment[.]

[A] neuroma is oftentimes a surgical condition[.] [A]ll treatments offered and performed on the patient were, and are[,] commonly practiced within the podiatric community, and designed to provide a surgical alternative. I cannot think of any commonly available treatment that was not employed to treat her condition. I strongly believe that I, as a podiatrist, firmly met the standard of care expected by my peers and that surgery is often the result of a long[-]standing painful neuroma.

(*Id.* at 2.)

75. On August 19, 2015, the Board requested that Dr. Rushton provide the complete medical records for Patients A through F. In response, Dr. Rushton provided the Board with a copy of the chart notes for those patients. He did not provide the Board with the corresponding "face sheets" because he believed them to be duplicative of information already contained in the chart notes.[29] (Test. of Rushton; Tr. at 304.)

76. On November 23, 2015, counsel for Dr. Rushton provided to the Board's Chief Investigator a CD of complete medical charts for Patients A through F. (*See* Exs. R30, R31.) In an email to Mr. Brown dated November 23, 2015, counsel stated that it was her understanding that the original documents provided to the Board consisted only of chart notes, and not the patients' complete charts—including chart notes, correspondence, outside records, and billing information. (Ex. R31 at 1.)

77. On December 3, 2015, Dr. Rushton participated in an interview with a subcommittee of the Board's Investigative Committee. (Ex. A9 at 1-18.) He was represented by counsel during the interview. (*See id.* at 2.)

- He admitted that the repeated reference to "Achilles tendonitis" in Patient A's chart notes was "a mistake." (*Id.* at 8.)
- He stated that after his electronic medical record (EMR) "crashed" in 2014, he performed less "hands-on" modifications to the cut and pasted entries in his chart notes. (*Id.* at 5.)

[29] The chart notes the Board received from Dr. Rushton in response to the August 19, 2015 request constitute Exhibits A3 through A8. (Test. of Brown; Tr. at 262-263.)

- He stated that his older [chart] notes were "a lot more accurate as to what actually happened." (*Id.* at 6.)
- He stated that the sclerosing injection templates he used in the charts were "only used a few times per year." (*Id.* at 5.)
- He stated that if he was more "proactive," he could likely make the EMR he used work better, but even though "it's not like it's impossible to change things [in the EMR] * * * [he is] just not much into computers" and it is personally difficult for him to use the EMR. (*Id.* at 11.) He expressed excitement at obtaining a new, and hopefully better, EMR in a few months. (*Id.*)
- He stated, "I don't send my patients to a lot of people. * * *. Very few other people are going to read those notes." (*Id.*)

78. The transcript of the Board interview included the flowing partial exchange between Dr. Thaler and Dr. Rushton:

> **Rushton:** [I] can't sit here and defend my notes because as I read through them after I'm kind of going, like, wow. I didn't realize my notes were as bad as they are, you know. I see exactly what's going on.
>
> When I look through my notes they make perfect * * * sense to me because they're my notes. You know, if I look at this and I can say, okay, I did this, I did this and I'm doing this and I'm planning on doing this[.] [F]or a primary doc to look at them, the basics are there. But ideally, you know, it would say, 10 percent better, 30 percent better, 50 percent better, and that's not there.
>
> **Thaler:** [Y]ou know your patients. You know what's going on. You can tell me about them. But if I'm anybody else and I'm not a podiatrist, I'm an internist and I'm trying to treat this complicated patient, I can't tell anything from your notes.
>
> **Rushton:** I agree, because there are certainly limitations and I'm going to * * * get that fixed. * * *.
>
> Yeah, the notes can be better. And I've had primary care docs tell me, Dr. Rushton, you know, your notes should be better. * * *.
>
> * * * * *
>
> [I]f there's anything that I'm doing with the patient that would affect primary care, if I'm writing a prescription for something or if I'm treating something more serious, I'm going to let them know. I'm going to add medicine to their list.

(Ex. A9 at 9.) Later on in the interview, Dr. Rushton stated:

> [A]s I look through my chart notes, I really can't defend them. You know, I read through them and say, well, I'm lacking this. I'm lacking that. I'm lacking which foot the injection was on.
>
> * * * * *
>
> I don't think there's anything crazy important in here that is missing but it's certainly not crystal clear[.]

(*Id.* at 15.) When asked during the interview whether his experience in being investigated by the Board had changed his view regarding the importance of the medical record, Dr. Rushton answered, "[a]bsolutely" and he admitted, "I understand that I need to do better." (*Id.*). Dr. Rushton and the Board's counsel had the following exchange:

> **Foote:** [D]o you think that if the Board took a look at your patient charts, say, six months, 12 months downstream from today there would be a significant change in your charting?
>
> **Rushton:** There would be a gigantic change.
>
> **Foote:** What type of changes do you think the Board would see?
>
> **Rushton:** A lot more detail. Certainly, you know, the mistakes are frustrating to me. I just didn't see those and I didn't realize that they were sneaking through[.]

(*Id.* at 16.)

Dr. Michael's Opinions

79. Dr. Elliot Michael reviewed the chart notes for Patients A through F, but not the "face sheets." (Test. of Michael; Tr. at 86, 89, 107-108, 113.) Dr. Thaler did not provide the "face sheets" to Dr. Michael because he believed them to be mere billing records that were not pertinent to the patients' medical records as a whole. (Test. of Thaler; Tr. at 479; *see also* Test. of Brown; Tr. at 428-436, 487.)

80. In Dr. Michael's opinion, it is important for a provider to document a patient's response to treatment, whether it is a negative or positive response, and whether a patient's pain symptoms are changing. He believes that chart notes should include the efficacy of the treatment, so as to support whether treatment should continue or whether other options should be considered. (Test. of Michael; Tr. at 95.)

81. In Dr. Michael's opinion, whether Dr. Rushton administered 1 cc versus 3 cc of a sclerosing solution to a patient over the course of seven injections could be relevant because the more volume that is injected into an enclosed space, the more pressure that is exerted into the space. Repetitive injections at a higher volume could cause some weakening of some of the

structures within the intermetatarsal space. Although it is unlikely that knowing whether a previous provider injected 1 cc versus 3 cc in a patient would affect Dr. Michael's subsequent treatment of that patient, such knowledge could give him insight as to any problems or complications that present in the patient. (Test. of Michael; Tr. at 92-93, 98-99, 153, 166, 268-269.)

82. Dr. Michael believes it is helpful for chart notes to specify the location of a patient's pain symptoms and where any injections were administered (*i.e.* which metatarsal space, on which foot) because then a new provider for the patient would know whether the patient was experiencing a recurrent issue, or a new issue that warranted treatment.[30] (Test. of Michael; Tr. at 93-94.)

83. Dr. Michael has concerns regarding the repetitive nature of Dr. Rushton's charts for Patients A through F, and the fact that there was little to no differentiation between treatment plans for different patients. In his opinion, the charts were sometimes confusing as to what conditions were being treated and what actual treatments were being administered.[31] He also observed a lack of documentation as to patient progress from treatment to treatment, a lack of information as to what therapeutic results Dr. Rushton was seeking, and a lack of substantive findings to support continued treatment. He observed that the charts repeatedly failed to note which foot was at issue and precisely where Dr. Rushton administered injections (*e.g.* whether in the second or third metatarsal space). (Test. of Michael; Tr. at 89, 91, 160, 167.)

84. In Dr. Michael's opinion, Dr. Rushton's charting was below the standard of care, and constituted "[n]egligence in the appropriate charting." (Test. of Michael; Tr. at 91.) Dr. Michael has not seen the degree of charting errors in other podiatrists' chart notes as he saw in Dr. Rushton's. Although he has observed charting errors caused by cutting and pasting by other podiatrists, such errors were isolated, and not continuous and repetitive as in Dr. Rushton's chart notes. (*Id.* at 138, 165-166.)

85. Although Dr. Michael does not believe that the charting errors alone would cause deleterious effects to Dr. Rushton's patients, he believes the errors could affect continuity of care. (Test. of Michael; Tr. at 89, 101.) He does not believe that Dr. Rushton's charting constituted gross negligence, that he violated any ethical standards, or that he actually harmed any of his patients. (*Id.* at 117.)

