Oregon Medical Board
BOARD ACTION REPORT
July 15, 2018

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between June 16, 2018, and July 15, 2018.

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

Printed copies of the Board Orders not provided with this report are available to the public. To obtain a printed copy of a Board Order not provided in this report, please complete the License Verification and Malpractice Report Request ([http://www.oregon.gov/OMB/ombforms1/request-licensee-info-verification.pdf](http://www.oregon.gov/OMB/ombforms1/request-licensee-info-verification.pdf)) found under the Forms link on the Board's web site. Submit it with the $10.00 fee per licensee and mail to:

Oregon Medical Board  
1500 SW 1st Ave, Ste 620  
Portland, OR 97201

*Copies of the Orders listed below are mailed to Oregon hospitals where the Licensee had self-reported that he/she has privileges.*

*Ashori, Mohammad, MD; MD170360; Portland, OR*  
On July 12, 2018, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and willfully violating any Board rule or order. This Order reprimands Licensee; assesses a $5,000 civil penalty; and suspends Licensee from the practice of medicine for 30 days.

*Bergstrom, Christina Ng, MD; MD160810; Portland, OR*  
On July 12, 2018, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's January 4, 2018, Corrective Action Agreement.

*Bogard, Peter Shelby, DO; DO18557; Grants Pass, OR*  
On July 12, 2018, the Board issued a Final Order by Default for unprofessional or dishonorable conduct; gross or repeated acts of negligence; willfully violating a board rule, order, or request; and refusing an invitation for a Board requested informal interview. This Order revokes Licensee's license to practice osteopathic medicine in Oregon and assesses a civil penalty of $10,000.
*Buncke, Geoffrey Harry, MD; MD23806; Portland, OR
On July 12, 2018, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence. This Order reprimands Licensee; assesses a $4,000 civil penalty; requires Licensee to complete a pre-approved course on professional boundaries; requires Licensee to enter into a professional coaching relationship; requires that Licensee develop a practice protocol for maintaining boundaries; and subjects Licensee's practice to no-notice chart audits and office visits by the Board's designee.

Harmon, Elizebeth Rose, MD; MD15582; Salem, OR
On July 3, 2018, a Temporary Restraining Order (TRO) issued by the Marion County Circuit Court was rescinded subsequent to a hearing to show cause. The TRO held the Board's June 12, 2018, Order of Emergency Suspension in abeyance. The Order of Emergency Suspension suspends Licensee's medical license due to the Board's concern for the safety and welfare of Licensee's current and future patients. The suspension was effective from June 7, 2018, to June 26, 2018, and is now effective from July 3, 2018, at 4:30 p.m., until otherwise ordered by the Board. (This order was included in the June 15, 2018 Board Action Report)

*Harmon, Elizebeth Rose, MD; MD15582; Salem, OR
On July 12, 2018, the Board issued an Order Terminating Order of Emergency Suspension. This Order terminates the Order of Emergency Suspension issued to License on June 7, 2018.

*Harmon, Elizebeth Rose, MD; MD15582; Salem, OR
On July 12, 2018, Licensee entered into an Interim Stipulated Order to voluntarily follow the Endocrine Society Clinical Practice Guidelines in the treatment of patients with estrogen, testosterone, or thyroid hormones; cease the treatment of premenopausal women with testosterone; cease the treatment of male patients with testosterone whose testosterone levels are within the normal range; and cease the treatment of patients whose Thyroid-stimulating levels are within the normal range pending the completion of the Board's investigation into her ability to safely and competently practice medicine.

*Jacobson, Lawrence Edward, MD; MD20522; Portland, OR
On July 12, 2018, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order reprimands Licensee.

*Lewis, Sue Ann, MD; MD19554; Portland, OR
On July 12, 2018, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's October 6, 2016, Stipulated Order.

*Liu, Helen, MD; MD161201; Lake Oswego, OR
On July 12, 2018, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses on wound closures, dermatology pathology, dermatology billing/coding, and medical professionalism; and undergo a chart audit by a pre-approved, board certified dermatologist.

*Murphy, James Michael, MD; MD23891; Portland, OR
On June 28, 2018, the Board issued a Final Order on Reconsideration for unprofessional or dishonorable conduct; willfully or negligently divulging a professional secret without the written
consent of the patient; fraud or misrepresentation in applying for a license or registration in this state; and willfully violating any Board rule. This Order revokes Licensee's Oregon medical license; assesses a $10,000 civil penalty; and assesses the costs of the contested case hearing held in the matter.

*Rana, Hiren Thakorbhai, MD; MD14344; Lake Oswego, OR
On July 13, 2018, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order Licensee retires his medical license while under investigation.

*Roberts, Brenda Diane, MD; MD21507; Troutdale, OR
On July 12, 2018, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated negligence; and violation of the federal Controlled Substances Act. With this Order Licensee surrenders her medical license while under investigation.

*Sampson, Robert Allan, DPM; DP00217; Portland, OR
On July 12, 2018, the Board issued a Final Order by Default for unprofessional or dishonorable conduct; impairment; willfully violating a board rule, order, or request; and refusing an invitation for a Board requested informal interview. This Order revokes Licensee's license to practice podiatric medicine in Oregon and assesses a civil penalty of $5,000.

*Schultz, George Edward, DO; DO21031; Medford, OR
On July 12, 2018, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved CPEP education plan, and no-notice chart audits by the Board's designee.

*Simmons, Carolyn Elizabeth, MD; MD170122; Myrtle Creek, OR
On July 12, 2018, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's February 27, 2017, Interim Stipulated Order.

*Sincavage, David Louis, Jr., MD; MD156207; Gold Beach, OR
On July 12, 2018, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and for disciplinary action by another state of a license to practice. With this Order Licensee retires his medical license while under investigation.

*Suk, Samuel Soong, MD; MD21879; Beaverton, OR
On July 12, 2018, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on prescribing for chronic pain; complete 20 hours of pre-approved continuing medical education related to prescribing; and complete a pre-approved course on medical documentation which includes a follow-up chart review.

*Vajdos, Margaret Adelle, MD; MD19676; Portland, OR
On July 12, 2018, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's April 3, 2014, Corrective Action Agreement.

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

MOHAMMAD ASHORI, MD
LICENSE NO. MD170360

STIPULATED ORDER

1.

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

2.

On April 5, 2018, the Board issued a Complaint and Notice of Proposed Disciplinary
Action 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 up to 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); and ORS 677.190(17) willful violation of any rule
adopted by the board, board order, or failing to comply with a board request pursuant to ORS
677.320.

3.

Licensee is a board-certified family physician practicing medicine in Portland, Oregon.
Licensee’s acts and conduct that violated the Oregon Medical Practice Act follow:

3.1 In early May of 2017, Licensee worked occasional clinical shifts at the Kaiser
Permanente Urgent Care Clinic [Kaiser Clinic] in Portland and also worked as a physician at the
Aurora Clinic (a medical marijuana clinic). One day while at work in the Aurora Clinic in early
May 2017, a female co-worker, Patient A, informed Licensee that she had recently been having
episodic heart palpitations and that her nurse practitioner told her that she needed to have an
EKG done. Patient A did not know what to do. In response, Licensee invited Patient A and another female co-worker to accompany him to the Kaiser Clinic after work to get the EKG done, and afterwards, they could go to a local bar for drinks. (Licensee was not scheduled to perform a clinical shift at the Kaiser Clinic that day.) At the end of their work day, Licensee and the two co-workers drove to the Kaiser Clinic and entered the waiting room of the Urgent Care Clinic, which was crowded with patients waiting to be seen. Licensee escorted the co-workers past the check-in desk, and using his pass badge to open the security door, escorted the two co-workers into the clinic area. Licensee subsequently approached the nurses’ station and asked the on-duty Registered Nurse (RN), to perform an electrocardiogram (EKG) on Patient A, because she was experiencing heart palpitations. Patient A was not registered with Kaiser Permanente as a patient, and had not been checked in at the front desk. The RN protested that that patient needed to be checked in, that she didn’t do EKGs, and did not recall from her early training how to perform one. Licensee told her that it was easy and urged her to proceed. Licensee escorted the two co-workers into a clinic examination room, and left the room. The RN did not record Patient A’s name nor record her vital signs. The RN, assisted by a Licensed Practical Nurse (LPN), accessed Google on their cell phones to determine where to place the electrodes, and subsequently attached ten electrodes to Patient A. The electrocardiogram was turned on and a tracing was produced and printed. Licensee quickly inspected the print-out and informed Patient A that she “looked fine.” Licensee subsequently left the Kaiser clinic accompanied by the two co-workers. They subsequently went to a local bar for drinks together. No patient record was created to record the events at the clinic and the EKG record was not retained. Licensee’s described behavior with Patient A constituted an improper physician-patient relationship that was contrary to recognized standards of ethics.

3.2 In a letter dated September 25, 2017, Licensee was asked to submit a response to the Board. The letter requested in part, the identities of the two females he brought to the Kaiser Clinic. In his response, Licensee failed to provide this information, stating that the females did not want to be identified. On October 26, 2017, Board staff left a voicemail for the Licensee.
regarding this response, informing him that he was compelled by statute to provide the requested
information, and referred him to Oregon Revised Statutes 677.190 and 677.320. Licensee
returned the call and in a voicemail stated that he had read the statutes and that he would not be
providing the identities of the two females. It was not until November 17, 2017, when
investigative staff conducted an in-person interview with Licensee that he finally revealed the
requested names. Licensee’s refusal to provide the requested information violates ORS
677.190(17).

4.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
Licensee understands that he has the right to a contested case hearing under the Administrative
Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
right to a contested case hearing and any appeal therefrom by the signing of and entry of this
Order in the Board’s records. Licensee admits that he engaged in the conduct described in
paragraph 3 (above) and that this conduct violated ORS 677.190(1)(a) as defined in ORS
677.188(4)(a); and ORS 677.190(17). Licensee understands that this Order is a public record
and is a disciplinary action that is reportable to the National Data Bank and the Federation of
State Medical Boards.

5.

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

5.1 Licensee is reprimanded.

5.2 Licensee must pay a civil penalty of $5,000 in two payments. The first payment
of $2,500 must be paid within 60 days from the effective date of this Order. The second
payment of $2,500 must be paid within 30 days thereafter.

5.3 Licensee is suspended from the practice of medicine for 30 calendar days, effective
the first day of the month following the month in which this Order becomes effective.
5.4 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

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

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

IT IS SO STIPULATED THIS 30th day of May, 2018.

Mohammad Ashori, MD

IT IS SO ORDERED THIS 12th day of July, 2018.

Oregon Medical Board
State of Oregon

K. Dean Gubler, MD
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

CHRISTINA NG BERGSTROM, MD
LICENSE NO. MD160810

ORDER TERMINATING
CORRECTIVE ACTION AGREEMENT

1.

On January 4, 2018, Christina Ng Bergstrom, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee’s Oregon license. On April 2, 2018, Licensee submitted documentation that she has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the January 4, 2018, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair

ORDER TERMINATING CORRECTIVE ACTION AGREEMENT
– Christina Ng Bergstrom, MD
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

PETER SHELBY BOGARD, DO
LICENSE NO. DO18557

FINAL ORDER BY DEFAULT

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. Peter Shelby Bogard, DO (Licensee) is a licensed osteopathic physician in the State of Oregon.

2.

On April 6, 2018, 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 pursuant to ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, 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); ORS 677.190(13) gross or repeated acts of negligence; ORS 677.190(17) willful violation any provision of ORS Chapter 677 or any board rule, board order, or failing to comply with a board request pursuant to ORS 677.320; and ORS 677.190(22) refusing an invitation for an informal interview with the board requested under ORS 677.415. The Notice informed Licensee that if he failed to submit a request for hearing or failed to appear at a scheduled hearing, the Board may issue a final order by default. In a letter to the Board dated April 24, 2018, Licensee acknowledged receipt of the Board’s April 6, 2018, letter but 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’s acts and conduct that violated the Medical Practice Act follow:

3.1 Licensee is a family practice physician in Grants Pass, Oregon. Licensee and the Board entered into a Stipulated Order on July 11, 2002, that placed Licensee on probation with certain conditions. The Board terminated this Order on July 12, 2007. Licensee and the Board entered into another Stipulated Order on October 8, 2015, which is currently in effect. This Order specified certain conditions, to include term 4.1 which states in part that “Licensee must not treat chronic pain with any DEA scheduled medications. For purposes of this Order, chronic pain is defined as pain that persists or progresses over a period of time greater than 30 days. Licensee may prescribe DEA scheduled medications for his patients who are enrolled in hospice or have a life expectancy of less than six months. Licensee must certify on the written prescription that the patient is a hospice patient.” In addition, term 4.4 states that “Licensee may treat acute or intermittent pain, with short acting opiates for no more than 30 days per patient in a calendar year and not to exceed 60 morphine equivalent doses (MED) per day.” Term 4.10 states that “Licensee must obey all federal and Oregon state laws and regulations pertaining to the practice of medicine.” Term 4.11 of that same Stipulated Order states that “Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for further disciplinary action under ORS 677.190(17).”

3.2 Pursuant to ORS 677.320(5) and ORS 677.415(9), the Board requested Licensee to appear for an interview with members of the Board’s Investigative Committee (IC) on December 7, 2017. Licensee failed to appear for this interview.

3.3 The Board issued an investigative subpoena for Licensee to provide copies of medical records pertaining to Patient F and to respond by June 29, 2017. Licensee did not comply with the Board’s subpoena for the timely production of these patient records.
3.4 On August 30, 2017, and September 5, 2017, Licensee informed two different staff members of the Board that he did not have a medical record pertaining to his treatment of Patient F. Licensee sent a letter to the Board dated October 27, 2017, in which he wrote that he did have medical records for Patient F, in paper chart only, contradicting his previous statements to Board staff. The medical records of Patient F were received by the Board on or about November 20, 2017. The records of Patient F were in a different format than the electronic medical records that Licensee provided for other patient charts that were requested by the Board. The records attributed to Patient F and provided by Licensee were transcribed. On November 30, 2017, a Board investigator spoke with Licensee and requested that he provide a receipt for the transcription of the medical record of Patient F. Licensee failed to provide the requested receipt.

3.5 The Board conducted a review of Licensee’s management and treatment of Patients A – E that Licensee treated with opiates and other controlled substances in excess of 30 days for a calendar year. This review revealed that Licensee had prescribed controlled substances for these patients in excess of the limitations imposed in terms 4.1, 4.4, and 4.10 of the 2015 Stipulated Order.

3.6 The Board’s review of Licensee’s charts for Patients A – E also revealed that Licensee’s charts reflect that he failed to comply with the standard of care by failing to document his rationale to support the prescriptions or the patient response to the medications, failing to document periodic urine drug screens (UDS), and failing to check the Prescription Drug Monitoring Program (PDMP) prior to prescribing controlled substances for new patients or patients with compliance issues. Specific examples pertaining to Licensee’s conduct in regard to Patients A – E, which violated the terms of his Stipulated Order in violation of OAR 847-001-0024(2) and ORS 677.190(17) and the standard of care, are set forth below:

a. Patient A, a 31-year-old male, transferred his care to Licensee on October 10, 2016, with complaints of ongoing neck and back pain that originated from a helicopter accident sustained while on active duty. Licensee conducted a physical
examination and performed two osteopathic manipulation therapies. Without checking Patient A’s medical records from previous providers and without ordering a UDS or checking the PDMP, Licensee prescribed a refill of hydrocodone & acetaminophen (Vicodin, Schedule II) 10/325 mg on three occasions as follows: #60 tablets on October 10, 2016; #90 on November 11, 2016; and #90 on December 6, 2016. Licensee’s chart is inadequate, lacking a UDS, PDMP check, rationale to support the prescriptions, or patient response to the medications.

b. Patient B, a 47-year-old male, presented to Licensee on July 7, 2016, with complaints of neck and right arm pain after a night of heavy drinking. Licensee conducted a physical examination and informed Patient B that there was evidence of a bulging cervical disc. Licensee referred Patient B for an MRI (magnetic resonance imaging) of the neck. Licensee’s chart does not reflect any muscle testing or check of deep tendon reflexes. Licensee prescribed Vicodin 10/325 mg, #120 on July 8, 2016, and prednisone 20 mg on July 7, 2016. The MRI scan revealed a bulging disc and bone spur with some evidence of degenerative bone disease. On July 26, 2016, Patient B returned and reported persistent pain that interfered with his sleep. Licensee prescribed oxycodone & acetaminophen (Percocet, Schedule II) 10 mg, #120 (MED 60 per day). There is no record that Licensee checked the PDMP or ordered a UDS. Licensee’s patient record is inadequate, lacking a documented rationale to support the prescriptions or the patient’s response to the medications.

c. Patient C, a 37-year-old male, presented to Licensee on February 1, 2016, after suffering a motorcycle accident about a month earlier, with complaints of right shoulder and arm pain with weakness. Licensee examined Patient C, diagnosed cervical disc disease, and prescribed Vicodin 10/325 mg, #120, along with prednisone bolus, and zolpidem (Ambien, Schedule IV) 10 mg. Patient C continued to report pain in his arm and shoulder over the next four months. Licensee conducted a physical examination each time Patient C presented at the clinic, but Licensee did not conduct a neurological
examination of the shoulder or arm. Licensee ordered neck traction and prescribed refills of Vicodin 10/325 mg, #90 on March 29, 2016, and May 23, 2016. Licensee’s patient record is inadequate, lacking a rationale to support the prescriptions, or notes reflecting the patient’s response to the medications.

d. Patient D, a 46-year-old female, presented to Licensee on February 11, 2016, reporting that she sustained injury after falling down the stairs in her home and complaining of low back pain radiating to the toes. Her physical examination was normal except for a positive straight leg raise bilaterally with pain radiating into the toes. She was referred for physical therapy, and was prescribed Vicodin 5/325 mg, #120. On February 25, 2016, Licensee prescribed oxycodone 10 mg, #60; on March 31, 2016, Licensee prescribed acetaminophen with codeine, #60; and on April 8, 2016, Licensee prescribed Vicodin 10 mg, #100. Licensee also prescribed other controlled substances, to include zolpidem tartrate (Ambien, Schedule IV) 10 mg, #30 on April 8, 2016, May 16, 2016, June 10, 2016, and October 22, 2016; and carisoprodol (Soma, Schedule III) 350 mg, #120. Licensee’s patient record is inadequate, lacking a UDS, a PDMP check, a diagnosis, a rationale to support the prescriptions, or the patient’s response to the medications.

e. Patient E, a 73-year-old male, presented to Licensee on April 26, 2016, with a history of migraine headaches and complaints of back pain. Licensee prescribed Fiorinal with codeine (Schedule III) as follows: #40 on May 3, 2016; #160 on May 6, 2016; #180 on July 15, 2016; #180 on September 9, 2016; #180 on October 21, 2016; #200 on November 23, 2016; #180 on December 24, 2016; and #180 on January 21, 2017. Licensee also prescribed oxycodone-acetaminophen 10/325 mg, #90 (MED 75) for Patient E on July 14, 2016. During each patient visit, Licensee charted that he performed a comprehensive physical examination, but did not document that he examined Patient E’s back. Neither did Licensee address Patient E’s headaches during any successive clinical visit after the initial encounter. Licensee eventually referred Patient E to a pain
specialist in February 2017. Licensee’s patient record is inadequate, lacking a UDS, PDMP check, or rationale to support the prescriptions, or the patient’s response to the medications.

3.7 The Board conducted a review of the submitted medical record of Patient F and found that Licensee has been treating Patient F, a family member, primarily for musculoskeletal pain since at least 2004. Licensee’s care and management of Patient F included regular prescriptions for benzodiazepines and other controlled drugs. The current guidelines from the American Medical Association state that in general, physicians should not treat members of their own families. However, it may be acceptable to do so in emergency settings, or isolated settings where there is no other qualified physician available, until another physician becomes available. Nothing in the records submitted to the Board indicated that an emergency existed.

3.8 Licensee treated Patient F with diazepam (Valium, Schedule IV) 10 mg, #90 on April 4, 2016; #90 on July 1, 2016; #90 on September 29, 2016; #90 on January 6, 2017; and #90 on May 1, 2017. Licensee’s patient record is inadequate, lacking a rationale to support the prescriptions or patient response to the medications.

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 failure to appear before the IC for an interview violated ORS 677.190(22) refusing an invitation for an informal interview with the board requested under ORS 677.415.

4.2 Licensee’s failure to comply with the Board’s subpoena for the timely production of patient records violated OAR 847-001-0024(1) and ORS 677.190(17).

