Oregon Medical Board

BOARD ACTION REPORT

March 15, 2020

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between February 16, 2020, and March 15, 2020.

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.

***Bullard, Amicia Grace, PA; PA00783; Tigard, OR**

On February 18, 2020, 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.

***Code, Patrick Theodore, DPM; DP00220; Medford, OR**

On February 20, 2020, Licensee entered into an Interim Stipulated Order to voluntarily cease the prescribing of all any Scheduled II-IV controlled substances pending the completion of the Board's investigation into his ability to safely and competently practice podiatric medicine

***Code, Patrick Theodore, DPM; DP00220; Medford, OR**

On March 5, 2020, the Board issued an Order Terminating Board Order. This Order terminates Licensee's July 17, 2019, Interim Stipulated Order.

Cowles, Robert Michael, LAc; AC196665; Happy Valley, OR
On February 27, 2020, Applicant entered into a non-disciplinary Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to complete a 280-hour mentorship with a Board-approved clinical supervisor.

***Johnston, James Patrick, DO; Applicant; Matthews, NC**
On March 5, 2020, the Board issued a Default Final Order for unprofessional or dishonorable conduct; fraud or misrepresentation in applying for or procuring a license to practice medicine in this state; failing to comply with a Board request; willfully violating any Board rule; and lack of moral character. This Order denies Applicant's license application and assesses a $2,000 civil penalty.

***Jutla, Rajninder Kaur, MD; MD27622; Lake Oswego, OR**
On March 5, 2020, the Board issued a Default Final Order for unprofessional or dishonorable conduct; obtaining any fee by fraud or misrepresentation; repeated acts of negligence; making a fraudulent claim; and prescribing controlled substances without a legitimate medical purpose. This Order revokes Licensee's medical license and assesses a $5,000 civil penalty.

Nelson, Joan Catherine, PA; PA00882; Portland, OR
On February 26, 2020, the Board issued an Order Terminating Consent Agreement for Re-Entry to Practice. This Order terminates Licensee's May 6, 2019, Consent Agreement for Re-Entry to Practice.

Reddy, Latha N, PA; PA184460; Portland, OR
On February 26, 2020, the Board issued an Order Terminating Consent Agreement for Re-Entry to Practice. This Order terminates Licensee's July 18, 2018, Consent Agreement for Re-Entry to Practice

***Russell, Trent James, PA; PA174765; Portland, OR**
On March 5, 2020, the Board issued a Default Final Order for unprofessional or dishonorable conduct and willful violation of a Board rule. This Order revokes Licensee's physician assistant license and assesses a $2,000 civil penalty.

Sas-Ciampoli, Brianna Gabrielle, LAc; AC196872; Portland, OR
On February 27, 2020, Applicant entered into a non-disciplinary 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 30 hours of continuing education.

Tapelband, Gerda Ellen, MD; MD20822; Bend, OR
On February 26, 2020, the Board issued an Order Terminating Consent Agreement for Re-Entry to Practice. This Order terminates Licensee's June 11, 2019, Consent Agreement for Re-Entry to Practice.

***Vogt, Amber Janeen, DO; DO179860; Clackamas, OR**
On February 19, 2020, 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.

Weaver, Erin Elizabeth, LAc; AC196824; Portland, OR
On February 20, 2020, Applicant entered into a non-disciplinary 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 18 hours of NCCAOM-approved CEUs.

The following Licensees/Applicants were issued Complaint and Notices of Proposed Disciplinary Action/Notices of Intent to Deny License Application. *Note, in these instances the Board has not taken a final action.*

- Cardwell, Kevin Wayne, PA; PA177486; Corvallis, OR
- Cohen, Tal, LAc; AC161122; Portland, OR
- Currier, Nathan Robert , MD; *Applicant*; Salt Lake City, UT
- Elliott, John David, MD; MD23633; The Dalles, OR
- Schrimsher, John Patrick, MD; MD171625; Warm Springs, OR
- Sharma, Anjmun, MD; MD160466; Monument, CO
- Shilland, Eric William, DO; DO27920; Portland, OR
- Soldevilla, Francisco Xavier, MD; MD14348; Portland, OR
- Tambakis-Odom, Constance Roseann, MD; MD166388; Jacksonville, NC
- Thompson, Albert Prather, MD; MD13058; Lincoln City, OR
- Von Dippe, Patrick Beauregard, MD; MD27158; Coquille, OR
- Zhai, Juan, MD; MD22940; Portland, OR

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	)	
	)	
AMICIA GRACE BULLARD, PA	)	INTERIM STIPULATED ORDER
LICENSE NO. PA00783	)	
	)	

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physician assistants, in the State of Oregon. Amicia Grace Bullard, PA (Licensee) is a licensed physician assistant 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).