Dr. Hutchinson's Opinions

86. Approximately 70 percent of Dr. Hutchinson's practice is by referral from other podiatrists, and he rarely gets or needs records from the other podiatrists. When he does receive such records on a patient, he does not look at them until after he has examined a patient and

[30] At hearing, Dr. Michael admitted that Dr. Rushton's failure to identify right versus left on Patient A's medical records did not appear to negatively affect Dr. Clarke's subsequent care of the patient. (Test. of Michael; Tr. at 133.)

[31] At hearing, Dr. Michael stated, in part: "I don't think that there was ever a question in my mind as to whether the sclerosing injections were performed. * * *. There was a question as to the specific site of the injection, but not whether the injection was done or not." (Test. of Michael; Tr. at 90.)

determined the patient's condition. In his opinion, when establishing care with a new patient, a provider must conduct an examination and use his or her own expertise to understand the patient's condition[s]. He considers records from other providers as "just a tool to help you if you need." (Test. of Hutchinson; Tr. at 237.) Many of the records he reviews from other providers contain errors such as referring to a male patient as a "she," and vice versa, or referring to the wrong foot. (*Id.*; *see also id.* at 247-248, 251.)

87. If Dr. Hutchinson sees a patient for the same condition seven visits in a row, his chart notes for those seven visits will look the same because of template-driven cutting and pasting. The only difference in the chart notes for the visits might be the subjective comments provided by the patient each time. (Test. of Hutchinson; Tr. at 241.)

88. Dr. Hutchinson would grade Dr. Rushton's records for Patients A through F as a "C" or "C-." (Test. of Hutchinson; Tr. at 247.)

89. In Dr. Hutchinson's opinion, Dr. Rushton's charting neither harmed nor had the potential to cause harm to Patients A through F. (Test. of Hutchinson; Tr. at 225, 236.) In his opinion, none of Dr. Rushton's charting errors created a risk of harm for subsequent treatment of the patients by another podiatrist. (*Id.* at 236-239, 249.)

90. In Dr. Hutchinson's opinion, Dr. Rushton did not practice in a manner that constituted a danger to the health and safety of the public, did not practice in a manner that constituted unprofessional or dishonorable conduct, did not practice in a manner that either did or might adversely affect another doctor's ability to safely and skillfully practice podiatry. (Test. of Hutchinson; Tr. at 223-224, 249.)

91. In Dr. Hutchinson's opinion, the seven injections administered to Patient A were not excessive and did not pose a risk of harm to her. (Test. of Hutchinson; Tr. at 234-235.) At hearing, Dr. Hutchinson testified, in part:

> [S]even injections is a reasonable way to treat these people when they have these symptoms, and oftentimes when I was doing this, I don't — I didn't record how they were doing with every injection. These patients are usually committed to having more than one of these injections. So it's irrelevant to me.

(*Id.* at 234.)

Dr. Jones' Opinions

92. When Dr. Jones previously utilized sclerosing injections to treat neuromas, he would ask a patient how he or she responded to the previous injection (*e.g.* whether there was an increase or decrease in pain level), note the patient's response in the chart, and use the response to inform the course of treatment. (Test. of Jones; Tr. at 471.)

93. Because the administration of seven sclerosing injections is a repetitive treatment, Dr. Jones would expect the chart notes for the seven visits to appear repetitive, unless something changed between visits that warranted documenting. (Test. of Jones; Tr. at 464-465.)

94. Dr. Jones believes that Dr. Rushton's medical records for Patients A through F were "definitely deficient in certain things." (Test. of Jones; Tr. at 452.) Dr. Jones would give the records a grade of "C." (*Id.* at 473.)

95. In Dr. Jones' opinion, repetitive charting errors could cause some confusion for a physician taking over the care of a patient. (Test. of Jones; Tr. at 468.)

96. Dr. Jones does not believe that Dr. Rushton's recordkeeping deficiencies harmed Patients A through F, or had the potential to harm them. (Test. of Jones; Tr. at 464, 466.) Dr. Jones believes that despite any of Dr. Rushton's charting deficiencies, he would be able to effectively treat Patients A through F if he subsequently took over their care from Dr. Rushton. (*Id.* at 454.)

97. Dr. Jones regularly sees medical records from other podiatrists that lack a reference to which foot is affected by a neuroma and that do not specify which interspace is injected. In his opinion, Dr. Rushton's medical records are "totally" within the standard of care, considering medical records he has reviewed from other podiatrists. (Test. of Jones; Tr. at 453.)

98. In Dr. Jones' opinion, it is "helpful, but not necessary" to know where a previous podiatrist administered a sclerosing injection. (Test. of Jones; Tr. at 470.)

99. In Dr. Jones' opinion, Dr. Rushton's administration of seven sclerosing injections to Patient A was not excessive, did not pose a risk of harm to her, and fell within the standard of care. (Test. of Jones; Tr. at 463.)

100. In Dr. Jones' opinion, Dr. Rushton did not practice in a manner that constituted a danger to the health and safety of the public, did not practice in a manner that constituted unprofessional or dishonorable conduct, was not grossly or repeatedly negligent, and did not practice in a way that did or might adversely affect a doctor's ability to safely and skillfully practice podiatry. (Test. of Jones; Tr. at 451.)

Dr. Rushton's Charting Efforts since the Board's Investigation

101. Since the Board began its investigation involving Dr. Rushton's charting practices, Dr. Rushton has taken a four-hour course regarding charting. (Test. of Rushton; Tr. at 284.) He has changed his sclerosing injection template to reflect that he generally gives a 1 cc sclerosing injection. He has also changed the format of his "face sheets" so that they now contain a checklist section for his examination and he can note by hand any changes from previous visits. The revised "face sheets" also contain a section where a medical assistant documents the foot involved and the specific location of any symptoms or treatments. Dr. Rushton then has a different employee enter all of the patient's information into a computer to produce one chart note for the visit. If the chart note is missing the specific foot involved or the employee notices

some other error or issue, the employee brings it to Dr. Rushton's attention so the matter can be adequately addressed. Since instituting this new system, the employee typically discusses three or four chart note issues with Dr. Rushton each day. (*Id.* at 284-286, 291, 299.)

Board's Proposed Sanctions

102. The Board is seeking the following sanctions:

- Reprimand;
- $10,000 civil penalty;
- Periodic chart audits at Dr. Rushton's expense by persons designated by the Board, not to exceed one chart audit per calendar year;
- In addition to the period chart audits (referenced above), random chart audits by Board personnel or their designee(s);
- Random office visits by Board personnel or their designees;
- Continuing Medical Education (CME), pre-approved by the Board's Medical Director;
- Probation for 10 years (consisting of quarterly meetings with a Board member or the Board's Compliance Officer, and may also include appointment of a mentor for charting, if the chart audits identify ongoing deficiencies);
- No later than 10 days before the delivery of any medical services to a patient, Dr. Rushton must information the Board of all practice site locations; and
- Assessment of costs of the proceeding.

(Pleading P12.)

CONCLUSIONS OF LAW

1. Dr. Rushton did not engage in unprofessional conduct, as defined in ORS 677.188(4)(a), by practicing podiatry in a manner that may have constituted a danger to the health or safety of a patient.

2. Dr. Rushton committed repeated acts of negligence in the practice of podiatry.

3. Although the Board may impose the proposed sanctions set forth in its March 16, 2017 letter,[32] the ALJ recommended against imposing a civil penalty assessment.

OPINION

The Board alleges that Dr. Rushton committed violations of the Medical Practices Act, for which the Board has proposed a reprimand, a $10,000 civil penalty, 10 years' probation, assessment of the costs of the proceeding, and various other sanctions. *See* Pleading P12. The Board has the burden of establishing by a preponderance of the evidence that the violations alleged in the Complaint & Notice of Proposed Disciplinary Action (Notice) occurred and that the proposed sanctions are appropriate. ORS 183.450(2) ("The burden of presenting evidence to

[32] Pleading P12.

support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Metcalf v. AFSD*, 65 Or App 761, 765 (1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

Pursuant to ORS 677.265, the Board is vested with the authority to regulate the practice of podiatry in Oregon.[33] ORS 677.190 authorizes the Board to discipline an Oregon podiatric physician for any of several delineated reasons. Here, the Board proposes disciplining Dr. Rushton under the following provisions of ORS 677.190:

> (1)(a) Unprofessional or dishonorable conduct.
>
> * * * * *
>
> (13) Gross negligence or repeated negligence in the practice of * * * podiatry.