4.3 Licensee’s failure to comply with the Board’s requests for production in regard to Patient F violated OAR 847-001-0024(1) and ORS 677.190(17).
4.4 Licensee’s prescribing of controlled substances for Patients A – E in excess of the limitations imposed in terms 4.1, 4.4, and 4.10 of the 2015 Stipulated Order, violated OAR 847-001-0024(2) and ORS 677.190(17).

4.5 Licensee’s care provided for Patients A – E failed to comply with the standard of care by failing to document his rationale to support the prescriptions, the patient response to the medications, failing to document periodic urine drug screens (UDS), and failing to check the prescription drug monitoring program (PDMP) prior to prescribing controlled substances for new patients, which violated the terms of his Stipulated Order in violation of OAR 847-001-0024(2) and ORS 677.190(17) and the standard of care; in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated acts of negligence.

4.6 Licensee’s ongoing treatment of a family member in non-emergent situations violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a).

5.

ORDER

The Board has the statutory duty to protect the public from the practice of medicine from licensees who engage in unprofessional conduct and otherwise demonstrate that they cannot be trusted with a medical license by repeatedly disobeying Board subpoenas, requests for production or to appear for an interview, as well as gross or repeated acts of negligence in the delivery and charting of medical care for patients. In order to protect the public and appropriately address Licensee’s conduct, license revocation is the appropriate sanction.
IT IS HEREBY ORDERED THAT the license of Peter Shelby Bogard, DO, to practice osteopathic medicine is revoked and that he pay a civil penalty of $10,000, payable within 60 days from the date this Order is signed by the Board Chair.

DATED this 10th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
BOARD 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: GEOFfrey Harry Buncke, MD LICENSE NO. MD23806

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. Geoffrey Harry Buncke, MD (Licensee), is a licensed physician in the state of Oregon.

2. On March 8, 2017, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross or repeated negligence; ORS 677.190(17) violation of this chapter or any board rule; and ORS 677.415(4) self-report within 10 working days of any official action taken against the licensee.

3. Licensee’s acts and conduct that violated the Medical Practice Act follow:

3.1 Licensee is board certified in plastic surgery. Patient A, an adult female patient, presented to Licensee at his office on October 12, 2015. Patient A presented with a wound that Licensee characterized as a piece of thorn in her right ring finger that was infected. On October 20, 2015, Licensee made a small incision, removed the foreign body from Patient A’s finger, and closed the incision with sutures. On November 4, 2015, Licensee removed the sutures from Patient A’s finger. At the conclusion of this visit, Licensee wrote his phone number and "Café
Latte” on a slip of paper and handed it to Patient A. Patient A subsequently walked to her car, got in, and prepared to drive away. As she did so, she heard a knock on her car window. It was Licensee, who told her: “you were going to ditch me.” Licensee and Patient A went to a local café and had coffee together. As they prepared to leave, Licensee told her: “we should go to happy hour.” The next day, Patient A received a text message from Licensee asking her to go to happy hour with him. She declined, indicating that her husband would not like it. After this, when Patient A encountered Licensee in the clinical setting (she returned to the clinic for physical therapy), Licensee was abrupt and told her that her finger looked “horrible.” Licensee called her about a week later and told her that he “was not stalking her.” He went on to say that he was closing her file and that he needed to know how her finger was doing. Patient A ended the phone call by telling the Licensee that she never wanted him to call her again. Patient A felt very troubled by this conversation and Licensee’s earlier conduct towards her. Licensee’s conduct towards Patient A constitutes an inappropriate boundary violation that breached well recognized standards of medical ethics and caused Patient A emotional and mental harm, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS 677.190(13) gross or repeated negligence.

4.

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

Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s records. Licensee admits that he engaged in the conduct described in paragraph 3 (above) and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS 677.190(13). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

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Page 2 – STIPULATED ORDER – Geoffrey Harry Buncke, MD
Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following terms and conditions:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a civil penalty of $4,000 within six months from the effective date of this Order. Licensee may make payments, as long as no payment, excepting the final payment, is less than $100.

5.3 Within nine months from the effective date of this Order, Licensee must attend a professional boundaries training for physicians that is pre-approved by the Board’s Medical Director.

5.4 Licensee must enter into a professional coaching relationship as outlined in the Acumen assessment of April 18, 2017. The professional coach must be pre-approved by the Board’s Medical Director and shall initially submit quarterly reports to the Board’s Compliance Section. Licensee must sign all necessary releases to allow full communication and exchange of documents and reports between the Board and the professional coach. After one year of compliance with this term the frequency of the reports may be reduced by the Board’s Medical Director. All changes must be requested in writing and with written support from the professional coach, including the cessation of the relationship. Licensee will be notified in writing of any changes to the required frequency of reports.

5.5 Within three months of completion of term 5.3, Licensee must develop a personal practice protocol for the maintenance of boundaries and professionalism as described in the Acumen assessment of April 18, 2017, this protocol is subject to approval by the Board’s Medical Director.

5.6 Within 60 days from the effective date of this Order, Licensee must hire or identify an employee within his practice to serve as an advisor to Licensee’s social interactions with patients, as outlined in the Acumen assessment of April 18, 2017. In the event the advisor leaves employment with the practice, a new advisor must be identified within 30 days. Licensee
must report the name of the appointed advisor, and any changes to the advisor to the Board’s Compliance Section within ten calendar days.

5.7 Licensee must not engage in any sort of dual relationship (business, marketing, social, or otherwise) with any patient within two years of the last patient interaction of any type.

5.8 Licensee’s practice is subject to no-notice visits and chart audits by the Board or its designee.

5.9 Licensee must notify the Board’s Compliance Section of all practice locations, and any changes in practice locations within ten days of the change.

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

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

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

IT IS SO STIPULATED THIS 4th day of April, 2018.

GEOFFREY HARRY BUNCKE, MD

IT IS SO ORDERED this _____ day of ________, 2018.

OREGON MEDICAL BOARD

K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

ELIZABETH ROSE HARMON, MD
LICENSE NO. MD15582

INTERIM STIPULATED ORDER

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

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

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

3.1 Licensee must not treat any premenopausal women with testosterone. Licensee must follow the Endocrine Society Clinical Practice Guidelines for treating postmenopausal women.

3.2 Licensee must comply with the Endocrine Society Clinical Practice Guidelines for treatment with estrogen, testosterone, or thyroid hormones. Licensee must refrain from treating
male patients with testosterone whose testosterone levels test within the normal range, as
recognized by the Endocrine Society. Licensee must refrain from treating patients whose
Thyroid-stimulating hormone level is within the normal range as recognized by the Endocrine
Society.

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

3.4 Licensee understands this Order becomes effective the date it is signed by the
Board Chair.

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 Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 30th day of January, 2018.

ELIZABETH ROSE HARMON, MD

IT IS SO ORDERED THIS 30th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
BOARD CHAIR
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

ELIZABETH ROSE HARMON, MD
LICENSE NO. MD15582

ORDER TERMINATING ORDER
OF EMERGENCY SUSPENSION

1.

On June 7, 2018, the Oregon Medical Board (Board) voted to issue an Order of Emergency Suspension to Elizbeth Rose Harmon, MD (Licensee), which suspended her Oregon medical license effective June 13, 2018. The suspension was held in abeyance by order of the Circuit Court of Marion County on June 26, 2018; the abeyance was rescinded by court order on July 3, 2018. On July 12, 2018, Licensee entered into an Interim Stipulated Order with the Board in which Licensee voluntarily agreed to certain limitations regarding her practice.

2.

Having fully considered the July 12, 2018, Interim Stipulated Order, the Board terminates the June 7, 2018, Order of Emergency Suspension, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

[Signature]
K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

LAWRENCE EDWARD JACOBSON, MD
LICENSE NO. MD20522

STIPULATED ORDER

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

2. On April 5, 2018, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty, and assessment of costs, 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).

3. The Board opened an investigation after receiving a report that Licensee voluntarily resigned his employment at Shriners Hospitals for Children in Portland. The Board’s investigation revealed that over a number of years while working at Shriners Hospitals, Licensee engaged in a pattern of unprofessional conduct that was disruptive in the clinical setting by inappropriately interacting with nurses and hospital staff members on numerous occasions. Licensee’s conduct violated ORS 677.190(1)(a), as defined by ORS 677.188(4)(a); AMA Ethical Opinion 1.1.1, the Patient-Physician Relationship, and AMA Ethical Opinion 9.4.4, Physicians with Disruptive Behavior.
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 admits that he engaged in the conduct described in paragraph 3 above and in the Board's Notice and that this conduct violated ORS 677.190(1)(a), as defined by ORS 677.188(4)(a), AMA Ethical Opinion 1.1.1, the Patient-Physician Relationship, and AMA Ethical Opinion 9.4.4, Physicians with Disruptive Behavior. Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Data Bank and the Federation of State Medical Boards.

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

5.1 Licensee is reprimanded.

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

5.3 Licensee must obey all federal and Oregon state laws and regulations pertaining to the practice of medicine.
5.4 Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for further disciplinary action under ORS 677.190(17).

IT IS SO STIPULATED THIS 12th day of June, 2018.

LAWRENCE EDWARD JACOBSON, MD

IT IS SO ORDERED THIS 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
BOARD CHAIR
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of
)
)
SUE ANN LEWIS, MD ) ORDER TERMINATING
LICENSE NO. MD19554 ) STIPULATED ORDER
)

1.
On October 6, 2016, Sue Ann Lewis, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee’s Oregon medical license. On March 16, 2018, Licensee submitted a written request to terminate this Order.

2.
Having fully considered Licensee’s request and her successful compliance with the terms of this Order, the Board terminates the October 6, 2016, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

HELEN LIU, MD
LICENSE NO. MD161201

CORRECTIVE ACTION AGREEMENT

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. Helen Liu, MD (Licensee) is a licensed physician in the State of Oregon and holds an active license.

2.
Licensee is a board certified dermatologist who practices medicine in Lake Oswego, Oregon. The Board opened an investigation into Licensee’s care and treatment of patients and her record keeping.

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 Data Bank and the Federation of State Medical Boards.

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Page 1 -- CORRECTIVE ACTION AGREEMENT – Helen Liu, MD
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 Within six months from the signing of this Agreement by the Board Chair, Licensee must successfully complete courses wound closures, dermatology pathology, dermatology billing/coding, and medical documentation that are pre-approved by the Board’s Medical Director.

4.2 Within one year of the completion of the courses outlined in term 4.1, Licensee must undergo a chart audit at her own expense. The audit must be conducted by a board-certified dermatologist who has been pre-approved by the Board’s Medical Director, and the audit report will be submitted to the Board. Charts to be included in the audit will be selected by the OMB.

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

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

IT IS SO STIPULATED THIS 24th day of May, 2018.

HELEN LIU, MD

IT IS SO ORDERED THIS 24th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
BOARD CHAIR
BEFORE THE
OREGON MEDICAL BOARD

STATE OF OREGON

IN THE MATTER OF: ) ) FINAL ORDER UPON
JAMES MICHAEL MURPHY, MD ) RECONSIDERATION
LICENSE NO. MD23891 )

HISTORY OF THE CASE

On August 10, 2015, the Oregon Medical Board (Board) issued a Complaint & Notice of Proposed Disciplinary Action (Notice) to James Michael Murphy, MD. The Notice proposed imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of Dr. Murphy’s license, to impose a $10,000 fine, and to assess the costs of the proceeding. On or about August 16, 2015, Licensee requested a hearing. The Board referred the matter to the Office of Administrative Hearings (OAH) on September 21, 2015. The OAH assigned the case to Senior Administrative Law Judge (ALJ) Bernadette Bignon.

ALJ Bignon convened a telephone prehearing conference on October 29, 2015. Attorney Thomas Cooney represented Licensee. Senior Assistant Attorney General Warren Foote represented the Board. ALJ Bignon scheduled the hearing for March 14 through 17, 2016.

On November 4, 2015, the Board filed a Motion for a Qualified Protective Order. Mr. Cooney responded to the Board’s Motion for a Qualified Protective Order on November 13, 2015. On November 18, 2015, ALJ Bignon issued a Qualified Protective Order Limiting Use and Disclosure.

On January 15, 2016, the Board filed a Motion for Summary Determination (Board’s Motion) with supporting documents marked as Attachments A through K. On February 10, 2016, Mr. Cooney filed a Response to the Board’s Motion for Summary Determination (Response) with a supporting affidavit and Exhibit 1. In his Response, Mr. Cooney indicated that he would be withdrawing as attorney of record in this matter, but would remain available for any oral argument on the Board’s Motion.

On February 12, 2016, Licensee filed a Motion for Summary Determination (Licensee’s Motion). Between February 12 and 15, 2016, Licensee also filed supporting exhibits, a certificate of mailing, and an exhibit key.

Thereafter, the OAH assigned the matter to Senior ALJ Monica A. Whitaker for purposes of ruling on the Board’s Motion and Licensee’s Motion.

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On February 22, 2016, ALJ Whitaker convened a telephone conference for purposes of hearing oral argument on the Board’s Motion. Mr. Foote represented the Board. Mr. Cooney represented Licensee. Licensee did not appear. As advised in his filings of February 10, 2016 on behalf of Licensee, Mr. Cooney’s withdrawal from representing Licensee became effective at the close of oral argument on February 22, 2016. Licensee proceeded pro se.

On February 23, 2016, in response to Licensee’s Motion, the Board filed its Response to Motion for Summary Determination (Board’s Response). Also on February 23, 2016, Licensee filed a request for oral argument. On February 24, 2016, ALJ Whitaker denied Dr. Murphy’s request. On February 25, 2016, ALJ Whitaker issued a Ruling on Board’s Motion for Summary Determination and Respondent’s Motion for Summary Determination. ALJ Whitaker denied both the Board’s Motion for Summary Determination and Licensee’s Motion for Summary Determination. The matter remained scheduled for hearing on March 14 through March 17, 2016.

On February 26, 2016, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action (Amended Notice). As with the original Notice, the Amended Notice proposed imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of Dr. Murphy’s license, to impose a $10,000 fine, and to assess the costs of the proceeding. The Amended Notice reiterated the allegations contained in the original Notice, but added an allegation that Dr. Murphy had engaged in a pattern of belligerent and obstructive behavior which, the Board alleged, amounted to unprofessional or dishonorable conduct under ORS 677.190(1)(a).

On February 26, 2016, Dr. Murphy filed a request to postpone the hearing. The Board also informed ALJ Bignon that it had received a copy of Dr. Murphy’s request to postpone the hearing. Although the Board did not object to the request, the Board requested a prehearing conference to select new hearing dates.

On February 29, 2016, ALJ Bignon granted Dr. Murphy’s request, unopposed by the Board, to postpone the hearing. On March 2, 2016, ALJ Bignon held a prehearing conference by telephone. Mr. Foote, accompanied by Eric Brown and Michelle Provinsal, represented the Board. Dr. Murphy appeared and represented himself. The hearing was rescheduled to be held July 12 through July 15, 2016 at the Board’s offices in Portland.

On June 29, 2016, the Board issued a Second Amended Complaint and Notice of Proposed Disciplinary Action (Second Amended Notice). The Second Amended Notice, as with the Amended Notice, proposed imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of Dr. Murphy’s license, to impose a $10,000 fine, and to assess the costs of the proceeding. The Second Amended Notice removed an allegation that Dr. Murphy had failed to provide fingerprints, as requested by the Board, and some corrections and clarifications of citation to statutes and administrative rules.

A hearing was held July 12 through July 15, 2016 at the Board’s offices in Portland, Oregon. Dr. Murphy appeared without counsel and testified on his own behalf. The Board was represented by Mr. Foote. Dr. Murphy presented testimony from William Powell, Colonel...
On June 21, 2016, Dr. Murphy, pursuant to ORS 183.645 and OAR 471-060-0005(3), filed a request for a change in the administrative law judge assigned to the case with then-Chief ALJ Gary Tyler. However, due to Chief ALJ Tyler’s retirement and absence from the office beginning June 23, 2017, Governor Brown appointed Presiding ALJ Mann to serve as Interim Chief ALJ, pending the appointment of a permanent Chief ALJ. Given his new role, Interim Chief ALJ Mann determined that it would be inappropriate for him to rule on the motion and therefore delegated it to Presiding ALJ Donna Moursund Brann for a ruling. On June 28, 2017, the Board, through Mr. Foote, submitted an objection to Dr. Murphy’s request. Later on June 28, 2017, Dr. Murphy submitted a response to the objection.

On July 7, 2017, Presiding ALJ Brann issued a ruling denying Dr. Murphy’s request to reassign the case. Interim Chief ALJ Mann then took the matter under advisement, completed his review of the record, and issued a proposed order on September 6, 2017 finding and recommending:

1. The Board did not prove the following allegations by a preponderance of the evidence:
   - Conducting an unauthorized pap smear;
   - Unprofessional or dishonorable conduct or willful violation of ORS chapter 677 by failing to comply with a board request, for the incorrect information Dr. Murphy provided on his license application;
   - Violations of HIPAA;
   - Impersonating a Board licensee.

2. The Board did prove the following allegations by a preponderance of the evidence:
   - Dr. Murphy violated ORS 677.190(8) by providing false information on his October 29, 2013 renewal application;
   - Dr. Murphy violated ORS 677.190(1)(a), committing unprofessional and dishonorable conduct by submitting a declaration to the Multnomah County Circuit Court, alleging the United States National Guard Office of Complex Investigations (OCI) investigation found the allegations against him unsubstantiated when, in fact, the OCI investigation found they were substantiated;
   - Dr. Murphy violated ORS 677.190(5) by willfully divulging a professional secret without the patient’s consent, by publicly divulging Patient A’s private health information and...
confidential medical records without Patient A’s consent;

• Dr. Murphy also thereby violated ORS 677.190(1)(a), committing unprofessional and dishonorable conduct;

• Dr. Murphy violated ORS 677.190(17) by refusing to comply with a Board investigator’s request for documentation;

• Dr. Murphy violated ORS 677.190(1)(a), committing unprofessional and dishonorable conduct by asking witnesses not to cooperate with the Board’s investigation, to impede such investigation;

• Dr. Murphy violated ORS 677.190(1)(a), as defined in ORS 677.188(4)(a), committing unprofessional and dishonorable conduct by belittling a patient, mocking his colleagues and Board staff, and making public comments (including to a reporter) that detracted from public trust in the medical community.

(3) For the violations the Board proved by a preponderance of the evidence, the Board should revoke Dr. Murphy’s medical license, assess a civil penalty of $10,000 against him, and assess the costs of the proceeding ($112,140.62) against him.

Dr. Murphy timely filed written exceptions1, was scheduled to present oral exceptions on October 5, 2017, but ultimately did not appear to present oral exceptions, reporting that he had developed a scheduling conflict. The Board has considered Dr. Murphy’s exceptions, to the extent they did not attempt to introduce new facts or evidence, or advance arguments on facts or evidence not in the record, and finds they are without merit.

On March 2, 2018, the Board issued a Final Order adopting the findings of fact and conclusions of law in the Proposed Order by ALJ Mann, and ordered the revocation of Dr. Murphy’s Oregon medical license, as well as an assessment of a $10,000 civil penalty and the costs of the proceeding against Dr. Murphy. On or about April 27, 2018, Dr. Murphy petitioned the Oregon Court of Appeals for judicial review of the Final Order and, on May 3, 2018, the Board voted to withdraw its final order for reconsideration, to consider the bill of costs in the case. On May 7, 2018, the Board issued a bill of costs to Dr. Murphy with the right to present exceptions, which Dr. Murphy timely presented. The Board has considered Dr. Murphy’s additional exceptions, to the extent they did not attempt to introduce new facts or evidence or advance arguments on facts or evidence not in the record, and finds that these exceptions are also without merit.

EX PARTE COMMUNICATIONS

Between July 11 and August 17, 2017, Dr. Murphy sent multiple unsolicited emails to ALJ Mann that were not sent to Mr. Foote or to the Board. ALJ Mann did not read nor respond to the emails and did not consider their content in reaching the decision in this case. However, because the emails were clear attempts at ex parte communications, the emails have been made part of the record and will be sent to the parties under separate cover2.

1 Dr. Murphy attempted to file additional exceptions multiple times after the window for filing exceptions had closed on September 16, 2017, but the Board considered only the exceptions timely filed.

2 Although Dr. Murphy’s ex parte communications were made part of the record, they were not made part of the evidentiary record and were not, therefore, considered.
ISSUES

1. Whether Dr. Murphy engaged in unprofessional conduct, in violation of ORS 677.190(1)(a), as defined by ORS 677.188(4)(a), and/or conduct that does or might constitute a danger to a patient and gross negligence, in violation of ORS 677.190(13), by performing an unauthorized Pap smear on a patient on November 19, 2011.