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 18 day of February, 2020.

[redacted]

AMICIA GRACE BULLARD, PA

IT IS SO ORDERED THIS 18 day of February, 2020.

State of Oregon
OREGON MEDICAL BOARD

[redacted]

NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of PATRICK THEODORE CODE, DPM LICENSE NO. DP00220	)))))	INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including podiatric physicians, in the State of Oregon. Patrick Theodore Code, DPM (Licensee) is a licensed podiatric physician in the State of Oregon and holds an active podiatric 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, and will remain in effect while this matter is under investigation, and provides that Licensee shall comply with the following conditions:

3.1 Licensee may not prescribe any Schedule II-IV controlled substance to any patient.

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

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3.3 Licensee understands this Order becomes effective the date it is signed by the Executive Director.

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 the license of Licensee 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 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 14th day of February, 2020.

[redacted]

PATRICK THEODORE CODE, DPM

IT IS SO ORDERED THIS 20 day of February, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
PATRICK THEODORE CODE, DPM	)	ORDER TERMINATING INTERIM
LICENSE NO. DP00220	)	STIPULATED ORDER
	)	

1.

On July 17, 2019, Patrick Theodore Code, DPM (Licensee) entered into an Interim Stipulated Order with the Oregon Medical Board (Board) in which he agreed to voluntarily withdraw from practice and place his podiatric license at Inactive status.

2.

On February 14, 2020, Licensee signed an Interim Stipulate Order which placed limitations on Licensee's prescribing and became effective February 20, 2020. At its meeting on March 5, 2020, the Board reviewed this matter. The Board terminates the July 17, 2019, Interim Stipulated Order effective the date this Order is signed by the Board Vice Chair and Licensee's podiatric license is returned to Active status.

IT IS SO ORDERED this 5th day of March, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

SAURABH GUPTA, MD
Board Vice Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of JAMES PATRICK JOHNSTON, DO APPLICANT	)))))	DEFAULT FINAL ORDER

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. James Patrick Johnston, DO (Applicant) has applied for an unlimited license to practice medicine in Oregon.

2.

On November 8, 2019, the Board sent to Applicant by regular and certified mail a Notice of Intent to Deny Application (Notice) in which the Board proposed to deny Applicant's license application for a license to practice medicine in the State of Oregon and imposing up to the maximum range of potential sanctions identified in Oregon Revised Statutes (ORS) 677.205(2), to include a $10,000 civil penalty per violation, and assessment of costs, based upon violations of the Medical Practice Act, as follows: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) conduct contrary to recognized standards of ethics of the medical profession; ORS 677.190(8) fraud or misrepresentation in applying for or procuring a license to practice medicine in this state; ORS 677.190(17) failing to comply with a Board request and willfully violating any Board rule, specifically OAR 847-008-0058(1) omissions or false, misleading or deceptive statements or information on any Board application or affidavit; and ORS 677.100(1)(d) lack of moral character. The Notice informed Applicant that if he failed to submit a request for hearing within the time specified or failed to appear at a scheduled hearing, the Board may issue a final order by default. Applicant failed to submit a timely request for hearing. As a result, Applicant has waived his right to a hearing and now stands in default.

The Board elects in this case to designate the record of proceedings to date, which consists of Applicant's file with the Board as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

3.