The Board contends that, after reviewing Dr. Rushton's management and treatment of podiatric Patients A through F, the Board found "a pattern of practice" that posed a danger to the health or safety of his patients and constituted repeated acts of negligence. Pleading P1 at 5.

1. Unprofessional or Dishonorable Conduct

ORS 677.188(4)(a) defines "unprofessional or dishonorable conduct," in relevant part, as follows:

> (4) "Unprofessional or dishonorable conduct" means conduct unbecoming a person licensed to practice * * * podiatry, or detrimental to the best interests of the public, and includes:

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[33] ORS 677.265 states that the Board may, for example:

> (1) Adopt necessary and proper rules for administration of this chapter including but not limited to:
>
> (a) Establishing fees and charges to carry out its legal responsibilities[.]
>
> * * * * *
>
> (c) Enforcing the provisions of this chapter and exercising general supervision over the practice of * * * podiatry within this state[.]
>
> (2) Issue, deny, suspend and revoke licenses and limited licenses, assess costs of proceedings and fines and place licensees on probation as provided in this chapter.

> (a) Any conduct or practice contrary to recognized standards of ethics of the * * * podiatric profession or *any conduct or practice which does or might constitute a danger to the health or safety of a patient* or the public or any conduct, practice or condition which does or might adversely affect a physician's ability safely and skillfully to practice * * * podiatry[.]

(Emphasis added.)

A. Charting

There is no dispute that Dr. Rushton's medical records for Patients A through F contain numerous charting errors and deficiencies.[34] And the record establishes that, in general, a patient chart containing erroneous information could impact future treatment for that patient and potentially lead to patient injury. The issue, however, is whether the specific errors and deficiencies in the chart notes for Patients A through F posed a danger to those patients.

The record establishes the following with regard to Dr. Rushton's medical records for Patients A through F:

- In multiple chart entries, Dr. Rushton repeatedly noted that he administrated 3 cc of 5 percent absolute alcohol to the patients, when in fact he administered some other amount.

- Dr. Rushton repeatedly failed to identify which foot he was treating and repeatedly failed to document the specific location of injection sites.

- Dr. Rushton repeatedly failed to document patient responses to treatment, and he administered successive treatments for patients without documenting the efficacy of the treatments.

- In five chart notes for Patient A, Dr. Rushton incorrectly noted a diagnosis of Achilles tendonitis. *See* Exhibit A3 at 2, 4, 6, 10, 12.

- After recommending a course of seven sclerosing injections to multiple patients, Dr. Rushton did not clearly document whether each patient completed the full course of injections, and he noted no explanation for why a patient did not complete the full course.

The Board contended that charting is the foundation of medical practice and that Dr. Rushton's repeated charting errors put patients at risk of harm. To support its contention, the Board relied on the opinions of Dr. Michael.[35]

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[34] These errors and deficiencies are discussed in detail in the next section of the Opinion, regarding negligence.

[35] The fact that Dr. Michael did not review the "face sheets" for Patients A through F does not render his opinions regarding the standard of care and the deficiencies in Dr. Rushton's patient charts unpersuasive. This is particularly true given that Dr. Rushton asserted at hearing that there was nothing on the "face sheets" that was not also in the chart notes. (*See* Test. of Rushton; Tr. at 304.)

Dr. Rushton acknowledged at hearing that charting is important to podiatric practice, and he conceded that erroneous chart notes could result in patient harm, particularly with regard to continuity of care with another provider.[36] *See* Transcript at 31. He contended, however, that the errors and deficiencies in his chart notes posed no risk to patient safety. To support his contention he relied on the opinions of Drs. Hutchinson and Jones.

At hearing, Dr. Michael expressed concerns regarding the repetitive nature of Dr. Rushton's charts notes, the fact that there was little to no differentiation between treatment plans for different patients, the lack of documentation as to patient progress from treatment to treatment, the lack of information as to what therapeutic results Dr. Rushton was seeking, and the lack of substantive findings to support continued treatment. Although Dr. Michael does not believe that the charting errors and deficiencies alone would cause deleterious effects to Dr. Rushton's patients, and he acknowledged there was no evidence of any actual patient harm, he believes the deficiencies could affect continuity of care.

For example, Dr. Michael believes it is helpful for chart notes to specify the location of a patient's pain symptoms and where any injections were administered because then a new provider for the patient would know whether the patient was experiencing a recurrent issue, or a new issue that warranted its own treatment. However, he admitted at hearing that Dr. Rushton's failure to identify right versus left on Patient A's medical records did not appear to negatively affect Dr. Clarke's subsequent care of the patient.[37]

As another example, Dr. Michael believes that whether Dr. Rushton administered 1 cc versus 3 cc of sclerosing solution to a patient over the course of seven injections could be relevant information because repetitive injections at a higher volume could cause weakening of some of the structures within the intermetatarsal space. However, Dr. Michael admitted that it is unlikely that knowledge of the dosage injected by a previous provider would affect his subsequent treatment of a patient.

Although Dr. Hutchinson would give Dr. Rushton's records a grade of "C" or "C-" because of the numerous charting errors they contain, he does not believe the errors harmed, or had the potential to harm, the patients at issue. Transcript at 247, 225, 236. In Dr. Hutchinson's opinion, Dr. Rushton's errors did not pose any risk of harm to patients who may have sought subsequent treatment from other podiatrists. Based on his own experience, Dr. Hutchinson does not consider a previous provider's chart notes necessary for a new provider to effectively treat the patient of that previous provider. He considers a referring provider's chart notes a tool that

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[36] He provided the following example at hearing:

> [I]f I've done three cortisone injections and I failed to document those injections, and [the patient] go[es] to a provider that says, oh, you have this condition, and they suggest cortisone injections, and for whatever reason that patient can't remember what's been done, they may end up with a series of four, five or six cortisone injections, which could be detrimental to the patient's health.

(Test. of Rushton; Tr. at 31.)

[37] In Dr. Jones' opinion, it is "helpful, but not necessary" to know where a previous podiatrist administered a sclerosing injection. (Test. of Jones; Tr. at 470.)

can be used if needed. However, when establishing care with a new patient, he believes a provider must conduct an examination and use his or her own expertise to understand the patient's conditions.

Dr. Hutchinson also distinguishes between treating a patient with conservative measures (such as orthotics, which pose little to no risk of harm to a patient) versus treating a patient surgically (which carries potentially significant risks). Dr. Rushton provides only conservative podiatric treatment, and the treatment that is primarily at issue in this case involves the administration of sclerosing injections—a conservative treatment that carries a low risk of complications.

Dr. Jones similarly acknowledged at hearing that the medical records at issue were "definitely deficient in certain things," and because of those deficiencies he would give the records a grade of "C." Transcript at 452, 473. And while Dr. Jones concedes that repetitive charting errors could cause some confusion for a physician taking over the care of a patient, he is confident that, despite any of Dr. Rushton's charting deficiencies, he would be able to effectively treat Patients A through F if he took over their care from Dr. Rushton. He does not believe that Dr. Rushton's recordkeeping deficiencies harmed Patients A through F, or had the potential to harm them.

After weighing the expert medical opinions, the ALJ found that medical chart accuracy is important and that charting errors and deficiencies can cause patient harm or place patients at risk of harm, particularly with regard to subsequent treatment from other providers. However, the record falls short of establishing, more likely than not, that the charting errors and deficiencies contained in Dr. Rushton's records for Patients A through F either harmed those patients or placed them at risk of harm. Therefore, the ALJ concluded that the Board has not proven that Dr. Rushton engaged in unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), with regard to his charting and he is not subject to discipline pursuant to ORS 677.190(1)(a).

B. Administration of Seven Sclerosing Injections to Patient A

The Board contended that Dr. Rushton's administration of seven sclerosing injections to Patient A between May 14, 2014 and June 25, 2014 was excessive and, without any evidence that they were improving her condition, they posed a risk of harm to her.