2. Whether Dr. Murphy provided false, misleading, and deceptive information in connection with his October 29, 2013 application to renew his medical license by stating that his highest level of education was an associate's degree and that he could speak and understand Quechua sufficiently to communicate for clinical purposes in violation of OAR 847-008-0058, ORS 677.190(8) and/or ORS 677.190(1)(a) and (17).

3. Whether Dr. Murphy acted in a manner contrary to recognized standards of ethics of the medical profession, in violation of ORS 677.190(1)(a) as defined by ORS 677.188(4)(a), by filing a false or misleading declaration in connection with a proceeding in Multnomah County Circuit Court.

4. Whether Dr. Murphy, or individuals acting on his behalf, disclosed private health information and confidential medical records of a patient in violation of HIPAA privacy regulations (45 CFR 164.502), ORS 677.190(5) and/or ORS 677.190(1)(a), as defined by ORS 677.188(4)(a).

5. Whether Dr. Murphy violated ORS 677.080(3) and ORS 677.190(10) by calling a nurse supervisor at Tuality Healthcare in 2015 while representing himself by the name of “Dr. Hanson.”

6. Whether Dr. Murphy violated ORS 677.190(17) and OAR 847-001-0024(1) by failing to comply with a Board investigator's request for medical records in connection with an investigation into Dr. Murphy’s alleged prescribing of controlled substances to two patients.

7. Whether Dr. Murphy violated ORS 677.190(1)(a) as defined by ORS 677.188(4)(a) by asking individuals not to cooperate with the Board’s investigation thereby impeding that investigation.

8. Whether Dr. Murphy engaged in a pattern of belligerent and obstructive behavior during the course of the Board’s investigation and, if so, whether that pattern of behavior constitutes unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a) as defined by ORS 677.188(4)(a).
If one or more violations are proven, whether the Board may revoke Dr. Murphy’s Oregon medical license, assess a $10,000 civil penalty, and assess the costs of the proceedings. ORS 677.205(1) and (2).

EVIDENTIAL RULINGS

The Board offered Exhibits A1 through A57, which were admitted into the record without objection.

Dr. Murphy offered exhibits marked with letters A through W. Dr. Murphy’s Exhibits A1 through A4 therefore are marked similar to the Board’s Exhibits. To avoid confusion, those exhibits are now marked for the records as Exhibits L-A1 through L-A4. The remainder of Dr. Murphy’s Exhibits are marked using their original designations.

Dr. Murphy’s Exhibits L-A1 through L-A4, D1 through D5, E2, F1 through F3, F5 (page 1 only), G1 through G3, H1 through H2, J2 through J5, K1, MC2 through MC6, R1 through R6, S1, T, and W2, W3 and W5 were admitted into the record without objection.

The Board’s objections to Dr. Murphy’s Exhibits B1 through B4, C1 through C6, E1, F5 (page 2), J1, K2 through K5, L1, M1 through M4, MC1, P1, P2, and U2 were sustained and the exhibits were not admitted into the record.

Dr. Murphy withdrew Exhibits E3, F4, G4, H1 through H4, N1, Q1, U1, V1 through V4, and W1.

FINDINGS OF FACT

(1) Dr. Murphy graduated medical school in 1996. He completed his anesthesiology residency in 2002. Dr. Murphy also completed a year of family practice as a resident, and two years of residency in general surgery. (Ex. A27 at 392)

2013 License Renewal Application

(2) Board licensees are required to submit a license renewal application every two years. Initial and renewal applications may be submitted on-line. In October 2013, Laura Mazzucco, a Board Executive Support Specialist, was responsible for reviewing renewal applications for completion. (Test. of Mazzucco, tr. at 194; Ex. A36 at 1-4.)

(3) On October 29, 2013, Dr. Murphy submitted an on-line application for renewal of his medical license. (Test. of Mazzucco, tr. at 194; Ex. A36a at 1-11.) Dr. Murphy completed the question “Highest Level of Education” by selecting “Associate Degree” from a drop-down menu. Dr. Murphy indicated that he was not currently practicing medicine and that his future plans included “Leaving the field (with intention to work in another field).” (Test. of Mazzucco, tr. at 194-195, 204-206; Ex. A36a at 1, 4, 5.)
(4) Dr. Murphy earned an Associate of Science degree in nursing on January 17, 1990. (Ex. G3.)

(5) The renewal application also includes the following question: “Please enter Language(s), other than English, in which you can communicate adequately for clinical purposes.” Underneath the question, Dr. Murphy entered “Quechua” in a box for “Other Language 1.” (Test. of Mazzucco at 195; Ex. A36a at 1.) Immediately below the language selection tabs, applicants are informed that “The Board may make language information available to those who are seeking providers with specific language competencies.” (Test. of Mazzucco, tr. at 196, 202, 204-205; Ex. A36b at 4.)

(6) At the time he completed his renewal application, Dr. Murphy was not fluent in Quechua. Dr. Murphy knew a few words in Quechua that he learned from a computer language program that he used on a single flight to Ecuador and from being around native speakers of the language while volunteering in Ecuador. (Test. of Murphy, tr. at 1329-1335.)

(7) Ms. Mazzucco forwarded Dr. Murphy’s renewal application to the Board’s investigations unit because his practice address needed to be verified and because she believed other information in the renewal application was questionable. (Test. of Mazzucco, tr. at 198.) Ms. Mazzucco did not have authority to reject an application if the application was complete on its face. (Ex. A36 at 3-4.)

(8) The Board initially placed Dr. Murphy’s license in inactive status because his renewal application indicated that he was not currently practicing medicine and that he intended to leave the field. In addition, Dr. Murphy’s renewal form showed “zero” number of hospital and non-hospital hours and listed no other activities related to his practice. (Test. of Mazzucco, tr. at 199, 206-207; Exs. A36a at 4, A36c at 11.) His license was subsequently returned to active status after he informed the Board that he was practicing medicine with the military. (Ex. W3.)

(9) On August 27, 2015, Dr. Murphy sent an email to Ms. Mazzucco and several other Board employees to address the answers he gave on his October 29, 2013 renewal application. In that email, Dr. Murphy wrote, in part:

a. Quechua is my primary spoken language when I am doing medical work in the Andes – only I must have originally started out filing the renewal when I was in Equator [sic] or Peru – can you make that correction or just put an asterisk by my answer for me. English is the answer I believe is on my initial application – I assumed that would be referenced if there were any questions and you would have called me to clarify.

b. The highest ‘grade/degree * * * that I graduated from was: college or an off shore med school - but I don’t really think that is totally accurate – I just
took about 12 years to complete the BA and MD – life got in the way and I had to earn a living. So again - junior college is really where I stopped collecting degrees and went to work full time and did the school / training part time from that point forward[.]

(Test. of Mazzucco; Ex. A36c at 1-2.)

(10) Patient A is a female who at all times relevant to this decision was an active member of the Oregon Air National Guard (ORANG). (Test. of Patient A, tr. at 137.)

(11) On November 19, 2011, Patient A reported to the ORANG 142nd Medical Group facility for a preventative health assessment (PHA). She was examined by Dr. Murphy. (Test. of Patient A, tr. at 138; Ex. A4 at 2-3.) Dr. Murphy completed a Chronological Record of Medical Care form documenting the examination. (Ex. A1.) Under a section labeled “Provider Exam,” Dr. Murphy wrote “No medical issues.” (Id. at 1.) The form contains no indication that a gynecological examination was performed in connection with the PHA. (Id.)

(12) In early December 2013, Patient A attended an Air National Guard training session in Tennessee. (Test. of Patient A, tr. at 141; Exs. A9 at 37, A27 at 124). Technical Sergeant (TSgt.) Rachel Albright, from the 142nd Medical group, also attended the training. Prior to the training, TSgt. Albright was casually acquainted with Patient A from working on the base but they were not friends. (Test. of Albright, tr. at 487-488; Exs. A9 at 9 and 31, A27 at 124, 200 and 202; Test. of Patient A, tr. at 142.)

(13) One evening, while discussing people from work with Patient A, TSgt. Albright mentioned Dr. Murphy’s name among the flight surgeons with whom she worked. Patient A immediately commented that Dr. Murphy was “weird.” (Test. of Albright, tr. at 489; Exs. A9 at 10, A27 at 207.) TSgt. Albright asked Patient A why she would say that. (Test. of Albright, tr. at 489; Exs. A9 at 10, A27 at 206.) Patient A told TSgt. Albright that she felt awkward and embarrassed when Dr. Murphy asked her if she needed a chaperone when he performed a Pap smear on her in connection with a PHA. (Test. of Albright, tr. at 489; Exs. A9 at 10, A27 at 206.)

(14) TSgt. Albright asked Patient A why she had a Pap smear on the base because those were not done during PHAs. Patient A insisted that such procedures were performed because she had one. (Test. of Albright, tr. at 489-90.) TSgt. Albright showed Patient A Dr. Murphy’s picture on Facebook to make sure Patient A was not mistaken in identifying Dr. Murphy as the doctor who performed her 2011 PHA. (Exs. A9 at 70, A27 at 203.) Patient A confirmed that she was referring to the same person that TSgt. Albright showed her on Facebook. (Id.)
After hearing TSgt. Albright say that such exams were not done at the clinic, Patient A appeared to be angry and upset. (Test. of Albright, tr. at 490, A27 at 207.) TSgt. Albright agreed to call the head medical technician at the base, to see if Patient A’s chart notes documented the Pap exam during the 2011 PHA. (Test. of Albright, tr. at 490-491, test. of Patient A, tr. at 143-144; Ex. A9 at 38, 76.)

TSgt. Albright called Master Sergeant (MSgt.) Brian Frederick, the head medical technician at the 142nd Air Group facility, that same night and asked whether or not PAP smears were done at the base medical clinic. MSgt. Frederick told her that the clinic had not done them for a while. (Test. of Albright, tr. at 490-91; Exs. A9 at 76, A27 at 266-267.) TSgt. Albright explained that Patient A said that she had been given a Pap smear during her five-year PHA and wanted someone to look at her records to verify if it was documented. (Test. of Albright, tr. at 490-491, test. of Patient A, tr. at 143-144; Ex. A9 at 38, 76.) MSgt. Frederick told TSgt. Albright that he would look at Patient A’s records, but later realized he could not do so without Patient A’s consent. (Ex. A27 at 267.)

On December 7, 2013, TSgt. Albright sent a text to MSgt. Frederick stating that Patient A was “freaking out” and needed to know what was in her medical records. (Exs. A9 at 76, A27 at 267.) MSgt. Frederick told TSgt. Albright he could not talk to her about the record but that he could talk directly to Patient A if she completed and returned a signed release. MSgt. Frederick told her to have the patient contact him the next day and he could send her the necessary release so that he could talk to Patient A about her records. (Test. of Albright, tr. at 490-491; Exs. A9 at 31, A27 at 208-209, 267-268.)

The following morning, December 7, 2013, Patient A received, signed and returned a release to allow MSgt. Frederick to look at her records. (Test. of Patient A, tr. at 144; Ex. A4 at 5.) MSgt. Frederick reviewed Patient A’s records and verified that Dr. Murphy had performed a PHA on Patient A in November 2011, but there was no documentation of a Pap smear. (Exs. A9 at 76, A27 at 266-269.) MSgt. Frederick later spoke with Patient A on the phone and told her what he had learned. MSgt. Frederick thought that Patient A was shocked by his answer. MSgt. Frederick asked if she intended to pursue the matter. Patient A replied with something like “Hell, yes, I don’t want him to do this to anybody else.” (Ex. A27 at 270.) MSgt. Frederick informed Patient A that he had asked about her intent because he needed to take her allegations to his commander. (Id.)

MSgt. Frederick later reported the allegation to Colonel (Col.) Heidi Kjos, the ORANG Medical Group Commander. (Test. of Kjos, tr. at 771-772.) Col. Kjos called Patient A to discuss the allegation. Patient A, who sounded tearful on the phone, told her that Dr. Murphy had conducted a Pap smear on her in connection with a P11A “a couple years ago.” (Test. of Kjos, tr. at 773-774.) Patient A apologized for not coming forward sooner, but said that she did not realize that it was unusual to get a Pap smear. When Col. Kjos asked if Dr. Murphy had used a speculum, Patient A stated that she did not know “the tools” but confirmed there had been penetration. (Id. at 774.) Col. Kjos asked Patient A
to put her allegation in writing and to send it to her via email. (Test. of Patient A, tr. at 145; test. of Kjos, tr. at 775).

On December 8, 2013 at 12:05 p.m., Patient A emailed a written statement outlining her allegation. The statement included a description of a brief social interaction that Patient A had with Dr. Murphy and other people from the base in December 2010. (Ex. A9 at 37, 40.) With regard to the events of November 19, 2011, Patient A wrote:

I had an appointment at the clinic on drill weekend. I believe it was for my 5 year physical. Dr. Murphy was my provider. During the appointment, he asked me when the last time I had a Pap smear. I told him it was before I had my son, who was born [in] January 2009. He said that I needed one. I felt uncomfortable since I knew him but said ok anyways. He then said “You don’t need a female in here, do you?” I remember the exact phrase because of the way it made me feel. I felt obligated to say no, giv[en] the fact that we had a social interaction almost a year prior. Also the way he asked me made me feel that if I said yes, there was something wrong with me.

He proceeded to do the pap. I was extremely uncomfortable and felt this situation was odd. Afterwards, I told Tess Jaeger about it and she told me she didn’t think that our base does those. But I told her, yes they do, Maj. Murphy just did one. She also thought it was weird that he was the one doing it, considering the prior social interaction. I also told my husband about it and told him how weird and uncomfortable it was because I knew the[] doctor.

(Ex. A9 at 37.)

Patient A remained visibly upset and emotional during the remainder of the training. (Test. of Albright, tr. at 492; Ex. A9 at 72.)

Following her conversation with Patient A, Col. Kjos called her supervisor, Col. Richard Wedan and told him about Patient A’s complaint. Afterward, Col. Kjos and MSgt. Frederick met with Col. Wedan. (Test. of Kjos, tr. at 786; test of Wedan, tr. at 368-360.) Because the nature of the complaint was out of the ordinary, Wedan called in his leadership team and legal staff for the meeting with Col. Kjos and MSgt. Frederick. (Test. of Wedan, tr. at 369-370, Ex. A27 at 336-337.) MSgt. Frederick and Col. Kjos briefed the group on the situation. (Test. of Wedan, tr. at 369-370; Ex. A27 at 336-337.)

After the meeting, Wedan elected to refer the matter to the National Guard’s Office of Complex Investigations (OCI). The OCI was formed in response to increased public scrutiny and dissatisfaction with military investigations in which

3 Col. Richard Wedan was, at that time, the 142nd Fighter Wing Commander, Oregon Air National Guard. (Test. of Wedan, tr. at 367.)
there were reports that findings adverse to the military had sometimes been overturned by higher level command. (Test. of Wedan, tr. at 371-373; Ex. A29 at 338-339.)

(24) On December 8, 2013, Col. Kjos met with Dr. Murphy and informed him that a patient had filed a complaint alleging that Dr. Murphy had performed a Pap smear, an inappropriate medical examination, during a PHA, and that Dr. Murphy had failed to document it in Patient A’s chart. (Exs. A9 at 48, 64, A27 at 398-399.)

(25) During the December 8, 2013 meeting, Col. Kjos gave Dr. Murphy a written memorandum explaining that the ORANG was initiating a Command Directed Investigation (CDI) into the allegations. (Exs. A5, A27 at 399.) In that memorandum, Col. Kjos informed Dr. Murphy that he was prohibited from performing unchaperoned physicals while the CDI was pending and that he was prohibited from retaliating against anyone who had made a complaint or who was involved in an investigation. The memorandum also advised Dr. Murphy not to discuss any matter related to the investigation or the underlying facts of the complaint with anyone other than his counsel. The memorandum also provided the name and telephone number of military defense counsel Major Michael Adams, who Dr. Murphy could contact once the CDI was formally initiated. (Ex. A5.)

(26) Dr. Murphy was angry about the allegation and denied having performed a Pap smear on Patient A as alleged. (Exs. A9 at 48, A27 at 399.)

(27) Patient A returned to the base immediately after training. TSgt. Albright returned several days later. (Ex. A27 at 155-56.) After TSgt. Albright returned to the base, Patient A asked if she would be willing to come with her to look at exam rooms to see if it would help her with the memory of what had happened. Patient A and TSgt. Albright entered a room and found gynecological equipment in a drawer under the exam table. The equipment looked old and dirty. Patient A told TSgt. Albright that Dr. Murphy had examined her in that room. (Test. of Albright; tr. at 493-495.) After discovering the equipment, Patient A asked that it be collected and taken for DNA testing. (Ex. A9 at 71.) The equipment was collected; however the lab that examined it found insufficient DNA for analysis. (Ex. A17 at 3.)

(28) The exam room where Patient A and TSgt. Albright found the equipment was normally used by Col. Kjos. On November 19, 2011, Col. Kjos was scheduled to see a patient at 11:00 a.m. Dr. Murphy was scheduled to examine Patient A at 10:30 a.m. (Ex. MC6.)

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4 At the time the memorandum was issued, Major Adams was in a defense counsel position with the ORANG, however Major Adams and Dr. Murphy did not form an attorney-client relationship. In fact, Major Adams immediately asked his supervisor to have someone else assigned to represent Dr. Murphy, as Major Adams had just finished training to be the victim rights coordinator for the region, and was subsequently assigned to Patient A.
On December 30, 2013, Dr. Murphy went to the Board offices and spoke with Board investigator Terry Lewis. Dr. Murphy told Mr. Lewis about Patient A’s allegation and that the military was investigating the matter. (Ex. A6.) Dr. Murphy emailed Mr. Lewis and Eric Brown (another Board investigator) to notify them that the military’s investigation would take longer than he expected. He also provided the Board investigators with the name and contact number of his military legal counsel, Col. Thomas Patton. (Ex. A8.)

In early January 2014, Dr. Murphy met with Col. Wedan to discuss the investigation. Col. Wedan recalls that Dr. Murphy thought that the investigation should be conducted locally, rather than by OCI. Col. Wedan explained that he believed it was best to have it conducted by OCI to ensure that the investigation was professional and unbiased. (Test. of Wedan; tr. at 378-79.) At one point in the conversation, Col. Wedan recalled that Dr. Murphy said something to the effect of “I just don’t know why we will hang a guy out to dry for conducting a procedure that he didn’t know he wasn’t supposed to do.” (Id.; tr. at 379.) The statement struck Col. Wedan as “odd;” he told three different people, including his attorney, about the statement and made a note of it. (Id.)

OCI staff conducted an investigation in Portland from February 6 through 12, 2014. The team collected documentary evidence and interviewed 10 witnesses, including Patient A and Dr. Murphy. (Ex. A9 at 4.)

OCI investigators interviewed Patient A on February 7, 2014. Patient A told investigators that during the November 19, 2011 PHA, Dr. Murphy asked her when she had her last Pap smear. She stated that after she told him that it had been over three years, he told her that one was due. Patient A told investigators that Dr. Murphy took her to another exam rooms and asked her “[Y]ou don’t need a female in here, do you?” (Ex. A9 at 30.)

Patient A told investigators that the Pap smear seemed to be a normal procedure except that she did not feel any pain as she had in previous exams. She told them that Dr. Murphy used instruments that were in the exam room and inserted something inside her, but she could not remember if he inserted his fingers or whether he wore gloves. She told the investigators that the exam lasted approximately 10-15 minutes and she never received lab results following the exam. (Ex. A9 at 30-31.)

A summary of Patient A’s interview also states:

A few months after the Pap smear, the victim was talking to her friend, SSgt Tess Jaeger. She said to SSgt Jaeger, “I forgot to tell you. Guess who gave me a Pap smear? Maj Murphy did.” * * * SSgt Jaeger told her that Pap smears are not performed at the base. The victim told her they were because she had one by the reported perpetrator.

(Ex. A9 at 31.)
OCI investigators interviewed Staff Sergeant (SSgt.) Jaeger on February 9, 2014. A summary of that interview states:

SSgt Jaeger became aware of the allegations four to five months ago when she and the victim were driving to lunch. ** For reasons SSgt Jaeger cannot recall, the reported perpetrator’s name was mentioned during their conversation. (SSgt Jaeger supposes the reported perpetrator may have called or dropped by the finance office earlier in the day.) The victim believed it awkward that, before the reported perpetrator performed a Pap smear on her during her five year physical health assessment (PHA), he stated “You don’t need a female in here do you?” The victim then explained it was awkward because the way he “asked” the question made her feel as though she could not ask for a chaperone without appearing to mistrust the doctor. Therefore, she agreed to have the exam without a chaperone.