FINDINGS OF FACT

Applicant is an osteopathic physician, board certified in family medicine, who submitted an application for an active license to practice medicine in Oregon on September 19, 2018. Applicant's acts and conduct that violated the Medical Practice Act and constitute the basis to deny this license application follow:

3.1 Review of this application file reveals that Applicant answered "no" to question #7 of the application, which asked: "Have you ever been arrested, convicted of, or pled guilty or "nolo contendere" (no contest) to ANY offense in any state in the United States or any foreign country, other than minor traffic violations? Matters in which you were pardoned and/or diverted, or the conviction was deferred, set aside or expunged must be disclosed." Applicant's answer was not accurate. In fact, Applicant was arrested in 1996 for Criminal Trespass and Disorderly Conduct in Florida; was arrested for carrying a concealed weapon in Scioto, Ohio on August 29, 2000; and was also arrested in 2006 for misdemeanor Disorderly Conduct and Protesting without a Permit in Jackson, Mississippi. While charges in all cases were dismissed, the arrests were still reportable.

3.2 The Board sent a request for information to Applicant on February 25, 2019, in which Applicant was asked to explain his failure to disclose the above described arrests in 1996, 2000, and 2006. Applicant failed to respond. The Board sent a second letter for a response to the allegations on March 25, 2019. Applicant failed to respond. The Board sent a third request for a response to the allegations on April 16, 2019. Applicant was given a deadline of April 30, 2019, to provide a written response. Applicant provided a written response on April 29, 2019, in which he explained that his arrest in 1996 was due to his distributing religious literature at a "satanic rock" concert. He had been asked by a law enforcement officer to leave

the area or be arrested and Applicant stated he "called his bluff" and refused to leave and was arrested. Applicant stated after a trial the charges were dropped and the record expunged. Applicant was again arrested in 2000, during a traffic stop for speeding, for carrying a concealed weapon (a loaded handgun) on his person as well as having a stun gun in the glove compartment of his motor vehicle, nunchuks on the passenger floorboard and a survival knife near the driver seat. Applicant stated in his response that charges in this case were later dropped after courts accepted his affirmative defense that he had armed himself due to threats from "narcotic seekers" at his practice. The 2006 arrest stemmed from Applicant participating in a protest in which he was accused of blocking a sidewalk and refusing to move. Applicant stated that he did not know that the arresting officer had warned the protest organizer that participants would be arrested if they did not move. Applicant was arrested; however, the charge in this case was also dropped. Applicant asserted that all three incidents were "false" arrests.

3.3 Applicant is not a person in the military service of the United States.

4.

CONCLUSIONS OF LAW

Based upon its examination of the record in this case, the Board finds that the acts and conduct of Applicant described above is supported by reliable, probative and substantive evidence and violated the Medical Practice Act, as set forth below:

4.1 Applicant's failure to accurately report his arrests on his application violates ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) as conduct contrary to recognized standards of ethics of the medical profession; ORS 677.190(8) fraud or misrepresentation in applying for or procuring a license to practice medicine in this state; and ORS 677.190(17) willfully violating any provision of the Medical Practice Act or a Board rule, specifically ORS 677.100(1)(d) and OAR 847-008-0058(1).

4.2 Applicant's failure to respond to the Board's letter on February 25, 2019, and on March 25, 2019, in a timely manner, and his disingenuous answer that he was the victim of "false" arrests was false, misleading or deceptive and reflects that he is not qualified for

licensure, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) as conduct contrary to recognized standards of ethics of the medical profession.

4.3 Applicant's above described conduct also constitutes fraud or misrepresentation in applying for or procuring a license to practice medicine in this state, in violation of ORS 677.190(8); as well as ORS 677.190(17) failing to comply with a Board request and willfully violating any Board rule, specifically OAR 847-008-0058(1) omissions or false, misleading or deceptive statements or information on any Board application.

4.4 In its review of Applicant's application, the Board concludes that Applicant has failed to demonstrate that he is of good moral character. His failure to comply with Board's letter and his disingenuous answer reflect moral turpitude and cause the Board to have substantial doubts about Applicant's honesty, fairness and respect for the rights of others and the laws of this state, in violation of ORS 677.100(1)(d).

5.

ORDER

In order to protect the public and appropriately address his conduct, the Board enters the following order:

IT IS HEREBY ORDERED THAT the license application of James Patrick Johnston, DO, to practice medicine in the State of Oregon is denied. This Order is effective immediately upon the signature of the Board Chair. In addition, Applicant must pay a civil penalty of $2,000,

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payable within 90 days from the date this Order is signed by the Board Vice Chair. Violation of the terms of this Order constitute a violation of the Medical Practice Act.