Although the precise amount of sclerosing solution that Dr. Rushton administered to Patient A for each of those injections is unknown, his customary dosage range of between 0.5 and 3 cc falls within the standard of care for neuroma treatment. Moreover, his administration of seven injections falls within the acceptable range of treatment, particularly given that Patient A had shown some improvement after her second injection. *See* Exhibit A3 at 23; *see also* Exhibit R8 at 46 ("I can move my toes!"); Test. of Hutchinson; Tr. at 227, 229-230; Test. of Jones; Tr. at 446-447; Test. of Rushton; Tr. at 34-36, 50; Test. of Michael; Tr. at 97, 270. Dr. Hutchinson believes that the course of seven injections was a reasonable way to treat Patient A, given her symptoms, and he admitted at hearing that when administering sclerosing therapy, he did not record patient responses after every injection. Transcript at 234. In the opinions of both Drs.

Hutchinson and Jones, the seven injections administered to the patient were not excessive and did not pose a risk of harm. *Id.* at 234-235, 463. The Board offered no persuasive evidence to rebut those opinions. Consequently, the ALJ concluded that the Board has not proven that Dr. Rushton engaged in unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), with regard to these injections and he is not subject to discipline pursuant to ORS 677.190(1)(a).

2. Gross or repeated negligence in the practice of podiatry

The Board contends that Dr. Rushton committed repeated acts of negligence, in violation of ORS 677.190(13), with respect to his charting for Patients A through F.

The Board asserted at hearing that Dr. Rushton's charting was repeatedly negligent because it deviated from the accepted standard of care in the podiatric community. In reaching this conclusion, the Board relied on the opinion of Dr. Michael. Dr. Rushton contended that, although his charting had various deficiencies, it nonetheless fell within the standard of care in the podiatric community — particularly given his rural, non-surgical practice. To support his position, Dr. Rushton relied on the opinions of Drs. Hutchinson and Jones.

Although the term "negligence" is not specially defined in the Medical Practice Act, it has the following recognized legal definition: "The failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation[.]" *Black's Law Dictionary* 1061 (8th ed 2004). In the professional negligence context, the Oregon Supreme Court has recognized that the standard of care is that of "a reasonably prudent, careful and skillful practitioner of that discipline in the community or a similar community under the same or similar circumstances." *Coffey v. Bd. of Geologist Examiners*, 348 Or 494, 509-510 (Or 2010), *citing Creasey v. Hogan*, 292 Or 154, 163 (1981) (malpractice claim against podiatrist); *see also Getchell v. Mansfield*, 260 Or 174, 179 (1971).

A. Standard of Care for Charting

The record establishes that the standard of care for podiatric physicians includes maintaining adequate chart notes. The disputed issue is what degree of chart note accuracy and thoroughness was required for Dr. Rushton to meet the standard of care.

Dr. Michael's Opinions

Dr. Michael believes that "charting is charting," and that the general standards for medical recordkeeping do not change based on where a podiatrist practices or whether a treatment provided is surgical versus conservative. Transcript at 271, 119-123. Although Dr. Michael recognizes that the community in which a podiatrist practices may, for example, affect whether the podiatrist keep electronic versus handwritten charts, he maintains that there are certain recordkeeping standards that are universal.

In Dr. Michael's opinion, it is important for a provider to document a patient's response to treatment — including the efficacy of the treatment — to support whether treatment should continue or whether other options should be considered. He also believes a podiatrist should

document whether he or she administered, for example, 1 cc versus 3 cc of a sclerosing solution to a patient over the course of seven injections, as repetitive injections at a higher volume could cause weakening of some of the structures within the intermetatarsal space, and the knowledge might give a subsequent provider insight into problems that present in the patient. He also believes a podiatrist should document the specific location of a patient's pain symptoms and where any injections were administered because a new provider might then know whether the patient was experiencing a recurrent issue, or a new issue that warranted its own treatment.

Dr. Michael considers Dr. Rushton's patient charts deficient because they omit information pertaining to the location of symptoms and treatments administered, they contain repeated errors and repetitive cutting and pasting with little to no differentiation between treatment plans for different patients, they lack documentation as to patient progress, they lack information as to what therapeutic results Dr. Rushton was seeking, and they lack substantive findings to support continued treatment.

As a podiatrist and a peer reviewer of other provider's medical records, Dr. Michael has had occasion to review many podiatry charts. While he has observed charting errors in other providers' records due to cutting and pasting, such errors were isolated, and not as continuous and repetitive as what he observed in Dr. Rushton's chart notes. In sum, Dr. Michael has not seen the degree of charting errors and deficiencies in other podiatrists' records that he saw in Dr. Rushton's. In Dr. Michael's opinion, Dr. Rushton's charting was below the standard of care.

Dr. Hutchinson's Opinions

In general, Dr. Hutchinson seemed to place much less value on the accuracy and thoroughness of another provider's chart notes than Drs. Michael, Jones, and Rushton. Although the majority of Dr. Hutchinson's patients are referred by other podiatrists, he rarely receives records from those other podiatrists, and he does not often find the records necessary for his treatment of the patients.

Dr. Hutchinson also believes there is a lower standard of care for recordkeeping in rural communities because a private practitioner working in a small community is unlikely to have the type of recordkeeping technology available to a practitioner working for a health care system in a major city. He also believes there is a lower standard of care for recordkeeping with conservative care than with surgical care due to the "entirely different risk profile" for the two types of treatment. Transcript at 244-246.

Dr. Hutchinson has seen errors in other providers' medical records that are similar to those contained in Dr. Rushton's charts for Patients A through F (*e.g.* listing of an incorrect diagnosis). Transcript at 237-247-248. Dr. Hutchinson does not take issue with a podiatrist's use of cutting and pasting in chart notes and he stated at hearing that if he sees a patient for the same condition seven visits in a row, his chart notes for those seven visits will look the same because of template-driven cutting and pasting. The only difference in his chart notes for the visits might be the subjective comments provided by the patient each time.

Dr. Hutchinson does not believe that Dr. Rushton's charting fell below the standard of care.

Dr. Jones' Opinions

Dr. Jones acknowledged at hearing that repetitive charting errors could cause confusion for a physician taking over the care of a patient.

Because the administration of seven sclerosing injections is a repetitive treatment, Dr. Jones expects that chart notes for the seven visits will appear repetitive, unless something changed between visits that warranted documenting. When Dr. Jones previously utilized sclerosing injections to treat neuromas, he would ask a patient how he or she responded to the previous injection, note the patient's response in the chart, and use the response to inform the course of treatment.

In Dr. Jones' opinion, Dr. Rushton's charting is "totally" within the standard of care, considering medical records Dr. Jones has reviewed from other podiatrists (which frequently omit reference to the right or left foot and the specific location of an injection). Transcript at 453.

Conclusion re: Standard of Care

Dr. Rushton admits that his patient chart notes are often repetitive. But he asserts that this is because the treatment itself is often repetitive (*i.e.* patients come in for a series of successive injections, *etc.*). He testified at hearing that his repeated use of the cut and pasted excerpt regarding neuroma treatment was to merely convey to other providers that he had administered a sclerosing agent to the patients. He concedes that cutting and pasting exact language in successive chart notes may not be a best practice, but he denies that it falls below the standard of care.

Utilizing cut and pasted (or template-driven) portions of language in chart notes appears to be a common practice in podiatry, and the Board did not take issue with the mere fact that Dr. Rushton utilized cut and pasted language in his chart notes. However, after weighing the various expert opinions, the ALJ concluded that the standard of care dictates that cut and pasted language used in chart notes not contain repetitive errors and that, where appropriate, the language is tailored to an individual patient and the particular patient encounter.[38]

While it is possible that the community in which a podiatrist practices could affect the method by which he or she maintains charts (*i.e.* electronic versus handwritten), the ALJ was not persuaded that some urban/rural divide or inequity in technological resources available to a particular practitioner translates to a lesser standard for accurate, error-free, thorough chart notes. And, while a greater level of charting detail might be appropriate when providing surgical treatment, the fact that a podiatrist provides less risky, more conservative treatments does not mean that he or she is held to a lesser standard for accurate, error-free, thorough chart notes that

[38] While patients may present with similar symptoms, there are may be circumstances unique to an individual patients.

are appropriate for the specific treatment. For example, although the chart notes for a podiatrist performing a neurectomy on a patient may be more detailed than a podiatrist performing a sclerosing injection on a patient, there is no rational basis to assert that the podiatrist performing the sclerosing injection should not, at a minimum, chart such basic facts as which foot is affected, which interspace is injected, and how much sclerosing solution is used. Such "details" should constitute the baseline for charting such a treatment.