SSgt Jaeger was surprised and confused when she heard that a doctor on base performed a Pap exam. She wondered why the victim would agree to this exam since the medical clinic does not perform Pap exams. SSgt Jaeger stated there would be no reason for a provider to perform a Pap exam because AGR members have their own civilian healthcare providers “for those exams.”

SSgt Jaeger told the victim she did not believe the base medical clinic was supposed to perform Pap exams. The victim seemed embarrassed, and the two even made jokes about it. However, because neither were medical professionals, they convinced themselves they did not know for sure. They did both agree that the incident was “creepy,” “awkward,” and “gross” particularly given the statement the doctor made about not having a chaperone in the room.

(Ex. A9 at 66-67.)

On April 6, 2014, Colonel Kjos prepared a memorandum documenting the results of interviews with 25 women who had been examined by Dr. Murphy at ORANG over the previous four years. All 25 women reported that they had not received a pelvic exam or a Pap smear at the clinic in the last five years. (Ex. A9 at 93.)

The OCI issued a report on August 21, 2014. In a cover letter accompanying an executive summary of the report, Maj. Bayne C. Johnston, Acting Chief of OCI wrote, in part:

The investigative team determined the report of sexual assault is substantiated based on a preponderance of the evidence. This finding is

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According to the memorandum, Dr. Murphy had examined a total of 30 women at ORANG during that period. Of the five women who were not interviewed, one had been transferred to another state, another one was retired, and ORANG was not able to contact the remaining three. (Ex. A9 at 93.)
based upon the victim’s credibility as demonstrated in the consistency of her
recitation of the sexual assault to others, her physical and emotional reaction
to the assault, her demeanor during her interview, the electronic
communications provided by the victim and witnesses, the statements of
witnesses as to their observations of the victim’s behavior before and after
the victim learned she had been purposefully assaulted, and the absence of
any apparent reason for the victim to make a false allegation.

(Ex. A9 at 3; emphasis in original.)

(38) On September 6, 2014, Col. Marshall Wilde sent an email, accompanied by
a copy of the OCI investigation as an attachment, to Col. Patton and to Patient A’s
military attorney, Maj. Michael Adams (who represented Patient A in the OCI
investigation), to be reviewed with their respective clients. Col. Wilde’s cover
e-mail included a set of orders from Brigadier General (Brig. Gen.) Michael
Stencel, ORANG Commander, instructing Dr. Murphy and Patient A not to
discuss the report or the matters it contained with witnesses listed in the report,
except as required for preparation for any related disciplinary actions, for one year
or until further ordered. Brig. Gen. Stencel also ordered that the matters
contained in the report were for official use only (FOUO) and contained PII
(personally identifiable information), not to be disclosed except for official
purposes. (Ex. A15 at 1-2.)

(39) Later on September 6, 2014, Col. Patton forwarded Col. Wilde’s email to
Dr. Murphy. (Ex. A15; test. of Patton, tr. at 900.) In a message accompanying
the forwarded email, Col. Patton wrote, in part:

I just got off the phone with Col. Wilde. Bad news: he said they found
[Patient A’s] accusation substantiated. He said they decided to believe her
because she didn’t have a motive to lie. I’ll hopefully have it by tomorrow
and I’ll give you a call.

(Ex. A15 at 1; emphasis added.)

(40) Col. Patton received a copy of the report summary the following day. (Test.
of Patton, tr. at 901.) Dr. Murphy later called Col. Patton to discuss the report,
but specifically asked not to be provided a copy. (Test. of Patton, tr. at 860.) Col.
Patton told Dr. Murphy that the OCI had found against him. (Test. of Patton, tr.
at 902.) Dr. Murphy asked Col. Patton if OCI investigators had “substantiated”
the allegations with any evidence. (Test. of Patton, tr. at 861.) Col. Patton told
him that they had not. (Test. of Patton, tr. at 861.)

(41) On September 8, 2014, Dr. Murphy emailed Board investigators Eric Brown
and Terry Lewis to inform them that OCI had issued its report. In that email, Dr.
Murphy wrote (among other things):

My understanding is that the OCI, after 9 mo[nths] of investigation, because
they could not establish the patient’s motive for the false allegation,
concluded their report on the complaint as ‘substantiated’. I have no idea why, because they could not establish a motive, they would therefore leap to the conclusion that her complaint was ‘substantiated’.

(Ex. A16; quotations marks in original.)

Defamation Lawsuit

(42) On June 10, 2014, Dr. Murphy, acting without an attorney, filed a lawsuit in Multnomah County Circuit Court alleging that Patient A had defamed him by bringing what he asserted was a false allegation that he had performed a Pap smear on her in November 2011. The lawsuit sought $300,000 in damages, plus court costs and legal fees. (Ex. A12.)

(43) Sometime in June or July of 2014, Dr. Murphy contacted an Oregonian Reporter, Maxine Bernstein, to see if she was interested in writing an article about false allegations in the military. Dr. Murphy spoke to Ms. Bernstein by phone approximately two or three times about the issue. (Test. of Murphy, tr. at 1318-1320.)

(44) On September 14, 2014, Patient A’s civilian defense attorney, Joel Shapiro, filed a Special Motion to Strike Pursuant to ORS 31.150, a statute that permits a court to dismiss a civil action that arises out of statements made in the context of certain legislative, executive or judicial proceedings. (Ex. A14.)

(45) On October 3, 2014, Dr. Murphy filed Plaintiff’s Response to Defendant’s Special Motion to Strike Pursuant to ORS 31.150. (Ex. A18.) Within the response, Dr. Murphy wrote (among other things): “Since the complaint was filed, a 10 month investigation ensued which determined that there was no evidence to support the accusation.” (Id. at 3.) He also wrote:

Plaintiff can show that an extensive ten month long investigation conducted by the Washington DC based ORANG Office of Complex Investigations found no evidence to support Defendant’s claims and stated that Defendant’s claims were completely unsubstantiated.

(Id. at 4; emphasis in original.) Dr. Murphy signed the response directly under a paragraph that stated:

I HEREBY DECLARE THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND IT IS MADE FOR USE AS EVIDENCE IN COURT AND IS SUBJECT TO PENALTY FOR PERJURY.

(Id. at 7.)

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(46) Patient A’s military counsel, Major Adams, asked Col. Wilde whether it would be permissible to provide a copy of an 18 page OCI summary report to the Multnomah County Circuit Court. Col. Wilde told Major Adams that because he was not Major Adams’ supervisor, he could not authorize the release. However, he told him that he believed that releasing it to the court would be a permissible use. (Test. of Wilde; tr. at 44-45 and 63-65.)

(47) Major Adams provided the 18 page OCI summary to the Multnomah County Circuit Court to demonstrate that the report actually found Patient A’s allegation to be substantiated. The summary report, unlike the full 274 page OCI report, did not include Patient A’s protected health information. (Test. of Lewis; tr. at 255-57.)

(48) Dr. Murphy and Mr. Shapiro appeared before the Honorable Judith H. Matarazzo on October 10, 2014 to present oral argument on Mr. Shapiro’s motion to Strike. At the conclusion of the hearing, Judge Matarazzo told the parties that she was inclined to grant the motion and asked Mr. Shapiro to prepare an order for her signature and to provide a copy to Dr. Murphy before he submitted it to her. (Ex. A19 at 20-21.)

(49) On October 17, 2014, Dr. Murphy emailed Col. Wilde to express his concern that Maj. Adams had released the OCI report to the Multnomah County Circuit Court. Dr. Murphy stated that he had been advised to have the court record sealed “to protect my professional reputation.” (Ex. A13 at 15.) Dr. Murphy asked Col. Wilde whether ORANG would support a motion to have the record sealed. Dr. Murphy asserted that he would be filing a complaint against Maj. Adams and accused him of acting unethically. (Id.) In addition, Dr. Murphy criticized Col. Kjos as wanting to “ride the political wave and make [Dr. Murphy] into a villain.” (Id. at 16.) Dr. Murphy also wrote that “unlike Kjos, I was not given a princess pass in life.” (Id.)

Administrative Discharge Proceedings

(50) By letter dated October 23, 2014, Brig. Gen. Stencel notified Dr. Murphy that he recommended that Dr. Murphy be discharged from ORANG for his “pattern of misconduct, professional dereliction, and substandard performance of duty[.]” (Ex. A27, Recorder’s Ex. 2.) Brig. Gen. Stencel alleged that Dr. Murphy knew or should have known to refrain from conducting the Pap smear on Patient A, and that he negligently failed to do so; that he negligently failed to document the Pap smear; that Dr. Murphy knowingly gave a false statement to OCI investigators when he denied performing the Pap smear; and that he made a false unsworn declaration in a court proceeding claiming that a military investigation had concluded that Patient A’s allegation was unsubstantiated. (Ex. A27, Recorder’s Ex.2 at 1-2.)
(51) The Notification Letter also advised Dr. Murphy of his right to an administrative hearing to contest the discharge and his right to counsel. On December 5, 2014, Dr. Murphy requested a hearing. (Ex. A27, Recorder's Ex.3.)

(52) On October 25, 2014, at 7:47 p.m., Dr. Murphy emailed the Oregon National Guard Adjutant General (TAG) to request a copy of the OCI report. (Ex. A13 at 20.) Dr. Murphy stated that the report “apparently was ordered by the TAG office and approved for public release.” (Ex. A13 at 20.) Dr. Murphy also asserted that he had not seen the entire report, but had only seen a “biased, edited version provided by a Maj. Michael Adams, which he placed in the public record of Multnomah County.” (Id.)

(53) On October 25, 2014, at 7:47 p.m., Dr. Murphy emailed Chief Master Sergeant Eddings to express a number of concerns. Dr. Murphy wrote, in part:

> Hey chief – funny that OCI did not talk to you? the clinic chief? funny that they asked Albright the bulk of their questions about PHAs. Albright who probably knows the least about medical personal [sic] (not a medic or nurse) and the physical exam process. That investigator should be shot – he is worthless.

> So do you really think that it would even be imaginable – all the exam beds have stirrups – why change rooms? Crazy story – did she hide the instruments in the wrong room? * * * I will bet that Kjos was in the room that they ‘found’ the instruments that day – Kjos thinks she is going to make General off of this.

> I should have been more like [name deleted] – make it all about me. ‘What an’ suck up’ [sic] piece of shit.

> How come you are not speaking up??? Did you tell Wedan how crazy this is? I know you are an honorable person – I am surprised by your silence.

> I may lose my job on Monday – it is a government (military) contract and I think they found out about the investigation. I will probably never work as a doc again – no matter what happens.

> Tell Jim, I am getting my guns and heading out to Eastern Oregon with him – civilization sucks.

/////
What happened to honor??

I am going to take all these assholes down -- one way or the other.

(Ex. A13 at 19-20.)

(54) On October 30, 2014 Dr. Murphy emailed a number of people at ORANG along with Board investigator Eric Brown. In the email, Dr. Murphy again questioned the release of the OCI report and stated that Maj. Adams had released it “to the public record (presumably to the media as well[.].)” (Ex. A13 at 21.) He also wrote that he would be reporting Col. Kjos to the Board for failure to report the alleged incident between Dr. Murphy and Patient A, along with allegations that Col. Kjos unlawfully prescribed medication for financial gain, and had performed unnecessary medical examinations. Dr. Murphy also asserted that Brig. Gen. Stencel was under investigation for allegedly abusing his authority to pressure Dr. Murphy and medical clinic command to hire a nurse. Because of this alleged investigation, Dr. Murphy asserted that Brig. Gen. Stencel should be removed from participation in any disciplinary actions against him. (Id.)

(55) On October 31, 2014, Dr. Murphy submitted to Judge Matarazzo a Motion to Vacate Proposed Order, Alternatively Amend the Findings and provide Corrections to the record prior to the Order Granting Defendant’s Special Motion to Strike (Motion to Vacate). (Ex. A21.) Dr. Murphy’s submission sought to correct the record with regard to some statements he had included in his response to Mr. Shapiro’s Special Motion to Strike. Among those corrections, Dr. Murphy wrote:

The plaintiff also unintentionally stated that the OCI did not ‘substantiate’ the defendant’s allegation of sexual assault when in fact the report did come to that conclusion. However, the report failed to ‘substantiate’ any evidence to support the allegation and even noted the absurdity of the alleged contact.

(Id. at 3.)

(57) On November 1, 2014, Dr. Murphy sent an email to Col. Wilde and others at ORANG with a copy also sent to Mr. Brown. (Ex. A13 at 23-24.) In that email, Dr. Murphy stated that he would be filing a bar complaint against Col. Wilde for failure to report the alleged incident between Dr. Murphy and Patient A, and a bar complaint against Maj. Michael Wetzle (his military attorney at that time) for alleged failure to communicate with Dr. Murphy and for alleged “ex parte contacts with opposing parties.” (Id. at 23.) As result of these complaints, Dr. Murphy asked that Col. Wilde recuse himself from further involvement in the case and stated that Maj. Wetzle was “fired as my defense counsel.” (Id. at 24.)

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6 Col. Patton resigned as Dr. Murphy's defense counsel at the end of the OCI investigation. (Test. of Patton, tr. at 870.)
(58) On November 3, 2014, Dr. Murphy emailed Col. Wilde and several other members of the military. (Ex. A13 at 27.) Dr. Murphy wrote, in part:

I hope you are all proud of yourself [sic]. This has psych case written all over it. How many psych meds has she been on? All her gyn dates are messed up? Her screwed up relationship with her husband. I love the fact that they sent her back to the pharmacy to dispose of the valium and Percocet because she was pregnant and did not know it. What happened to that pregnancy was it the one in 2008. Did she stick the instruments (that she put in the drawer) inside her vagina before she ‘found’ them – is that the DNA test you are sending to my mil? 

(Ex. A13 at 27.) Dr. Murphy concluded the email with “The cops will get it from you, they are coming, so are the bar investigators.” (Id. at 28.)

(59) On or around November 4, 2014, Maj. Adams emailed Board investigator Terry Lewis a copy of Dr. Murphy’s October 31, 2014 Motion to Vacate. Maj. Adams noted that Dr. Murphy had corrected his previous mischaracterization of the OCI report and now conceded that OCI had found Patient A’s allegations to be substantiated. Maj. Adams opined that Dr. Murphy did so because he had received the notification letter from Brig. Gen. Stencel which included an allegation that Dr. Murphy had misled the court. (Ex. A13 at 29.)

(60) On November 9, 2014, Dr. Murphy emailed Col. Wilde to address, among other things, his intention to pursue “any and all means to exonerate [his] professional reputation.” (Ex. A13 at 34.) Dr. Murphy also informed Col. Wilde that he had “provided the court with a copy of the report” and that it was “now part of the public record alongside Maj. Adams’s edited version.” (Id.)

(61) On November 12, 2014, Col. Wedan issued a Debarment Letter to Dr. Murphy, denying him access to Portland Air National Guard Base. The letter was sent, via certified mail, to Dr. Murphy’s home in Oregon. Col. Wedan issued the letter after he was shown Dr. Murphy’s October 25, 2014 email in which Dr. Murphy stated that an investigator should be shot, called another physician a “piece of shit,” and wrote that he would “take all these assholes down—one way or the other.” (Ex. A13 at 70.)

(62) On November 19, 2014, Dr. Murphy sent a lengthy email to Col. Wilde to discuss the status of his legal action and to express several points of disagreement with the OCI report. (Ex. A13 at 36-39.) He complained about Maj. Adams’ conduct in connection with his legal action and asked Col. Wilde to have him removed from the case for misconduct. He wrote that Maj. Adams had acted inappropriately by submitting what Dr. Murphy claimed was an edited version of the report and told Col. Wilde that he planned “to submit the entire report to the court as an addendum to [his] motion in pursuit of fairness and justice.” (Id. at 37.)

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7 The term “mil” likely refers to a .mil email address extension used by members of the armed forces.
(63) Also on November 19, 2014, Dr. Murphy emailed Judge Matarazzo’s judicial assistant, Tiffany Fox, to discuss scheduling a hearing on his Motion to Vacate. (Ex. A13 at 51-52.) In that email, Dr. Murphy told Ms. Fox that he would like to submit the entire OCI report, and not “the edited version that Michael (Maj.) Adams submitted.” (Id. at 51.) Mr. Shapiro responded to the email and told Ms. Fox that he had no objection to Dr. Murphy submitting the report. In addition, Mr. Shapiro clarified that the portion of the report that he had submitted earlier was “excerpted, rather than edited.” (Id. at 50.) Dr. Murphy later filed the full report with the Court. (Test. of Murphy, tr. at 1323.) That full report included Patient A’s National Guard medical records and other personal information. (Ex. A44 at 1.)

(64) The full OCI report submitted by Dr. Murphy, and the summary report provided by Mr. Adams, was reviewed in-camera in Judge Matarazzo’s chambers. They were not made part of the court record and were not available to the public. The exhibits, medical records, and transcripts associated with the case were destroyed by the court in June 2015 per an order signed by the Presiding Judge. (Ex. A58.)

(65) On November 24, 2014, Dr. Murphy emailed Col. Patton, Col. Wilde, Maj. Adams, and others at ORANG to inform them that the Board had opened an investigation. Dr. Murphy asked that ORANG fully cooperate with the Board and to provide any requested documents concerning his military service and the military’s ongoing investigative process. The email also noted that the OCI report showed that Patient A had taken two anti-depressants in the past. (Ex. A13 at 40-41.)

(66) In an email to Mr. Lewis dated November 28, 2014 Dr. Murphy provided information related to his civil action against Patient A. (Ex. A44 at 4-6.) In the email, Dr. Murphy wrote that he filed suit against Patient A with the goal of “having [her] recant her false allegation or risk financial consequences.” (Id. at 6.) He also confirmed that he had provided a full copy of the OCI report to the court which, he asserted, was “now part of a public record.” (Id.)

(67) Also in the November 28, 2014 email, Dr. Murphy wrote, regarding physician chaperone policies: “[F]rom past experience, I know that the OMB places a greater value on policies (even policies that don’t apply) than physician training and judgment.” (Id. at 4.)

(68) On November 29, 2014, Dr. Murphy emailed Col. Wilde, Col. Patton and Linda Beuckens of ORANG with various observations about his upcoming discharge proceeding and the Board’s investigation. Dr. Murphy also copied Ms. Bernstein (Oregonian reporter) on the email. (Ex. A13 at 56-57.) Among his observations, Dr. Murphy wrote that Maj. Adams might be “unethically involving himself in something that does not concern him – the OMB investigation.” (Id. at 57.) He also wrote:
By the way did BG Stencel have time to review the responses in my other pending litigation to see if there was anything else from the civil courts or small claims court that he wanted to add to his conclusions regarding my [dereliction] of duty?

Only hope the State [Inspector General] or the Oregonian are taking note of how due process and justice is served in the ORANG.

Just out of curiosity, are you getting help for the emotionally distraught SSgt? Contact Dr. Kjos – she is a physician, I think.

* * * * *

If the OMB starts calling my jobs with this allegation – I will immediately be terminated. Maj. Adams will really get to know me at that point.

(Id.)

(69) On December 15, 2014, Dr. Murphy emailed Col. Wilde and several other ORANG personnel in which he reported that he had just learned “via forwarded email” that he had been restricted from the Portland Air National Guard base. (Ex. A13 at 66.) In the email, Dr. Murphy asked for the names of people who felt threatened by him and asked whether he should stay out of the city of Portland or perhaps out of the entire state of Oregon. (Id.) Dr. Murphy also requested various documents and information from Col. Wilde as “part of a discovery process.” (Id. at 67.) Among his requests, Dr. Murphy asked for Patient A’s medication lists along with the names of the providers who prescribed her “psych meds.” (Id.) He also asked for a copy of an alleged investigation of a relationship between Patient A and another married officer who Dr. Murphy identified by name. (Id.)

(70) On December 21, 2014, Dr. Murphy emailed Col. Wilde, with copies to Col. Beuckens, Col. Patton, Captain Joni Carlisle,* Maj. Adams, and Maj. Kyle Abraham. Dr. Murphy reported that his Motion to Vacate had been denied resulting in the dismissal of the case. However, Dr. Murphy wrote that he intended to refile the case the following week. He also stated that he intended to file a lawsuit, a bar complaint, and a complaint with the inspector general against Maj. Adams. (Ex. A13 at 79.)