DATED this 5th day of MARCH 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

SAURABH GUPTA, MD
BOARD VICE CHAIR

Right to Judicial Review

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

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of RAJNINDER KAUR JUTLA, MD LICENSE NO. MD27622	)))))	DEFAULT FINAL ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. Rajninder Kaur Jutla, MD (Licensee) is a licensed physician in the State of Oregon and holds an active medical license.

2.

2.1 On September 13, 2019, the Board sent to Licensee by regular and certified mail 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 identified in ORS 677.205(2), to 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) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(4) obtaining any fee by fraud or misrepresentation; ORS 677.190(13) gross or repeated acts of negligence; ORS 677.190(20) making a fraudulent claim; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose. The Board's Notice informed Licensee of her right to request a hearing, and that the "...Board must receive Licensee's written request for hearing within twenty-one (21) days of the mailing of this Notice to Licensee." The Notice also informed Licensee that if she failed to submit a request for

hearing or failed to appear at a scheduled hearing, the Board may issue a final order by default. Licensee failed to submit a timely request for hearing. Instead, Licensee submitted a request for hearing through her attorney (who holds a license to practice law in the State of Washington) on October 15, 2019, which was 32 days after the Notice was issued. The Board informed Licensee's counsel by letter dated October 21, 2019, that the request was untimely. The Board received a letter, dated December 9, 2019, from an Oregon licensed attorney retained by Licensee, which explained that Licensee did not ignore the Board's Notice, and "...made efforts to retain an attorney to assist her in preparing and submitting her request for hearing." Counsel requested that the Board accept Licensee's late request for hearing.

2.2 The Board has reviewed the letter submitted by Licensee's legal counsel explaining the circumstances of her failure to submit a timely request for hearing and accepts the representations made by counsel in that letter. As a result, there is no factual dispute for the Board to address in its analysis. The legal standard that the Board applies to its review of this late request for hearing is found in OAR 137-003-0528(1)(b) and (d), which state:

> (1)(b) The agency may accept any other late hearing request only if:
>
> (A) There was good cause for the failure to timely request the hearing, unless other applicable statutes or agency rules provide a different standard; and
>
> (B) The agency receives the request before the entry of a final order by default or before 60 calendar days after the entry of the final order by default, unless other applicable statutes or agency rules provide a different timeframe.
>
> (d) In determining whether to accept a late hearing request, the agency may require the request to be supported by an affidavit or other writing that explains why the request for hearing is late and may conduct such further inquiry as it deems appropriate.

It is apparent from the record of correspondence in this case, to include the explanation provided by Licensee's legal counsel, that the Board's Notice was promptly sent to Licensee, that she was aware of her right to be represented by legal counsel and of her right to request a hearing, and that she consulted with or called three different legal counsel prior to the passage of the 21 days provided to request a hearing, which was due on October 3, 2019. Licensee did not submit a

request for hearing until October 15, 2019. After the Board's letter of response, Licensee submitted an explanation for the late request on December 9, 2019. The question for the Board is whether there was good cause for Licensee's failure to timely request a hearing. OAR 137-003-0501(7) states that:

> ..."good cause" exists when an action, delay or failure to act arises from an excusable mistake, surprise, excusable neglect, reasonable reliance on the statement of a party or agency relating to procedural requirements, or from fraud, misrepresentation, or other misconduct of a party or agency participating in the proceeding.

The Board concludes that Licensee has not demonstrated good cause for her failure to timely request a hearing. Licensee has not set forth a basis to conclude that her failure to request a hearing within the time specified is attributable to an excusable mistake or neglect, surprise nor any other reason or circumstance that would constitute good cause for Licensee not to submit a timely request for hearing. As a result, the Board concludes that Licensee has waived her right to a hearing and now stands in default. The Board elects in this case to designate the record of proceedings to date, which consists of Licensee's file with the Board as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

3.