Based on the above, the ALJ concluded that to meet the standard of care for podiatric charting, Dr. Rushton's medical records (which include chart notes and "face sheets") should — at a minimum — be free of repetitive errors; contain accurate diagnoses; document all treatments administered; document the location of symptoms and treatments administered; document the dosages (where appropriate) of treatments administered; and note patient responses to treatments.

B. Whether Patient Records Met Standard of Care

Patient A

On May 14, 2014, Patient A presented for treatment of neuroma, and Dr. Rushton administered the first of seven recommended sclerosing injections. The chart note for the visit includes an excerpt regarding neuroma treatment that appears in an identical or substantially similar manner throughout Patient A's chart notes (as well as other patients' chart notes). *See* Exhibit A3 at 27- 28. The excerpt states, in part: "This area of nerve was injected with 3 cc of 5% absolute alcohol in a solution of 0.5% marcaine with epinephrine." *Id.* at 28. Although Dr. Rushton testified at hearing that he treated Patient A's left foot and that he likely injected between .5 and 1 cc of sclerosing solution into the second interspace, the medical records do not document which foot he treated and where he administered the injection. *See* Transcript at 51-52; Exhibits A3 at 27-28, R8 at 48. Moreover, the portion of the chart note discussing neuroma treatment (which he repeated throughout Patient A's chart notes) incorrectly states that he administrated 3 cc of 5 percent absolute alcohol to the patient. Dr. Rushton actually administered anywhere from .5 cc to 3 cc of solution to all of his sclerosing patients. Thus, he failed to chart the location of the injection site, including which foot, and he noted the incorrect amount of sclerosing solution he administered to Patient A.

On May 21, 2014, Patient A received a second sclerosing injection from Dr. Rushton. The chart note for that visit contains the same excerpt regarding neuroma treatment, referencing the incorrect amount of sclerosing solution. The chart note does not specify the location of the injection site, including which foot. *See* Exhibit A3 at 25-26. In addition, neither the May 21, 2014 chart note nor the May 21, 2014 "face sheet" indicate how Patient A responded to the first injection she received. *See id.* at 25-26; *see* Exhibit R8 at 47.[39]

[39] The Board also alleged that Dr. Rushton did not document that he conducted any clinical examination of Patient A during the May 21, 2014 visit. However, the chart note for the visit indicates that Patient A's lower extremity skin temperature was "warm to cool, proximal to distal;" her touch, pin, vibratory, and proprioception sensations were normal except for the affected digits; her deep tendon reflexes and muscle tone were normal; she had good coordination; and she had "pain with palpation to affected interspace with a positive Moulders and Sullivans [*sic*] sign." (*See* Ex. A3 at 25.)

On May 28, 2014, Patient A again treated with Dr. Rushton, and he noted in the chart, "Patient states she can move her toes." Exhibit A3 at 23; *see also* Exhibit R8 at 46 ("I can move my toes!").) He administered a third sclerosing injection. The chart note for that visit contains the same excerpt regarding neuroma treatment, referencing the incorrect amount of sclerosing solution. The chart note does not specify the location of the injection site, including which foot. *See* Exhibit A3 at 23-24.

Patient A received additional sclerosing injection from Dr. Rushton on June 4, 11, 18, and 25, 2014. The chart notes for each of those patient encounters contain the same cut and pasted excerpt regarding neuroma treatment, referencing the incorrect amount of sclerosing solution. The chart notes do not specify the location of the injection site, including which foot. *See* Exhibit A3 at 15-22. None of the chart notes or corresponding "face sheets" for the visits indicate how Patient A responded to the previous injections.[40] *See id.* at 19-22; *see* Exhibit R8 at 42-45.

On July 30, 2014, Patient A presented again to Dr. Rushton with symptoms consistent with a neuroma, and Dr. Rushton noted in the chart that the patient "states her condition is 70% better since the injections." Exhibit A3 at 13; *see also* Exhibit R8 at 41.

The Board has established standard of care violations against Dr. Rushton with regard to the above-referenced medical records because the records contain repeated errors regarding sclerosing injection dosages; they repeatedly fail to document which foot is being treated and which interspace is injected; and they largely fail to document patient response to treatment.

The Board also alleges that Dr. Rushton failed to provide any medical evidence to support the patient's assertion that her neuroma condition was 70% improved since receiving the seven injections. However, Dr. Rushton noted in the chart that Patient A's touch, pin, vibratory, and proprioception sensations were "normal," her epicritic sensations were "intact," and "Tinels sign, Mulder's sign and Valleix phenomenon [were] absent."[41] *See* Ex. A3 at 13. In addition, Dr. Hutchinson explained at hearing that pain symptoms related to neuromas are subjective and a podiatrist must rely on patient reports to assess improvement. *See* Transcript at 233-234 ("[P]atients report how they're doing with treatment. You * * * can't just palpate the nerve and go, yeah, it feels like it's 70 percent better than it was last time. * * *. So we rely on what patients tell us, to tell us how they are doing with treatment."). The Board provided no persuasive evidence to rebut Dr. Hutchinson's opinion. Consequently, the Board has not

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[40] At hearing, however, Dr. Rushton testified that Patient A showed some improvement after receiving her first three injections, so he followed standard protocol and proceeded to continue with the fourth, fifth, sixth, and seventh injections. (Test. of Rushton; Tr. at 55.)

[41] At hearing, Dr. Rushton testified in part:

> Where before she had what they call a Mulder's click, and remember she had decreased sensations to the affected digits, now under the neurological exam, she now has a[n] absent Mulder's sign * * *, and now touch pin vibratory proprioceptives are all normal and the epicritic sensations are intact[.]

(Tr. at 57.)

established a standard of care violation with regard to Dr. Rushton's charting of Patient A's improved condition on July 20, 2014.

On August 6, 2014, Dr. Rushton diagnosed Patient A with "extensor tendonitis." Exhibit A3 at 11-12. The chart note does not specify which foot is affected. *See id.* Chart notes for Patient A repeatedly, and incorrectly, state that she was undergoing physical therapy evaluation and treatment for Achilles tendonitis (which is not the same as extensor tendonitis). *See id.* at 2, 4, 6, 10, 12. This repeated documentation error constitutes a standard of care violation.

On October 1, 2014, Patient A followed up with Dr. Rushton for arch pain extending up the leg. Dr. Rushton noted that the patient "has symptoms consistent with a neuroma" and he listed a diagnosis of Morton's neuroma. Exhibit A3 at 1. Dr. Rushton administered a steroid injection into Patient A's foot, to the "point of maximum tenderness." *Id.* at 2; *see also* Exhibit R8 at 36.

The Board contends that the October 1, 2014 chart note does not include clinical findings for Morton's neuroma, and fails to document the location of the diagnosed condition. The Board is correct that the chart note lacks any findings regarding, for example, a positive Mulder's or Sullivan's sign, and it does not specify the affected foot or interspace. *See* Ex. A3 at 1-2. These documentation deficiencies constitute a standard of care violation.

The Board also alleges that Dr. Rushton administered the steroid injection to Patient A "without discussing in the chart the risk of causing injury due to the previous series of treatments." Pleading P1 at 7. However, the chart note states, in part:

> I explained the risks and benefits of an injection to the area. All the patient[']s questions were answered to their [*sic*] satisfaction. The patient agreed to an injection[.]

Exhibit A3 at 2. The Board has not established a standard of care violation with regard to the steroid injection and a lack of discussion as to risks.

In conclusion, the Board has established standard of care violations against Dr. Rushton with regard to Patient A's medical records because the records contain repeated errors regarding sclerosing injection dosages; they contain repeated references to an erroneous Achilles tendonitis diagnosis; they repeatedly fail to document which foot is being treated and which interspace is injected; they largely fail to document patient response to treatment and the efficacy of such treatment; and they fail to include clinical findings to support a diagnosis of Morton's neuroma on October 1, 2014.

Patient B

On July 8, 2014, Patient B treated with Dr. Rushton. He diagnosed Morton's neuroma, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the same excerpt regarding neuroma treatment that appeared in Patient A's chart notes. *See* Exhibit A4 at 6.

On July 22, 2014, Patient B again presented to Dr. Rushton for treatment of neuroma. He noted in her chart that "[p]atient states it feels like [her] socks are rolled up underneath ball of foot." *Id.* at 3. The chart note does not state whether Patient B received the second of the course of seven recommended injections. *See id.* at 3-4.

On June 9, 2015, Patient B again treated with Dr. Rushton. He diagnosed Morton's neuroma, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the excerpt regarding neuroma treatment. *See id.* at 2. Neither the June 9, 2015 chart note nor the June 9, 2015 "face sheet" indicate whether, and to what extent, Patient B received past injections for neuroma. The medical records also do not indicate how Patient B responded to any such past treatment. *See id.* at 1-2; *see also* Exhibit R9 at 18.

The Board contends that Dr. Rushton's failure to document in the chart notes whether Patient B actually received the course of seven sclerosing injections he recommended on July 8, 2014, and his failure to document how she responded to any injections she did receive falls below the standard of care.

At hearing, Dr. Rushton asserted that for Patients A through F, when there was an injection given, the chart notes "clearly state an injection was given." Transcript at 287. He testified that it was "crystal clear to him" from the chart notes and that "[t]here's never a time where that's ambiguous at all. Always in the chart note. Always clearly given." *Id.*; *see also id.* at 289. Dr. Hutchinson asserted at hearing that in looking at the medical records at issue, he could figure out "exactly how many injections each one of those patients got." *Id.* at 249. And, Dr. Michael testified, in part: "I don't think that there was ever a question in my mind as to whether sclerosing injections were performed. * * *. There was a question as to the specific site of the injection, but not whether the injection was done or not." *Id.* at 90.

Dr. Rushton confirmed at hearing that Patient B did not receive a sclerosing injection on July 22, 2014, that the June 9, 2015 injection was her second injection, and that the first injection had "worked wonders" for her. Transcript at 69, 67.

It is not clear from the chart notes why Patient B did not receive the second recommended injection during her visit with Dr. Rushton on June 22, 2014. And, when the patient returned to Dr. Rushton almost a year later, on June 9, 2015, it is not clear from the chart notes whether she had experienced a positive response to the previous injection. Dr. Rushton's failure to include this relevant (yet quite basic) information in the chart notes does not meet the standard of care.

Patient C

On October 13, 20, and 27, 2010, December 12, 2012, January 23, 2013, and September 4 and 18, 2013, the patient received sclerosing injections from Dr. Rushton for the treatment of Morton's neuroma. The chart notes for each of those patient encounters contain the same excerpt regarding neuroma treatment found in the chart notes for other patients. Patient C's chart

notes reference the incorrect amount of sclerosing solution administered, and they do not specify the location of the injection site, including which foot. None of the chart notes or corresponding "face sheets" for the visits indicate how Patient C responded to the previous injections.[42] *See* Exhibit R10 at 1-37.

The Board has established standard of care violations against Dr. Rushton with regard to Patient C's medical records because they contain repeated errors regarding sclerosing injection dosages; they repeatedly fail to document which foot is being treated and which interspace is receiving an injection; and they fail to document patient response to treatment and the efficacy of such treatment.

Patient D

Patient D treated with Dr. Rushton from December 4, 2013 to March 18, 2015. On December 4, 2013, she presented with a chief complaint of pain in the forefoot, for which Dr. Rushton diagnosed metatarsalgia and callosities. Exhibit R11 at 11-12. On December 18, 2013, she followed up with Dr. Rushton regarding her forefoot pain. *Id.* at 9. A "face sheet," dated January 22, 2014, indicates that she received an injection on that date. *Id.* at 51. The record contains no chart note for a visit on January 22, 2014, and it is unknown what type of injection she received. *See id.* at 1-72, 51.

On January 29, 2014, the patient presented to Dr. Rushton for evaluation of a neuroma. Dr. Rushton diagnosed Morton's neuroma at the third interspace on the left, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the same excerpt regarding neuroma treatment that appeared in other patients' chart notes. *Id.* at 7-8.

On February 5, 2014, the patient presented to Dr. Rushton for evaluation of symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the patient had been experiencing symptoms for several months and they were continuing to worsen. *Id.* at 5. Despite the reported worsening of symptoms and Dr. Rushton's previous recommendation that she receive six more injections, there is no indication in either the chart note or the February 5, 2014 "face sheet" that Patient D received an injection on that date. There is also no note explaining why the patient did not receive an injection. *See id.* at 5-6, 49.

On February 19, 2014, the patient followed up with Dr. Rushton and he noted that the patient "states her condition is better and it even feels better when she walks barefoot." *Id.* at 3.

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[42] At hearing, in response to the question, "How did the patient respond to the first injection?" Dr. Rushton replied, in part:

> We went on to a second and a third injection, which tells me there — she was receiving no benefit or she was receiving some benefit. Because she went to all seven injections, that tells me that after the third injection, she was somewhat better. When she concluded her seven injections, she went on a year later to have two more injections, which tells me that the first series of seven had helped her for I think over a year before she came back[.]

Transcript at 71.

There is no indication in either the chart note or the February 19, 2014 "face sheet" that Patient D received an injection on that date. *See id.* at 3-4, 48.

On March 18, 2015, the patient presented to Dr. Rushton for treatment of a neuroma. He administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the same cut and pasted excerpt regarding neuroma treatment. *Id.* at 1-2.

The Board contends that is not clear from Patient D's medical records how many injections she received from Dr. Rushton.

At hearing, in response to the question, "How many total injections did this patient receive," Dr. Rushmore answered, "Two. They were about a year apart, very common." Transcript at 74. However, a "face sheet" dated January 22, 2014, indicates that Patient D also received an injection on that date. *See* Exhibit R11 at 51. The record contains no chart note for a visit on January 22, 2014, and the "face sheet" does not specify what type of injection Patient D received on that date. *See id.* at 1-72, 51.

Dr. Rushton's hearing testimony regarding Patient D only receiving two injections is contradicted by the medical record. The Board has established that there is some ambiguity in Patient D's records regarding how many (and what type of) injections she received from Dr. Rushton. Moreover, it is not clear from the chart notes why Patient D did not receive the second recommended injection during her visit with Dr. Rushton on February 5, 2014. And, when the patient returned to Dr. Rushton almost a year later, on March 18, 2015, it is not clear from the chart notes whether she had experienced a positive response to the previous injection. Dr. Rushton's failure to include this relevant information in the chart notes does not meet the standard of care.

Patient E

On February 5, 2013, Patient E presented to Dr. Rushton for evaluation of a neuroma. Dr. Rushton diagnosed Morton's neuroma, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the same cut and pasted excerpt regarding neuroma treatment that appeared in other patients' chart notes. Exhibit R12 at 7-8.

On February 19, 2013, the patient again presented to Dr. Rushton for evaluation of a neuroma. On the chart note, Dr. Rushton noted that the patient had been experiencing symptoms for several months and the symptoms were worsening. However, there is no indication in either the chart note or the February 19, 2013 "face sheet" that Patient E received an injection on that date. *See id.* at 5-6, 23.

On October 1, 2013, the patient again presented to Dr. Rushton for evaluation of a neuroma. Dr. Rushton again diagnosed Morton's neuroma, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that

visit contains the same cut and pasted excerpt regarding neuroma treatment, and it does not indicate how the patient responded to the previous injection. *Id.* at 3-4.

On February 18, 2014, the patient again presented to Dr. Rushton for evaluation of a neuroma. Dr. Rushton diagnosed Morton's neuroma, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the same cut and pasted excerpt regarding neuroma treatment. *Id.* at 2-3. Neither the February 18, 2014 chart note nor the corresponding "face sheet" indicate how Patient E responded to her previous injections. *See id.* at 1-2, 19.

The Board contends that it is not clear from Patient E's medical records how many injections she received from Dr. Rushton, and how she responded to the injections she did receive.

Patient E's medical records do not indicate whether she completed any of the recommended courses of seven sclerosing injections, and if she did not, there is no notation in the records explaining why she did not. It is unknown, for example, why Dr. Rushton did not administer a sclerosing injection to the affected area during a visit on February 19, 2013, when he had recommended a course of seven injections just two weeks prior and the patient was reporting continuing (and, in fact, worsening) symptoms. *See id.* at 5-6, 8, 23. And, aside from noting her worsening symptoms on February 19, 2013 (two weeks after receiving a sclerosing injection), none of Patient E's medical records note how she responded to the sclerosing treatment. Dr. Rushton's failure to include this relevant information in the chart notes does not meet the standard of care.

Patient F

On September 3, 2013, Patient F presented to Dr. Rushton for evaluation of a neuroma. Dr. Rushton diagnosed Morton's neuroma on the left, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note for that visit contains the same cut and pasted excerpt regarding neuroma treatment found in other patients' records. Exhibit R13 at 9-10. Neither the February 18, 2014 chart note nor the corresponding "face sheet" specify the location of the injection (*i.e.* which interspace). *See id.* at 9-10, 36.

On September 17, 2013, Dr. Rushton diagnosed Patient F with Morton's neuroma on the right, administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note contains the same cut and pasted excerpt regarding neuroma treatment. Neither the September 17, 2013 chart note nor the corresponding "face sheet" indicate how Patient F responded to her previous injection. *See id.* at 7-8, 35.

On October 1, 2013, Dr. Rushton diagnosed Patient F with Morton's neuroma on the left, in the third interspace. He administered a sclerosing injection, and recommended that the patient follow up with six other injections. The chart note contains the same cut and pasted excerpt regarding neuroma treatment. Neither the October 1, 2013 chart note nor the corresponding "face sheet" indicate how Patient F responded to her previous injections. *See id.* at 5-6, 32.

On October 22, 2013, Patient F followed up with Dr. Rushton regarding symptoms consistent with a neuroma. Dr. Rushton noted that the patient had been experiencing symptoms for several months and the symptoms were worsening. There is no indication as to whether the patient was experiencing symptoms in both feet. There is no indication in either the chart note or the October 22, 2013 "face sheet" that Patient F received an injection on that date. *See id.* at 3-4, 31.

On November 12, 2013, Patient F followed up with Dr. Rushton regarding symptoms consistent with a neuroma. On the chart note for the visit, Dr. Rushton noted that the "[p]atient states she is doing great!" *Id.* at 1; *see also id.* at 30. Upon examination, he noted that touch, pin, vibratory, and proprioception sensations were "normal," Tinels sign, Mulder's sign, and Valleix phenomenon were "absent," and the patient experienced pain "with evaluation and palpation of [the] affected interspace."[43] *Id.* at 1-2. He diagnosed Morton's neuroma.[44] There is no indication in either the chart note or the November 12, 2013 "face sheet" that Patient F received an injection on that date. *See id.* at 1-2, 30.

The Board contends that it is not clear from Patient F's medical records how many injections she received from Dr. Rushton, and how she responded to the injections she did receive.

Patient F's medical records do not indicate whether she completed any of the three recommended courses of seven sclerosing injections, and if she did not, there is no notation in the records explaining why she did not. It is unknown, for example, why Dr. Rushton did not administer a sclerosing injection to the affected area during a visit on October 22, 2013, even though he previously recommended a course of seven injections and the patient was reporting continuing symptoms. And, aside from noting her worsening symptoms on October 22, 2013, and that she was "doing great" on November 12, 2013, Dr. Rushton did not otherwise document her response to the sclerosing injections. Dr. Rushton's failure to include this relevant information in the chart notes does not meet the standard of care.

As set forth above, the ALJ concluded that the Board has proven that Dr. Rushton engaged in repeated acts of negligence, in violation of ORS 677.190(13). The Board adopts the ALJ's findings of fact and conclusion of law.

3. Sanctions

Because Dr. Rushton committed repeated acts of negligence in the practice of podiatry, he is subject to discipline under ORS 677.190(13).

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[43] With regard to Dr. Rushton's noted physical findings upon examination, there are no material differences between the October 22, 2013 and November 12, 2013 chart notes. However, the October 22 chart note indicates that the patient's symptoms were worsening, while the November 12 chart note indicates that the patient was "doing great." (*See* Ex. R13 at 1, 3.) Those apparent differences in her condition belie the exact same findings noted upon examination at each office visit.

[44] The chart note does not specify the affected interspace and whether it was the right or left. (*See* Ex. R13 at 1-2.)

ORS 677.205(1)(b) allows the Board to discipline a licensee who has "[b]een found to be in violation of one or more of the grounds for disciplinary action * * * as set forth in this chapter[.]"

Under ORS 677.205(2), the Board may use one or more of the following disciplinary methods: (a) suspend the judgment; (b) place the licensee on probation;[45] (c) suspend the license; (d) revoke the license; (e) place limitations on the license; and (f) "[t]ake such other disciplinary action as the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty or assessment of a civil penalty not to exceed $10,000, or both."

In this case, the Board proposed at hearing to impose the following sanctions:

- Reprimand;
- $10,000 civil penalty;
- Periodic chart audits at Dr. Rushton's expense by persons designated by the Board, not to exceed one chart audit per calendar year;
- In addition to the periodic chart audits (referenced above), random chart audits by Board personnel or their designee[s];
- Random office visits by Board personnel or their designee[s];
- Continuing Medical Education (CME), pre-approved by the Board's Medical Director;
- Probation for 10 years (consisting of quarterly meetings with a Board member or the Board's Compliance Officer, and may also include appointment of a mentor for charting, if the chart audits identify ongoing deficiencies);
- No later than 10 days before the delivery of any medical services to a patient, Dr. Rushton must inform the Board of all practice site locations; and
- Assessment of costs of the proceeding.

Dr. Rushton contends that the Board's proposed sanctions are an extreme overreaction to the facts of the case, and that any established violations merit no more than a letter of concern and some degree of continuing medical education.

Given the range of sanctions available to the Board, a reprimand is one of the least stringent. Moreover, the Board's proposed periodic and random chart audits, office visits, continuing medical education requirements, practice site location notification requirements, and probation conditions are sanctions that are all proportionate and rationally related to the established charting violations. The imposition of the costs of the proceeding is also a

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[45] ORS 677.205(4) states:

> If the board places any licensee on probation as set forth in subsection (2)(b) of this section, the board may determine, and may at any time modify, the conditions of the probation and may include among them any reasonable condition for the purpose of protection of the public or for the purpose of the rehabilitation of the probationer, or both. Upon expiration of the term of probation, further proceedings shall be abated if the licensee has complied with the terms of the probation.

reasonable sanction. However, considering the nature of the violations, the fact that the Board did not show evidence of patient harm or risk of harm, and the fact that Dr. Rushton has already taken affirmative steps to improve his patient charting, the Administrative Law Judge found the assessment of a $10,000 civil penalty to be overly punitive and recommended against it.

EXCEPTIONS

The Board received written exceptions from Dr. Rushton's legal counsel on February 15, 2018, and his legal counsel appeared before the Board on April 5, 2018, to present oral argument. Counsel for Dr. Rushton raises a number of issues, which the Board will now address.

Exceptions 1 -2: Dr. Rushton contends that his charting met the standard of care. The Board does not accept Dr. Rushton's contention that there are two different standards of care (rural v. urban) in Oregon and that his charting met the standard of care. Uncorrected and repeated charted errors, as set forth in this case, are not acceptable whether they occur in an urban or rural environment—patients are entitled to have accurate chart notes reflecting their care, which enhances patient safety and assists other care providers in providing continuity of care.

Exception 3: Dr. Rushton argues that the ALJ erred in sustaining the Board's objection to allowing Dr. Rushton's attorney review the Board's consultant written report. The Board rejects this contention. ORS 676.175(3)(d) reflects that the Board is under no obligation to disclose to the licensee the reports of expert witnesses. The written report prepared by Dr. Michael, the Board's consultant and expert witness, was not subject to disclosure either before or during the hearing.

Exception 4 and 5: Dr. Rushton's contentions in these exceptions are irrelevant and lack merit.

Exception 6: The ALJ's contention that there was no allegation in the Board's Complaint relating to the failure to correct errors or addend records. The Board agrees, but finds no error, because although the findings of fact in question accurately reflect reliable testimony presented at hearing, the conclusions of law that Dr. Rushton engaged in repeated acts of negligence did not refer to or in any way rely upon any failure of Dr. Rushton to correct errors in his records or add an addendum to the medical record.

Exception 7: Dr. Rushton's arguments against Dr. Michael lack merit. The exhibit packets from the Board and Dr. Rushton were at the hearing, his testimony was subject to direct and cross examination, and he drew upon his extensive training and experience as he provided his testimony. The Board rejects Dr. Rushton's contention that he was disqualified because he allegedly had no experience reviewing records of podiatrists from eastern Oregon. It is the standard of care that all physicians, to include podiatric physicians, maintain accurate chart notes regardless of the region of the state where they practice.

Exceptions 8: Dr. Rushton takes issue with the finding that his chart notes made the observation that "metatarsal splay was increased." The Board acknowledges that this repeated

comment appears under the heading of "Plan" in his chart note, but the note itself is indicative of an observation and not part of a treatment plan. This exception lacks merit.

Exceptions 9 – 11: The Board has reviewed these exceptions and finds them to be lacking in merit.

Exception 12: Dr. Rushton argues that the ALJ erred in concluding that he "incorrectly noted a diagnosis of Achilles tendonitis" in five chart notes for Patient A. The Board does not find merit in this exception. Review of Exhibit A3, to include pages 3-4, 6, 10 and 12 reflects Dr. Rushton's impression of "Posterior tibial tendonitis." This reflects a diagnostic impression, which is followed later in the same note under the heading of "Plan" with the following comment: "Physical Therapy evaluation and treatment for Achilles tendonitis." These chart notes speaks for themselves—there was a diagnostic impression followed by a treatment plan to address the identified condition. The Board will not alter the ALJ's finding of fact.

Exception 13: Dr. Rushton takes issue with the ALJ's finding that it was not clear from the chart note whether Patient C experienced a positive response to the previous injection. The Board notes that that chart note for July 8, 2014 with the heading "Musculoskeletal" (Exhibit A4 at 5) reflects that Patient C had a "positive Moulders and Sullivans sign." And the chart note for July 22, 2014 with the heading "Musculoskeletal lower extremity " (Exhibit A3 at 3) reflects "Mulders sign and Valleix phenomenon absent." Dr. Rushton did not comment on this examination finding as to whether there was a connection between the disparate examination findings and the treatment. It is not clear from this chart note whether Patient C did experience a positive response to the previous injection. The Board will not alter the ALJ's finding.

Exceptions 14: Dr. Rushton points out that in September 2010, Patient C filled out a form in which she identified a problem with her left foot and the he charted that he treated the left foot a week later (Exhibit R10, at 21 - 22). That is a correct observation, and yet all the other chart notes fail to identify which foot was being treated during successive patient visits. The purpose of chart notes is not only for the benefit of the treating physician, but also for other care providers who may not have access to the entire chart, and must parse through the entire chart to find the single reference Dr. Rushton made identifying which foot was receiving treatment.

Exceptions 15-21: The Board has reviewed these exceptions and finds that they lack merit.

Exception 22: The Board notes that physicians on probation are not required to drive to the Board's office four times a year for an in-person interview.

Exception 23: Lacks merit.

Exception 24: Here, counsel for Dr. Rushton gives his version of settlement negotiations that took place prior to hearing. Settlement discussions are not part of this record, and the Board will not respond to counsel's assertions and argument in this regard.

Regarding the bill of costs, the Board received written exceptions from Dr. Rushton's legal counsel dated July 5, 2018. Counsel for Dr. Rushton raises a number of issues, which the Board will now address.

Exception 1: The Board rejects Dr. Rushton's contention that the bill of costs should be reduced and apportioned. Although the allegations that Dr. Rushton engaged in unprofessional or dishonorable conduct were not affirmed in this Order, the Administrative Law Judge (and the Board) have concluded that Dr. Rushton engaged in repeated acts of negligence in regard to Patients A – F. It is appropriate, therefore, that Dr. Rushton pay the full costs as set forth in the Board's Amended Bill of Costs.

Exception 2: The Board hired security personnel for the purpose of Dr. Rushton's contested case hearing.

Exception 3: The Board has reviewed this exception and finds that it lacks merit.

Exception 4: The Administrative Law Judge determined that imposing the costs of the proceeding is a reasonable sanction. The Board is entitled to recover the portion of the Board's costs attributable to the contested case hearing.

Exception 5: Dr. Rushton was afforded the opportunity to submit exceptions. OAR 137-003-0655 does not require a hearing on costs.

ORDER

The Oregon Medical Board now issues the following order:

Based on the commission of repeated acts of negligence, in violation of ORS 677.190(13), Michael James Rushton, DPM, is sanctioned as follows:

- Reprimand;
- Probation for ten years with required in-person probation interviews at each of the Board's quarterly meetings, unless otherwise directed by the Board's Investigative Committee or its Compliance Officer (at the Board's discretion, interviews may be held electronically using Board established protocols for the location and electronic transmission of the meeting); Dr. Rushton may request termination of probation after five years of successful compliance with the terms of this Order;
- Periodic chart audits at Dr. Rushton's expense by persons designated by the Board, not to exceed one chart audit per calendar year;
- No-notice office visits and chart audits conducted by Board personnel or their designee[s];
- Completion of a course on medical documentation, pre-approved by the Board's Medical Director;
- Notification to the Compliance Section of the Board of any and all practice sites, as well as any changes in practice addresses, employment, or practice status within 10 days; and

- Assessment of costs of the proceeding, which are detailed in the Amended Bill of Costs dated June 21, 2018. Costs are due within 60 days of issuance of this final order by the Board.

DATED this 5th day of September 2019.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

K. DEAN GUBLER, DO
BOARD CHAIR

APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 *et sec.*

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of:	)	
	)	
MICHAEL JAMES RUSHTON, DPM	)	AMENDED BILL OF COSTS
License No. DP00321	)	
	)	

1.

On January 19, 2018, Administrative Law Judge Jennifer Rackstraw issued a Proposed Order in the matter of Michael James Rushton, DPM (Licensee). In this Proposed Order, Licensee was assessed the costs related to his Contested Case Hearing held April 3 – 4, 2017.

2.

Under the authority of ORS 677.205(2)(f), the State of Oregon, by and through its Oregon Medical Board, claims costs related to the April 3 – 4, 2017, Contested Case Hearing in the above-captioned case as follows:

Total Dept. of Justice costs	$	14,341.10
AAG – 57.5 hours @ $175/hr:		10,062.50
AAG – 12.7 hours @ $182/hr:		2,311.40
Paralegal – 21.7 hours @ $90/hr:		1,953.00
Other DOJ Charges (motor pool/witness fee/postage):		14.20
Office of Administrative Hearings costs	$	17,728.42
OAH Direct Charges:		11,379.62
OAH Admin. Charges:		5,936.97
OAH working capital charge:		411.83
Consultant:	$	1,125.00
Security:	$	1,233.00
Court Reporter Appearance - Naegeli Corp.:	$	1,974.78
TOTAL COSTS DUE:	**$**	**36,402.30**

The above costs are certified as a correct accounting of actual costs incurred preparing for and participating in the Contested Case Hearing in this matter.

Dated this 21st of June, 2018

OREGON MEDICAL BOARD
State of Oregon

[redacted]

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
JOANNA MAGDALENA ZAMORA, MD	)	INTERIM STIPULATED ORDER
	)	
LICENSE NO. MD173312	)	

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. Joanna Magdalena Zamora, MD (Licensee) is a licensed physician in the State of Oregon.

2.

The Board received credible information regarding Licensee that resulted in the Board initiating an investigation. The results of the Board's investigation to date have raised concerns to the extent that the Board believes it necessary that Licensee agree to cease the practice of medicine until the investigation is completed.

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

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

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

3.3 Licensee must notify the Oregon Medical Board within 10 days as to how patients may access or obtain their medical records.

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 Practitioner 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 29 day of August, 2019.

[redacted]

JOANNA MAGDALENA ZAMORA, MD

IT IS SO ORDERED THIS 29 day of August, 2019.

State of Oregon
OREGON MEDICAL BOARD

[redacted]

JOSEPH THALER, MD
MEDICAL DIRECTOR