(71) Also on December 21, 2014, Dr. Murphy emailed Col. Wilde, Col. Beuckens, and Ms. Bernstein, and copied several other military personnel. (Ex. A13 at 88-89.) In the email, Dr. Murphy asserted that either Patient A or her attorney had told a reporter (Ms. Bernstein) that Patient A had requested that civilian law enforcement investigate her allegation. Dr. Murphy noted that this was inconsistent with a letter previously issued by the Adjutant General. Dr.

* On November 4, 2014, Col. Wilde appointed Captain Carlisle as Dr. Murphy’s military counsel effective January 15, 2015. (Ex. A13 at 27.)
Murphy wrote “Who is lying here? * * * I assume the Oregonian will be seeking an answer to this question. I will also request that the Governor’s office investigate [the Adjutant General] to determine the true nature of the alleged victim’s request regarding notification of local law enforcement.” (Id at 89.) In addition, Dr. Murphy wrote that he intended to depose the Adjutant General when he refiled his lawsuit against Patient A. He wrote that he suspected that the deposition would demonstrate that Patient A “was again perjuring herself and misleading the press” but that he doubted that ORANG would take any action against her for her “criminal actions.” (Id.)

(72) On December 24, 2014, Dr. Murphy emailed Mr. Shapiro and Ms. Bernstein, with a copy to Col. Wilde. Dr. Murphy asked Mr. Shapiro whether Patient A had previously requested a law enforcement investigation. Dr. Murphy wrote that he intended to refile his lawsuit and that he would seek disciplinary actions by the court against Mr. Shapiro and Maj. Adams if he determined that they had concealed a law enforcement investigation. (Ex. A13 at 83-84.)

(73) On December 30, 2014, Maj. Adams emailed Board investigator Lewis to outline the various complaints and actions that Dr. Murphy had taken since Patient A made her allegations. Maj. Adams listed the following:

- Threatened congressional complaints and suggesting that the Adjutant General be removed by the Governor.
- Filed a civil action against Patient A and misled the court about the outcome of the OCI investigation.
- Attempted to file the entire OCI report with the Multnomah County Court so that it would become part of the public record. The report contained many of Patient A’s personal medical records.

(Ex. A13 at 104.) Maj. Adams then opined:

[Dr. Murphy] acts like a bully on the playground to coerce others to take the actions he desires. He keeps cc’ing Maxine Bernstein the Oregonian Reporter. Again, everyone else’s fault, while taking no responsibility. * * *. With this much stress, I am not sure how he can be that stable. I think it is only a matter of time before he implodes.

(Id.)

(74) Maj. Adams attached a document from Dr. Murphy to his December 30, 2014 email. In that document, Dr. Murphy accused Maj. Adams and Patient A of fraud and extortion. He also wrote “Your fraudulent behavior should result in disciplinary actions by the Court and the Oregon Bar. (Ex. A13 at 106.)
On February 5, 2015, Dr. Murphy sent an email to Dr. Joseph Thaler (the Board’s Medical Director) and Dr. Lisa Snyder. In that email, Dr. Murphy wrote that he had submitted a comment to the Oregonlive.com website commenting on Patient A’s allegations. Dr. Murphy wrote that he submitted the comment because “this accusation is apparently being tried in the court of public opinion.”

I am very familiar with this case which was unethically made part of the public record by the accuser’s [military attorney]. The article failed to mention the following –

the accuser has been on psych medication for over 10 years without disclosing it to the military (no wonder the military has so many of these friendly fire/active shooter incidents.)

the accuser previously received a breast and gyn exam from a male flight surgeon at that same clinic in the past, flight surgeons are general medical officers and as such are qualified to do physical exams (including gyn and rectal exams)

the physician has never been a complaint of inappropriate contact or relations with patients in almost 30 yrs of working as a healthcare worker

* * * * *

the gyn instruments were ‘found’ in a female physician’s exam room (not Murphy’s exam room) and all the exam rooms are configured with the same stirrups on the exam table.

the accuser was previously involved in an affair with a married officer, she sent a flirtatious email to Murphy which he ignored, weeks later she came up with this alleged gyn exam stating it occurred years earlier – which she had never noted in her medical history (in fact she sought out a gyn exam in 2013 even though she would not have been due, if she truly believed that she had received one in 2011.)

On February 6, 2015, Judge Matarazzo issued a General Judgement of Dismissal, dismissing Dr. Murphy’s defamation action and awarding costs and attorney fees to Patient A. (Ex. A23.)

On a Saturday in February 2015, Dr. Murphy called Tuality Hospital in an attempt to reach Kathryn Gilbert, R.N. (Test. of Gilbert, tr. at 125-126.) The

It is unclear from the record who Dr. Snyder is or what her role was in this case.
switchboard referred the call to John Sparks, the administrative nurse supervisor on duty at that time. (Test. of Sparks, tr. at 554-555.) The switchboard operator forwarded the call to Mr. Sparks because the caller, who identified himself as a physician, was very insistent. However, the operator did not recognize the name the caller provided. (Id.)

(78) When Sparks answered the phone, the caller identified himself as a doctor on staff, and used the name that Sparks recalled as “Hansen,” “Hamson,” or something similar. The caller wanted Ms. Gilbert’s phone number, but Mr. Sparks would not provide it. Due to the caller’s insistence that he was trying to reach Gilbert about an urgent medical matter, Sparks took the caller’s phone number and then called or paged Ms. Gilbert, who was not then on duty. (Test. of Sparks, tr. at 555-557, 559.)

(79) Ms. Gilbert was at a gym when she received the page from Mr. Sparks. She called Mr. Sparks who told her that a “Dr. Hanson” was trying to reach her regarding a “cath lab order set” for a patient. (Test. of Gilbert, tr. at 125-126; Ex. A37 at 1.) Sparks gave her the telephone number the caller had provided. Gilbert did not recognize the name Sparks had relayed but recalled that she worked with a Dr. Hamdon and thought that he might be the caller. (Test. of Gilbert, tr. at 126.)

(80) When Ms. Gilbert called the number provided by Mr. Sparks, her cell phone identified the number as that of Dr. Murphy. Dr. Murphy formerly worked with Ms. Gilbert at Tuality Hospital and Ms. Gilbert had socialized with Dr. Murphy and his wife on occasion. When Dr. Murphy answered the telephone, Ms. Gilbert recognized his voice. Ms. Gilbert asked Dr. Murphy why he told the hospital he was someone else but does not recall his answer. Dr. Murphy did not discuss any medical issues, but engaged in some small talk and also told Ms. Gilbert about some difficulty he was having with someone in the National Guard who had alleged that he had sexually assaulted her. (Test. of Gilbert, tr. at 126-129; Ex. A37 at 1-2.)

Public Disclosure of Confidential Information

(81) On March 17, 2015, Dr. Murphy filed an 11 page document with the Multnomah County Circuit Court that was titled “Settlement Offer -- Murphy v. [Patient A].” (Id. at 14-25.) The settlement offer contained Dr. Murphy’s extensive discussion of Dr. Murphy’s view of the facts of his dispute with Patient A, including a detailed account of Patient A’s allegations regarding the alleged Pap smear. The document also includes a section labeled “THE DEFENDANT’S HISTORICAL LACK OF HONESTY-CONCEALING PSYCHOLOGICAL PROBLEMS FROM THE MILITARY.” (Id. at 19; emphasis in original.) Dr. Murphy wrote in the document that Patient A failed to notify the military of a psychological issue and her past use of anti-depressant medications. The document also contains a detailed account of Patient A’s self-reported online health assessments, including discussions of past Pap smears, a C-
section, a list of psychiatric medications, and an assertion that Patient A used a psychiatric medication while she was pregnant. (Id. at 22.) The settlement offer was included in the official court record and was available to members of the public through the court’s electronic information system, OJIN. (Test. of Lewis; tr. at 621.)

Also on March 17, 2015, Dr. Murphy sent an email to multiple people, including Mr. Shapiro, Ms. Bernstein, several members of the military, and several others. (Ex. A44 at 27.) The email included the 11 page settlement agreement as an attachment and had the subject line “Public Record – filed with Circuit Court – Settlement Offer in 15CV02439.” (Id.) At the end of the email, Dr. Murphy asked the recipients to “Please forward this settlement offer to any interested party, ask them to contact the Oregon State Military Office or the Governor’s office to put an end to this non-sense.” (Id.)

On March 18, 2015, Dr. Murphy sent an email to his military attorney, Captain Carlisle, and another military attorney, Col. Monique DeSpain. He also copied Board investigators Lewis and Brown, Board Medical Director Dr. Thaler, several members of the military, and Ms. Bernstein. (Ex. A24.) In the email, Dr. Murphy stated that he wished to separate from ORANG and asked Captain Carlisle to send him the appropriate paperwork. He asserted that he wanted to focus his effort on litigating claims against the Board, including harassment and retaliation. He accused the Board of “intentionally delaying” its investigation. (Id. at 1.) Dr. Murphy further wrote:

I suspect the delay is a direct result of the inept but malicious investigative and legal staff at OMB/DOJ, who did not have the courage or integrity to respond with an explanation.

By removing the separation hearing, it will provide one less excuse for the investigator’s continued harassment and retaliation. The OMB investigative staff are a group of non-professionals who lead physicians like Joe Thaler around by the nose, making the OMB’s entire process almost as absurd as that report produced by the OCI.

Obviously, this has been a frustrating process, when a mentally deranged patient with an absurd complaint manages to convert a routine established complaint process into a 1 1/2 year circus. The main clowns being Heidi Kjos and Monique DeSpain – who made a patient[’]s complaint into something it wasn’t, just to bring attention to themselves as female activists (politically popular). And of course OMB’s Terry Lewis is always interested in undermining physicians in order to justify his existence (bad idea for a morbidly obese male with no doubt some underlying pathology that will require medical assistance someday soon).

(Id. at 2.)
On April 11, 2015, Dr. Murphy sent an email to MSgt. Frederick, Chief Master Sergeant Michelle Marshall (both of ORANG leadership), and to Board Investigators Lewis and Brown. In that email, Dr. Murphy wrote:

I was contacted by a patient who I saw in the medical clinic sometime back. The patient told me that they had been contacted regarding my care. I formally request that if any of my patients (any patients) are contacted by the investigators from the Oregon Medical Board that they do NOT cooperate. [T]he OMB has no investigative authority outside of license holders. If there is a question regarding patient care, the investigator can contact me. This is a significant infringement on patient confidentiality. This of course applies to any and all medical records as well.

(Ex. A25; emphasis in original.)

Administrative Discharge Hearing

The Oregon Military Department’s Administrative Discharge Board held a hearing on Dr. Murphy’s appeal of the recommended discharge from May 7 through 9, 2015 in Portland, Oregon. Legal Advisor Col. William D. Bunch presided at the hearing. The Board was comprised of three voting members, all of whom were colonels in the Air National Guard. Dr. Murphy participated in the hearing and was represented by his military counsel, Captain Carlisle. Both Dr. Murphy and Patient A, among others, testified at the hearing. (Ex. A27.)

At the conclusion of the hearing, the Administrative Discharge Board found against Dr. Murphy on all charges. Specifically, the Board concluded:

- Dr. Murphy was derelict in the performance of his duties by negligently failing to refrain from conducting a genital exam or Pap smear on Patient A;
- Dr. Murphy was derelict in the performance of his duties by failing to document the genital exam or Pap smear on a Patient A;
- Dr. Murphy knowingly made a false statement to an OCI investigator by asserting that he did not perform a Pap smear or similar procedure on Patient A; and
- Dr. Murphy knowingly made a false statement in an unsworn declaration that claimed that a military investigation had found Patient A’s allegation to be unsubstantiated.
(Ex. A27, Ex. 10.) As a result of these findings, the Administrative Discharge Board recommended that Dr. Murphy be separated from the National Guard with an other than honorable conditions discharge. (Id.)

Board Request for Records

(87) On May 12, 2015, Mr. Lewis sent Dr. Murphy a request for information, pursuant to the Board’s authority under ORS 677.320, asking Dr. Murphy to provide the following:

A complete copy of the medical record[s] for your care and treatment for patients [B] and [C]. Please include all information regarding your prescribing for these patients in 2013-2014.

(Ex. A29.) Dr. Murphy did not provide the requested medical records to the Board. (Test. of Lewis, tr. at 1264-65.)

(88) A subcommittee of the Board’s Investigative Committee interviewed Dr. Murphy on June 4, 2015. (Ex. A31 at 4.) The Board’s Medical Director, Dr. Thaler, Board Investigator Lewis, and Mr. Foote were also present for the interview. (Id.)

(89) Dr. Murphy had copies of documents at the interview that he believed the subcommittee might ask about, including medical records of Patients B and C. Dr. Murphy did not tell anyone that he had the medical records with him, nor did he offer them to the subcommittee. (Test. of Murphy, tr. at 1269-1271; test. of Lewis, tr. at 1264-1265.)

(90) At the conclusion of the interview, when Dr. Murphy asked if he should continue to provide any additional evidence to Mr. Lewis, Mr. Foote replied “Well, he’s your point of contact if you have anything further * * * [because] these things will be considered by the Board so if there’s something you want to submit, go through him.” (Ex. A31 at 39.) Other than an affidavit of Col. Patton, Dr. Murphy did not offer, or attempt to offer, any other documents to the subcommittee or to Mr. Lewis before leaving the interview. (Test. of Murphy; tr. at 1265; Ex. A31 at 37-39.)

(91) Prior to submitting exhibits in preparation for the current contested case hearing, Dr. Murphy failed to produce the documents requested by the Board in Mr. Lewis’s May 30, 2015 letter. (Test. of Murphy, tr. at 1263; Exs. MC2, MC3, MC4, and MC5.)

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10 Ex. A27 is a transcript of Dr. Murphy’s Administrative Discharge Board hearing. The information in Finding of Fact 86 is derived from Exhibit 1 from that hearing.
E-Mail Communication with the Board

(92) On August 15, 2015, Dr. Murphy sent an email to Mr. Lewis, Mr. Brown, and Mr. Foote. (Ex. A34.) In that email Dr. Murphy wrote, in part:

Mr. Lewis,

When do you imagine that you folks might finish fabricating these unsupported violations? How long does it take to ‘finalize’ BS?

As you are obviously aware, I am currently in litigation regarding the medical board’s last illegal and unethical action and I want to make sure the court is aware of the OMB’s latest attempt at retaliation.

So Terry, if you are going to ‘get me back’ or ‘teach me a lesson’ (try to intimidate me), you need to stop stuffing your face, put down your comic books and use your crayons to come up with something in writing – pronto. Oh hey – thanks again for lying to me about having to report a patient’s complaint in 10 days, [etc.]* * * [Patient A’s] allegation is false and she is going to go to jail for making it. This is pathetic, I try to help people and make a difference every day and all you folks can do is make up non sense [sic] to justify your own existence. And of course you retaliate against anyone who calls you out on your Emperor’s clothing.

Dr. Thaler and the other physicians involved in this – shame on you.

* * * * *

oh yea – good morning Mr. Lewis – the great and powerful Oz has spoken.

(Id. at 1.)

(93) On August 22, 2015, Dr. Murphy emailed Kevin Danielson, an attorney in the United States Attorney’s Office in Oregon, and Mr. Foote. (Ex. A35.) Dr. Murphy informed Mr. Danielson that he “gave up on [his] civil suit” against Patient A because “[s]he does not have any money and your office and the federal court system made it too cost prohibitive and complicated to continue.” (Id.) In addition, Dr. Murphy informed Mr. Danielson of the Board’s investigation, writing “Now the board (mostly a morbidly obese investigator with a high school diploma and a chip on his shoulder) is mounting some kind of vendetta.” (Id.) He also wrote:

The Board is now going beyond the so called “casting a wide net” approach and is actually posting complete nonsense on their website. The OMB (maybe other medical boards as well) functions via blatant intimidation of licensed providers, because the board does not feel that they have to answer to anyone who works under the banner of ‘public safety’.
Currently I am pursuing litigation against the State for damages from a previous false claim by the OMB (supported by an Oregon State Court of Appeals ruling). But clearly there is collusion between the State AG office in their efforts to “persuade me to drop it” and the OMB (Kathy Haley) who is aware of or is encouraging their investigator Terry Lewis to simply fabricate issues like he did previously.

I think it is unethical, maybe illegal. I believe it would take a federal prosecutor to make that determination. What are your thoughts? I have copied Ms. Haley and Mr. Foote in order to be transparent. I am not an attorney (although I have enrolled in an online JD course), so I really don’t know.

(Id.; emphasis in original.)

(94) In an August 27, 2015 email to Ms. Mazzucco, Dr. Murphy responded to some questions about his 2013 license renewal application. (Ex. A36c.) In that email, Dr. Murphy wrote, in part:

Now in the summer of 2015, one of the board members (a chiropractor – a non MD with the usual low self esteem of going to a ‘medical’ school in a shopping center) is questioning some of the answers on my renewal application from way back then as part of a medical board vendetta.

* * * * *

It is tough to give the ‘right answers’ when you are working class and not some silver spoon “Doctor or Lawyer” who has never done real work and had some fancy graduation from a frat house. The Board does not understand working during the day, then doing the school thing only when time and money allowed.

* * * The medical board has no idea about how the building they are sitting in – was built, where the food that Terry Lewis stuffs his face with comes from, or how even the garbage is handled, [etc.].

(Id. at 1-2)

Ethical Standards of the Medical Profession

(95) Joseph Thaler, MD, is board certified in internal medicine. He practiced internal medicine for 29 years. He was a member of the Board from 1999 to 2006, and was the Board chair in 2005. He has been the Board’s Medical Director since 2012. (Ex. A52.)

(96) In his role as Medical Director, Dr. Thaler often reviews records from Board licensees to determine if the licensees are meeting standards of care and standards of ethics that apply to the medical profession. In making such determinations, Dr.
Thaler, and the Board, will look to the American Medical Association (AMA) Code of Medical Ethics for guidance. The Board also relies on other sources including professional literature. (Test. of Thaler, tr. at 515-516.)

(97) The AMA has published formal ethical opinions which pertain to the professional and ethical obligations of physicians. AMA Opinion 8.02 is titled “Ethical Guidelines for Physicians in Administrative or Other Non-clinical Roles.” (Ex. A33 at 1.) The opinion provides, in part:

Throughout their formal education and their practice of medicine, physicians profess and are therefore held to standards of medical ethics and professionalism such as those expressed in the AMA Code of Medical Ethics. Complying with these standards enables physicians to earn the trust of their patients and the general public. This trust is essential to successful healing relationships and, therefore, to the practice of medicine.

The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care. Rather, these obligations are binding on physicians in non-clinical roles to the extent that they rely on their medical training, experience, or perspective. When physicians make decisions in non-clinical roles, they should strive to protect the health of individuals and communities.

(Id.)

(98) AMA Opinion 9.07 is titled “Medical Testimony.” (Ex. A33 at 3.) The opinion provides, in part:

As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.

When a legal claim pertains to a patient the physician has treated, the physician must hold the patient’s medical interests paramount, including the confidentiality of the patient’s health information, unless the physician is authorized or legally compelled to disclose the information.

Physicians who serve as fact witnesses must deliver honest testimony. This requires that they engage in continuous self-examination to ensure that their testimony represents the facts of the case.

* * * * *

Organized medicine, including state and specialty societies and medical licensing boards can help maintain high standards for medical witnesses by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate.

(Id.)
AMA Opinion 5.05 is titled “Confidentiality.” (Ex. A39.) The opinion provides, in part:

The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are justified because of overriding considerations.

When a patient threatens physical harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim. * * *

When the disclosure of confidential information is required by law or court order, physicians generally should notify the patient. Physicians should disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law. * * *

AMA Opinion 5.04 is titled “Communications Media: Standards of Professional Responsibility.” (Ex. A38.) The opinion provides, in part:

Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients. When information concerning a specific patient is requested by the media, the physician must obtain the consent of the patient or an authorized representative before releasing such information. The physician may release only the authorized information or that which is public knowledge. The patient-physician relationship and its confidential nature must be maintained.

* * * * *

Certain news that is part of the public record, such as deaths, may be made available without the consent of the patient or authorized representative. * * *

AMA Opinion 10.0.15 is titled “The Patient-Physician Relationship.” (Ex. A45.) The opinion provides, in part:
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

A patient-physician relationship exists when a physician serves a patient’s medical needs, generally by mutual consent between physician and patient (or surrogate). In some instances the agreement is implied, such as in emergency care or when physicians provide services at the request of the treating physician. Nevertheless, the physician’s obligations to the patient remain intact. The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patient’s welfare.

(Id.) Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount. (Id.)