FINDINGS OF FACT

Licensee is a board-certified anesthesiologist and pain medicine specialist who practices medicine in multiple locations in the State of Washington and in Lake Oswego, Oregon. The Board conducted a review of Licensee's management and treatment of chronic pain patients (Patients A – D), which revealed a pattern of practice that constituted a danger to the health and safety of patients and breached the standard of care[1]. The Center for Disease Control and Prevention (CDC) and Oregon's task force adopted guidelines for the safe prescribing of opioids, which set the standard of care and are designed to ensure the health and safety of patients. The American Medical Association's Code of Medical Ethics Opinion 9.6.6 states that it is the

[1] *See* the Oregon Chronic Opioid Prescribing Guidelines and the CDC 2016 Guidelines for Prescribing Opioids for Chronic Pain.

physician's ethical responsibility to "prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectation of effectiveness for the particular patient." The Opinion further states at 9.6.6(c)(i) that physicians should "avoid direct or indirect influence of financial interest on prescribing decision by declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products."

3.1 Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1.1 Licensee maintained the identified patients on a long-term course of controlled substances in a manner that does or might constitute a danger to the health or safety of her patients and that breached the standard of care;

3.1.2 Licensee maintained patients on excessive dosages of opiates with morphine equivalent doses (MED) in excess of 50, even though patient function and pain failed to improve over time;

3.1.3 Licensee did not prescribe the lowest effective dosage of opioids, with initial dosages of opioids for patients in excess of MED 50 per day, and for one patient, in excess of 90 MED;

3.1.4 Licensee failed to conduct an adequate risk assessment during the course of treatment;

3.1.5 Licensee failed to consistently check the Oregon Prescription Drug Monitoring Program (PDMP) at the inception and during the course of treatment with opioids;

3.1.6 Licensee failed to identify and address evidence of aberrant departures from the treatment plan, to include the use of Schedule I drugs detected in urine drug screens (UDS).

3.2 Specific patient care concerns are set forth in the paragraphs below:

3.2.1 Patient A, a 25-year-old male, presented to Licensee on October 8, 2017, via a physician referral with a three-year history of chronic back pain after major spinal

reconstructive surgery. Patient A's treatment history included prescriptions from different providers, to include oxycodone HCL, 5 mg, #30 on June 17, 2016, and tramadol (Ultram, Schedule IV) HCL, 300 mg, #30 on September 20, 2017. Licensee conducted an evaluation, with normal findings on the physical examination. Patient A did not report a history of psychiatric issues or substance abuse. Without querying the PDMP, Licensee prescribed tapentadol (Nucynta IR, Schedule II) 50 mg, daily; tramadol (Ultram, Schedule IV) 100 mg; diclofenac, 75 mg; and tizanidine (Zanaflex) 4 mg; as well as Naloxone nasal spray, 4 mg to use if necessary in case of overdose, at the first visit. The patient chart contains an unsigned Material Risk Notification (MRN). During a second office visit on November 15, 2017, Patient A reported that the pharmacy would not fill the prescription for Nucynta. A UDS was consistent with the prescription for tramadol. Licensee noted Schizophrenia in Patient A's history and discussed various treatment options with Patient A. Licensee discontinued Nucynta and tramadol, and initiated treatment with oxycodone HCL (Schedule II), 10 mg, 4 times a day #112; Oxycontin (Schedule II) 10 mg, 1 daily, #28; and baclofen (Lioresal) 10 mg, 1 daily #28 (total MED 75). Licensee initiated treatment with an excessive dose of opioids[2] instead of seeking to prescribe the lowest effective dose of short acting opioids for a limited duration. Licensee also failed to check the Oregon PDMP during the course of treatment to ensure that Patient A was receiving medications from a single source.

3.2.2 Patient B, a 45-year-old morbidly obese male, presented to Licensee by way of referral on December 21, 2016, with a history of osteoarthritis of the knees, sciatica, and obstructive sleep apnea. Licensee obtained an extensive history and physical exam. Licensee assessed Patient B as low risk for opioid dependence, discussed treatment options, and had Patient B sign an opioid agreement. Licensee recommended physical therapy and prescribed oxycodone 15 mg, 1 tablet every 4 – 6 hours, #140 (MED 112); diclofenac, 75 mg, 1 tablet every 12 hours #56; and ranitidine, 150 mg, 1

[2] An MED of 75 is an excessive dosage to initiate treatment with an opiate. *See* the Oregon Acute and Chronic Opioid Prescribing Guidelines.

