

Oregon Medical Board
BOARD ACTION REPORT
September 15, 2021

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between August 16, 2021, and September 15, 2021.

Scanned copies of Interim Stipulated Orders, Orders of Emergency Suspension, Stipulated Orders, Final Orders, Termination Orders, Modification Orders, Voluntary Limitations, and non-disciplinary Corrective Action Agreements 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 the following actions are **not** included in this report:

- Consent Agreements and their modifications/terminations (non-disciplinary, do not impose practice limitations)
- Terminations of non-disciplinary Corrective Action Agreements
- Complaint and Notices of Proposed Disciplinary Action (not final actions by the Board)

These documents, however, are public and are available upon request.

Printed copies of documents not provided with this report are available to the public. To obtain a printed copy of a document 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. You may submit the form by fax to (971) 673-2670, by email to info@omb.oregon.gov, or by 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 self-reported that he/she has privileges.

***Boudreaux, Lauren Elizabeth, DO; DO171825; Gresham, OR**

On September 2, 2021, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to enter into a mentorship with a board-certified, pre-approved dermatologist practice mentor who will meet with Licensee monthly, review charts, and provide quarterly reports to the Board; and Licensee will complete pre-approved CME in subject areas identified by the mentor.

Culligan, Kimberly Rose, LAc; AC166186; Eugene, OR

On August 20, 2021, Licensee entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to complete a 120-hour mentorship with a Board-approved clinical supervisor.

Lang, Kathie Jean, MD; MD22164; Klamath Falls, OR

On September 2, 2021, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates the April 1, 2021, Corrective Action Agreement.

***LaTulippe, Steven Arthur, MD; MD22341; Dallas, OR**

On September 2, 2021, the Board issued a Default Final Order for dishonorable or unprofessional conduct; repeated negligence in the practice of medicine; and gross negligence in the practice of medicine. This Order revokes Licensee's medical license and assesses a \$10,000 fine.

Ottenheimer, Edward Joseph, III, MD; MD20394; Roseburg, OR

On September 2, 2021, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates the April 11, 2019, Corrective Action Agreement.

***Read, Robert Allen, MD; MD21063; Corvallis, OR**

On September 2, 2021, the Board issued an Order Terminating Interim Stipulated Order and Withdrawing Complaint and Notice of Proposed Disciplinary Action Without Prejudice. This Order terminates the October 5, 2016, Interim Stipulated Order and withdraws the May 17, 2019, Complaint and Notice of Proposed Disciplinary Action.

***Rosen, Ronald Daniel, MD; MD17449; Bend, OR**

On September 2, 2021, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. With this Order, Licensee surrenders his medical license while under investigation.

Singh, Jeevan Kaur, LAc; AC203870; Portland, OR

On September 2, 2021, the Board issued an Order Terminating Consent Agreement for Re-Entry to Practice. This Order terminates the April 8, 2021, Consent Agreement for Re-Entry to Practice.

***Stevens, Ryan Richard, MD; MD22325; Corvallis, OR**

On September 2, 2021, Licensee entered into a Stipulated Order with the Board. This Order restricts Licensee from performing surgery on the head or neck of any patient for the treatment of cancer except for small sample biopsies; requires Licensee to obtain a pre-approved practice mentor who will meet with Licensee at least twice a month, perform chart reviews, and provide quarterly reports to the Board; requires Licensee to remain enrolled and in good standing in a monitoring program; and requires Licensee to maintain a therapeutic relationship with a pre-approved healthcare provider.

Weaver, Erin Elizabeth, LAc; AC196824; Portland, OR

On September 2, 2021, the Board issued an Order Terminating Consent Agreement for Re-Entry to Practice and Order Modifying Consent Agreement for Re-Entry to Practice. This Order terminates the February 20, 2020, Consent Agreement for Re-Entry to Practice and the February 25, 2021, Order Modifying Consent Agreement for Re-Entry to Practice.

The following Licensee was issued a Complaint and Notices of Proposed Disciplinary Action.
Note, in this instance the Board has not taken a final action.

- **Major, Jonathan Michael, LAc; AC155574; Jacksonville, OR**

The following Licensee was issued an Order **Withdrawing** Complaint and Notices of Proposed Disciplinary Action.

- **Boudreaux, Lauren Elizabeth, DO; DO171825**

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

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
LAUREN ELIZABETH BOUDREAUX, DO) CORRECTIVE ACTION AGREEMENT
LICENSE NO. DO171825)
)

1.

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

2.

The Board opened an investigation after receiving credible information regarding concerns about Licensee’s medical decision making, specifically in forming a differential diagnosis, obtaining appropriate diagnostic examinations, procedures, and specialty consultations, and developing an appropriate treatment plan in a patient with a breast mass. If this matter were to proceed to hearing the Board believes they may be able to prove violations of ORS 677.190(1)(a) and ORS 677.190(13).

3.

Licensee and the Board now desire to settle this matter by entry of this Agreement. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Agreement in the Board’s records. The Board agrees to close the current investigation and does not make a finding in regard to any violation of the Medical Practice Act. This Agreement is a public document; however, it is not a disciplinary action. This document is reportable to the National Practitioner Data Bank and the Federation of State Medical Boards.

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4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

4.1 Licensee agrees, at her own expense, to enter into an agreement with a board-certified dermatologist who is pre-approved by the Board's Medical Director to serve as her practice mentor.

4.1.1 On at least a monthly basis, Licensee shall send a complete list of her patients and their dermatologic diagnoses to the mentor. The mentor shall select no fewer than 10 patients, with the most challenging diagnoses, from the list for review and discussion. Licensee and the mentor shall meet at least monthly in person or by teleconference to review the chart records, including photographs, and discuss differential diagnosis, treatment options, and expectations.

4.1.2 The mentor shall provide to the Board robust quarterly reports detailing Licensee's clinical knowledge, medical decision making, and identifying areas for improvement in Licensee's care. Late or inadequate quarterly reports will require Licensee to obtain a new practice mentor with qualifications as described in paragraph 4.1 and who is pre-approved by the Board's Medical Director.

4.1.3 After four quarterly reports and with the mentor's support, Licensee may submit a request to the Board's Medical Director to reduce the frequency of case review to 15 cases per quarter; the same selection criteria will apply to this reduced number of cases. Licensee will be notified in writing should approval be granted.

4.1.4 Subsequent to the approval of reduced chart review as described in term 4.1.3, after four additional quarterly reports, and with the mentor's support, Licensee may request termination of the mentorship. Licensee will be notified in writing should approval be granted.

4.1.5 If deficiencies are identified at any point during the mentorship, the frequency of case review may be maintained or increased.

1 4.2 Prior to December 31, 2021, Licensee agrees to complete eight hours of AMA
2 Category I CME in subject areas identified by the mentor under term 4.1.2 and as pre-approved
3 by the Board's Medical Director.

4 4.3 Between January 1, 2022, and December 31, 2022, Licensee agrees to complete
5 eight hours of AMA Category I CME in subject areas identified by the mentor under term 4.1.2
6 and as pre-approved by the Board's Medical Director.

7 4.4 If Licensee has not successfully completed the mentorship by January 1, 2023,
8 Licensee agrees to complete 15 hours of AMA Category I CME by December 31, 2023, in
9 subject areas identified by the mentor under term 4.1.2 and as pre-approved by the Board's
10 Medical Director.

11 4.5 At the discretion of the Board or its designees, random, no notice chart audits and
12 office visits may be conducted by Board designees.

13 4.6 Licensee agrees to inform the Compliance Section of the Board of any and all
14 practice sites, as well as any changes in practice address(es), employment, or practice status
15 within 10 business days. Additionally, Licensee agrees to notify the Compliance Section of any
16 changes in contact information within 10 business days.

17 4.7 Licensee agrees to obey all federal and Oregon state laws and regulations
18 pertaining to the practice of medicine.

19 4.8 Licensee agrees that any violation of the terms of this Agreement constitutes
20 grounds to take disciplinary action under ORS 677.190(17).