(102) Barry Egener, MD, is board certified in internal medicine and has been practicing medicine for over 34 years. At the time of the hearing in this case, Dr. Egener was the Medical Director for both the Foundation for Medical Excellence and its subdivision, the Northwest Center for Physician-Patient Communication. He was also a member of the faculty in internal medicine for Legacy Health Systems. (Test. of Egener, tr. at 422-23; Ex. A51 at 1.) In addition, he was a faculty member of the American Academy on Physician and Patient, and a clinical assistant professor in public health at the Oregon Health Sciences University (OHSU). (Ex. A51 at 2.) Dr. Egener has authored numerous journal articles on the topics of professionalism and physician-patient communication. (Test. of Egener, tr. at 423-24; Ex. A51 at 4.) Dr. Egener believes that the essence of professionalism is for the professional (including physicians) to execute a fiduciary responsibility to the more vulnerable party. In Dr. Egener’s view, in all professional relationships patients or clients rely on the unique expertise of the professional to make judgments about the patient or client’s best interest. It is this imbalance of expertise that gives rise to the fiduciary responsibility. Dr. Egener has identified three separate domains of physician professionalism: 1) the relationship between the physician and the patient; 2) the relationship between the physician and other members of a healthcare team; and 3) the relationship between the profession of medicine and society as a whole. (Test. of Egener, tr. at 425-26 and 430.)

(103) Medical Professionalism in the New Millennium: A Physician’s Charter (the Charter), published by the American Board of Internal Medicine in 2004, is a well-respected document that has been cited in at least 600 published articles. (Test. of Egener, tr. at 427; Ex. A49.) The preamble to the Charter states, in part:

Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician, setting and
maintaining standards of competence and integrity, and providing expert advice to 
society on matters of health. The principles and responsibilities of medical 
professionalism must be clearly understood by both the profession and society. 
Essential to this contract is public trust in physicians, which depends on the 
integrity of both individual physicians and the whole profession.

(Ex. A49 at 1; emphasis in original.) Among the principles enumerated in the Charter are a 
commitment to patient confidentiality, a commitment to maintaining trust by managing conflicts 
of interest, and a commitment to professional responsibilities. (Id. at 1-2.) As part of the 
commitment to professional responsibilities, the Charter states:

As members of a profession, physicians are expected to work collaboratively to 
maximize patient care, be respectful of one another, and participate in the process 
of self regulation, including remediation and discipline of members who have 
failed to meet professional standards. * * * These obligations include engaging in 
internal assessment and accepting external scrutiny of all aspects of their 
professional performance.

(Id. at 2.)

(104) In an article titled “Toward a Normative Definition of Medical 
Professionalism,” published in the journal Academic Medicine in June 2000, 
Herbert M. Zwick, MD, noted that medical professionalism is comprised of the 
following sets of behaviors:

• Physicians subordinate their own needs to the interests of others. * * * 
• Physicians adhere to high ethical and moral standards. * * * 
• Physicians respond to societal needs, and their behaviors reflect a social 
contract with communities served. * * * 
• Physicians evince core humanistic values, including honesty and integrity, 
caring for others, and trustworthiness. * * * 
• Physicians exercise accountability for themselves and for their colleagues. 
* * * 
• Physicians demonstrate a continuing commitment to excellence. 
• Physicians exhibit a commitment to scholarship and to advancing their 
field. * * * 
• Physicians deal with levels of complexity and uncertainty. * * * 
• Physicians reflect upon their actions and decisions.

(Id. at 3-4; italics in original.)

(105) Dr. Egener reviewed numerous emails from Dr. Murphy directed toward 
colleagues, members of the military, attorneys, the Board, and others. In Dr. 
Egener’s view, Dr. Murphy’s October 25, 2014 email to Chief Master Sergeant 
Eddings (Ex. A13) (in which he wrote that an investigator should be shot, implied 
that Dr. Kjos was using Patient A’s allegation to try to secure a promotion, 
referred to another person as a “piece of shit,” stated that he was taking guns and
going out to eastern Oregon, and that he was going to “take all these assholes down,”) was “denigrating, [showed a] lack of respect [and had] some element of arrogance.” (Test. of Egener, tr. at 434.) Dr. Egener believed that this email demonstrated unprofessional behavior. In particular, Dr. Egener believed that the comments in the email undermined collegiality that is necessary to the smooth functioning of a health care team. (Id.)

Dr. Egener also reviewed Dr. Murphy’s March 18, 2015 email (Ex. A24), sent to numerous recipients including members of the military, members and employees of the Board, and a reporter, in which Dr. Murphy referred to Patient A as “mentally deranged,” referred to a Board Investigator as “morbidly obese” with “an underlying pathology,” and referred to two colleagues as “female activists” who were “trying to bring attention to themselves.” (Test. of Egener, tr. at 435.) Dr. Egener viewed this email as unprofessional in the way that it referred to Patient A, by undermining the role of the Board and the credibility of the medical profession, and by undermining his relationship with his colleagues. Dr. Egener also believed that the email demonstrated arrogance which, he opined, detracted from Dr. Murphy’s ability to be professional. (Id. at 436-39.)

CONCLUSIONS OF LAW

The Board adopts ALJ Mann’s conclusions of law, his supporting opinion except as noted in the Board’s discussion of one of Dr. Murphy’s violations of ORS 677.190(1)(a), dishonorable and unprofessional conduct, and ALJ Mann’s recommendation that Dr. Murphy’s license be revoked, Dr. Murphy be assessed a civil penalty of $10,000, and Dr. Murphy be assessed the cost of these proceedings.

1. The evidence did not establish that Dr. Murphy performed an unauthorized Pap smear on a patient on November 19, 2011 in violation of ORS 677.190(1)(a), as defined by ORS 677.188(4)(a), and/or conduct that does or might constitute a danger to a patient and gross negligence, in violation of ORS 677.190(13).

2. Dr. Murphy provided false, misleading, and deceptive information in connection with his October 29, 2013 application to renew his medical license by stating that his highest level of education was an associate’s degree and that he could speak and understand Quechua sufficiently to communicate for clinical purposes in violation of ORS 677.190(8). Dr. Murphy did not violate OAR 847-008-0058 because the rule was not in effect at the time that he submitted his application. The record did not establish that Dr. Murphy’s false answers on his October 29, 2013 renewal application violated ORS 677.190(1)(a) and (17).

3. Dr. Murphy acted in a manner contrary to recognized standards of ethics of the medical profession, in violation of ORS 677.190(1)(a) as defined by
ORS 677.188(4)(a), by filing a false or misleading declaration in connection with a proceeding in Multnomah County Circuit Court.

4. Dr. Murphy disclosed private health information and confidential medical records of a patient in violation of ORS 677.190(1)(a) and (5), as defined by ORS 677.188(4)(a). The record did not establish that Dr. Murphy violated HIPAA privacy regulations (45 CFR 164.502).

5. Dr. Murphy did not violate ORS 677.080(3) and ORS 677.190(10) by calling a nurse supervisor at Tuality Healthcare in 2015 while representing himself by the name of “Dr. Hanson.”

6. Dr. Murphy violated ORS 677.190(17) and OAR 847-001-0024(1) by failing to comply with a Board investigator’s request for medical records in connection with an investigation into Dr. Murphy’s alleged prescribing of controlled substances to two patients.

7. Dr. Murphy violated ORS 677.190(1)(a) as defined by ORS 677.188(4)(a) by asking individuals not to cooperate with the Board’s investigation thereby impeding that investigation.

8. Dr. Murphy engaged in a pattern of belligerent and obstructive behavior during the course of the Board’s investigation and that pattern of behavior constitutes unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a) as defined by ORS 677.188(4)(a).

9. The Board may revoke Dr. Murphy’s Oregon medical license, assess a $10,000 civil penalty, and assess the costs of the proceedings.

OPINION

The Board alleges that Dr. Murphy committed several violations of the Medical Practices Act, for which the Board has proposed revocation of his medical license, a $10,000 civil penalty, and assessment of the costs of the disciplinary proceeding. The Board has the burden of establishing by a preponderance of the evidence that the violations alleged in the Second Amended Notice occurred and that the proposed sanctions are appropriate. ORS 183.450(2) (“The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position”); Harris v. SAIF, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); Metcalf v. AFSD, 65 Or App 761, 765 (1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 402 (1987).
Pursuant to ORS 677.265, the Board is vested with the authority to regulate the practice of medicine in Oregon. ORS 677.190 authorizes the Board to discipline an Oregon physician for any of several delineated reasons. The Board has proposed disciplining Dr. Murphy under the following provisions of ORS 677.190:

The Oregon Medical Board may refuse to grant, or may suspend or revoke a license to practice for any of the following reasons:

(1)(a) Unprofessional or dishonorable conduct.

(5) Willfully or negligently divulging a professional secret without the written consent of the patient.

(8) Fraud or misrepresentation in applying for or procuring a license to practice in this state, or in connection with applying for or procuring registration.

(10) Impersonating another licensee licensed under this chapter or permitting or allowing any person to use the license.

(17) Willfully violating any provision of this chapter or any rule adopted by the board, board order, or failing to comply with a board request pursuant to ORS 677.320.

In addition, ORS 677.188(4)(a) defines “unprofessional or dishonorable conduct” for purposes of ORS 677.190(1)(a). ORS 677.188(4)(a) provides:

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

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

The central issue in dispute in this case is whether Dr. Murphy performed a Pap smear on Patient A during a five-year preventative health assessment (PHA) in November 2011. While there is no dispute that Dr. Murphy conducted a PHA on Patient A, Dr. Murphy vehemently denies Patient A’s allegation that he performed a Pap smear.

Recently, the Oregon Court of Appeals has reiterated that “credibility depends not only on demeanor but also on such factors as inherent probability, or improbability of the testimony, the possible internal inconsistencies, the fact that it is or is not corroborated, that it is contradicted by other testimony or evidence and finally that human experience demonstrates it is logically incredible.” Osuna-Bonilla v. Teacher Standards and Practices Comm., 282 Or App 260, 268-269 (2016), citing with approval Preferred Funding, Inc. v. Jackson, 185 Or App 693, 699 (2003).

With regard to the allegations in this case, there is nothing inherently probable or improbable with either Patient A’s allegation, nor with Dr. Murphy’s denial. Nor is there anything about the allegation or the denial that is logically incredible. Furthermore, both Patient A and Dr. Murphy have been relatively consistent in their accounts of the events of November 19, 2011. The only contemporaneous evidence of the PHA is the medical record prepared by Dr. Murphy. That record contains no indication that a Pap smear was performed. The absence of such a record is consistent with Dr. Murphy’s denial. However, it is also consistent with the Board’s allegation that the procedure was unauthorized because it is unlikely that Dr. Murphy would have documented a procedure that he knew was improper.

The following evidence is consistent with Dr. Murphy’s denial:

- Dr. Murphy denies any memory of the PHA. He has not offered a competing version of events to try to rebut Patient A’s allegations. This would be expected if, as he asserts, nothing out of the ordinary occurred during the PHA.

- There is no evidence that Dr. Murphy has ever engaged in, or been accused of, similar conduct in the past.

- The incident was alleged to have occurred in an exam room that Dr. Murphy normally did not use, but that was often used by another physician who also performed PHAs that day.

- The National Guard interviewed 25 of the 30 women that Dr. Murphy had examined over a four year period. None of them reported that Dr. Murphy had performed a pelvic exam or a Pap smear on them.

The following evidence, however, is consistent with Patient A’s allegations:
Patient A told TSgt. Albright that Dr. Murphy performed a Pap smear. At the time she relayed this information, Patient A contends that she did not believe that the procedure was unauthorized. Patient A appeared to be shocked to learn that Pap smears were not performed at the ORANG base.

Patient A appeared visibly upset when she learned that there was no record of the procedure.

Patient A identified the exam room in which she asserts the procedure occurred. She and Albright discovered gynecological examination equipment in that room.

Patient A insisted that the equipment be seized by authorities for DNA testing; a request which she would be unlikely to make if she did not believe that the equipment had been used to examine her.

SSgt. Jaeger and Patient A recall a conversation, sometime prior to December 2013, in which Patient A disclosed that Dr. Murphy had performed a Pap smear on Patient A during a PHA.

However, there are some aspects of the above evidence that casts doubt on its reliability. First, it is unclear from the record whether Patient A immediately and correctly identified the room in which the procedure allegedly took place. Patient A did not search the exam rooms with TSgt. Albright until TSgt. Albright returned from training, several days after Patient A returned. While it is true that Patient A and TSgt. Albright found gynecological equipment in an examination room, it was not the room normally used by Dr. Murphy when he performed PHAs.

Second, at the hearing in this case Patient A testified that Dr. Murphy spent approximately five to ten minutes in an exam room for an initial examination. She testified that he told her that they would need to go to separate exam room only after determining that she needed a Pap smear. However, in a written report to Col. Kjos on December 8, 2013, Patient A did not mention having changed rooms. TSgt. Albright testified in the administrative discharge proceeding that Patient A told her that Dr. Murphy first took her into one room and then said “Oh no, let’s go in this one.” Ex. A27 at 244. At the Board’s hearing in this case, TSgt. Albright testified that Patient A identified the exam room where the alleged Pap smear took place, and remembered passing by a couple of different rooms before getting to the room where the exam allegedly took place. At no time did TSgt. Albright testify that Patient A mentioned having changed rooms. Indeed, despite TSgt. Albright’s role in assisting Patient A to locate the exam room, nothing in the record suggests that Patient A ever told TSgt. Albright that she had changed exam rooms.

In addition, if Dr. Murphy had intended to perform a Pap smear on Patient A that day, and knew that the tools were in another exam room, it is not clear why he would not have simply taken her to that room initially, or perhaps moved the tools into his own exam room. Col. Kjos, who normally used the exam room where the gynecological equipment was found was also conducting PHAs that day, and was scheduled to see a patient at 11:00 a.m., close in time to Dr. Murphy’s examination of Patient A. It is unlikely that Dr. Murphy, if he had intended to perform
an unauthorized Pap smear, would have moved to this exam room which he would have known
would significantly increase his chances of being caught.

While it is true that Patient A found gynecological equipment in an exam room, several
witnesses testified that they were not surprised that such equipment was there. The base was
previously used by the Air Force Reserves and many of the rooms contained equipment that may
have been used at that time. TSgt. Albright testified that the equipment looked as though it had
not been used in some time. There is also no direct evidence that Dr. Murphy knew that the
equipment was in that room. Nor is there any direct evidence that the equipment was in the
room in November 2011, two years before it was located by Patient A and TSgt. Albright.

Finally, Patient A gave contradictory accounts of when she told her friend, SSgt. Jaeger,
about the Pap smear. In a December 8, 2013 written report to Col. Kjos, Patient A wrote that she
told SSgt. Jaeger about the exam shortly afterwards. When SSgt. Jaeger told her that she did not
think that Pap smears were performed on base, Patient A wrote that she told her “yes they do,
Maj. Murphy just did one.” Emphasis added. Patient A later testified that she told SSgt. Jaeger
about the Pap smear a few months afterward, not immediately. SSgt. Jaeger gave yet another
account, placing the conversation four or five months prior to February 2014, near in time when
Patient A disclosed the information to TSgt. Albright. SSgt. Jaeger’s testimony regarding the
alleged conversation was more detailed, including a description of the location and circumstance
of the exchange. If SSgt. Jaeger’s time estimate is accurate, then the conversation would have
taken place in September or October of 2013, two to three months prior to Patient A’s
Patient A that she did not believe that Pap smears were performed on base. To the extent that
SSgt. Jaeger’s timing is accurate, it casts additional doubt on the reliability of Patient A’s
assertion that she was surprised when TSgt. Albright confirmed that Pap smears were not
performed on base.

In short, the record contains evidence that supports both Patient A’s allegation and Dr.
Murphy’s denial. However, given the unreliability of some of the evidence, and the long passage
of time between the alleged incident and the report, the record simply does not demonstrate by a
preponderance of the evidence that Dr. Murphy performed an unauthorized Pap smear as alleged
in the Board’s notice.

In finding that Patient A’s allegation was substantiated, the OCI placed great weight on
Patient A’s lack of any apparent motive to fabricate the incident. Oregon law recognizes
consideration of a witness’s motive in determining credibility. ORS 44.370 provides, in part:

A witness is presumed to speak the truth. This presumption, however, may be
overcome by the manner in which the witness testifies, by the character of the
testimony of the witness, or by evidence affecting the character or motives of the
witness, or by contradictory evidence[.]

Emphasis added. In this case, Dr. Murphy has a clear motive to deny that he performed an
unauthorized Pap smear; an allegation that has led to disciplinary actions in the military and now
threatens the loss of his medical license. In contrast, the record does not contain any evidence
that Patient A had any motive to fabricate her allegation. Nevertheless, the absence of evidence of such a motive is insufficient to overcome the unresolved conflicts in the evidence offered in support of the allegation.

The Board asserts that Patient A’s conduct after TSgt. Albright informed her that Pap smears were not performed on base lends additional weight to her allegations. It is true that several witnesses testified that Patient A had a strong emotional reaction to learning that the Pap smear was unauthorized. However, Dr. Murphy’s behavior after the allegation was made is also consistent with his denial. He has consistently, aggressively, and often inappropriately, denied Patient A’s allegation. He claims not to remember what happened on November 19, 2011 and thus offered no counter-explanation for what occurred that day. This is consistent with his assertion that nothing noteworthy occurred during the PHA. To the extent that the behavior of Patient A and Dr. Murphy bears on the reliability of Patient A’s accusation, the evidence of such behavior does not provide a basis for concluding that Dr. Murphy performed an unauthorized Pap smear.

Col. Wedan testified that, during a conversation in January 2014, Dr. Murphy told him something to the effect that he could not believe that the military would “hang a guy out to dry for conducting a procedure that he didn’t know he wasn’t supposed to do.” However, other than this single statement, Dr. Murphy has consistently denied performing a Pap smear. He has never asserted that he performed the procedure under the mistaken belief that it was authorized. Despite the implicit admission entailed in Dr. Murphy’s alleged statement, there is no indication in the record that Col. Wedan followed up on this question or asked for any clarification. Col. Wedan did not appear to recall the exact words that Dr. Murphy used, or the context in which the statement was made. Without that context, and given the absence of any similar statements, it is not appropriate to rely on that single statement to infer that Dr. Murphy was admitting to having performed the Pap smear.

Given the nature of this allegation, and the long passage of time between the November 2011 PHA and the December 2013 report, it is impossible to establish what occurred with any reasonable degree of reliability. The evaluation of evidence in this record should not be interpreted as a definitive finding of what occurred. Nor should it be interpreted as casting aspersions on Patient A’s credibility. There are only two witnesses to what occurred during the PHA in November 2011, and their testimony is in direct conflict. Dr. Murphy has consistently denied having performed a Pap smear on Patient A. The Board has simply not provided sufficient evidence to overcome that denial.

2. Providing false, misleading, and deceptive information to the Board

The evidence is undisputed that Dr. Murphy submitted a renewal application to the Board that listed his highest level of education was an associate’s degree. It is also undisputed that in that same application Dr. Murphy indicated that he could communicate in the Quechua language adequately for clinical purposes. Both statements were false.

In an August 27, 2015 email to the Board, Dr. Murphy, who holds an MD, did not contend that he listed associate degree as an error or an oversight. Rather, he contended that he was referring to an associate degree in nursing that he earned prior to becoming a physician. It is unclear in the record precisely why Dr. Murphy chose to deliberately omit his highest
educational degree, and the one most clearly relevant to his renewal application. Dr. Murphy, as a licensed physician, was likely aware that the Board already knew of his educational background from his previous applications.

The evidence also established that, at the time he answered the question, Dr. Murphy was not fluent in Quechua. Nor could he communicate in that language adequately for clinical purposes. His sole education in the language, according to Dr. Murphy, came from listening to a computer language program during a flight to Ecuador and from interacting with local residents of Ecuador. He admitted that he was not fluent in the language; however, he testified that his Quechua language skills, when he was in Ecuador, were sufficient to allow him to say things like “open your mouth” and “take a deep breath.” Dr. Murphy believed that this was sufficient for his purposes as an anesthesiologist.

Despite his belief, however, Dr. Murphy’s response was, at the very least, misleading. The renewal application asked for languages in which he could communicate for clinical purposes. It also indicated that the Board might provide information about language available to those seeking providers with specific language competencies. Dr. Murphy’s rudimentary Quechua language skills, picked up from listening to a computer language program on a single flight and augmented by sporadic communication with local residents, could not reasonably be considered sufficient for clinical purposes. Nor would it be reasonable for the Board to represent to others that Dr. Murphy was a provider with a “specific language competenc[y]” in Quechua.

The Board alleged that Dr. Murphy’s false answers violated ORS 677.190(8) which allows the Board to discipline a licensee based upon:

Fraud or misrepresentation in applying for or procuring a license to practice in this state, or in connection with applying for or procuring registration.