tablet daily, # 28. Patient B returned to Licensee's clinic monthly, and was authorized medication refills at the same or similar dosage. Chart review reveals that on December 13, 2017, Licensee's medication regimen for Patient B included oxycodone, 15 mg, 1 tablet every 4 – 6 hours, #140; diclofenac, 75 mg, 1 tablet every 12 hours, #56; ranitidine, 150 mg, 1 tablet daily, # 28; and Oxycontin, 30 mg, 2 daily, #56.[3] Patient B underwent surgical repair of a bladder fistula and colon resection in February 2018. On May 30, 2018, Licensee discontinued Oxycontin, and maintained Patient B on oxycodone, 15 mg, 1 tablet every 4 hours, #168;[4] diclofenac, 75 mg, 1 tablet every 12 hours, #56; ranitidine, 150 mg, 1 tablet daily, # 28. Licensee maintained Patient B on a long-term course of an excessive amount of opiates, well over 50 MED a day. Licensee also failed to check the Oregon Prescription Drug Monitoring Program (PDMP) during the course of treatment to aid in the monitoring of Patient B's narcotic intake.

3.2.3 Patient C, a 52-year-old male, was referred to Licensee in 2013 with a history of chronic pain in his back and shoulders from motor vehicle accidents. Licensee performed a history and physical examination and discussed various treatment options with Patient C. Licensee maintained Patient C on oxycodone, 15 mg, 4 tablets daily, #112 (MED 90). On August 5, 2015, Licensee's medication regimen for Patient C included morphine ER (Schedule II) 15 mg, 1 tablet every 12 hours, #56; oxycodone, 15 mg, 1 tablet every 8 hours, #84; and oxycontin, 30 mg, 1 tablet every 12 hours, # 56 (MED 187.5). On March 15, 2017, Licensee's medication regimen for Patient C included oxycodone, 15 mg, 1 tablet every 6 hours, #112; and Oxycontin, 40 mg, 1 tablet every 12 hours, # 56 (MED 210). Patient C underwent periodic urine drug screens (UDS) that reflected aberrant use of Schedule I and II substances during the course of treatment. A UDS in August of 2014 detected the presence of clonazepam (Schedule IV), which was not prescribed by a treating physician for Patient C. A UDS in August 2016 detected methamphetamine and THC. Additionally, a UDS in September

[3] MED of 202.
[4] MED 135.

2017 detected methamphetamine and amphetamine, unexpected positive test results indicating that Patient C was self-administering Schedule I substances. Licensee's chart notes reflect that she failed to address these occasions of aberrant behavior by Patient C, to include conducting a new risk assessment or to increase the frequency of a UDS. Licensee's conduct unnecessarily exposed Patient C to the risk of harm, by maintaining this patient on excessive dosages of opiates for approximately four years and by failing to address Patient C's repeated violations of the treatment plan by his self-administering Schedule I and II substances.

3.2.4 Patient D, a 33-year-old male with a history of chronic back pain, first presented to Licensee in September 2015. Licensee performed a history and physical examination and initiated treatment with oxycodone, 45 mg daily (MED 67.5), and gabapentin (Neurontin), 300 mg. On March 16, 2016, Licensee maintained Patient D on oxycodone, 15 mg, 4 tablets daily, #112; Oxycontin, 40 mg, 2 tablets daily, #56; and gabapentin, 900 mg, 4 tablets daily (MED 210). Licensee switched Patient D to hydromorphone (Schedule II) later that year. On November 23, 2016, Licensee prescribed Oxycontin, 15 mg, 1 tablet per day, #28; hydromorphone IR, 8mg, 4 daily, #112; and hydromorphone ER, 8 mg, 2 daily (MED 214.5). On May 31, 2017, the medication regimen included hydromorphone IR, 8 mg, 4 – 6 daily, #140; hydromorphone ER, 8 mg, 1 daily, #28 (MED 160 - 224); and diazepam (Schedule IV) for pre-flight anxiety. Licensee subsequently tried to taper Patient D off of opioids, but on February 7, 2018, Licensee remained on hydromorphone IR, 8 mg, 3 daily, #84 (MED 96), and ropinirole 1 mg, 1 daily.