21 IT IS SO AGREED THIS 21 day of July, 2021.

22 
23 LAUREN ELIZABETH BOUDREAUX, DO

24 IT IS SO ORDERED THIS 22nd day of September, 2021.

25
26 OREGON MEDICAL BOARD
27 State of Oregon
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KATHLEEN M. HARDER, MD
BOARD CHAIR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
STEVEN ARTHUR LATULIPPE, MD) FINAL ORDER UPON DEFAULT
LICENSE NO. MD22341)

On or about July 16, 2021, the Oregon Medical Board (Board) properly served a Complaint and Notice (Notice), proposing revocation of the medical license of Steven Arthur LaTulippe, MD (Licensee) assessment of a civil penalty of \$10,000 per violation, and assessment of costs of the proceeding against Licensee. The Notice designated the Board file on this matter as the record for purposes of establishing a *prima facie* case upon default. Licensee did not request a hearing. Therefore, upon consideration of the facts and law, the Board enters the following Order:

FINDINGS OF FACT AND ULTIMATE FACTS

1. License is a physician who most recently practiced family medicine in Dallas, Oregon, and describes himself as also specializing in pain medicine and addiction medicine. Licensee was certified by the American Board of Family Medicine at all relevant times.

COVID-19 CLINICAL ISSUES

2. SARS-CoV-2 is a coronavirus that causes COVID-19, an infectious disease. The mode of transmission of respiratory viruses, including COVID-19, is via fluid droplets expelled during normal talking and especially during coughing or sneezing. It has even been shown to be transmitted by individuals with few or no symptoms. Although masks vary in effectiveness, even the simplest mask can be expected to contain the largest, most infectious droplets. The effectiveness of masks has been scientifically shown to decrease disease transmission in the current pandemic. Every member of the public is at risk – this virus is easily transmitted from

1 person to person. The elderly, those with chronic health conditions, those living in group care
2 settings, and health care workers are particularly at risk for developing life threatening illness.
3 The standard of care recognized by the State of Oregon with respect to provider care and
4 protocols during the relevant periods of the SARS-CoV-2 (COVID-19) pandemic were the
5 guidelines published by the Centers for Disease Control¹; the Oregon Health Authority (OHA),
6 under the authority of the state of emergency declared by Governor Kate Brown on March 8,
7 2020, and the related Executive Orders issued by the Governor under ORS 401.165; and the
8 basic principles of respiratory physiology and infectious respiratory disease. Steps to protect
9 oneself and others include: Covering the nose and mouth by wearing a mask when in public,
10 washing or sanitizing hands frequently, remaining at least six feet away from people outside of
11 one's household, avoiding crowds, staying home and away from others if sick, elderly, or have
12 underlying medical conditions.

13 3. On February 28, 2020, the Oregon Health Authority (OHA) confirmed Oregon's
14 first presumptive case of COVID-19. On March 8, 2020, Oregon Governor Kate Brown declared
15 a state of emergency pursuant to ORS 401.165. (See *Elkhorn Baptist Church v. Brown*, 366 Or
16 506, 512 (2020) (discussing Governor Brown's issuance of Executive Order No. 2020-03 on
17 March 8, 2020).) On March 11, 2020, the World Health Organization (WHO) declared the
18 COVID-19 outbreak a global pandemic. The declared state of emergency is still in place as of the
19 date of this Complaint and Notice.

20 4. Under basic principles of respiratory physiology, the body reflexively maintains
21 carbon dioxide content within narrow parameters, by adjusting the minute ventilation (the
22 volume of gas inhaled and exhaled in 60 seconds). The amount of carbon dioxide re-breathed
23 within a mask is trivial and would easily be expelled by an increase in minute ventilation so
24 small it would not be noticed. Although patients with extremely advanced lung disease may not
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27 ¹ The CDC guidelines are also the standard recognizes by the American Board of Family Medicine. See
<https://www.theabfm.org/covid-19#Info>

1 be able to increase their minute ventilation, their pre-existing metabolic compensation would
2 readily address the trivial potential increase in carbon dioxide content.

3 5. The standard of care set forth in Governor Brown’s relevant Executive Orders
4 included physical distancing and face coverings.²

5 6. The standard of care as set forth in formal guidance promulgated by the Center for
6 Disease Control during the relevant periods of the COVID-19 pandemic included health care
7 practitioners wearing masks and requiring patients and staff to wear masks in the clinical
8 setting.³

9 7. The standard of care as set forth in formal guidance promulgated by the Oregon
10 Health Authority during the relevant periods of the COVID-19 declared state of emergency

11 ² Effective June 5, 2020, Governor Brown issued Executive Order No. 20-27, which stated, in part:

12 * * *

13 2. [P]ursuant to ORS 401.168(1), ORS 401.175(3), ORS 401.188(2) to (3), and ORS
433.441(3):

14 * * *

15 b. Individuals must comply with any public health directives set forth in my Executive
Orders.

16 c. Individuals should maintain physical distancing of at least six feet from any person who
is not a member of their household, when possible, and should adhere to any applicable
Oregon Health Authority (OHA) guidance, including but not limited to guidance on
physical distancing and face coverings. OHA guidance is available at
<https://govstatus.egov.com/OR-OHA-COVID-19>.

17 * * *

18 9. Guidance. At my direction, and under the authority of this and other Executive Orders,
OHA and other appropriate agencies have issued and will continue to issue and revise
detailed guidance for the public, for employers, and for particular sectors of the economy[.]

19 * * *

20 25. Legal Effect. This Executive Order is issued under the authority conferred to the
Governor by ORS 401.165 to 401.236. Pursuant to ORS 401.192(1), the directives set
forth in this Executive Order shall have the full force and effect of law, and any existing
laws, ordinances, rules and orders shall be inoperative to the extent they are inconsistent
with this exercise of the Governor’s emergency powers.

21 26. Enforcement. The directives in this Executive Order and any guidance issued by OHA or other
state agencies to implement this Executive Order are effective statewide, unless otherwise specified.

22
23 ³ On June 9, 2020, the CDC issued updated guidance for healthcare facilities, titled “Healthcare Facilities:
Managing Operations During the COVID-19 Pandemic” (June 9, 2020 Guidance). (See Ex. A10 at 1-5.) The CDC
24 noted in the June 9, 2020 Guidance that previous guidance “was preventative and meant to help healthcare facilities
prepare for community transmission, while current guidance is for managing operations during the pandemic.” (*Id.*
25 at 1.) The June 9, 2020 Guidance recommended that healthcare systems adjust their standard delivery approaches to
reduce the need for in-person care by optimizing the use of telehealth and managing mildly ill patients at home. (*Id.*
26 at 2-3.) To prevent the transmission of COVID-19 by COVID-19 infected persons who may or may not be showing
symptoms, the June 9, 2020 Guidance recommended that healthcare facilities use source control for all persons (*e.g.*,
27 staff, patients, and visitors) who enter a healthcare facility. The June 9, 2020 Guidance specified that cloth masks
are considered source control (and not personal protective equipment (PPE)), and while cloth masks may be
appropriate for patients and visitors, healthcare personnel should wear PPE.

1 included requiring health care practitioners to wear masks and require patients and staff to wear
2 masks in the clinical setting.⁴

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4 ⁴ OHA standards included but were not limited to:

5 On May 9, 2020, the OHA issued an update to its “Clinical Care, and Healthcare Prevention and Control Guidance
6 for COVID-19” recommending universal source control (*i.e.*, masking) for both patients and providers in all
7 healthcare settings and advising that healthcare providers wear a face covering or face mask at all times while in a
8 healthcare facility, unless alone in a private office. Effective July 20, 2020 – All health care clinics must: have and
9 enforce policies that require all individuals who enter the health care office to wear a face mask, face covering or
10 face shield while inside, including when in a private examination room, except as follows: If a patient cannot
11 tolerate any form of face mask, face covering or face shield due to a medical condition, strict physical distancing
12 must be observed until the patient can be placed or roomed in an area that minimizes risk to others. A face mask,
13 face covering or face shield is not required to be worn during an examination or procedure in which access to parts
14 of the face that are covered by a face mask, face covering or face shield is necessary. A face mask, face covering or
15 face shield is required to be worn as soon as the examination or procedure in question has completed; have and
16 enforce policies that require health care personnel to wear appropriate personal protective equipment (PPE) for the
17 care of patients with suspected COVID-19, confirmed COVID-19, or a known exposure to COVID-19. All health
18 care providers must: Wear a face mask or face covering that covers the nose and mouth at all times while in the
19 health care office, except when in a private office by themselves; face masks should be prioritized over face
20 coverings because they offer both source control and protection for the health care provider from potentially
21 infectious droplets, splashes, or sprays; cloth face coverings may not be worn instead of a respirator or face mask if
22 more than source control is needed; health care providers should avoid touching the outside (contaminated) surface
23 of a face mask or face covering. If a health care provider must adjust the face mask or face covering, hand hygiene
24 should be performed immediately after adjustment; face shields should be worn in addition to, but not in place of,
25 face masks for the purposes of eye protection and additional layer of splash protection; face masks or face coverings
26 are not required while eating or drinking, but strict physical distancing should be maintained while face masks, face
27 shields, or face covering are not worn; health care providers must wear N95 masks or higher-level respiratory
protection instead of a face covering or face masks for patient care that warrants a higher level of protection (See
“PPE for Healthcare Personnel” Section); respirators with exhalation valves may not be worn. Patients and visitors:
All patients and visitors when visiting a health care office are required to wear a face mask, face covering, or face
shield unless the individual is under five (5) years of age, except as follows: Face masks, face shields or face
coverings are not required while eating or drinking, but strict physical distancing (6 feet or more) should be
maintained while face masks, face shields, or face covering are not worn; a face mask, face covering or face shield is
not required to be worn during an examination or procedure where access to parts of the face that are covered by a
face mask, face covering or face shield is necessary; a face mask, face covering or face shield is required to be worn
as soon as the examination or procedure in question has completed; face masks, face shields or face coverings can
be briefly removed in situations where identity needs to be confirmed by visual comparison; if possible, limit
speaking while the cover is off as speaking generates aerosols and droplets that can contain viruses; it is not
recommended that individuals wear a face shield instead of a face mask or face covering - face shields provide
protection for the eyes and additional layer of splash or spray protection, but the role of face shields as a method of
source control has not been established; use of a face shield alone should be limited to situations when wearing a
face mask or face covering is not feasible in the following situations: when a person has a medical condition that
prevents them from wearing a face mask or face covering; when people need to see mouth and tongue motions in
order to communicate (e.g., when communicating with people with hearing impairments).
Effective July 31, 2020: An office must implement strict infection controls in accordance with following OHA
guidance: Symptoms of COVID-19 include fever, cough, shortness of breath, fatigue, myalgia, and headache. Less
common symptoms include sore throat, diarrhea, and loss of smell and taste. Fever is likely during the clinical
course, but some data indicate that fewer than half of hospitalized COVID-19 patients present with fever. Severity of
illness may worsen in the second week of infection. Atypical presentations have been described in older adults and
persons with comorbidities. CDC has provided details on the clinical presentation of COVID-19. RNA from the
virus that causes COVID-19 (SARS-CoV-2) has been identified from patients who never develop symptoms
(asymptomatic) and in patients before symptoms develop (presymptomatic). Transmission during both the
asymptomatic and the pre-symptomatic period has been documented. The degree to which pre-symptomatic and
asymptomatic transmission have contributed to the COVID-19 pandemic remains unclear. SARS-CoV-2 is believed

1 8. During all relevant times, Licensee treated Oregon Health Plan (OHP) patients
2 who have limited resources and limited ability to transfer their care to another provider.

3 9. During all relevant times, Licensee’s staff conducted an initial screening of
4 patients for COVID-19 illness when a patient first called the clinic to make an appointment. The
5 clinic receptionist would conduct a “telephone triage” and ask questions about the patient’s
6 symptomology and course of illness. Licensee’s clinic COVID-19 screening protocol did not
7 include calling patients proximal to their regularly scheduled appointments to screen for potential
8 COVID-19 symptoms. Licensee instead relied upon “common sense” and expected that if a
9 patient with a regularly scheduled appointment was “significantly sick,” the patient would call
10 prior to their appointment to report such illness.

11 10. Licensee’s COVID-19 screening protocols did not include taking temperatures on
12 all patients who presented at the clinic. Licensee’s COVID-19 screening protocols did not
13 include asking patients if they had been in close contact with any person who had COVID-19
14 symptoms or who had tested positive for COVID-19.

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16 to spread mainly between people in close contact or through respiratory droplets produced by coughs and sneezes.
17 The virus can survive on surfaces for hours to days but can be rendered inactive by routine cleaning and disinfection
18 procedures. (See “Environmental Infection Control in Healthcare Setting” Section.)
19 Effective 11/13/2020: Source control (i.e., universal masking) for patients and visitors. Healthcare facilities shall
20 have policies in place requiring all individuals who enter the facility to don a face covering or face mask while in the
21 building. If a face covering or face mask is not available or is not tolerated by a patient, face shields can also be
22 utilized. If a patient cannot tolerate any form of face covering due to a medical condition, strict physical distancing
23 must be observed until the patient can be placed or roomed in an area that minimizes risk to others. • Source control
24 (i.e., universal masking) for health care personnel. Health care personnel shall wear a face covering or face mask at
25 all times while they are in the healthcare facility. Medical-grade face masks should be prioritized for health care
26 personnel, as they offer both source control and protection for the health care personnel from potentially infectious
27 droplets, splashes, or sprays. Cloth face coverings should not be worn instead of a respirator or face mask if more
than source control is needed. Health Care Personnel shall ensure that the mask covers their nose and mouth at all
times. Health care personnel should avoid touching the outside (contaminated) surface of the mask. If Health Care
Personnel must adjust the mask, hand hygiene should be performed immediately after adjustment. N95s or higher-
level respiratory protection should replace face masks for patient care that warrants a higher level of protection.
Respirators with exhalation valves are not recommended for source control. Universal eye protection for health care
personnel. Wearing eye protection in addition to face mask or an N95 respirator ensures the eyes, nose, and mouth
are all protected from exposure to respiratory secretions during encounters in healthcare settings. Due to the
increased risk of spread in long-term care settings and the likelihood for close-contact exposures to residents and
coworkers, long-term care facility staff should wear a face mask and eye protection (goggles or face shield) at all
times within the facility (See “Extended Use of Personal Protective Equipment” Section). Health care personnel in
other settings should consider the addition of eye protection to universal masking, particularly in scenarios where
patients are unable to wear a face covering. Universal use of PPE does not eliminate the need for physical distancing
among health care personnel in the workplace.

1 11. As of approximately March 2020, when a patient arrived at the clinic for a routine
2 scheduled appointment, Licensee relied upon his receptionist to assess whether the patient had
3 symptoms suggestive of COVID-19. Licensee had trained his receptionist “to look at [the
4 patient] and just take a look at them and see if they look sick,” and, if the patient was “smiling
5 and happy,” the receptionist was instructed to ask how the patient was feeling. If the patient
6 indicated that they “felt fine” and they were “not ill,” the receptionist would direct the patient to
7 sit in the waiting area until Licensee’s wife led them to an examination room. If Licensee’s
8 receptionist made a visual determination that a patient looked sick, or if the patient indicated that
9 they had symptoms of COVID-19 or they were not feeling well, the patient was taken to a
10 designated examination room.

11 12. Absent surgical procedures, Licensee did not wear a mask when treating patients
12 at the clinic between March 2020 and December 2020.

13 13. Licensee did not require patients or clinic visitors to wear masks in the clinic
14 between March 2020 and December 2020, unless they were “acutely ill, coughing, [or]
15 congested,” or otherwise had signs suggestive of respiratory illness. Licensee estimates that at
16 least 95 percent of his patients chose not to wear a mask while at his clinic.

17 14. Licensee’s wife and his receptionist did not wear masks at the clinic between
18 March 2020 and December 2020.

19 15. Licensee admitted that, on one occasion during the declared state of emergency
20 for COVID-19, Licensee treated a male patient who had developed “SARS-CoV-2 full-blown
21 syndrome.” According to Licensee, the patient was coughing violently, had nausea, severe
22 muscle aches and fever; and he complained of feeling as though he was going to die. Licensee
23 had the patient don a mask during parts of the exam, but did not put on a mask himself.

24 16. It was Licensee’s wife’s responsibility to bring patients with known or presumed
25 COVID-19 from the waiting room to an examination room, where she was then in close contact
26 with the patients while taking their temperature, blood pressure, and other vitals. Licensee

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1 informed his wife that she was at risk in caring for such patients and he urged her to take “all
2 precautions.” “All precautions” did not include his wife wearing a mask.

3 17. From March to December 2020, Licensee engaged in an informed consent process
4 with each patient “to establish whether or not they should be wearing a mask,” based on his
5 personal opinions in general opposition to mask wearing. Licensee regularly told his patients that
6 masks are ineffective in preventing the spread of COVID-19 and should not be worn. Licensee
7 further asserted that, because virus particles are so small, they will pass through the
8 recommended masks and most other face coverings people choose to wear. Licensee routinely
9 directed patients to watch a YouTube video titled, “Tammy K. Herrera Clark on Face Mask
10 Effectiveness,” that suggested mask wearing was ineffective to prevent spread of diseases like
11 COIVD-19.

12 18. Patient A. In approximately May or June 2020, Licensee informed Patient A, who
13 was experiencing elevated blood pressure, that wearing a mask might be contributing to her
14 condition. Licensee also told the same patient that she was at greater risk from CO2 toxicity
15 from mask wearing than she was from getting COVID-19.

16 19. On at least one occasion, Licensee’s wife, working under the direction of
17 Licensee, told Patient A that COVID-19 was no different than a cold and that the flu was more
18 hazardous.

19 20. Patient B. On or about June 8, 2020, Licensee’s wife working under the direction
20 of Licensee, immediately directed an elderly patient, Patient B, to remove her mask when
21 Patient presented for her examination. Licensee’s wife then told Patient B and Patient B’s adult
22 daughter who had accompanied her to the appointment, that the mask would cause CO2 issues
23 and compromise Patient B’s breathing. A short time later, while observing that the patient’s
24 adult daughter continued to wear her mask during the appointment, Licensee’s wife made a
25 comment such as “Oh, you’re one of those people,” effectively discouraging Patient B from
26 wearing a mask.

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1 21. Patient C. In July 2020, Patient C, an Oregon Health Plan patient who had
2 previously established care with Licensee, called the clinic to seek medical advice following a
3 potential COVID-19 exposure. Licensee's wife working under the direction of Licensee, spoke
4 with the patient, who reported that she had recently been camping with friends, outdoors and
5 unmasked. Upon hearing that the patient was not experiencing any symptoms of COVID-19,
6 Licensee's wife informed Patient C that she did not need to get a COVID-19 test, that she did not
7 need to isolate, that being exposed to other people would provide immunities from COVID-19,
8 and that masks are ineffective for reducing the spread of COVID-19. Patient C was concerned
9 about the advice she received from Licensee's wife, so she called the clinic again the following
10 day, with the hope of obtaining medical advice from someone different. Patient C again spoke
11 with Licensee's wife, who reiterated that masks do not work. Licensee's wife also directed the
12 patient to a YouTube video from Tammy K. Herrera Clark, titled "Destroying the Mask
13 Narrative." One or two days later, Patient C again called the clinic, with the goal of learning the
14 full name and credentials of the woman (*i.e.*, Licensee's wife) with whom she had spoken on the
15 previous occasions. Patient C was again routed to speak with Licensee's wife, who appeared
16 displeased with the patient's request for identifying information. A few days later, Patient C
17 received a letter from the clinic, stating that she was no longer a patient at the clinic and
18 requesting that she, her household members, and any spouses or boyfriends do not call or visit
19 the clinic.

20 22. Licensee believes that approximately 75 patients he treated at the clinic in late
21 October 2019, early November 2019, late January 2020, and early February 2020 had COVID-
22 19. Between late November 2020 and early December 2020, Licensee reports he treated
23 approximately 125 patients with COVID-19 in the clinic.

24 23. Licensee did not recommend masking to any COVID-19 infected patients he
25 treated in 2020. Rather, he recommended isolation, distancing, avoiding contact with shared
26 objects and people, and increased frequency of hand washing.

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1 24. Licensee did not perform COVID-19 testing at the clinic. The patients he treated
2 with confirmed COVID-19 infections were tested elsewhere.

3 25. Licensee regularly advised, particularly for his elderly and pediatric patients, that
4 it is “very dangerous” to wear masks because masks exacerbate COPD and asthma and cause or
5 contribute to multiple serious health conditions, including but not limited to heart attacks,
6 strokes, collapsed lungs, MRSA (methicillin-resistant staph aureus infection,) pneumonia, and
7 hypertension. Licensee asserts masks are likely to harm patients by increasing the body’s carbon
8 dioxide content through rebreathing of gas trapped behind a mask.

9 26. In Licensee’s opinion, he has been “a strong asset to the public in educating them
10 on the real facts about this pandemic, and likewise * * * none of my patients were placed in
11 immediate danger. I would say that at least * * * 98 percent of my patients were so extremely
12 thankful that I did not wear a mask or demand wearing a mask in my clinic[.] They did not
13 perceive an immediate danger.”

14 27. In a letter dated August 13, 2020, a Board investigator notified Licensee of the
15 Board’s investigation and summarized the relevant allegations against Licensee:

16 It is alleged that Licensee is not following social-distancing guidelines in his
17 practice and care of patients. It is also alleged that Licensee is advising patients
18 and the public that masks required under the current guidelines do not work and
should not be worn.

19 *In the letter, the investigator requested that Licensee respond to the allegations in detail,*
20 *describe his adherence to social distancing guidelines in the practice setting, and*
21 *explain why he has encouraged “non-compliance with a government order to limit the*
22 *spread of COVID-19.” Licensee responded by affirming that he would continue to*
23 *refuse wearing a mask in his clinic and continue to refuse to require others to do so, and*
24 *by asserting that masks are wholly ineffective in preventing the spread of COVID-19.*

25 28. In a letter to Licensee dated November 9, 2020, the Board’s Medical Director
26 stated, in part:

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1 It has come to the attention of the [Board] that you may be in direct and active
2 violation of current Governor Executive Orders, to include Executive Order 20-22
3 and 20-59. These Executive Orders specify that elective and non-urgent
4 procedures across all care settings that utilize PPE are allowed, but only to the
5 extent they comply with guidance or administrative rules issued by the Oregon
6 Health Authority. These rules require all people to wear properly fitted facemasks
7 when indoors in any care setting. Masking has been shown to significantly reduce
8 the spread of the novel coronavirus responsible for the current worldwide
9 pandemic.

10 It is the expectation of the Board that you immediately comply not only with the
11 legal mandate, but with practices and professional conduct appropriate to the
12 standards of medical care expected for a licensed medical professional in the state
13 of Oregon.

14 The current standard of practice in a primary care setting includes, at a minimum,
15 pre-appointment and pre-entry screening of all patients to identify those who are
16 or may be infectious with SARS-CoV-2; appropriate sequestration of such
17 patients; appropriate protection of all staff with PPE; and thorough cleaning of
18 instruments and surfaces between patients. Care that you provide to your patients
19 that is not consistent with the standards may be found to be negligent and may also
20 constitute unprofessional or dishonorable conduct in that it does or might
21 constitute a danger to the health or safety of a patient or the public, and may be
22 subject to administrative sanctions.

23 29. On December 2, 2020, a Board investigator visited Licensee's clinic and
24 observed: neither patients nor health care providers were wearing masks; no screening
25 procedures were in place or being conducted (e.g., taking patient temperatures on or before
26 entering the clinic); no hand sanitizer was available in the waiting area; a sign was posted in the
27 public area of the clinic with "warning signs" of CO₂ toxicity; an article was posted in the public
area of the clinic, with a portion of the article highlighted that claims 94% of the individuals who
will experience serious effects of COVID-19 have co-morbidities.

30. On December 4, 2020, the Board emergently suspended Licensee's medical
license, based on Licensee's actions and the actions of his staff in his medical clinic, as described
above, creating an immediate and serious danger to public health and safety.

31. Licensee has confirmed that he will refuse to abide by the state's COVID-19
protocols in the future as well, affirming that in a choice between losing his medical license

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1 versus wearing a mask in his clinic and requiring his patients and staff to wear a mask in his
2 clinic, he will, “choose to sacrifice my medical license with no hesitation.”⁵

3 32. The degree of care, skill, and diligence of an ordinarily careful family medicine
4 physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious
5 respiratory illness -- includes wearing a mask in the physician’s medical clinic. The degree of
6 care, skill, and diligence of an even minimally careful family medicine physician in the midst of
7 a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness -- includes
8 wearing a mask in the physician’s medical clinic when treating patients whom the physician
9 believes to be positive for and actively ill with COVID-19.

10 33. The degree of care, skill, and diligence of an ordinarily careful family medicine
11 physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious
12 respiratory illness -- includes requiring patients, visitors, and staff to wear masks in the medical
13 clinic.⁶

14 34. The degree of care, skill, and diligence of an ordinarily careful family medicine
15 physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious
16 respiratory illness transferred via respirator droplets – does not include counseling patients that
17 masks are ineffective to prevent transfer of respiratory droplets.

18 35. The degree of care, skill, and diligence of an ordinarily careful family medicine
19 physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious
20 respiratory illness transferred via respiratory droplets – does not include counseling ordinary
21 patients that wearing masks is dangerous, more dangerous than a potential COVID-19 infection,
22 and even potentially fatal.

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25 ⁵ On May 4, 2021, after a contested case hearing on the matter, the Board confirmed its Order of Emergency
Suspension of Licensee’s medical license, such order to remain effective for the duration of the declared state of
emergency related to COVID-19.

26 ⁶ If a patient cannot tolerate any form of face mask, face covering or face shield due to a medical condition, strict
27 physical distancing must be observed until the patient can be placed or roomed in an area that minimizes risk to
others. A face mask, face covering or face shield is not required to be worn during an examination or procedure in
which access to parts of the face that are covered by a face mask, face covering or face shield is necessary

1 36. The degree of care, skill, and diligence of an ordinarily careful family medicine
2 physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious
3 respiratory illness -- does not include allowing the physician's staff to direct patients to remove
4 their masks in the clinic, counsel patients against wearing masks in the clinic and in public, or
5 counsel patients that COVID-19 is less dangerous than influenza.

6 37. Licensee's instruction and example to patients to shun masks actively promoted
7 transmission of the COVID-19 virus within the extended community.

8 38. Licensee's advice to patients regarding the failure of masks to prevent viral
9 transmission and potential patient harm due to masks, were counter to basic principles of
10 epidemiology and physiology and undermine acceptability among Licensee's patients of one of
11 the primary measures known to significantly diminish viral transmission.

12 PAIN, ADDICTION, AND PSYCHIATRIC PRACTICE

13 39. Licensee's charts from 2017 to 2020 were reviewed for the following patients.

14 40. Patient D. Patient D is a male in his 50s diagnosed with: osteoarthritis of the knee;
15 arthralgia of the knee, patella, tibia, and fibula; cervical spondylosis; generalized anxiety
16 disorder; social phobia; and mild recurrent depression. He was prescribed 2.5 mg of methadone
17 three times per day (MME⁷ = 22.5). Licensee executed a long-term opioid agreement with
18 Patient D on or about February 11, 2019, and obtained several urine drug screens (UDS) over the
19 course of his care of Patient D.

20 41. There is no record of conservative (non-opioid) treatment of Patient D by
21 Licensee, no review of old medical records, no imaging supporting conditions that require long-
22 term opioid use, no consultation with specialists, no material risk notices (MRN), and no review
23 of Patient D's prescription drug monitoring program records (PMDP). In most of Licensee's
24 chart notes on Patient D from 2017 to 2019, exam of Patient D's knee was normal except for
25 pain on palpation. Most of Licensee's chart notes were similar or identical. The history of
26 present illness regularly reports mental health and social problems, but Patient D's present illness

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⁷ Morphine Milligram Equivalents

1 history is often inconsistent with Patient D's social history. Licensee frequently notes having
2 reviewed Patient D's current medication list and yet, the list is not current; various medications,
3 including methadone, are frequently omitted.

4 42. Patient E. Patient E is a woman in her 50s who Licensee was treating for anxiety,
5 irritable bowel syndrome, fibromyalgia, migraine headaches, lumbar disc degeneration, low back
6 pain, opioid dependence, insomnia, thoracolumbar spondylosis, and menopause. Licensee
7 prescribed Patient E 10 mg of oxycodone three times per day (MME = 45). Licensee completed a
8 long-term opioid agreement with Patient E on or about January 3, 2019, and completed a
9 Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R) for Patient E on or
10 about October 23, 2019.

11 43. Licensee obtained several UDS on Patient E, but on February 8, 2018, May 1,
12 2019, and several others during 2019, screens were positive for methamphetamines,
13 amphetamines, oxycodone, and benzodiazepines. Patient E attributed these findings to
14 inadvertent consumption and Licensee failed to further investigate or make changes in
15 prescribing.

16 44. There was no imaging included in Patient E's records to support diagnoses
17 requiring chronic opioids. There were no MRNs or review of Patient E's PDMP records in the
18 patient records.

19 45. On Patient E's first exam, she had normal shoulder, lumbar spine, and cervical
20 spine exams, except for tenderness to palpation. On July 9, 2018, Licensee ordered a shoulder x-
21 ray to evaluate Patient E's pain, but the x-ray was negative. On March 8, 2019, Patient E had a
22 knee x-ray that was normal except for a small effusion, and an ankle x-ray that was normal. On
23 multiple subsequent visits, Licensee performed comprehensive physical examinations of Patient
24 E which were normal except for pain on palpation. On May 30, 2019, Licensee referred Patient E
25 to an orthopedic surgeon for knee pain. The following discrepancies are evident in Licensee's
26 records on Patient E: under the patient's history or present illness, Licensee records the patient
27 drinking alcohol significantly, but his social history of the patient reports no drinking; Licensee's

1 chart notes repeat this discrepancy; and Licensee's October 8, 2018, chart notes on Patient E
2 provides, both: "Lumbosacral spine exhibited spasm of paraspinous muscles" and "Lumbosacral
3 spine exhibited no muscle spasms."

4 46. Patient F. Patient F is a woman in her 60s whom Licensee was treating for bipolar
5 disorder, spondylosis, chronic obstructive pulmonary disease (COPD), hypertension,
6 fibromyalgia, irritable bowel syndrome, lumbar disc disease, low back pain, insomnia,
7 thoracolumbar spondylosis, and recovering drug addiction. Licensee prescribed Patient F 10 mg
8 of methadone four times a day (MME = 120) and 5 mg of oxycodone per day (MME = 7.5).

9 47. Licensee entered a long-term opioid agreement with Patient F on January 8, 2019,
10 and filed a SOAPP-R for this patient on October 22, 2019. Licensee obtained multiple UDSs on
11 Patient F. However, there was no record of an MRN or of Licensee reviewing her PDMP
12 records. Most of Licensee's chart notes show normal musculoskeletal exams except for pain on
13 palpation. Licensee notes having reviewed Patient F's medication list, but it is not up-to-date and
14 omits methadone and oxycodone.

15 48. Patient G. Patient G is a man in his 60s whom Licensee was treating for Stage 3
16 kidney disease, lumbar disc degeneration and spondylosis, peripheral neuropathy, opioid
17 dependence, post laminectomy syndrome, obesity, hypogonadism, and recovering alcoholism.
18 Licensee prescribed Patient G 10 mg of methadone four times per day (MME = 120). On or
19 about October 7, 2019, Licensee and Patient G executed a long-term pain management
20 agreement. However, Licensee obtained only one UDS from Patient G. There is no report of old
21 record review, an MRN or any review of Patient G's PDMP in the patient's medical records. Nor
22 was there any imaging or other diagnostic study in Patient G's records supporting diagnoses
23 requiring long-term opioid use.

24 49. Licensee saw Patient G periodically, often conducting comprehensive
25 musculoskeletal exams with normal results. Patient G had an abnormal neurologic exam, but no
26 subsequent work up. The social history Licensee documented in the medical record states that
27 Patient G is a recovering alcoholic whose last drink was taken in June of 2007. This social

1 history is inconsistent with Licensee's documentation of the history of present illness, which
2 frequently reports that Patient G is consuming alcohol.

3 50. Patient H. Patient H is a man in his late 50s whom Licensee was treating for
4 lumbar spondylosis and degenerative disc disease, polyarthritits, cervical spondylosis, PTSD,
5 depression, anxiety, bipolar disorder, diabetes with neuropathy, hypertension, obesity, peptic
6 ulcer disease, and idiopathic pulmonary fibrosis. Licensee prescribed Patient H 10 mg of
7 oxycodone four times per day (MME = 60).

8 51. Licensee and Patient H executed a long-term pain management agreement on or
9 about January 7, 2019, and Licensee filed a SOAPP-R on or about October 17, 2019. Licensee
10 obtained frequent UDSs on Patient H, who, on or about May 15, 2019, tested positive for
11 hydrocodone and hydromorphone, yet Licensee did not appropriately address the discrepancies.
12 There is no record of: conservative treatment; review of old records; imaging supporting
13 diagnoses requiring chronic opioids; consultation for complex mental health conditions; any
14 MRNs; or any review of Patient H's PDMP records. Most of Patient H's visits were related to
15 mental health issues, not chronic pain, yet Licensee made no referral to a mental health
16 practitioner for consultation or treatment.

17 52. In most of Patient H's visits, he had normal musculoskeletal exams except for
18 pain on palpation. Licensee's charting for Patient H is inconsistent: it reports alcohol dependence
19 with continued drinking, yet also reports recovering alcoholism; it records a diagnosis of
20 idiopathic pulmonary fibrosis, but idiopathic pulmonary fibrosis is not included in the problem
21 list and there is no consultation or work up; and the medication and problem lists are frequently
22 inaccurate, although Licensee claims to have reviewed them. There is no record of ongoing
23 management of Patient H's diabetes with peripheral neuropathy or of comprehensive care of his
24 diabetes. Patient H's chart shows he has continued consuming alcohol, tobacco, cannabis, and
25 methamphetamines.

26 53. Patient I. Patient I is a man in his 50s whom Licensee treated for cervicalgia,
27 depression, lumbar disc degeneration, low back pain, lumbar spondylosis, nicotine dependence,

1 restless leg syndrome, and bilateral knee pain. Patient I had multiple prior surgeries, including
2 on: left shoulder, right shoulder, low back, right wrist, right hand, right knee, left knee, and a
3 hernia. Licensee prescribed Patient I 10 mg of methadone four times per day (MME = 120).
4 Licensee and Patient I executed long-term opioid agreements on or about January 3, 2019, and
5 January 1, 2020. Licensee obtained several UDSs from Patient I and completed a SOAPP-R on
6 October 9, 2019. Although Patient I had multiple surgeries, his records contained no imaging
7 supporting a diagnosis that required chronic opioids. There were no MRNs and no reviews of
8 the patient's PDMP records. Licensee referred Patient I to an orthopedic surgeon for knee pain,
9 and the orthopedic surgeon performed a complete knee arthroplasty; however, the orthopedic
10 surgeon expressed concern over the patient's methadone use.

11 54. In several of Patient I's chart notes, Licensee indicates having reviewed the
12 medications lists, yet the lists are inaccurate. On January 9, 2019, Licensee begins Patient I on
13 metformin⁸ but Licensee assigns no clear diagnosis and does not add diabetes to the patient's
14 problem list. Lab reports show the patient had four glycosylated hemoglobin tests, one (January
15 18, 2019) with a result of 6.5, which meets the criteria for diabetes. Licensee subsequently noted
16 the patient has neuropathy, but completed no work up.

17 55. Patient J. Patient J is a woman in her late 40s whom Licensee treated for major
18 depression, PTSD, migraine headaches, fibromyalgia, generalized anxiety, osteoarthritis of both
19 ankles, paranoid schizophrenia, arthralgia, insomnia, panic disorder with social phobia, and
20 cannabis dependence. Licensee prescribed Patient J 5 mg of oxycodone four times per day
21 (MME = 30). Licensee and Patient J executed a long-term opioid agreement on or about August
22 2, 2019, and Licensee reviewed a SOAPP-R on or about October 16, 2019. Patient J completed
23 multiple UDSs over a two-year period, but failed four of them in 2019, including 3 for presence
24 of methamphetamines. Licensee noted the failed UDSs resulting from inadvertent exposure to
25 methamphetamine. Licensee failed to document discussion and advice for avoiding inadvertent
26 exposure after the first failed test, then failed to institute interventions upon repeated failures.

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⁸ Often prescribed for Type 2 diabetes.

1 There were no MRNs or reviews of Patient J's PDMP records in the file. There were no imaging
2 or other diagnostic studies supporting the use of chronic opioids.

3 56. Licensee consistently recorded Patient J's social history and review of symptoms
4 as essentially normal, yet in her history of present illness, mental health and family issues are
5 regularly noted. Despite Patient J's serious and complex mental health diagnoses, Licensee did
6 not consult with or refer Patient J to a mental health specialist. Patient J regularly reported
7 symptomatic schizophrenia, but Licensee did not consult or refer Patient J to a psychiatric
8 specialist.

9 57. In several chart notes, Patient J's exams for cervical spine, lumbar spine, and
10 ankles were negative except for pain on palpation. Patient J's neurological exam was also
11 normal. In many chart notes, Licensee often reports reviewing or reconciling Patient J's
12 medication list, yet the medication lists were not up to date. They included errors related to such
13 things as Depakote, propranolol, and hydroxyzine on multiple occasions.

14 58. Patient K. Patient K is a man in his 50s whom Licensee was treating for PTSD,
15 dysthymic disorder, anxiety, lumbar degenerative disc disease and spondylosis, lumbar canal
16 stenosis with neurogenic claudication, panic disorder with agoraphobia, paranoid schizophrenia,
17 schizophreniform disorder, generalized anxiety, bipolar I disorder, fibromyalgia, cervical
18 spondylosis, and cervical degenerative disc disease. Licensee entered a long-term opioid
19 agreement with Patient K on February 4, 2019, and filed a SOAPP-R on October 26, 2019.
20 Patient K frequently had normal or near-normal musculoskeletal exams and on January 22, 2019,
21 an MRI showing that Patient K's degenerative disc disease did not include significant disc
22 bulging or protrusion, nerve root impingement or canal stenosis, yet Licensee prescribed him 10
23 mg of oxycodone twice per day (MME = 30). There is no MRN or review of Patient K's PDMP.
24 There is no record of conservative treatment, review of old records, or imaging studies that
25 supports chronic opioid use.

26 59. Licensee's chart on Patient K contains multiple internal conflicts regarding mental
27 health, social problems, family discord, alcohol use and both notations of Patient K's paranoid

1 schizophrenia and notations that Patient K has no paranoid schizophrenia. Patient K misused
2 prescriptions, including haloperidol.⁹ Despite ongoing, serious, and complex mental health issues
3 including troubling episodic visual and auditory hallucinations, Licensee did not consult or refer
4 Patient K to a mental health specialist. Patient K had severe cycles of depression and Licensee
5 prescribed multiple psychoactive medications for Patient K – again, without psychiatric consult
6 or referral. On March 13, 2018, Patient K reported to Licensee a recent visit to an emergency
7 room for a panic attack and hallucinations including hearing voices, but Licensee did not
8 subsequently consult with or refer Patient K to a psychiatrist or other mental health specialist.

9 60. The degree of care, skill, and diligence of an ordinarily careful family medicine
10 physician treating patients with chronic opioid medications, includes: clearly establishing the
11 diagnosis or diagnoses that require treatment with opioid medications; monitoring for changes in
12 such diagnoses; clearly defining the goals of treatment; exploring, trialing, and evaluating the
13 effectiveness of non-opiate and alternative treatment modalities; regularly assessing and
14 documenting the benefits of treatment or lack thereof; regularly monitoring compliance by
15 checking the Oregon PDMP and performing drug screens and documenting results thereof;
16 appropriately addressing and managing evidence of noncompliance; annually updating material
17 risk notification and patient controlled substance agreements; and seeking expert consultation for
18 patients with complex mental health comorbidities.

19 61. The degree of care, skill, and diligence of an ordinarily careful family medicine
20 physician requires maintaining thorough, accurate, and relevant patient charts.

21 62. The degree of care, skill, and diligence of an ordinarily careful family medicine
22 physician treating patients with severe, complex, and chronic and acute mental illness requires
23 consultations with and referrals to psychiatric and other mental health specialists, and
24 coordinating those patients' care with psychiatric and other mental health specialists.

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⁹ An anti-psychotic medication.

1 **APPLICABLE LAW**

2 1. ORS 677.190(1)(a) and (13), and ORS 677.205(1)(b) and (2)(b) to (f) authorize
3 the Board to place conditions on, suspend or revoke a license to practice, place a licensee on
4 probation, and take other disciplinary action, including assessment of the costs of the disciplinary
5 proceedings or a civil penalty of up to \$10,000 for the reasons of: unprofessional or dishonorable
6 conduct; and repeated acts of negligence in the practice of medicine. As a Licensee of the
7 Oregon Medical Board, Licensee is subject to the laws, rules, and standards established by the
8 Oregon Medical Board, including but not limited to Oregon Revised Statutes chapters 676 and
9 677 and Oregon Administrative Rules chapter 847.

10 2. Under ORS 677.188(4)(a), unprofessional or dishonorable conduct means conduct
11 unbecoming a person licensed to practice medicine, or detrimental to the best interests of the
12 public, and includes:

13 Any conduct or practice contrary to recognized standards of ethics of the medical or podiatric
14 profession or any conduct or practice which does or might constitute a danger to the health or
15 safety of a patient or the public or any conduct, practice or condition which does or might
16 adversely affect a physician’s ability to safely and skillfully practice medicine.

17 3. Professional negligence in Oregon occurs when a professional breaches the
18 standard of care. *See, e.g., Getchell v. Mansfield*, 260 Or 174, 179, 489 P2d 953 (1971). ORS
19 677.095(1) and ORS 677.265(1)(c) define the standard of care as “that degree of care, skill and
20 diligence that is used by ordinarily careful physicians in the same or similar circumstances in the
21 community of the physician or a similar community.”

22 4. Professional gross negligence in Oregon is an error “of such magnitude or
23 recurrence” that a willful indifference to the consequences of the act may be inferred. *Hambleton*
24 *v. Bd. of Engineering Examiners*, 40 Or App 9, 12, 594 P2d 416 (1979).

25 **CONCLUSIONS OF LAW**

26 1. By refusing to wear a mask in his medical clinic in the midst of a global pandemic
27 caused by COVID-19 -- a deadly and contagious respiratory illness, Licensee engaged in conduct

1 which does or might constitute a danger to the health or safety of a patient or the public. The
2 conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds
3 for discipline under ORS 677.190(1)(a).

4 2. By refusing to wear a mask in his medical clinic when treating patients whom he
5 believed were positive for and actively ill with COVID-19 -- a deadly and contagious respiratory
6 illness, Licensee engaged in conduct which does or might constitute a danger to the health or
7 safety of a patient or the public. The conduct was therefore unprofessional and dishonorable
8 under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

9 3. By counseling patients that masks are ineffective to prevent transfer of respiratory
10 droplets or that COVID-19 is less dangerous than influenza, both generally and specifically in
11 his care of Patient A, Licensee engaged in conduct which does or might constitute a danger to the
12 health or safety of a patient or the public. The conduct was therefore unprofessional and
13 dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

14 4. By counseling patients that wearing masks is dangerous, more dangerous than a
15 potential COVID-19 infection, and even potentially fatal, both generally and specifically in his
16 care of Patient A, Licensee engaged in conduct that does or might constitute a danger to the
17 health or safety of a patient or the public. The conduct was therefore unprofessional and
18 dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

19 5. Licensee's instruction and example to patients to shun masks, which
20 actively promoted transmission of the COVID-19 virus within the extended community, is a
21 practice that does or might constitute a danger to the health or safety of a patient or the public.
22 The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is
23 grounds for discipline under ORS 677.190(1)(a).

24 6. Licensee's advice to patients regarding the failure of masks to prevent viral
25 transmission and potential patient harm due to masks, which was counter to basic principles of
26 epidemiology and physiology, and which undermined acceptability among Licensee's patients of
27 one of the primary measures known to significantly diminish viral transmission, was a practice

1 that does or might does or might constitute a danger to the health or safety of a patient or the
2 public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a)
3 and is grounds for discipline under ORS 677.190(1)(a).

4 7. Licensee's treatment of serious and complex psychiatric and addiction conditions
5 for Patient J without consulting with and referring the patient to psychiatric and other mental
6 health specialists, and without coordinating his care of the patient with psychiatric and other
7 mental health specialists, was a practice that does or might constitute a danger to the health or
8 safety of a patient or the public. The conduct was therefore unprofessional and dishonorable
9 under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

10 8. Licensee's treatment of serious and complex psychiatric and addiction conditions
11 for Patient K without consulting with and referring the patient to psychiatric and other mental
12 health specialists, and without coordinating his care of the patient with psychiatric and other
13 mental health specialists, was a practice that does or might constitute a danger to the health or
14 safety of a patient or the public. The conduct was therefore unprofessional and dishonorable
15 under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

16 9. Licensee breached the standard of care and thereby engaged in professional
17 negligence by refusing to wear a mask his medical clinic in the midst of a global pandemic
18 caused by COVID-19 -- a deadly and contagious respiratory illness.

19 10. Licensee breached the standard of care and thereby engaged in professional
20 negligence by refusing to wear a mask his medical clinic when treating patients whom he
21 believed were positive for and actively ill with COVID-19 -- a deadly and contagious respiratory
22 illness.

23 11. Licensee breached the standard of care and thereby engaged in professional
24 negligence by counseling patients that masks are ineffective to prevent transfer of respiratory
25 droplets or that COVID-19 is less dangerous than influenza, both generally and specifically in
26 his care of Patient A.

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1 12. Licensee breached the standard of care and thereby engaged in professional
2 negligence by counseling patients that wearing masks is dangerous, more dangerous than a
3 potential COVID-19 infection, and even potentially fatal, both generally and specifically in his
4 care of Patient A.

5 13. Licensee breached the standard of care and thereby engaged in professional
6 negligence on three occasions by allowing his staff to direct patients to remove their masks in
7 clinic, to counsel patients against wearing masks in the clinic and in public, and to counsel
8 patients that COVID-19 is less dangerous than influenza, both generally and specifically in the
9 care of Patients A, B, and C.

10 14. Licensee breached the standard of care and thereby engaged in professional
11 negligence on eight occasions in his treatment of chronic opioid patients D, E, F, G, H, I, J, and
12 K by failing to: clearly establish the diagnosis or diagnoses that required treatment with opioid
13 medications; monitor for changes in such diagnoses; clearly define the goals of treatment;
14 explore, trial, and evaluate the effectiveness of non-opiate and alternative treatment modalities;
15 regularly assess and document the benefits of treatment or lack thereof; regularly monitor
16 compliance by checking the Oregon PDMP and performing drug screens and documenting
17 results thereof; appropriately address and manage evidence of noncompliance; and annually
18 update material risk notification and patient controlled substance agreements.

19 15. Licensee breached the standard of care and thereby engaged in professional
20 negligence on two occasions in his treatment of chronic opioid patients with mental health
21 comorbidities F and H by failing to seek psychiatric or mental health expert consultation on
22 those patients.

23 16. Licensee breached the standard of care and thereby engaged in professional
24 negligence on two occasions in his treatment of chronic opioid patients with severe, complex,
25 and chronic and acute mental illness, J and K, by failing to consult with and refer those patients
26 to psychiatric or other mental health specialists, and by failing to coordinate those patients' care
27 with psychiatric and other mental health specialists.

1 17. Licensee breached the standard of care and thereby engaged in professional
2 negligence on three occasions in his treatment of patients D, E, and F by failing to maintain
3 thorough, accurate, and relevant patient charts.

4 18. Repeated acts of negligence in the practice of medicine, which Licensee has
5 committed as detailed in the 22 occurrences above, is grounds for discipline under ORS
6 677.190(13).

7 19. Licensee's commission of negligence in the practice of medicine on 22 occasions,
8 in his treatment of 11 different patients, is a pattern of errors of such recurrence that Licensee's
9 willful indifference to the consequences of his acts may be inferred. Licensee thereby committed
10 gross negligence in the practice of medicine, which is grounds for discipline under ORS
11 677.190(13).

12 20. Licensee's instruction and example to patients to shun masks, which actively
13 promoted transmission of the COVID-19 virus within the extended community was an error of
14 such magnitude that Licensee's willful indifference to the consequences of his acts may be
15 inferred. Licensee thereby committed gross negligence in the practice of medicine, which is
16 grounds for discipline under ORS 677.190(13).

17 21. Licensee's advice to patients regarding the failure of masks to prevent viral
18 transmission and potential patient harm due to masks, which was counter to basic principles of
19 epidemiology and physiology, and which undermined acceptability among Licensee's patients of
20 one of the primary measures known to significantly diminish viral transmission, was an error of
21 such magnitude that Licensee's willful indifference to the consequences of his acts may be
22 inferred. Licensee thereby committed gross negligence in the practice of medicine, which is
23 grounds for discipline under ORS 677.190(13).

24 22. Licensee's treatment of serious and complex psychiatric and addiction Patient J
25 without consulting with and referring the patient to psychiatric and other mental health
26 specialists, and without coordinating his care of the patient with psychiatric and other mental
27 health specialists, were errors of such magnitude that Licensee's willful indifference to the

1 consequences of his acts may be inferred. Licensee thereby committed gross negligence in the
2 practice of medicine, which is grounds for discipline under ORS 677.190(13).

3 23. Licensee's treatment of serious and complex psychiatric and addiction Patient K
4 without consulting with and referring the patient to psychiatric and other mental health
5 specialists, and without coordinating his care of the patient with psychiatric and other mental
6 health specialists, were errors of such magnitude that Licensee's willful indifference to the
7 consequences of his acts may be inferred. Licensee thereby committed gross negligence in the
8 practice of medicine, which is grounds for discipline under ORS 677.190(13).


9 24. Committing dishonorable or unprofessional conduct, repeated negligence in the
10 practice of medicine, and gross negligence in the practice of medicine are grounds for license
11 discipline up to and including revocation, civil penalties up to \$10,000 per violation, and the
12 costs of the proceeding under ORS 677.205(1) and (2).

13 **ORDER**

14 Any of Licensee's acts of unprofessional or dishonorable conduct, any single instance of
15 Licensee's commission of gross negligence in the practice of medicine, or Licensee's repeated
16 negligence in the practice of medicine is each individually a sufficient basis for revocation of his
17 Oregon medical license. Therefore, for the reasons above, the Board **HEREBY: revokes the**
18 **Oregon medical license of Steven Arthur LaTulippe, MD, medical license number MD22341.**
19 In addition, the Board **HEREBY assesses a civil penalty in the amount of \$10,000** against
20 Steven Arthur LaTulippe, MD, for 8 instances of unprofessional or dishonorable conduct, 22
21 instances of negligence in the practice of medicine, and 5 instances of gross negligence in the
22 practice of medicine.

23 Dated this 2nd day of September 2021.

24 OREGON MEDICAL BOARD
25 State of Oregon

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27 KATHLEEN M. HARDER, MD
Board Chair

1 **NOTICE**

2 *Civil penalties imposed under this order are due and payable to the Oregon Medical Board 10*
3 *days after the order becomes final by operation of law or on appeal. See ORS 183.745*

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5 **APPEAL RIGHTS**

6 You are entitled to judicial review of this order in accordance with ORS Chapter 183.482 (*see*
7 *ORS 183.480 et seq.*). You may request judicial review by filing a petition with the Court of
8 Appeals in Salem, Oregon within 60 days from the date of service of this order. The date of
9 service is the day this order is mailed, not the day you receive it. The phone number for the
10 Oregon Court of Appeals is 503-986-5555.

1 OAR 847-010-0073(3)(b)(G) sexual misconduct, ORS 677.188(4)(a) any conduct or practice
2 contrary to recognized standards of ethics of the medical profession or any conduct or practice
3 which does or might constitute a danger to the health or safety of a patient or the public; and
4 ORS 677.190(13) gross or repeated acts of negligence. Licensee understands that this Order is a
5 public record and is a disciplinary action that is reportable to the National Practitioner Data Bank
6 and the Federation of State Medical Boards. Licensee understands the terms of this Order and
7 signs freely, without fraud or duress.

8 4.

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

11 4.1 Licensee surrenders his Oregon medical license while under investigation.

12 4.2 The Interim Stipulated Order of November 25, 2020, terminates effective the date
13 the Board Chair signs this Stipulated Order.

14 4.3 Licensee must not reapply for a medical license in the State of Oregon for at least
15 two years from the effective date of this Order.

16 4.4 Licensee must obey all federal and Oregon state laws and regulations pertaining
17 to the practice of medicine.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
RYAN RICHARD STEVENS, MD) STIPULATED ORDER
LICENSE NO. MD22325)
)

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. Ryan Richard Stevens, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On August 5, 2021, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions under the authority of and as identified in ORS 677.205(1) and (2), which may include the revocation of license, a \$10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) as defined in ORS 677.188(4)(a) condition which does or might adversely affect a physician's ability safely and skillfully to practice medicine; and ORS 677.190(13) repeated acts of negligence.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that Licensee failed to meet the standard of care as to Patients A and B in the manner described in the August 5, 2021, Notice and violated ORS 677.190(1)(a) as defined in ORS 677.188(4)(a); and

1 ORS 677.190(13). Licensee understands that this Order is a public record and is a disciplinary
2 action that is reportable to the National Practitioner Data Bank and the Federation of State
3 Medical Boards. Licensee understands the terms of this Order and signs freely, without fraud or
4 duress.

5 4.

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

8 4.1 Licensee must not perform surgery on the head or neck of any patient for the
9 treatment of cancer. This does not preclude small sample biopsies, but does preclude excisions of
10 tumors and suspected tumors.

11 4.2 Licensee must, at his own expense, enter into an agreement with a licensed
12 physician who is pre-approved by the Board's Medical Director to serve as his practice mentor.
13 Licensee must meet with the approved mentor at least twice a month, and the mentor must
14 review, on an ongoing basis, at least 20% of charts for patients seen by Licensee. The mentor is
15 to provide quarterly written reports to the Board on Licensee's ability to safely and competently
16 practice medicine. Licensee may request to terminate this term after one full year of compliance,
17 four quarterly reports from the mentor, and a written recommendation of termination from the
18 mentor.

19 4.3 Licensee may only practice at sites that are pre-approved by the Board's Medical
20 Director.

21 4.4 At the discretion of the Board or its designees, random, no notice chart audits and
22 office visits may be conducted by Board designees.

23 4.5 Licensee must remain enrolled and in good standing in the Health Professionals'
24 Services Program and in compliance with any monitoring requirements as long as he is licensed
25 in the State of Oregon.

26 4.6 Licensee must maintain an on-going therapeutic relationship with a healthcare
27 provider(s) pre-approved by the Board's Medical Director. Licensee must sign all necessary

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1 releases to allow direct communication between the Board and Licensee's healthcare providers,
2 who will provide regular written quarterly reports to the Board's Medical Director.


3 4.7 Licensee must inform the Compliance Section of the Board of any and all practice
4 sites, as well as any changes in practice address(es), employment, or practice status within 10
5 business days. Additionally, Licensee must notify the Compliance Section of any changes in
6 contact information within 10 business days.

7 4.8 Licensee must obey all federal and Oregon state laws and regulations pertaining
8 to the practice of medicine.

9 4.9 Licensee stipulates and agrees that any violation of the terms of this Order shall
10 be grounds for further disciplinary action under ORS 677.190(17).

11 4.10 Licensee stipulates and agrees that this Order becomes effective the date it is
12 signed by the Board Chair.

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14 IT IS SO STIPULATED THIS 19 day of August, 2021.

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16 
17 RYAN RICHARD STEVENS, MD

18 IT IS SO ORDERED THIS 29th day of September, 2021.

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20 OREGON MEDICAL BOARD
21 State of Oregon
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23 KATHLEEN M. HARDER, MD
24 BOARD CHAIR
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