The evidence established that Dr. Murphy’s answers with regard to his education and his language proficiency were false, misleading, and deceptive. The Board has therefore demonstrated that Dr. Murphy violated ORS 677.190(8).

In addition, however, the Board alleged that Dr. Murphy’s conduct violated OAR 847-008-0058(1) which provides:

Omissions or false, misleading or deceptive statements or information on any Board application, affidavit or registration is a violation of ORS 677.190(8) and is grounds for a $195 fine for the first violation, a $250 fine for the second violation, and a $500 fine for the third or subsequent violation. The applicant or licensee may be subject to further disciplinary action by the Board.

However, the Board may not rely upon OAR 847-008-0058 in imposing discipline in this case because the rule was first adopted effective October 8, 2014, nearly one year after Dr. Murphy submitted the application.

The Board also asserted that Dr. Murphy’s conduct violated ORS 677.190(1)(a) and (17). ORS 677.190(1)(a) prohibits “Unprofessional or dishonorable conduct.” ORS 677.190(17) prohibits “Willfully violating any provision of this chapter or any rule adopted by the board, board order, or failing to comply with a board request pursuant to ORS 677.320.” While the
Board demonstrated that information Dr. Murphy provided on the renewal application was false and misleading, the Board did not specifically articulate how those answers constituted unprofessional or dishonorable conduct. Nor did the Board provide evidence that Dr. Murphy’s misrepresentations were willful violations.

Nevertheless, the record demonstrated that Dr. Murphy violated ORS 677.190(8) by providing false information on his October 29, 2013 renewal application. The Board may therefore impose discipline on that basis.

3. Filing a False or Misleading Declaration in Multnomah County Circuit Court.

In June of 2014, Dr. Murphy filed a lawsuit against Patient A alleging defamation. Patient A’s attorney subsequently filed a motion seeking to have the lawsuit dismissed. On October 3, 2014, in a response to the motion, Dr. Murphy filed a declaration in which he asserted, among other things:

Plaintiff [Dr. Murphy] can show that an extensive, ten month long investigation conducted by the Washington DC based ORANG Office of Complex

Investigators found no evidence to support Defendant’s [Patient A’s] claims and stated that Defendant’s claims were completely unsubstantiated.

(Ex. A18 at 4.)

That statement was false. In fact, the OCI concluded that the allegation was “substantiated based upon a preponderance of the evidence.” (Ex. A9 at 3) Dr. Murphy does not dispute the language of the report, but he contends that he used the word “unsubstantiated” in a different sense than was used in the report. Dr. Murphy asserts that what he was trying to convey to the court was that the investigation found no evidence to “substantiate” the request. In this regard, he appears to assert that he meant to use the word “substantiate” as synonymous with “corroborate.” Given what he was trying to convey, Dr. Murphy asserts that his statement was not false nor was it an attempt to mislead the court.

The difficulty with that position is that Dr. Murphy consciously chose to use the word “unsubstantiated,” a word that directly contradicted the actual word used in the report in bold type. Dr. Murphy contends that he did not actually read the report prior to this filing, but instead relied on his attorney’s characterization of the report. However, in a September 2014 email to Dr. Murphy disclosing the results of the report, Dr. Murphy’s attorney wrote that OCI found the allegation to be “substantiated.” Dr. Murphy was aware of that conclusion, and actually reported to the Board’s investigator on September 8, 2014 that OCI had concluded that the allegation was substantiated. Given the use of the term “substantiated” in the OCI report, by Dr. Murphy’s attorney, and by Dr. Murphy himself, it is simply implausible that Dr. Murphy believed that the term “unsubstantiated” had a different meaning or that it was at all consistent with the actual findings of the report.

It is true that Dr. Murphy later informed the court that his earlier statement was false, writing that he had “unintentionally stated that the OCI did not ‘substantiate’ the defendant’s
allegation of sexual assault when in fact the report did come to that conclusion.” Ex. A21 at 3.

However, he did not make that correction until after he was informed that the National Guard
had instituted discharge proceedings against him based, in part, on his false statement to the
court.

Even if he did mean to use the term “substantiated” in a more limited sense, however, the
unambiguous impression left by his court filing is that OCI found the allegation to be baseless
and that he had been cleared by investigators after “an extensive, ten month long, investigation.”
(Ex. A18 at 4.) Indeed, Dr. Murphy went further than to state that the allegations were, in fact,
unsubstantiated in a narrow sense. He actually wrote that OCI “stated” that the allegations were
unsubstantiated. However, the report stated precisely the opposite. Dr. Murphy’s statement to
the court was false and misleading.

The Board asserts that Dr. Murphy’s misrepresentation to the court constituted
unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a). ORS 677.180(4)(a)
defines “unprofessional or dishonorable conduct,” in part as “[a]ny conduct or practice contrary
to recognized standards of ethics of the medical * * * profession.” In its Second Amended
Notice, the Board asserted that Dr. Murphy’s conduct violated (among other standards) AMA
ethics opinion 9.07 which provides, in pertinent part:

In various legal and administrative proceedings, medical evidence is critical. As
citizens and as professionals with specialized knowledge and experience,
physicians have an obligation to assist in the administration of justice.

* * * * *

Physicians who serve as fact witnesses must deliver honest testimony. This
requires that they engage in continuous self-examination to ensure that their
testimony represents the facts of the case. * * *

* * * * *

Organized Medicine, including state and specialty societies, and medical licensing
boards can help maintain high standards for medical witnesses by assessing the
claims of false or misleading testimony and issuing disciplinary sanctions as
appropriate.

Exhibit A33 at 3.

Dr. Murphy submitted a document to the court that included a false and misleading
statement concerning the OCI report. Dr. Murphy signed that document under penalty of perjury
and acknowledged to the court that the statement was intended for use as evidence. His conduct
was contrary to the standards of the medical profession as demonstrated by AMA ethics opinion
9.07. The Board has therefore established that his conduct constituted unprofessional and
dishonorable conduct in violation of ORS 677.190(1)(a).
4. Disclosing Private Health Information and Confidential Medical Records

The Board alleged that Dr. Murphy disclosed private health information and confidential medical records pertaining to Patient A, to the media and to other individuals, without Patient A’s consent. Dr. Murphy does not deny that he disclosed Patient A’s medical information, including disclosing it to an Oregonian reporter. Rather, he contends that the information was not confidential because it became a matter of public record after the OCI report (which included Patient A’s medical records) was filed with the Multnomah County Circuit Court.

However, Dr. Murphy had no reasonable basis to believe that the full report, including Patient A’s medical information, was a matter of public record. Patient A’s military attorney, Major Adams, provided an 18 page summary of the OCI report to the court in order to counter Dr. Murphy’s false assertion that OCI had concluded Patient A’s allegation was unsubstantiated. That summary did not include Patient A’s medical records. In response, Dr. Murphy filed the entire report—which included summaries of witness interviews, Patient A’s National Guard medical records, and significantly more information about Patient A’s allegations. Both reports were reviewed by the court in camera and were never made available to the public. Had Dr. Murphy inquired with the court he would have learned that neither the OCI report summary, nor the full report, were matters of public record.

Dr. Murphy’s disclosures went well beyond releasing a report to the court. He disclosed information about Patient A’s medical records and purported use of medication to multiple parties (including an Oregonian reporter) in the form of a “settlement offer.” In that document, Dr. Murphy alleges that Patient A concealed mental-health issues from the military, lists multiple prescription medications taken by Patient A, discloses Patient A’s self-reported history of Pap smears, and discloses Patient A’s prior pregnancy. Not only did he send the settlement offer to multiple different people, but he also urged them to forward it to “any interested party.” Ex. A44 at 27.

The Board alleged that Dr. Murphy’s conduct constituted a willful or negligent divulgence of a professional secret without the written consent of the patient, in violation of ORS 677.190(5); an unpermitted use and disclosure of protected health information in violation of HIPPA (Health Insurance Portability and Accountability Act) privacy regulations, 45 CFR § 164.502; and revealing a patient’s confidential communications or information without the consent of the patient, in violation of the American Medical Association (AMA) Ethical Opinion 10.01. The Board also determined the conduct was contrary to recognized standards of ethics and conduct that does or might constitute a danger to the patient in violation of ORS 677.190(1)(a), as defined by ORS 677.188(4)(a).

A physician’s obligation to maintain the confidentiality of a patient’s medical information is well established in law. ORS 677.190(5) prohibits a licensee from “Willfully or negligently divulging a professional secret without the written consent of the patient.” In Humphers v. First Interstate Bank, 298 Or 706, 720-721, (1985) the Oregon Supreme Court noted “A physician’s duty to keep medical and related information about a patient in confidence is beyond question. It is imposed by statute. ORS 677.190(5) provides for disqualifying or
otherwise disciplining a physician for ‘willfully or negligently divulging a professional secret.’ *
** The actionable wrong is the breach of duty in a confidential relationship[.]”

That obligation not to disclose a patient’s confidential information is also a recognized
ethical principal as noted in AMA Opinion 5.05. The opinion states, in part, that a physician
“should not reveal confidential information without the express consent of the patient, subject to
certain exceptions which are justified because of overriding considerations.” Ex. A39. Such
overriding considerations include the need to protect others when a patient threatens to harm
someone, or when disclosure is required by law or by a court order. Even in those situations,
AMA Opinion 5.05 states that physicians should “disclose the minimal information required by
law, advocate for the protection of confidential information and, if appropriate, seek a change in
the law.” *(Id.)*

The obligation to protect confidential information is also included in AMA Opinion 5.04
is titled “Communications Media: Standards of Professional Responsibility.” (Ex. A38. That
opinion specifically addresses disclosure of patient information to the media, noting:

Physicians are ethically and legally required to protect the personal privacy and
other legal rights of patients. When information concerning a specific patient is
requested by the media, the physician must obtain the consent of the patient or an
authorized representative before releasing such information. The physician may
release only the authorized information or that which is public knowledge. The
patient-physician relationship and its confidential nature must be maintained.

*(Id.)*

Dr. Murphy argues that he did not violate his ethical duties in releasing Patient A’s
confidential information. First, he asserts that he had never established a physician-patient
relationship because, he claims, “[b]y definition a physician patient relationship is not
established by a physician performing screening examination.” Murphy Closing Argument at 5.
However, Dr. Murphy cites no authority for that proposition. The evidence established that the
military required Patient A, and other members of the National Guard, to undergo regular
preventative health examinations. The record also established that the military provided medical
doctors (including Dr. Murphy) to conduct such examinations. In that context, Dr. Murphy was
performing a military *medical* examination that Patient A was required to undergo. In that
context, Patient A was clearly relying on Dr. Murphy’s medical expertise and his status as a
physician.

AMA Opinion 10.0.15 provides that “A patient-physician relationship exists when a
physician serves a patient’s *medical needs*, generally by mutual consent between physician and
patient (or surrogate).” Emphasis added. Although Patient A may not have been seeking
medical *treatment*, her need to undergo a health examination by a physician was sufficient to
constitute a “medical need” as used in AMA Opinion 10.0.15. The record therefore established
that Dr. Murphy had a physician-patient relationship with Patient A.

Dr. Murphy next argued that he did not disclose confidential health information until it
became part of the public record, and only with the approval of Patient A’s attorney. This
contention is not supported by the record. While it is true that Patient A’s attorney provided the Multnomah County Circuit Court a summary of the OCI report, that summary did not include Patient A’s confidential information. Second, although it is true that Patient A’s attorney did not object to Dr. Murphy providing the full report to the court, he did not consent to the confidential health information being disseminated further. Third, the information provided to the court, contrary to Dr. Murphy’s belief, was not part of the public record. The OCI reports were reviewed by the judge in camera and were never made available to the general public. Dr. Murphy appears to have assumed that the information was publicly available, but took no steps to confirm that assumption. Dr. Murphy was apparently sufficiently concerned about what he thought was the public disclosure of the OCI summary report that he considered requesting that the record be sealed. Notably, however, this was not out of any concern for Patient A’s confidentiality, but out of a concern for his own professional reputation.

In addition, Dr. Murphy argued that he had “the right to defend himself** against legal attacks” and that he had “no alternative” other than to disclose the entire report, both to the court and to the public, to “point out all the latent inconsistencies to a public that was now aware of the OCI’s conclusions.” Murphy Closing Argument at 5. However, it is important to note that Dr. Murphy was the plaintiff in the lawsuit and was therefore not “defending himself” against a legal attack. Secondly, Patient A’s attorney filed the summary report to demonstrate that Dr. Murphy had falsely asserted that OCI had “stated” that Patient A’s allegations were “unsubstantiated.” That use of the summary report did not constitute a “legal attack.”

But more significantly, Dr. Murphy’s belief that he needed to disclose the full report in order to point out inconsistencies to the public is clearly based on his assumption that the OCI summary report was part of the public record. As noted above, that assumption was false. Given the well-established ethical obligation not to disclose patient information, Dr. Murphy should have sought clarification from the court before proceeding on the false assumption that the OCI reports were publicly available. Had he done so, he would have discovered that his assumption was incorrect.

The Board also asserted that Dr. Murphy’s disclosure violated HIPPA privacy regulations. However, the record does not establish that Dr. Murphy’s conduct in this case fell under those regulations. It is true that HIPAA generally prohibits the disclosure of patient information by “covered entities” except under specifically enumerated circumstances. 45 CFR §164.502(a)(1). An individual physician can be a “covered entity,” but only when the physician “transmits any health information in electronic form in connection with a transaction covered [by HIPAA regulations.]” Such transactions generally include “the transmission of information between two parties to carry out financial or administrative activities related to health care.” 45 CFR §160.103. While Dr. Murphy did disclose Patient A’s confidential information through electronic means (email), the record does not include evidence that he transmitted such electronic information “to carry out financial or administrative activities related to health care.” The evidence is therefore insufficient to establish that Dr. Murphy’s disclosures violated HIPAA.

11 It is also important to note that Dr. Murphy first contacted a reporter to discuss Patient A’s allegations in June or July 2014, several months before Mr. Adams provided the OCI summary report to the court. While the record does not indicate precisely what information Dr. Murphy disclosed to the reporter, it is clear that he was attempting to bring the matter to the public’s attention well before the OCI report was provided to the court.
Nevertheless, Dr. Murphy’s disclosures violated ORS 677.190(5). In addition, such disclosures were contrary to well-established ethical standards of the medical profession and thus constituted unprofessional and dishonorable conduct in violation of ORS 677.190(1)(a).

5. Using a False Name when Contacting Tuality Hospital

ORS 677.080(3) provides that no person shall “Impersonate anyone to whom a license has been granted by the Oregon Medical Board.” Similarly, ORS 677.190(10) prohibits a licensee from “Impersonating another licensee licensed under this chapter or permitting or allowing any person to use the license.”

The evidence established that Dr. Murphy called Tuality Hospital in February of 2015 and asked to speak with Kathryn Gilbert, a registered nurse with whom he used to work and who he knew socially.

However, while Dr. Murphy did not use his own name, the evidence did not establish that he impersonated any specific licensee. In this case, neither Mr. Sparks nor the operator who took the call recognized the name used by the caller. Indeed, Mr. Sparks could not even recall what name was used, other than to say that it sounded like “Hansen,” or “Hansom” or something similar. Ms. Gilbert likewise did not recognize the name, but thought it could be a physician she knew named Hamdon. ORS 677.080(3), by its terms, prohibits impersonating “anyone” licensed by the Board. Similarly, ORS 677.190(10) prohibits impersonation of “another licensee.” Neither statute expressly prohibits using a fictitious name.

The Board provided evidence that there are a number of physicians licensed by the Board with the last name of Hanson. However, there is no evidence that Dr. Murphy intentionally tried to persuade anyone that he was one of those specific individuals. At most, the record established that Dr. Murphy used a false name – not referring to any specific licensed person – in order to speak with Ms. Gilbert. While such actions are undoubtedly deceptive, they do not violate ORS 677.080(3) or ORS 677.190(10).

6. Failure to Provide Records Requested by the Board

By letter dated May 12, 2015, Board investigator Terry Lewis requested that Dr. Murphy provide a complete copy of the medical records for his treatment and care of two patients, including all records of prescriptions he wrote for the patients in 2013-2014. The letter asked for a response by May 22, 2015. Dr. Murphy never provided the records.

Dr. Murphy testified that he brought the requested records with him to a meeting of the Board’s Investigative Committee on June 4, 2015. However, he did not provide them either to the Committee or to Mr. Lewis. After the meeting, Dr. Murphy met with Mr. Lewis and provided him an affidavit from his military attorney. However, Mr. Lewis did not specifically ask for the previously requested medical records and Dr. Murphy did not provide them.

ORS 670.190(17) prohibits “failing to comply with a board request pursuant to ORS 677.320.” ORS 677.320(2)(c) allows Board investigators to “compel the production of books,
papers, accounts, documents and testimony pertaining to the matters under investigation.” OAR 847-002-0024(1) provides:

Licensees and applicants must comply with a Board investigation, including responding to inquiries and providing requested materials within the time allowed and complying with a subpoena. Failure to comply with a Board investigation violates ORS 677.190(17) and is grounds for disciplinary action.

Mr. Lewis, as a Board investigator, had the authority to compel Dr. Murphy to provide the requested medical records. Dr. Murphy failed to provide them. Therefore, the record establishes that Dr. Murphy violated ORS 670.190(17).

7. Asking Others to Not Cooperate with the Board’s Investigation

The Board alleged that Dr. Murphy attempted to impede its investigation by asking individuals not to cooperate with the Board. The Board asserts that this violated ORS 677.190(1)(a) as defined by ORS 677.188(4)(a). The evidence supports that allegation.

On April 11, 2015, Dr. Murphy sent an email to three members of ORANG leadership and wrote:

I formally request that if any of my patients (any patients) are contacted by the investigators from the Oregon Medical Board that they do NOT cooperate. [T]he OMB has no investigative authority outside of license holders. If there is a question regarding patient care, the investigator can contact me. This is a significant infringement on patient confidentiality. This of course applies to any and all medical records as well.

Ex. A25; emphasis in original.

As an initial matter, Dr. Murphy’s statement that the Board has “no investigative authority outside of license holders” is incorrect. ORS 677.320(1) allows the Board to investigate “any alleged violation of this chapter.” ORS 677.080 prohibits “any person” from

ORS 677.080 prohibits provides:

No person shall:

(1) Knowingly make any false statement or representation on a matter, or willfully conceal any fact material to the right of the person to practice medicine or to obtain a license under this chapter.

(2) Sell or fraudulently obtain or furnish any medical and surgical diploma, license, record or registration, or aid or abet in the same.

(3) Impersonate anyone to whom a license has been granted by the Oregon Medical Board.

FINAL ORDER UPON RECONSIDERATION — James Michael Murphy, MD
Page 48 of 56
engaging in certain proscribed acts, including the unlicensed practice of medicine. It therefore
follows, as general principal, that the Board does have authority under ORS 677.320(1) to
investigate non-license holders.

Furthermore, the Board has specific statutory authority to contact witnesses. ORS
677.320(2) provides:

In the conduct of investigations, the board or its designated representative may:

(a) Take evidence;
(b) Take the depositions of witnesses, including the person charged;
(c) Compel the appearance of witnesses, including the person charged;
(d) Require answers to interrogatories; and
(e) Compel the production of books, papers, accounts, documents and
testimony pertaining to the matter under investigation.

Dr. Murphy’s email, “formally” asking that witnesses not cooperate with the Board was a
clear attempt to impede the Board’s investigation. The Board asserts that this constituted
unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a) as defined by ORS
677.188(4)(a).

As noted by Dr. Egener, and supported by Medical Professionalism in the New
Millennium: A Physician’s Charter, and the article by Dr. Zwick, “Toward a Normative
Definition of Medical Professionalism,” the ethical obligations of physicians include a standard
of professional conduct owed not just to patients, but to society as a whole. Logically entailed in
that obligation, is a duty to cooperate with the Board in its statutory obligation to regulate the
practice of medicine, including the Board’s duty to investigate allegations of unprofessional
conduct. See ORS 677.015 and 677.320. That important public duty is seriously undermined
when a physician attempts to prevent or discourage others from cooperating with a Board
investigation into the physician’s conduct. By formally asking patients not to cooperate, Dr.
Murphy attempted to undermine the Board’s investigation and thus engaged in unprofessional
and dishonorable conduct in violation of ORS 677.190(1)(a).

8. Pattern of Belligerent and Obstructive Behavior

The Board alleged that Dr. Murphy engaged in a pattern of belligerent and obstructive
behavior during the course of the Board’s investigation and that such behavior constituted
unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a) as defined by ORS
677.188(4)(a). The evidence supports that allegation.

Dr. Murphy self-reported Patient A’s allegations to the Board. His initial contacts with
the Board were professional and appropriate. However, over the course of the investigation his
communications became increasingly hostile, belligerent, and offensive. He refused to cooperate
with the Board’s investigation and “formally” encouraged witnesses to do the same

(4) Except as provided in ORS 677.060, practice medicine in this state without a license required
by this chapter.
He stated that Patient A was going to jail, and ended the email with “the great and powerful Oz has spoken.” *Id.*

His emails to members of the military, including former colleagues and those involved in investigating Patient A’s allegations, were hostile, belligerent, and unprofessional, including his suggestion that a military investigator “be shot.” He accused female officers of acting as politically popular “female activists.” He implied that Colonel Kjos was using the allegation as a way to advance her career. His communication with Mr. Shapiro was often hostile and unprofessional. Over the course of the litigation (which he initiated) and the various investigations, he either filed or threatened to file numerous complaints with the state bar, with the inspector General’s office, and with Congress.

The Board asserts that this constituted unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a) as defined by ORS 677.188(4)(a). In support of that assertion, the Board provided testimony from Barry Egener, MD, a board certified internist and the medical director for both the Foundation for Medical Excellence and its subdivision, the Northwest Center for Physician-Patient Communication, and the author of numerous journal articles on the topics of medical professionalism and physician-patient communication. Dr. Egener identified three broad domains of medical professionalism, focused on a physician’s relationship with patients, with colleagues, and with society. In Dr. Egener’s view, Dr. Murphy’s hostile, demeaning, and belittling behavior fell far short of his obligations as a professional.

In addition, both the Board and Dr. Egener placed great emphasis on concepts of professionalism outlined in *Medical Professionalism in the New Millennium: A Physician’s Charter* (the Charter), published by the American Board of Internal Medicine in 2004. Like Dr. Egener, the Charter emphasizes the societal obligations of a physician as a professional, including the obligation to maintain standards of competence and integrity, and to promote public trust in physicians. Notably, the Charter emphasizes the physician’s duty to:

> [W]ork collaboratively to maximize patient care, be respectful of one another, and participate in the process of self regulation, including remediation and discipline of members who have failed to meet professional standards. * * * These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

Ex. A49 at 2.

The Board also relied on the professional obligations set forth in the article “Toward a Normative Definition of Medical Professionalism,” published in the journal *Academic Medicine* in June 2000, by Herbert M. Zwick, MD. The obligations identified in the article include a responsibility to adhere to high ethical and moral standards, to act with honesty and integrity, to exercise accountability for themselves, and to reflect upon their actions and decisions.
In addition, the Board relied on AMA Opinion 8.02 which emphasizes the professional obligations of physicians outside of the clinical setting. The opinion notes that physicians must be held to standards of professionalism in order to earn the trust of both patients and the general public.

Dr. Murphy’s conduct fell well short of his obligations as a professional. He openly mocked and belittled his colleagues, Patient A, and numerous attorneys.\(^1\) He referred to Patient A, in an email to multiple recipients (including a reporter), as “mentally deranged.”\(^1\) He threatened numerous people with complaints to various regulatory bodies. In short, his conduct was hostile, belligerent and not consistent with his obligations as a physician and a professional. Indeed, his conduct violated his professional obligations in the three domains identified by Dr. Egener: he belittled a patient, he mocked his colleagues, and he made public comments (including to a reporter) that detracted from public trust in the medical community. The evidence therefore established that Dr. Murphy engaged in a pattern of belligerent and obstructive behavior during the course of the Board’s investigation and that his behavior constituted unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a) as defined by ORS 677.188(4)(a).

9. Sanction

ORS 677.205 authorizes the Board to sanction a licensee for violations of the Medical Practices Act as follows:

(1) The Oregon Medical Board may discipline as provided in this section any person licensed, registered or certified under this chapter who has:

* * * * *

(b) Been found to be in violation of one or more of the grounds for disciplinary action of a licensee as set forth in this chapter;

* * * * *

(2) In disciplining a licensee as authorized by subsection (1) of this section, the board may use any or all of the following methods:

(a) Suspend judgment.

(b) Place the licensee on probation.

(c) Suspend the license.

\(^1\) The Board has removed discussion of Dr. Murphy’s rude and insulting comments made to and about Board personnel, as well as his non-violent threats against the Board and personnel. Although Dr. Murphy failed to demonstrate civility or respect in his dealings with and comments about Board personnel, Dr. Murphy was exercising his 1st Amendment right to speak out against the government. While the Board finds Dr. Murphy’s manner of exercising that right regrettable, it is not a basis for professional license discipline.
(d) Revoke the license.

(e) Place limitations on the license.

(f) Take such other disciplinary action as the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty or assessment of a civil penalty not to exceed $10,000, or both.

The Board has proposed revocation of Dr. Murphy’s medical license, assessment of a $10,000 civil penalty, and assessment of the costs of the proceedings.

Recommending revocation of a physician’s medical license is a serious matter. Here, the determination of whether revocation is appropriate comes down to whether the Board can meet its statutory obligations to the public while still allowing Dr. Murphy to remain licensed.

The Board proposed revocation of Dr. Murphy’s license on multiple grounds; revocation of Dr. Murphy’s license would be appropriate for any one of a number of those grounds, including inappropriately disclosing confidential patient information, failing to provide documents properly requested by the Board, asking witnesses not to cooperate with the Board’s investigation, and engaging in a course of belligerent, unprofessional, and dishonorable conduct. That he committed so many of them, certainly warrants revocation of Dr. Murphy’s license.

By his behavior, Dr. Murphy has not demonstrated the sound judgment and professional responsibility required of physicians. Notably, he treated his ethical obligation to safeguard a patient’s confidential information in a cavalier and unprofessional manner. In the name of protecting himself in the eyes of the public, Dr. Murphy used Patient A’s medical records to smear her and to portray her as “mentally deranged.” He filed a defamation action against the patient before the military had even concluded its investigation. After the military issued the results of the investigation, Dr. Murphy intentionally misled the court as to the results of that investigation in an ultimately unsuccessful attempt to keep the case from being dismissed.

His communication with and about his colleagues has been unnecessarily vituperative and unprofessional. If he were ever to practice medicine in the future, it would likely be difficult for him to reestablish professional relationships with colleagues based on mutual respect and trust.

He urged others not to cooperate with the Board and he failed to provide documents that the Board requested during the course of its investigation. While going through an investigation is undoubtedly a stressful ordeal for a physician, the Board must be able to rely on the cooperation and professionalism of licensees in order for the Board to perform its statutory obligation to regulate the medical profession.

14 The Board removed the ALJ’s editorial comment regarding which of the alleged violations he believed to be most notable. Any of the serious grounds for discipline found in this case would make revocation appropriate.
The Board has established sufficient grounds for revocation of Dr. Murphy's license, and that the sanction is appropriate under the circumstances. Moreover, it is within the scope of the Board's authority to assess a $10,000 civil penalty and the costs of the proceeding against Dr. Murphy. In light of the number of serious violations, and Dr. Murphy's repeated instances of unprofessional and belligerent actions, those penalties are also appropriate. The costs for this proceeding are as follows:

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<th>Description</th>
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<tr>
<td>Total Dept. of Justice costs</td>
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<td>AAG - 252.7 hours @ $175/hr:</td>
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<td>AAG - 31.2 hours @ $182/hr:</td>
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<tr>
<td>Paralegal - 81.7 hours @ $90/hr:</td>
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<td>Paralegal - 1.3 hours @ $91/hr:</td>
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<td>Admin staff - 16.4 hours @ $55/hr:</td>
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<td>Other DOJ Charges</td>
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<td>(motor pool/witness fee/postage):</td>
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<td>Office of Administrative Hearings costs</td>
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<td>Court Reporter Appearance - Naegeli Corp.</td>
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<tr>
<td>TOTAL COSTS:</td>
<td>$112,140.62</td>
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ORDER

After considering all of the above, the Oregon Medical Board adopts the findings of fact and conclusions of law in the Proposed Order by ALJ Mann, as reflected in this document, and issues the following order:

1. The Oregon medical license of Licensee James Michael Murphy, MD is revoked.
2. Licensee is assessed a civil penalty of $10,000, which is due and payable as outlined in ORS 183.745(2).
3. Licensee is assessed the cost of these proceedings, in the amount of $112,140.62. Costs are due within 60 days of the issuance of this Final Order upon Reconsideration by the Board.

DATED this 28th day of June, 2018.

OREGON MEDICAL BOARD
State of Oregon

[Signature]
K. DEAN GUBLER, DO
Board Chair

APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.480 et seq.
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

HIREN THAKORBHAI RANA, MD
LICENSE NO. MD14344

STIPULATED ORDER

1.

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

2.

On May 14, 2018, the Board opened an investigation after receiving credible information regarding Licensee's ability to safely practice medicine.

3.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a), unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a). Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the DataBank and the Federation of State Medical Boards.
4. Licensee and the Board agree that the Board will close this investigation and resolve this matter by entry of this Stipulated Order, subject to the following conditions:

4.1 Licensee withdraws from the practice of medicine and his license is placed at Inactive status. This term is effective the date Licensee signs this Order.

4.2 Licensee retires his Oregon medical license while under investigation. This term is effective the date this Order is signed by the Board Chair.

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

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

5. This Order becomes effective the date it is signed by the Board Chair, with the exception of term 4.1 which is effective the date the Licensee signs this Order.

IT IS SO STIPULATED this 13th day of June, 2018.

[Signature]
HIREN THAKORBHAI RANA, MD

IT IS SO ORDERED this 13th day of October, 2018.

[Signature]
OREGON MEDICAL BOARD

K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of
BRENDA DIANE ROBERTS, MD
LICENSE NO. MD21507

STIPULATED ORDER

1.

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

2.

On April 13, 2017, the Board opened an investigation after receiving credible information regarding Licensee’s possible violation of the Medical Practice Act. On July 10, 2017, Licensee entered into an Interim Stipulated Order with the Board in which she agreed to practice only in clinical settings pre-approved by the Board. On September 5, 2017, Licensee entered into a second Interim Stipulated Order in which she agreed to withdraw from practice pending the completion of the Board’s investigation.

3.

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

Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s records. Licensee neither admits nor denies, but the Board finds that Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a), unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross negligence or repeated negligence in the practice of medicine; and ORS 677.190(23) violation of the federal
Controlled Substances Act. Licensee understands that this Order is a public record and is a
disciplinary action that is reportable to the DataBank and the Federation of State Medical
Boards.

4.

Licensee and the Board agree that the Board will close this investigation and resolve this
matter by entry of this Stipulated Order, subject to the following conditions:
4.1 Licensee surrenders her Oregon medical license while under investigation.
4.2 The Interim Stipulated Orders of July 10, 2017, and September 5, 2017, terminate
effective the date this Stipulated Order is signed by the Board Chair.
4.3 Licensee must obey all Federal and Oregon State laws and regulations pertaining
to the practice of medicine.
4.4 Licensee stipulates and agrees that any violation of the terms of this Order shall
be grounds for further disciplinary action under ORS 677.190(17).

5.

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

IT IS SO STIPULATED this 31st day of May 2018.

BRENDA DIANE ROBERTS, MD

IT IS SO ORDERED this 12th day of July 2018.

OREGON MEDICAL BOARD

K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

ROBERT ALLAN SAMPSON, DPM
LICENSE NO. DP00217

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. Robert Allan Sampson, DPM (Licensee) holds an inactive podiatric physician
license in the State of Oregon.

2. On April 23, 2018, the Board sent to Licensee by regular and certified mail and electronic
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, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the
Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as
defined in ORS 677.188(4)(a); ORS 677.190(7) impairment, as defined by ORS 676.303; ORS
677.190(17) willfully violating a board rule, order or request; and ORS 677.190(22) refusing an
invitation for a Board requested informal interview. The Notice informed Licensee that if he
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 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’s acts and conduct that violated the Medical Practice Act follow:

3.1 Licensee was arrested for driving under the influence of an intoxicant (DUII) in September of 2013. Licensee agreed to enter court diversion. On January 27, 2017, Licensee self-reported another arrest in Portland for DUII, in which he refused a breathalyzer but submitted to a blood draw, revealing a blood alcohol content of 0.268. Licensee pled guilty to DUII and was placed on monitored misdemeanor probation. Licensee subsequently enrolled in HPSP (the Health Professionals' Services Program) on June 21, 2017. The terms of enrollment required Licensee to submit to ongoing random urine drug screens (UDS). Licensee had a positive UDS (for alcohol) on July 20, 2017, and a positive repeat screening test on July 27, 2017. Licensee had repeated UDS positive tests for alcohol on or about November 11 and 14, 2017, and on January 4, 8, 12, 18 and 19, 2018. Licensee’s record of positive UDS results for alcohol indicates his substantial noncompliance with the terms of his HPSP enrollment, in violation of OAR 847-065-0065 and ORS 677.190(17). On September 14, 2017, Licensee requested that the Board inactivate his medical license.

3.2 Licensee ceased communications with Board investigators on or about November 2, 2017. Board staff made numerous attempts to contact Licensee regarding his repeated HPSP non-compliance events; contact attempts were made via telephone, email and letter. Additionally, Licensee failed to respond to a Notice of Investigation sent on August 16, 2017, as required by ORS 677.320.

3.3 The Board invited Licensee to appear before the Board’s Investigative Committee on February 1, 2018, for an informal interview pursuant to ORS 677.415(9). Invitations were sent by letter to Licensee’s home and practice addresses, by email, and by personal delivery through a third party. Licensee failed to appear.

/ / /

Page 2 – FINAL ORDER BY DEFAULT – Robert Allan Sampson, DPM
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 record of positive UDS results establish that Licensee is an impaired physician and is unable to practice with reasonable competence and safety due to the habitual or excessive use of alcohol, in violation of ORS 676.190(7).

4.2 Licensee’s failure to respond to communications from the Board violated ORS 677.190(17).

4.3 Licensee’s failure to appear for the IC interview violated ORS 677.190(17); and ORS 677.190(22).

5.

ORDER

The Board has the statutory duty to protect the public from the practice of podiatric medicine from impaired podiatric physicians and otherwise demonstrate that they cannot be trusted with a podiatric physician license. In order to protect the public and appropriately address his conduct, Licensee’s podiatric license must be revoked.

IT IS HEREBY ORDERED THAT the license of Robert Allan Simpson, DPM., to practice podiatric medicine is revoked and that he pay a civil penalty of $5,000, payable within 60 days from the date this Order is signed by the Board Chair.

DATED this 12th day of January, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DÔ
BOARD 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

GEORGE EDWARD SCHULTZ, DO
LICENSE NO. DO21031

CORRECTIVE ACTION AGREEMENT

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. George Edward Schultz, DO (Licensee) is a licensed osteopathic physician in
the state of Oregon and holds an active license.

2.
2.1 Licensee is a board certified internist practicing in Medford, Oregon. The Board
opened an investigation after receiving a complaint in regard to Licensee’s manner of prescribing
controlled substances for a patient. Licensee signed an Interim Stipulated Order on November
11, 2016.

2.2 Licensee voluntarily underwent an assessment at the Center for Personalized
Education for Physicians (CPEP) on September 11 – 12 and 26, 2017.

3.
Licensee and the Board now desire to settle this matter by entry of this Agreement.
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
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 Data Bank and the Federation of State Medical Boards.

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 that he will contract with CPEP for the development of an education plan within 30 days of the effective date of this Agreement. The cost of the development of an education plan must be borne by the Licensee. Licensee must sign all necessary releases to allow full communication and exchange of documents and reports between the Board and CPEP. Licensee must ensure CPEP submits the education plan reports directly to the Board.

4.2 Upon approval of the educational plan by the Board's Medical Director, Licensee must successfully complete the CPEP education plan, including any post-education evaluation, within 18 months from the date the educational plan is approved. All costs associated with the approved education plan must be borne by Licensee. Licensee must sign all necessary releases to allow full communication and exchange of documents and reports between the Board and CPEP. Licensee must keep the Board apprised of his compliance with the CPEP education plan throughout the duration of plan completion.

4.3 Licensee must provide the Board with written proof from CPEP upon successful completion of the approved education plan, including successful completion of any post-education evaluation, as defined above.

4.4 Licensee agrees that he is subject to no-notice chart audits at his own expense, conducted by the Board's designee.

4.5 The Interim Stipulated Order of November 11, 2016, terminates effective the date the Board Chair signs this Agreement.

4.6 This Agreement becomes effective upon signature by the Board Chair.
4.7 Licensee must obey all federal and Oregon State laws and regulations pertaining to the practice of medicine.

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

IT IS SO STIPULATED THIS ___ day of ___ , 2018.

GEORGE EDWARD SCHULTZ, DO

IT IS SO ORDERED THIS ___ day of ___ , 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
BOARD CHAIR
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

CAROLYN ELIZABETH SIMMONS, MD
LICENSE NO. MD170122

ORDER TERMINATING INTERIM STIPULATED ORDER

1.

On February 27, 2017, Carolyn Elizabeth Simmons, MD (Licensee) voluntarily entered into an Interim Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee’s Oregon medical license at inactive status pending the conclusion of the Board’s investigation.

2.

On July 12, 2018, the Board closed the investigation. The Board terminates the February 27, 2017, Interim Stipulated Order, and returns Licensee’s medical license to active status, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

DAVID LOUIS SINCAYAGE, JR., MD
LICENSE NO. MD156207

STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. David Louis Sincavage, Jr., MD (Licensee) is a licensed physician (lapsed status) in the State of Oregon.

2.

On February 22, 2017, the Board opened an investigation after Licensee reported that the Kentucky Board of Medical Licensure had taken an action against his Kentucky medical license. On May 25, 2017, Licensee entered into an Interim Stipulated Order with the Board in which he voluntarily withdrew from the practice of medicine in Oregon pending the completion of the Board’s investigation.

3.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board’s records. Licensee neither admits nor denies, but the Board finds that Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a), unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS 677.190(15) disciplinary action by another state of a license to practice. Licensee understands that this Order is a public
record and is a disciplinary action that is reportable to the DataBank and the Federation of State Medical Boards.

4.

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

4.1 Licensee retires his Oregon medical license while under investigation.

4.2 The Interim Stipulated Order of May 25, 2017, terminates effective the date the Board Chair signs this Stipulated Order.

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

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

5.

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

IT IS SO STIPULATED this 2018 day of April 1, 2018.

DAVID LOUIS SINCAVAGE, JR., MD

IT IS SO ORDERED this 2018 day of July 12, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

SAMUEL SOONG SUK, MD
LICENSE NO. MD21879

CORRECTIVE ACTION AGREEMENT

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. Samuel Soong Suk, MD (Licensee) is a licensed physician in the State of Oregon and holds an active license.

2.

Licensee is a board certified family medicine physician practicing in Beaverton, Oregon. The Board opened an investigation after receiving a complaint in regard to Licensee’s manner of prescribing combinations of controlled substances (opioids and benzodiazepines) for patients.

3.

Licensee and the Board now desire to settle this matter by entry of this agreement.

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 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 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 Within 6 months from the signing of the Agreement by the Board Chair, Licensee must successfully complete a course on prescribing to treat chronic pain that has been pre-approved by the Board’s Medical Director.

4.2 Subsequent to the completion of term 4.1, and within one year of the effective date of this Agreement, Licensee must complete 20 hours CME related to prescribing which have been pre-approved by the Board’s Medical Director.

4.3 Within one year from the signing of the Agreement by the Board Chair, Licensee must successfully complete a course on medical documentation that includes a follow-up component in which Licensee’s charting is reviewed. This course must be pre-approved by the Board’s Medical Director.

4.4 This agreement becomes effective upon signature by the Board Chair.

4.5 Licensee must obey all federal and Oregon State laws and regulations pertaining to the practice of medicine.
4.6 Licensee agrees that any violation of the terms of this Agreement constitutes grounds to take disciplinary action under ORS 677.190(17).

IT IS SO STIPULATED THIS 20 day of June, 2018.

SAMUEL SOONG SUK, MD

IT IS SO ORDERED THIS 13th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
BOARD CHAIR
BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

MARGARET ADELLE VAJDOS, MD
LICENSE NO. MD19676

ORDER TERMINATING
CORRECTIVE ACTION AGREEMENT

1. On April 3, 2014, Margaret Adelle Vajdos, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On May 1, 2018, Licensee submitted documentation that she has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2. The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the April 3, 2014, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 12th day of July, 2018.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair

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– Margaret Adelle Vajdos, MD