3.3 On July 24, 2019, the United States District Court for the Western District of Washington at Seattle issued Licensee an indictment, to include charges of Conspiracy to Pay and Receive Kickbacks, Receipt of Kickbacks, and Health Care Fraud due to Licensee's relationship and dealings with the company Insys Therapeutics. The indictment outlines an incident that occurred on or about August 30, 2013, in Portland, Oregon, at which Licensee

forged the signature of another healthcare provider on a sign-in sheet for an event which Licensee was the paid speaker. According to the indictment, the event was actually a birthday dinner with friends, and no presentation was made by Licensee; however, Licensee was compensated $800 as if she had delivered a presentation.

3.4 On May 21, 2019, Licensee voluntarily entered into an Interim Stipulated Order with the Board in which she agreed to cease the prescribing of all controlled substances pending the completion of the Board's investigation.

3.5 Licensee is not a person in the military service of the United States.

4.

CONCLUSIONS OF LAW

Based upon its examination of the record in this case, the Board finds that the acts and conduct of Licensee described above are supported by reliable, probative and substantive evidence and violated the Medical Practice Act, as set forth below:

4.1 Licensee's conduct unnecessarily exposed Patient A to the risk of harm and violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.2 Licensee's conduct unnecessarily exposed Patient B to the risk of harm, particularly in view of his comorbidities (obesity and sleep apnea) and violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.3 Licensee's conduct unnecessarily exposed Patient C to the risk of harm and breached the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(13) gross negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.4 Licensee's conduct unnecessarily exposed Patient D to the risk of harm by maintaining this patient on a prolonged course of treatment with opioids in excess of 90 mg daily, which also violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.5 Licensee's conduct described in the indictment of July 24, 2019, violates recognized standards of ethics for the medical profession and violates ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession; ORS 677.190(4) obtaining any fee by fraud or misrepresentation; and ORS 677.190(20) making a fraudulent claim.

5.

ORDER

In order to protect the public and appropriately address Licensee's conduct, the Board enters the following order:

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IT IS HEREBY ORDERED THAT the license of Rajninder Kaur Jutla, MD to practice medicine in the State of Oregon is revoked and that Licensee must pay a civil penalty of $5,000, payable in full within 90 days from the date this Order is signed by the Board Vice Chair. Violation of the terms of this Order constitutes a violation of the Medical Practice Act.

DATED this 5 day of March, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

SAURABH GUPTA, MD
BOARD VICE CHAIR

Right to Judicial Review

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

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
TRENT JAMES RUSSELL, PA LICENSE NO. PA174765	)	DEFAULT FINAL ORDER
	)	

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physician assistants, in the State of Oregon. Trent James Russell, PA (Licensee) is a licensed physician assistant in the State of Oregon.

2.

On December 11, 2019, the Board sent to Licensee by regular and certified mail 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 identified in ORS 677.205(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) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical 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 to safely and skillfully practice medicine; and ORS 677.190(17) willfully violating any rule adopted by the Board, specifically OAR 847-065-0055 Health Professional Services' Program (HPSP) Licensee Responsibilities. The Notice informed Licensee that if he failed to submit a request for hearing within the time specified or failed to appear at a scheduled hearing, the Board may issue a final order by default. Licensee did not request a hearing. As a result, Licensee has waived his right to a hearing and now stands in default. The Board elects in this case to designate the record of proceedings to date, which

consists of Licensee's file with the Board as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

3.

FINDINGS OF FACT

Licensee is licensed to practice medicine in the States of Oregon and Washington, and is currently certified by the National Commission on Certification of Physician Assistants (NCCPA). The NCCPA has published a Code of Conduct which states in part, "Certified or certifying PAs shall comply with all applicable laws, regulations and standards related to their professional role." Licensee's acts and conduct that violated the Medical Practice Act follow:

3.1 In early August 2018, Licensee enrolled in the Washington Physician Health Program (WPHP) for monitoring for the use of intoxicants, in which Licensee agreed to be monitored for five years. As part of Licensee's monitoring agreement, Licensee was required to use a Soberlink device (a remote breathalyzer). In November 2018, Licensee enrolled in the Oregon Health Professionals' Services Program (HPSP), while remaining in WPHP. At that time, HPSP became the primary monitoring program, requiring Licensee to continue to submit to ongoing toxicology testing, abstain from the use of intoxicants, participate in a weekly physician monitoring group, maintain weekly contact with an agreement monitor, and participate in self-help meetings and individual counseling. On March 14, 2019, Licensee signed an agreement to withdraw from the practice of medicine in Oregon, and subsequent to this, on July 29, 2019, transferred the primary monitoring responsibilities back to WPHP, while remaining enrolled in HPSP. Licensee failed to comply with the terms of his HPSP and WPHP monitoring agreements, to include the following "positive" toxicology testing results indicating Licensee's use of alcohol and his failures to submit to tests when required to do so:

3.1.1 12/8/2018: positive SoberLink test and self-reported use of alcohol, with follow up urine drug screen (UDS) and PEth tests on 12/11/2018, which were positive for alcohol.

3.1.2 12/20/2018: a positive SoberLink and self-reported use of alcohol, with follow-up UDS on 12/21/2018, which was positive for alcohol.

3.1.3 12/24/2018: positive SoberLink test for alcohol.

3.1.4 2/13/2019: Licensee missed two SoberLink tests.

3.1.5 2/14/2019: observed UDS positive for alcohol.

3.1.6 2/16-18/2019: Licensee missed seven Soberlink tests.

3.1.7 2/18/2019: observed UDS positive for alcohol.

3.1.8 2/20/2019: positive PEth test after Licensee admitted to alcohol relapse.

3.1.9 3/11/2019: use of prosthetic device for UDS testing, followed by observed UDS positive for alcohol (additional details below).

3.1.10 8/16/2019: missed SoberLink test for alcohol (WPHP report).

3.1.11 8/17/2019: positive SoberLink test for alcohol, followed by five missed retests on the same day (WPHP report).

3.2 On or about March 11, 2019, Licensee appeared at First In Health, Inc. for an observed UDS. In an attempt to deceive staff at the collection site, Licensee was observed to be using a prosthetic device with a phallus and an artificial external bladder containing "clean" urine with temperature control hidden inside his pant leg. Subsequent to the discovery of the device, Licensee produced an observed urine sample that tested positive for alcohol.

3.3 Licensee is not a person in the military service of the United States.

4.

CONCLUSIONS OF LAW

Based upon its examination of the record in this case, the Board finds that the acts and conduct of Licensee described above is supported by reliable, probative and substantive evidence and violated the Medical Practice Act, as set forth below:

4.1 Licensee's conduct, as set forth above, constitutes substantial non-compliance with the terms of his monitoring agreements with HPSP and WPHP, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical 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 or condition which does or might adversely affect a

physician's ability to safely and skillfully practice medicine; and ORS 677.190(17) willfully violating any rule adopted by the Board, specifically OAR 847-065-0055.

4.2 Licensee's attempted deceit during the observed urine test constitutes substantial noncompliance with the terms of his monitoring agreement, as well as unprofessional or dishonorable conduct, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession; and ORS 677.190(17) willfully violating any rule adopted by the Board, specifically OAR 847-065-0055(9).

5.

ORDER

In order to protect the public and appropriately address Licensee's conduct, the Board enters the following order:

IT IS HEREBY ORDERED THAT the license of Trent James Russell, PA, to practice as a physician assistant in the State of Oregon is revoked. This Order is effective immediately upon the signature of the Board Chair. In addition, Licensee must pay a civil penalty of $2,000, payable within 90 days from the date this Order is signed by the Board Vice Chair. Violation of the terms of this Order constitute a violation of the Medical Practice Act.

DATED this 5 day of MARCH, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

SAURABH GUPTA, MD
BOARD VICE CHAIR

Right to Judicial Review

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

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of AMBER JANEEN VOGT, DO LICENSE NO. DO179860	)))))	INTERIM STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including osteopathic physicians, in the State of Oregon. Amber Janeen Vogt, DO (Licensee) is a licensed osteopathic 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).

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 19th day of February, 2020.

[redacted]

AMBER JANEEN VOGT, DO

IT IS SO ORDERED THIS 20 day of February, 2020.

State of Oregon
OREGON MEDICAL BOARD

[redacted]

NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR