

Oregon Medical Board
BOARD ACTION REPORT
January 25, 2011

The information contained in this report summarizes new interim and final actions taken by the Oregon Medical Board between *December 16, 2010 and January 15, 2011*.

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 Corrective Action Agreements are not posted, as they are not disciplinary action and impose no practice limitations.** Complaint and Notices of Proposed Disciplinary Action are not listed in this report, as they are not final actions by the Board. Both Orders, however, are public and are available upon request as described below.

Printed copies of the Board Orders listed below are available to the public. To obtain a printed copy of a Board Order, please complete a [service request form](#) 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.

*Abbassian, Soraya, Ann, MD; MD23436; Portland, OR

The Board issued a Corrected Order of Emergency Suspension on January 13, 2011. This Order replaces the Order of Emergency Suspension issued on December 23, 2010.

*Abbassian, Soraya, Ann, MD; MD23436; Portland, OR

The Board issued an Order of Emergency Suspension on December 23, 2010. This Order suspended Licensee's Oregon medical license based on the Board's immediate concerns regarding patient safety.

*Bergin, Patrick, John, MD; MD15838; Eugene, OR

On January 13, 2011, licensee entered into a Voluntary Limitation with the Board to limit his practice to Administrative Medicine. This is not a disciplinary action.

*Campbell, Robert, Perry, MD; MD10884; Portland, OR

Licensee entered into an Interim Stipulated Order with the Board on January 11, 2011. In this Order, Licensee temporarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine. Licensee must notify the Oregon Medical Board within 10 days of the date of this Order how his patients may access or obtain their medical records.

Cheon, Sung, Jin, LAc; AC01102; Beaverton, OR

On January 13, 2011, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, licensee agreed to complete a charting course, obtain a practice mentor who will submit quarterly reports to the Board, and no-notice compliance inspections. This Agreement is not a disciplinary action.

*Dover, Eric, Alan, MD; MD16996; Portland, OR

On January 14, 2011, the Board issued a Final Order. This Order revoked Licensee's Oregon medical license, imposed a \$10,000 fine, and costs related to the disciplinary action. Licensee must also notify current and former patients about how to access their medical records.

*Duke, David, John, MD; MD17195; Springfield, OR

The Board issued an Order Terminating Stipulated Order on January 13, 2011. This Order terminated Licensee's December 3, 2009 Stipulated Order.

*Ey, Frederick, Sterling, MD; MD14443; Portland, OR

Licensee entered into an Interim Stipulated Order with the Board on January 10, 2011. In this Order, Licensee temporarily withdraws from the practice of medicine and his license is placed in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

*Friedlander, Jeffrey, MD; MD14269; Jesup, GA

The Board issued an Order of License Suspension on December 23, 2010. This order immediately suspended Licensee's Oregon medical license due to his incarceration. Per ORS 677.225(1)(b) provides that a medical license be suspended automatically if the licensee is an inmate in a penal institution.

Guilleux, Paul, Michael, DO; DO11449; Gresham, OR

On January 13, 2011, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, licensee agreed to complete courses on pain management and professionalism; pay a \$500 fine; and immediately cease self-prescribing.

*Maul, Casey, Jacob, PA; PA00970; Coquille, OR

Licensee entered into an Interim Stipulated Order on January 5, 2011. In this Order Licensee agreed to voluntarily withdraw from practice pending the conclusion of the Board's investigation into his ability to safely and competently practice medicine.

*Pliskin, Leslie, Arthur, MD; MD12017; Lebanon, OR

On January 13, 2011, Licensee entered into a Stipulated Order with the Board. This Order reprimanded Licensee and placed him on a minimum of five years probation. Licensee was also fined \$2,500 and required to complete a remedial educational program. Licensee is also required to notify any health care employer of this order and is subject to no-notice compliance audits.

*Powell, Diane, Hennacy, MD; MD25438; Medford, OR

On January 13, 2011, Licensee entered into a Stipulated Order with the Board. In this Order, Licensee agreed not to conduct therapy or treatment sessions by telephone except in specified emergencies; complete a charting course; monthly chart review by a board-certified psychiatrist with monthly reports to the Board; and no notice compliance inspections. This Order also terminated Licensee's October 8, 2010 Order of Emergency Suspension.

*Shoemaker, David, Whitman, Jr., MD; College Place, OR

On January 13, 2011, the Board issued an Order Terminating Final Order. This Order terminated Licensee's August 2, 2007 Final Order and his July 10, 2008 Order Modifying Final Order.

Stadtlander, Sean, Michael, MD; MD19575; Newberg, OR

On January 13, 2011, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete coursework on pain management and have a practice monitor for chronic pain management with quarterly written reports to the Board.

*Valenzuela, Eduardo, Rodolfo, PA; PA00950; Roseburg, OR

On January 13, 2011, Licensee entered into a Stipulated Order with the Board. In this Order Licensee was reprimanded and he agreed to surrender his Oregon physician assistant license while under investigation. Licensee also agreed not to reapply for an Oregon license for a period of two years.

*Yakimovsky, Yoram, MD; MD12635; Portland, OR

On January 13, 2011, Licensee entered into a Stipulated Order with the Board. In this Order Licensee was reprimanded and fined \$2,500.

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.

1 2.3 On December 15, 2010, at about 10:00 p.m., Licensee initiated a surgical
2 procedure without staff assistance on Patient A, a 59-year-old female, at Licensee's medical
3 clinic in Northeast Portland. Patient A was also an employee and friend of Licensee's. Prior to
4 commencing the surgical procedure Licensee failed to conduct an appropriate and sufficient
5 medical evaluation. At the beginning of the procedure, Licensee administered a local anesthesia
6 by subcutaneous injections into the skin of the abdominal wall. Shortly thereafter, Patient A
7 reportedly began to complain of chest pain and shortness of breath. Patient A subsequently had a
8 seizure and became unresponsive. Licensee reportedly attempted to revive her and administered
9 about 15 chest compressions and then called 911. Licensee admitted that she did not have a
10 "crash cart" at the clinic. When emergency medical personnel arrived at the scene, they found
11 Patient A unconscious in the clinic examination room with no CPR being performed. Patient A
12 was not breathing and did not have a pulse. Emergency medical personnel administered CPR to
13 Patient A, intubated her, established an IV line, gave her Advanced Cardiac Life Support
14 (ACLS) medications and subsequently transported her by ambulance to Portland Adventist
15 Medical Center, where she was admitted to the critical care unit. Patient A was maintained on
16 life support while treatment interventions were attempted. Patient A was declared dead at 8:20
17 a.m. on December 19, 2010. An autopsy by the Medical Examiner's Office revealed that Patient
18 A's brain was quite soft and friable, consistent with an anoxic brain injury. Multiple puncture
19 marks and bruising were noted across the lower abdominal wall. The initial impression is that
20 Patient A's cause of death is related to medication(s) she had received or a complication with
21 local anesthetics.

22 2.4 In an interview with Board staff on December 22, 2010, Licensee stated that she
23 regularly performs dermatological procedures by herself, without office staff present, in her solo
24 practice clinic. She also reported that on six occasions a year she has called emergency services
25 personnel to her clinic. Licensee stated that a component of her practice includes urgent care.

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3.

Based on the above information, the Board has determined that from the evidence available to the Board at this time, Licensee's continued practice of medicine would pose an immediate danger to the public. Licensee's decision to perform a surgical procedure on a personal friend late at night at her clinic without staff support displayed poor medical judgment and places her current patients at immediate risk of harm. Licensee's clinic was not equipped to address a medical emergency, and Licensee failed to respond in a competent manner to her patient's distress. Pursuant to ORS 677.205(3), the Board orders that the license of Soraya Ann Abbassian, MD, to practice medicine is suspended on an emergency basis. Licensee is directed to immediately cease the practice of medicine until otherwise ordered by the Board. Licensee must notify the Oregon Medical Board within 10 days of the suspension of how patients may access or obtain their medical records.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Counsel at the hearing may represent licensee. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days of the mailing of this Notice to Licensee, ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practicable.

IT IS SO ORDERED this 23rd day of December, 2010.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

LISA A. CORNELIUS, DPM
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
SORAYA ANN ABBASSIAN, MD) *CORRECTED*
LICENSE NO. MD 23436) ORDER OF EMERGENCY
SUSPENSION)

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. Soraya Ann Abbassian, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The acts and conduct that support this Order for Emergency Suspension follow:

2.1 The Board opened an investigation after Licensee failed two billing and chart audits since November 2007 at Providence Health *Plan*. Rather than complete a corrective action plan, Licensee elected to terminate her contract at Providence in July 2009. At the Board's request, Licensee subsequently underwent an assessment at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado. The CPEP assessment report, dated July 6, 2010, finds that Licensee demonstrated a knowledge base in internal medicine that was adequate overall, with some areas of discrete educational needs in medical topics of importance to internists. Her clinical judgment and reasoning were found to be adequate overall but with a few important gaps.

2.2 The Board reviewed ten patient charts that revealed a pattern of deficiencies, to include: illegible chart notes; the use of problem lists that are too long and contain duplicative information; diagnoses that are not well supported; and a lack of analysis of the history and physical; and ordering vitamin B-12 injections for every patient reviewed, even when B-12 levels were normal.

1 2.3 On December 15, 2010, at about 10:00 p.m., Licensee initiated a surgical
2 procedure without staff assistance on Patient A, a 59-year-old female, at Licensee's medical
3 clinic in Northeast Portland. Patient A was also an employee and friend of Licensee's. Prior to
4 commencing the surgical procedure Licensee failed to conduct an appropriate and sufficient
5 medical evaluation. At the beginning of the procedure, Licensee administered a local anesthesia
6 by subcutaneous injections into the skin of the abdominal wall. Shortly thereafter, Patient A
7 reportedly began to complain of chest pain and shortness of breath. Patient A subsequently had a
8 seizure and became unresponsive. Licensee reportedly attempted to revive her and administered
9 about 15 chest compressions and then called 911. Licensee admitted that she did not have a
10 "crash cart" at the clinic. When emergency medical personnel arrived at the scene, they found
11 Patient A unconscious in the clinic examination room with no CPR being performed. Patient A
12 was not breathing and did not have a pulse. Emergency medical personnel administered CPR to
13 Patient A, intubated her, established an IV line, gave her Advanced Cardiac Life Support
14 (ACLS) medications and subsequently transported her by ambulance to Portland Adventist
15 Medical Center, where she was admitted to the critical care unit. Patient A was maintained on
16 life support while treatment interventions were attempted. Patient A was declared dead at 8:20
17 a.m. on December 19, 2010. An autopsy by the Medical Examiner's Office revealed that Patient
18 A's brain was quite soft and friable, consistent with an anoxic brain injury. Multiple puncture
19 marks and bruising were noted across the lower abdominal wall. The initial impression is that
20 Patient A's cause of death is related to medication(s) she had received or a complication with
21 local anesthetics.

22 2.4 In an interview with Board staff on December 22, 2010, Licensee stated that she
23 regularly performs dermatological procedures by herself, without office staff present, in her solo
24 practice clinic. She also reported that on six occasions a year she has called emergency services
25 personnel to her clinic. Licensee stated that a component of her practice includes urgent care.

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3.

Based on the above information, the Board has determined that from the evidence available to the Board at this time, Licensee's continued practice of medicine would pose an immediate danger to the public. Licensee's decision to perform a surgical procedure on a personal friend late at night at her clinic without staff support displayed poor medical judgment and places her current patients at immediate risk of harm. Licensee's clinic was not equipped to address a medical emergency, and Licensee failed to respond in a competent manner to her patient's distress. Pursuant to ORS 677.205(3), the Board orders that the license of Soraya Ann Abbassian, MD, to practice medicine is suspended on an emergency basis. Licensee is directed to immediately cease the practice of medicine until otherwise ordered by the Board. Licensee must notify the Oregon Medical Board within 10 days of the suspension of how patients may access or obtain their medical records.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Counsel at the hearing may represent licensee. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days of the mailing of this Notice to Licensee, ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practicable.

IT IS SO ORDERED this 13th day of January, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

LISA A. CORNELIUS, DPM
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
PATRICK JOHN BERGIN, MD) VOLUNTARY LIMITATION
APPLICANT)

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. Patrick John Bergin, MD (Applicant) has applied for an active license to practice medicine in Oregon.

2.

On November 9, 2010, the Board issued an Amended Notice of Intent to Deny his application for an unlimited license to practice medicine in Oregon, to include assessment of the costs of the proceedings, and to impose a fine based upon alleged violations of the Medical Practice Act. The Amended Notice of Intent to Deny is a public document.

3.

Applicant and the Board desire to settle this matter by entry of this Voluntary Limitation. Applicant understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Applicant 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.

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4.

In order to address the concerns of the Board and for purposes of resolving this investigation, the Board agrees to close this investigation and issue a medical license to Applicant contingent upon Applicant entering into this Voluntary Limitation pursuant to ORS 677.410. Effective the date this Order is signed by the Board's Chair, Applicant agrees to abide by all of the following terms and conditions:

4.1 Applicant is granted a license to practice medicine which is limited to Administrative Medicine. Applicant must comply with all of the requirements set forth in OAR 847-008-0037, Administrative Medicine.

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

4.3 Applicant stipulates and agrees that any violation of the terms of this Order will be grounds for disciplinary action under ORS 677.190(17).

5.

Licensee understands that this is a final order under Oregon law and therefore is a public record. This order is not a disciplinary action, but is a limitation on Licensee's medical practice and is reportable to the Federation of State Medical Boards, the Health Care Integrity and Protection Data Bank and the National Practitioner Data Bank.

IT IS SO STIPULATED this 21st day of DECEMBER, 2010.

Signature Redacted

PATRICK JOHN BERGIN, MD

IT IS SO ORDERED this 13th day of January, 2011.

OREGON MEDICAL BOARD
St. ...

Signature Redacted

LISA A. CORNELIUS, DPM
BOARD CHAIR

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3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective at 5:00 PM on the date this Order is signed by Licensee:

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

3.2 Licensee must notify the Oregon Medical Board within 10 days of the date of this Order how his patients may access or obtain their medical records.

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

4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. Following that review, if the Board determines that Licensee shall not be permitted to return to the practice of medicine, Licensee may request a hearing to contest that decision.

5.

This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document.

6.

This Order becomes effective at 5:00 PM on the date it is signed by the Licensee.

IT IS SO STIPULATED THIS 11 day of January, 2011.

Signature Redacted

ROBERT PERRY CAMPBELL, MD

IT IS SO ORDERED THIS 11 day of January, 2011.

State of Oregon
OREGON MEDICAL BOARD

Signature Redacted

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

1 4. Patient B is a male, born in 1959. He has had surgery on both knees to repair the
2 ACL joints, and has orthopedic screws in each of his knees to help maintain the surgical result.
3 He was seen at Voter Power on January 4, 2008, seeking OMMP certification for chronic pain.
4 (Ex. A11). Licensee recorded Patient B's medical history and findings on documents with
5 Patient A's contact information, and again on documents with Patient B's contact information.
6 (Ex. A10 at 6; Ex. A11 at 15).
7

8 5. Patient C is a male, born in 1955. On May 10, 2006, he returned to the Voter
9 Power clinic to recertify for the OMMP. Patient C has had AIDS for 17 years, and has Hepatitis
10 C and hypertension as well. Patient C also has psychological diagnoses, including PTSD,
11 depression and a history of polysubstance abuse. He was seeking OMMP recertification for
12 severe nausea and loss of appetite. Licensee's physical examination of Patient C, noted on a
13 preprinted form, consists of 22 circled plus signs and an indication that the lungs and chest are
14 "clear;" the abdominal/gastrointestinal areas is "benign;" neurological was "intact;" and skeletal
15 was "WNL." On the form, Licensee also listed the medications and a list of diagnoses reported
16 by Patient C. (Ex. A15 at 72).
17

18 6. Patient D is a female, born in 1959. She came to the Voter Power clinic on May
19 6, 2008, seeking OMMP certification for chronic pain and muscle spasms due to multiple
20 sclerosis (MS) and fibromyalgia. Licensee's physical examination records, on the preprinted
21 form, eleven circled plus signs, an indication of neurological "weakness," and a list of
22 medications and diagnoses. (Ex. A16 at 210).
23

24 7. Patient E is a female born in 1955, who suffers from MS. She was seeking
25 recertification for OMMP due to chronic pain. Licensee's physical examination records, on the
26 preprinted form, eleven circled plus signs, and a list of medications and diagnoses. (Ex. A16 at
27 513).
28

29 8. Patient A and Patient B visited the Voter Power clinic on January 4, 2008, but did
30 not know each other at that time. Both filled out the OMMP paperwork to seek authorization for
31 medical marijuana, and handed the paperwork to Voter Power staff. Either the staff or Licensee
32 switched the files, sending Patient A's file (with his name and contact information at the top) in
33 to Licensee with Patient B. Licensee wrote Patient B's physical findings and information (48
34 years of age, bilateral knee condition with hardware surgically implanted) on Patient A's forms.
35 (Test. of Patient A; Ex. A1 at 7-9).
36

37 9. When Patient A was seen by Licensee, Licensee spent eight minutes with him and
38 did not do a physical examination. Patient A had removed his left shoe and sock because he
39 wanted Licensee to look at his left foot, where his gout symptoms were bothering him the most.
40 Licensee reviewed his records but did not look at the left foot. He told Patient A he did not have
41 enough information to justify OMMP certification, and sent the patient to a nearby clinic for x-
42 rays. (Test. of Patient A). When he wrote the x-ray order, Licensee requested a right foot x-ray,
43 not a left foot x-ray. (Ex. A1 at 6). Patient A had been treated since 2001 for gout, and provided
44 the records to Licensee for his review. (Test. of Patient A, Ex. A18).
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1 10. On the form entitled "Documentation of Review of Medical Records, Patient
2 History, Treatment Plan" Licensee indicated he reviewed Patient A's records (by writing "yes"),
3 and placed a check mark next to "Discussed risks/benefits of medical marijuana with patient".
4 Licensee partially circled "6-12 months" to answer the question of "Next doctor visit" and signed
5 the form. (*Id.* at 7). With Patient A and the other patients, Licensee did not think there were any
6 risks to the patient because of the benefits of using medical marijuana. (Test. of Licensee).
7

8 11. On the SOAP⁴ page, Licensee wrote the physical findings for Patient B on Patient
9 A's forms. (*Id.* at 8). On the "Physical Examination" page, Licensee circled several "plus"
10 marks on the page; indicated his lungs and chest were "clear;" indicated his abdominal exam was
11 "benign;" his neurological exam was "intact;" and Licensee recorded that Patient A had bilateral
12 knee scars with bad to severe crepitus and a past medical history of knee surgeries and
13 "extensive OA" (osteoarthritis). (*Id.* at 9). Those findings were for Patient B and did not match
14 Patient A's medical history. (Test. of Patient A).
15

16 12. In October 2008, Licensee recalled some of the information he reviewed in
17 Patient A's file:

18 He had 2 or 3 documented cases of acute gouty attacks that he went to Urgent
19 Cares for treatment from what I recall from the records he brought in[.]
20
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22 (Ex. A4 at 1). Patient A provided approximately 24 pages of documents to Licensee, including
23 the application forms. (Test. of Patient A; Ex. A18).
24

25 13. After obtaining the x-rays from the clinic, Patient A returned to Voter Power and
26 saw Licensee for an additional five minutes. Licensee refused to certify Patient A for the
27 OMMP at that time, and asked Voter Power to refund his money. (Test. of Patient A, Licensee).
28

29 14. After returning home that evening, Patient A's wife answered a phone call from
30 Patient B, who informed her that his medical records from Voter Power had Patient A's name
31 and contact information at the top, explaining how he knew to call Patient A's home. Patient A
32 talked to Patient B, verified the story, and decided to go back down to Voter Power the next
33 morning to find out how the records had been mixed up. When Patient A went back to Voter
34 Power the next day, he wanted to talk to Licensee, but Licensee refused to talk to him. Voter
35 Power staff sent Patient A home without answering his questions. (Test. of Patient A).
36

37 15. After Patient A returned home, he received another call from Voter Power and
38 was told that he was being certified for the OMMP, and to come back to the clinic. When
39 Patient A returned to the clinic, he was given further paperwork to fill out. At that point, the
40 director of Voter Power realized that Patient A's documents contained Patient B's medical
41 information. She grabbed the paperwork out of Patient A's hands and shredded it. Patient A
42 again asked if he could speak with Licensee, but was refused. (Test. of Patient A).
43

44 16. On January 27, 2008, Patient A sought treatment from Darryl George, DO, to be
45 evaluated for certification for the OMMP card. Dr. George examined Patient A, certified him for
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47 ⁴ SOAP is an acronym for "Symptoms (or Subjective), Objective, Assessment, and Plan.

1 the OMMP, and then wrote a letter to the Board to report Patient A's experiences with Licensee
2 and the Voter Power clinic. (Ex. A16). The letter was written approximately one week after
3 Patient A filed his complaint with the Board. (Ex. A1).

4
5 17. After the Board received the complaint from Patient A and the letter from Dr.
6 George, it opened an investigation of Licensee. The initial letters to Licensee were mistakenly
7 sent to him at the Voter Power address rather than at his Portland office address. (Test. of
8 Drum). Licensee responded:

9
10 My name is Dr. Eric Dover. I am a Family Physician. 80% of my work is
11 obligated to a clinical practice where I see patients at a reduced rate who are
12 either uninsured or have high deductibles associated with their insurance policies.
13 The other 20% of my work time is spent helping an organization called Voter
14 Power where I work as an independent contractor. Here I evaluate patients
15 regarding their qualifications for a Medical Marijuana Card. I take this situation
16 very seriously. I would not be involved with this if I did not feel it was beneficial
17 to patients. The readily available medical literature substantiates marijuana's
18 benefits.

19
20 [Patient A] was seen by myself at Voter Power. [He] came there seeking a
21 medical marijuana card for gout. I don't know if he indicated that in his letter to
22 the Board? [He] supposedly stated that I gave him back the wrong records. This
23 would be impossible.

24
25 (Ex. A2).

26
27 18. Based upon Patient A's complaint, which included the mixed up documents
28 between Patients A and B, the Board's investigator determined that Licensee was incorrect about
29 the possibility of a records mix-up and that the matter should be forwarded to the Medical
30 Director to see if further action was needed. (Ex. A3). The Medical Director asked the
31 investigator to request more files from Licensee, and Licensee responded to that request on
32 October 1, 2008. After reluctantly agreeing to provide additional files, Licensee stated:

33
34 After reviewing the Investigating Committee's backgrounds, I don't feel
35 comfortable with their knowledge regarding the treatment of gout. Nor do I feel
36 comfortable with their knowledge of medical marijuana and the treatment of
37 chronic pain or other medical problems. I do know that none of these members
38 treat chronic pain and that two of them are involved in specialties that leave
39 legions of chronic pain sufferers in their wake.

40
41 (Ex. A4 at 2).

42
43 19. At the Board's request, Family Practice physician James Calvert MD reviewed
44 Licensee's charts from his Portland office and from Voter Power. Included among the files were
45 the records of Patients A, B, C, D and E, all from Voter Power clinics. In all five cases, Dr.
46 Calvert concluded that the physical examinations and histories were superficial, and the medical
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1 decision-making did not meet the standard of care. (Ex. A5). Dr. Calvert has worked as an
2 independent contractor in clinics before, and certifies some of his patients to receive medical
3 marijuana under the OMMP. He has a special relationship with HIV patients, and has certified
4 several of them to receive medical marijuana under the OMMP. (Test. of Calvert).
5

6 20. Dr. Calvert reviewed Patient A's records and concluded that the x-rays requested
7 by Licensee showed luccncies consistent with gout. He noted that Patient A's records were
8 confused with Patient B's records ("an unfortunate but an understandable error"), and was
9 critical of the assessment done by Licensee in the cases.⁵ Dr. Calvert wrote:
10

11 The physical exams contain no detail and the medical histories are overly brief.
12 There is no evidence in either case of medical decision making regarding the risks
13 and benefits of use of marijuana or any rationale as to why the certification might
14 make sense in their cases. * * * It seems to me that when Dr. Dover indicates that
15 he had no evidence [that Patient A] had gout when he did in fact have that
16 evidencce, and that he did a physical examination on a patient when according to
17 the patient he did not, and then when he made an error in his record keeping he
18 denied doing so rather than trying to figure out what went wrong, his care is
19 characterized by gross negligence.
20

21 (Ex. A5 at 3).
22

23 21. Dr. Calvert reviewed Licensee's records concerning Patient C and ultimately
24 agreed with Licensee's recertification decision. However, he noted that Patient C's records also
25 contained evidence of "significant psychiatric disease," including PTSD, depression, suicidal
26 ideations and gestures, and a history of polysubstance abuse. Concluding that Patient C's case
27 was "extremely complicated, with numerous co-morbidities," Dr. Calvert noted that:
28

29 The medical decision-making is substantially below the standard of care for any
30 physician seeing such a complicated patient.
31

32 (*Id.*).
33

34 22. Dr. Calvert reviewed Licensee's records concerning Patient D. He concluded that
35 Licensee's analysis was superficial, with medical decision-making not well documented. He did
36 not consider the records to be up to a professional standard. (*Id.* at 4).
37

38 23. Dr. Calvert reviewed Licensee's records concerning Patient E. He agreed with
39 Licensee's diagnosis of MS, but concluded:
40

41 The evaluation performed by Dr. Dover is superficial, mostly using preprinted
42 forms that simply require a + mark or a circle to document the physical. His
43 diagnosis of MS is confirmed[.]
44

45
46 ⁵ The confusion in the records leads to documents with Patient A's personal information and Patient B's
47 medical information, so both patients are involved.

1 Dr. Calvert's written comments summarized the problems he found in all five cases. (*Id.*)

2
3 24. On June 4, 2009, Licensee was interviewed by the Board's Investigative
4 Committee. Included on the committee was Gary LeClair, MD. (Ex. A6 at 2). Licensee
5 insisted, at hearing, that the doctor's name was "St. Clair." (Test. of Licensee).

6
7 25. As part of the initial notice in the case, the Board required Licensee to attend an
8 evaluation with CPEP within 90 days. On December 3, 2009, Licensee sent a letter refusing to
9 attend:

10
11 I will not be attending the CPEP evaluation. This is not because I feel I have any
12 deficits as a physician, in fact it is quite the contrary. I personally feel I'm
13 probably one of the best doctors you actually have in this state. No, the reason I
14 won't attend is because I feel that it is money down the toilet. Why would I spend
15 \$10,000 plus for this program and \$30,000 to \$50,000 plus for a lawyer for your
16 "hearing" when I have a strong feeling your minds are already made up in my
17 situation. If I thought I had a snowballs chance in hell that all the money I would
18 spend would make a difference then I would go for it, but from the Medical
19 Boards actions and statements it's obvious it won't.

20
21 Why do I feel this way? **First, you have broken my confidentiality on three**
22 **separate occasions**, but this doesn't seem to matter. If I broke a patient's
23 confidentiality once, let alone three times, you all would have me on the ropes,
24 but for you it doesn't seem to matter whose confidentiality is broken nor how.
25 We'll eventually find out if it does or doesn't matter.

26
27 **Second, my lawyer * * * has made three separate requests for medical**
28 **records related to your allegations of me regarding my encounter with**
29 **[Patient A], yet nothing has been sent nor have you even acknowledged these**
30 **requests with a letter.** Dr. St. Claire tried to cancel the Investigative Committees
31 questioning of me some 5 months ago because I had not received the records.
32 The committee decided to continue. They then read from a computer screen a
33 statement supposedly from another physician's note stated that [Patient A] stated
34 that I had counseled him on a concealed weapons permit at our encounter. This is
35 ludicrous. I have never seen a copy of that supposed physicians chart note. They
36 asked numerous questions about my encounter with [Patient A]. **I had not seen**
37 **his records for 11/2 years and still haven't.** When I last saw them was the day
38 he took off with his, another individual's and the non profit's records. Yet, I'm
39 supposed to answer questions about a situation that has a tremendous effect upon
40 my and thousands of others lives. **Why should I continue with this absurd**
41 **process when I can't get records regarding it? That is why I will not**
42 **continue your process until all information you have is divulged to me. Is**
43 **this the way democracy works in Oregon?**

44
45 This only touches the surface of why I mistrust your governmental body. This is
46 why I will not throw away financial resources that are extremely important to my
47

1 family and me at this juncture. Now my families near term financial situation will
2 be dependent upon decisions made by a prejudiced and misinformed group of
3 individuals. You don't think I know this is political? I am in trouble with the
4 Medical Board because I was willing to sign a statement for individuals that
5 stated that medical marijuana may be beneficial for their medical condition. My
6 signature means nothing more or less. I was willing to do this for patients
7 because they have the State Right to obtain this important medication and their
8 doctors are either prejudiced against it, ignorant of it, are afraid to sign to
9 statement or are not allowed by the institutions they work for to sign it. It used to
10 be the physicians could say that they were afraid of the Feds if they signed the
11 Physician's Statement. Bush did nothing to any physician in any state who signed
12 it and Obama has stated that the Feds will state hands off. So now the only
13 governmental agency to fear is you – the Oregon Medical Board.
14

15 * * * * *

17 At this point, the best light I see the Medical Board in is that you are incompetent.
18 At worst I see you as corrupt, running this government body with your own
19 political agenda. What I have seen so far is a "witch hunt." What I expect in the
20 future is a kangaroo court followed by a lynch mob if I continued down the road
21 you have set in place for me. Why waste my time, energy and money on that
22 losing hand? Now, I am no longer playing defense. I am now on offense.
23 Nobody is going to get away with smearing my name in the community and
24 undermining my family's economic future when I have done nothing wrong. In
25 fact I have done everything right. Get ready for this to go very public because
26 you actually work for the public. They need to find out how you are undermining
27 their rights in this State.
28

29 * * * * *

31 (Ex. A8; emphasis in original). The Board sent documents to Licensee during the 90 day period
32 in which he could have complied with the request for an evaluation at CPEP, but Licensee did
33 not comply with the order after receiving the documents. (Test. of Licensee).
34

35 26. Alisa Wall was an employee of Voter Power at the time when Patient A and B
36 were there in January 2008. Wall testified that she saw Patient A write his name on the form
37 after he had seen Licensee. Wall then testified she did not see Patient A write his name on the
38 form after he had seen Licensee. (Test. of Wall).
39

40 27. In preparation for the hearing, Licensee sent written requests on his medical office
41 letterhead to several pharmacies in Southern Oregon, asking for a list of medications that Patient
42 A purchased. (Ex. L1-L22). Licensee did not ask for permission from Patient A before seeking
43 those records. (Test. of Licensee).
44

45 28. Patient A received prescriptions for allopurinol and colchicine from Walgreens
46 Pharmacy in Medford on December 12, 2007. (Ex. A19). He took two allopurinol tablets but
47

1 had a reaction to the medication and stopped taking it. (Test. of Patient A). In the bottle of
2 allopurinol brought by Patient A to the hearing, there were 28 of 30 tablets remaining. (Count by
3 Attorney Loney).
4

5 CONCLUSIONS OF LAW

6
7 1. Licensee engaged in one or more acts of unprofessional or dishonorable conduct,
8 thereby violating ORS 677.190(1)(a);
9

10 2. Licensee engaged in gross or repeated negligence in the practice of medicine,
11 thereby violating ORS 677.190(13);⁶
12

13 3. Licensee violated a Board order by refusing to be evaluated at The Center for
14 Personalized Education for Physicians (CPEP), thereby violating ORS 677.190(17).
15

16 4. The appropriate sanctions in this case are set forth below.
17

18 OPINION

19
20 The Board alleged several acts of unprofessional conduct and gross negligence in
21 Licensee's treatment of five patients at the Voter Power clinic. In addition, the Board contended
22 through counsel at the hearing that Licensee violated a Board order by refusing to be evaluated at
23 CPEP. All of the charges against Licensee arise from ORS 677.190, which states in part:
24

25 **Grounds for suspending, revoking or refusing to grant license, registration or**
26 **certification; alternative medicine not unprofessional conduct.** The Oregon
27 Medical Board may refuse to grant, or may suspend or revoke a license to practice
28 for any of the following reasons:
29

30 (1)(a) Unprofessional or dishonorable conduct.
31

32 * * * * *

33
34 (13) Gross negligence or repeated negligence in the practice of medicine or
35 podiatry.
36

37 * * * * *

38
39 (17) Willfully violating any provision of this chapter or any rule adopted by the
40 board, board order, or failing to comply with a board request pursuant to ORS
41 677.320.
42

43 A different statute contains the definition of unprofessional or dishonorable conduct:
44
45

46 _____
47 ⁶ The oral amendments involved the statutes in Issues 2 and 3.

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

5 (a) Any conduct or practice contrary to recognized standards of ethics of the
6 medical or podiatric profession or any conduct or practice which does or might
7 constitute a danger to the health or safety of a patient or the public or *any conduct,*
8 *practice or condition which does or might adversely affect a physician's or*
9 *podiatric physician and surgeon's ability safely and skillfully to practice medicine*
10 *or podiatry*[.]
11

12 ORS 677.188 (emphasis added).
13

14 As the proponent of the position that Licensee has violated the rules noticed above, the
15 Board has the burden of presenting evidence in support of its position. ORS 183.450(2). The
16 Board must prove its case by a preponderance of the evidence. *Sobel v. Board of Pharmacy*, 130
17 Or App 374, 379 (1994), *rev den* 320 Or 588 (1995) (standard of proof under the Administrative
18 Procedures Act is preponderance of evidence absent legislation adopting a different standard).
19 Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts
20 asserted are more likely true than not. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390
21 (1987). In this case, the ALJ found that the Board carried its burden.
22

23 **Procedural Matters** 24

25 Before addressing the merits of the case, several procedural matters that were raised
26 during and before the hearing must be addressed. Those matters include: 1) allegations of bias or
27 prejudice; 2) the motion for a protective order; 3) a motion to strike/dismiss a portion of the case;
28 and 4) how much weight to give hearsay evidence. In addition, the ALJ addressed Licensee's
29 argument that Dr. Calvert was not an appropriate peer reviewer in the case, as well as the
30 credibility of witnesses.
31

32 **Allegations of Bias or Prejudice.**⁷ It is important at the outset to identify, as the Board
33 through counsel did in closing argument, what this case is *not* about. Licensee worked as an
34 independent contractor for Voter Power, and certified patients for the OMMP. He argued in his
35 testimony and in his correspondence that the Board's real reason for attempting to discipline him
36 stemmed from his belief that medical marijuana was a legal and underutilized medication.
37

38 Under Licensee's theory, he is "one of the best doctors you actually have in this state,"
39 and a "compassionate, well informed physician," but the Board is a "lynch mob" who is out to
40 "hang" him because of his involvement with certifying patients for the OMMP. (Ex. A8).
41 However, leaving aside Licensee's considerations of his own prowess, the record does not
42 support that the Board is prejudiced against doctors involved in certifying patients for the
43 OMMP.
44

45 _____
46 ⁷ Although not stated in so many words, the ALJ interpreted Licensee's belief that the Board is pursuing
47 this case because of his involvement with the OMMP as an allegation of prejudice or bias.

1 Every one of the experts involved in the case was familiar with, and actually certified
2 patients for, the OMMP. Licensee did so through the Voter Power clinic and, presumably, in his
3 private practice in Portland. Dr. George, the physician who later treated Patient A, and may have
4 encouraged Patient A to file the complaint with the Board, certified Patient A for OMMP. Dr.
5 Calvert, the family practitioner who reviewed Licensee's records and testified as an expert for
6 the Board, also certifies patients for OMMP, including several certifications among HIV
7 patients.
8

9 Even the five cases relied upon in the Board's allegations against Licensee show that
10 certification for OMMP is not the issue. In four cases, Licensee certified the patient for OMMP
11 and in one case he refused to certify the patient.
12

13 In short, this case is not about whether physicians should certify patients for medical
14 marijuana, nor is it a vendetta against Licensee for his involvement with the program. Licensee
15 has failed to show any bias or prejudice on the Board's part.
16

17 **Motion for Protective Order.** As noted above, the Board sought a Protective Order in
18 the case and Licensee objected to its issuance, claiming there was no authority for such an order.
19 A prehearing conference was held on August 30, 2010, to address the arguments. Before the
20 conference, the Board filed a reply to Licensee's argument, including copies of a Craigslist
21 "blog" discussing the Board's complaint against Licensee and releasing information about the
22 patients whose records are part of the Board's allegations against Licensee.
23

24 Based upon ORS 676.175(4), concluding that Licensee (or his designee) was in violation
25 of the statute,⁸ ALJ Barber signed the Protective Order on August 30, 2010. (Doc. P17).⁹
26

27 **Motion to Strike 3.1.b of the complaint.** During the hearing, Licensee moved to
28 dismiss or strike a section of the complaint concerning the physical examination and chart notes
29 of Patient A. Licensee contended that there is no actual documentation of Patient A's visit to
30 Voter Power, because the findings on his forms are actually the physical findings of Patient B.
31 Consequently, he argues, Dr. Calvert never evaluated the Voter Power chart for Patient A,
32 making his opinion (that Licensee violated the standard of care in A's case) without foundation.
33

34 The Board countered by listing several pieces of evidence that show what occurred when
35 Licensee met with Patient A, and contended there is no basis to strike the complaint when there
36 is evidence on both sides. The ALJ took Licensee's motion under advisement.
37

38 The lack of actual documentation of what Licensee wrote on Patient A's forms (other
39 than the ones incorrectly containing Patient B's information) presents a problem of evidence that
40

41 _____
42 ⁸ Although Licensee argued that there was no proof he was the source of the Craigslist blog, the content
43 and the occasional use of the personal pronoun "I" convinced the ALJ that he was the source. Licensee's
44 comment in Exhibit A8 that the case was about to go "very public" strengthens the ALJ's belief.

45 ⁹ Licensee argued at hearing that the order of pleading documents makes it appear that the ALJ had his
46 objections to the Protective Order (dated August 30) at the time he signed the Protective Order. Licensee
47 correctly notes that his objections to the form of the order were received after ALJ Barber had signed the
order.

1 will be addressed in greater detail below. According to the ALJ, it is not a basis for a procedural
2 dismissal of the charge. The evidence, or lack of evidence, will be weighed accordingly, but the
3 motion is denied.
4

5 **Hearsay Evidence.** Licensee objected to evidence presented by Investigator Jay Drum,
6 concerning his phone conversation with Patient B, and objected to Patient A's testimony about
7 his wife's telephone conversation with Patient B. The Board responded that hearsay is
8 admissible in administrative hearings. ALJ Barber allowed the testimony into the record with
9 the understanding that he would apply the court's standards for evaluating that evidence under
10 *Reguero v. Teacher Standards and Practices*, 312 Or 402, 417-21 (1991). In *Reguero*, the court
11 looked at several factors when evaluating what weight to give to hearsay evidence:
12

13 "[T]he alternative to relying on hearsay evidence; the importance of the facts
14 sought to be proved by the hearsay statements to the outcome of the proceeding
15 and considerations of economy; the state of the supporting or opposing evidence,
16 if any; the degree of lack of efficacy of cross-examination with respect to the
17 particular hearsay statements; and the consequences of the decision either way."
18

19 312 Or at 418. The ALJ applied those standards to the hearsay objections made by
20 Licensee.
21

22 **Patient A's wife.** Patient A testified that his wife received a phone call from Patient B,
23 who was calling because Patient A's personal information was on Patient B's medical
24 documents. Patient A's wife did not testify but was present and willing to testify, if necessary.
25 Licensee decided not to cross-examine her. The ALJ gave full weight to Patient A's testimony
26 about his wife's phone conversation, which is elsewhere established in the record.
27

28 The other declarant, Patient B, was not present but his reported comment (A's name and
29 number were on B's medical records) is equally supported by the presence of those documents in
30 the record. There is no reason to disregard the testimony of Patient A (about the conversation
31 between his wife and Patient B), or to give it lesser weight.
32

33 **Investigator Drum's conversation with Patient B.** Investigator Drum testified about his
34 phone conversation with Patient B, when Patient B explained the mix-up in the records. Again,
35 there is other evidence showing Patient A's name and Patient B's physical findings on the same
36 document. The testimony is corroborated in the record and is not so important that Licensee's
37 rights are at risk by its introduction into evidence. The hearsay objections were overruled, and
38 full weight will be given to the evidence.
39

40 **Peer Review Qualifications.** Licensee contends that Dr. Calvert, the expert retained by
41 the Board, was not an appropriate peer reviewer to offer an opinion on the standard of care.
42 Licensee offered arguments in support of this contention, but no evidence.
43

44 Licensee contended that there are many doctors who perform independent contractor
45 duties in medical marijuana clinics in Oregon and in other states. He contends, relying on *Spray*
46
47

1 v. *Board of Medical Examiners*. 50 Or App 311 (1981), that only a physician with the exact same
2 experience as Licensee would be qualified to testify on the standard of care.
3

4 The ALJ disagreed. Under Licensee's analysis, only a physician working as an
5 independent contractor in a medical marijuana clinic would have the proper experience to
6 comment on Licensee's practices. The court in *Spray*, the case upon which Licensee relies,
7 presents the reasons why Licensee's argument must fail in this case.
8

9 Although the Petitioner in *Spray* used what the court called a "machine gun attack" on
10 the Board in that case, raising many issues, the court's conclusion on two of the issues guide the
11 Board's and the ALJ's analysis in this case:
12

13 *We begin our analysis with a self-evident proposition: What is inappropriate or*
14 *unnecessary medical treatment will vary from case to case. * * * Only expert*
15 *testimony elicited on a case by case basis can determine whether the treatment in*
16 *a particular case was inappropriate and/or unnecessary. We think it follows that*
17 *the use of expert testimony to determine the standards of treatment that would be*
18 *adhered to by the members of the medical community in any given case is implicit*
19 *in the statutory standard before us.*
20

21 50 Or App at 318 (emphasis added). The first point is clear: whether a physician violates the
22 standard of care is going to be decided on a case-by-case basis.
23

24 The quotation also alludes to the second point of guidance from *Spray*—that evidence of
25 the standard of care in the medical community is established through the use of expert testimony.
26

27 Citing *Spray*, Licensee wants to narrowly construe what "medical community" means, to
28 include only those physicians who work as independent contractors in medical marijuana clinics.
29 However, the *Spray* court stated:
30

31 It is to be determined through the testimony of qualified physicians as to just what
32 is the norm of treatment in the medical community in the particular case and
33 whether the course of treatment actually followed deviates from the norm to the
34 extent that the physician involved may be said to have used "inappropriate or
35 unnecessary treatment."
36

37 *Id.*, at 319. It stands to reason, therefore, that nature of the medical community is also an issue to
38 be established by expert testimony.
39

40 Therefore, if Licensee contends that there is a special "community" of independent
41 contractor physicians who work in medical marijuana clinics certifying patients for OMMP (or
42 similar programs in other states), he was required to bring one or more of those experts to the
43 hearing to explain what the standard of care should be. However, Licensee brought no expert
44 witnesses to the hearing.
45
46
47

1 Whether the Board's expert is a "qualified physician" is a question of fact to be
2 determined from the evidence of the case. Here, where Dr. Calvert has the same specialty as
3 Licensee (family practice), practices in a Southern Oregon community similar to where Licensee
4 did his Voter Power examinations (Klamath Falls to Medford), and has experience as an
5 independent contractor and at certifying patients for the OMMP, the ALJ concluded that he is
6 sufficiently within the "medical community" and is able to comment as an expert on Licensee's
7 practices.
8

9 In fact, because the issues in the case actually concern the completeness of Licensee's
10 physical examinations and chart notes, this case could probably have been reviewed by
11 physicians of many specialties and sub-specialties.
12

13 **Credibility.** A witness testifying under oath or affirmation is presumed to be truthful
14 unless it can be demonstrated otherwise. ORS 44.370 provides, in relevant part:
15

16 A witness is presumed to speak the truth. This presumption, however, may be
17 overcome by the manner in which the witness testified, by the character of the
18 testimony of the witness, or by evidence affecting the character or motives of the
19 witness, or by contradictory evidence.
20

21 The determination of a witness' credibility can be based on a number of factors other than the
22 manner of testifying, including the inherent probability of the evidence, internal inconsistencies,
23 whether or not the evidence is corroborated, and whether human experience demonstrates that
24 the evidence is logically incredible. *Tew v. DMV*, 179 Or App 443 (2002).
25

26 **Atisa Wall.** Licensee presented Ms. Wall's testimony in what was clearly an effort to
27 discredit Patient A's testimony. Wall, formerly a Voter Power employee, testified that Patient A
28 was causing a scene at the Voter Power clinic; that he grabbed documents that were not his; and
29 that he then (after the examination was completed) wrote his name on the documents.
30

31 Ms. Wall's testimony was internally inconsistent. At one point, to emphasize how sure
32 she was that Patient A had caused the scene, she testified that she watched him sign and fill out
33 the documents after the examination. Later, however, she admitted that she had *not* seen him
34 write on the documents at any time.
35

36 This testimony, and the fact that it was offered by Licensee, is troubling. Assuming for
37 the moment that Wall was correct—that Patient A caused a scene, grabbed someone else's
38 documents and wrote his name on them—the act would make no sense. In addition, questions
39 for Licensee and the clinic would only increase. If Patient A was able to write his name and
40 address on Patient B's documents at that late date, it would mean that Licensee was performing
41 his medical examination of the patients without even their names in the file.
42

43 While it is unclear whether Ms. Wall was fabricating her testimony to support Licensee
44 or to try to protect the Voter Power clinic, the ALJ concluded that her testimony is unreliable and
45 gave it no weight.
46
47

1 *Licensee.* Another dispute in the evidence arises when comparing Licensee's testimony
2 with Patient A's testimony. Licensee testified that he would spend approximately 30 minutes
3 with each OMMP certification patient at Voter Power. Patient A testified that he spent eight
4 minutes with Licensee on the first visit, then five minutes more once he returned from the x-ray
5 clinic. Licensee testified that he performed a physical examination; Patient A testified Licensee
6 did not perform a physical examination. Licensee testified that Patient A only had a couple of
7 documents, none showing gout. Patient A testified that he had several pages of documents that
8 he gave to Licensee.
9

10 Interestingly, Licensee commented on the documents he received from Patient A in a
11 letter written in 2008. He stated:

12
13 He had 2 or 3 documented cases of acute gouty attacks that he went to Urgent
14 Cares for treatment from what I recall from the records he brought in[.]
15

16 (Ex. A4 at 1). This letter impeaches his later testimony that there was insufficient evidence of
17 gout, and at the very least calls his memory into question.
18

19 The evidence establishes that Licensee talked with Patient A about his gout condition, as
20 shown by A's visit to the x-ray clinic. However, there is nothing in the record to show that an
21 actual physical examination took place. The only records with Patient A's name on them contain
22 the physical history of Patient B, and the references on the physical examination page are, as Dr.
23 Calvert said, cryptic and superficial.
24

25 In this case, the ALJ accepted Patient A's testimony over Licensee's, primarily because
26 Patient A only had one meeting with the doctor but Licensee had multiple meetings with other
27 patients at the clinic. Simply put, given Licensee's written comments in 2008 and the non-
28 existence of any contemporaneous chart notes with any detail, the ALJ did not trust Licensee's
29 memory.
30

31 Licensee and Ms. Alisa Wall went to great lengths to impeach Patient A. However,
32 Patient A testified directly and consistently. For instance, he testified he had taken two
33 allopurinol pills and then stopped taking them. Licensee did not believe Patient A, and went so
34 far as to violate Patient A's privacy rights by sending requests for Patient A's personal pharmacy
35 records. At hearing, Patient A presented his bottle of allopurinol—with two pills missing.
36 Patient A was credible. Licensee's testimony, on the other hand, was not.
37

38 **On the Merits** 39

40 As noted, the Board's allegations focus on alleged violations of the standard of care—as
41 both unprofessional conduct and repeated negligence—and Licensee's refusal to comply with the
42 Board's order concerning the CPEP evaluation. The Board relies upon Dr. Calvert's review and
43 analysis in support of the standard of care issues.
44

45 It was clear from the testimony that Licensee and the Board have differing views of what
46 the relationship is when Licensee would see a patient at the Voter Power clinic. The Board and
47

1 Dr. Calvert see a doctor-patient relationship. Licensee claims he is not the patient's physician,
2 and that he is just an independent contractor certifying that the person coming into the clinic has
3 one of the qualifying conditions for the OMMP. The ALJ agreed with the Board.
4

5 Licensee acknowledged that he was chosen for the clinic contract because he is a
6 physician. A medical doctor or an osteopathic physician can certify the persons coming in to the
7 clinic. A lawyer or a nurse or an architect cannot. Licensee is able to do the certification process
8 precisely because he is a medical doctor and when he is certifying patients for medical
9 marijuana, he is a medical doctor and the person he is seeing is his patient. Licensee owed the
10 same standard of care to that patient that he did to the one coming into his clinic in Portland.
11

12 *Violations of the Standard of Care.* The Board alleges that Licensee's records for the
13 patients seen at the Voter Power clinic do not meet the standard of care expected of a physician,
14 relying primarily upon the report and testimony of Dr. Calvert. Dr. Calvert testified that the
15 "plus minus" system used on the forms at Voter Power was insufficient to explain to any reader
16 what exactly Licensee found in his examination of the patient. Dr. Calvert referred to Licensee's
17 notes as "superficial," "cursory," and "cryptic" in places.¹⁰ He testified that the standard of care
18 was the same for an independent contractor physician as it would be for any other physician.
19

20 Dr. Calvert places little emphasis upon the clearest example of a mistake—the fact that
21 Patient A's personal information and Patient B's medical information ended up on the same
22 documents. However, that episode (and the conflict in testimony between Patient A and
23 Licensee about it) actually illustrates why record-keeping is important, and why a physician must
24 be thorough in describing the actions being taken. In essence, there is nothing in the documents
25 to show that Licensee actually saw Patient A, much less examined him.
26

27 Although the records of five different patients were reviewed by the Board as the basis
28 for this action, the allegations are very similar in all five cases. In all five, Licensee used
29 preprinted physical examination forms, SOAP forms, and "Documentation of Review" forms.
30 On all of those documents, says Dr. Calvert, Licensee's reported information failed to meet the
31 standard of care.
32

33 On the physical exam form, Licensee's comments consisted of circles around plus signs
34 and cryptic and unexplained comments. For instance, he wrote "weakness" in the neurological
35 section of Patient D's form, but did not explain the nature or the extent of the weakness. With
36 terms such as "benign" and "NA," Dr. Calvert was unable to tell what actual findings Licensee
37 had made. Two of the patients' forms had eleven circles; one had 22 circles around plus signs.
38

39 On one SOAP form, Licensee examined Patient B but used the paperwork signed by
40 Patient A. The record indicates that Licensee performed a physical examination on Patient B
41 without verifying that the information at the top of the page (Patient A's information) was
42 accurate. The ALJ accepted Patient A's testimony that he had filled the paperwork out before
43

44 ¹⁰ Licensee demanded that Dr. Calvert define his terms superficial, cursory and cryptic, arguing that those
45 words did not appear in any rule or statute. However, Dr. Calvert's analysis is not a legal analysis but
46 one of the standard of care. Dr. Calvert's definitions of the terms were roughly the same as a dictionary
47 would provide, and were entirely proper to use in his description of the patient notes.

1 the examination, but even if the ALJ did not accept that testimony it would mean that Licensee
2 performed a physical examination without *any* identifying information at the top of the page.
3

4 Licensee argues that Dr. Calvert's conclusion of unprofessional conduct in Patient A's
5 case is incorrect because the record does not contain his actual forms. Although Licensee's
6 argument is buttressed only by the apparent destruction of Patient A's application and documents
7 by Voter Power, the ALJ concluded it would not be appropriate to find unprofessional conduct
8 for the same documents for Patients A and B. Therefore, the ALJ found that the Board has
9 established four (rather than five) counts of unprofessional conduct arising from the way
10 Licensee recorded his findings of the patients. The Board will not disturb this finding and
11 therefore, concludes that Licensee engaged in unprofessional and dishonorable conduct as to
12 Patients A, C, D, and E, but not Patient B.
13

14 However, as to repeated negligence the ALJ found that the Board has established all five
15 counts. In addition to the record-keeping inadequacies, which were both unprofessional and
16 negligent for Patients A-E, it is very appropriate to find two counts of negligence in the mistakes
17 made with the files of Patient A and B. Patient B's forms have Patient A's personal data on the
18 top, and Patient A's forms have Patient B's medical data on the bottom.
19

20 *Willful violation of a Board order.* Licensee was ordered to attend an evaluation at
21 CPEP, and he was given a period of time within which to set the appointment and be evaluated.
22 On December 9, 2009, Licensee wrote to the Board and refused to attend the evaluation. In the
23 letter, he claimed to be one of the best doctors in the State of Oregon and accused the Board of
24 being out to "lynch" him. Licensee threatened the Board, and expressed his anger at the Board's
25 failure to provide records that he was seeking. (Ex. A8).
26

27 Leaving aside the content of the letter for a moment, the ALJ found that the Board proved
28 that Licensee violated its order by refusing to attend the CPEP evaluation. Licensee violated
29 ORS 677.190(17). The ALJ then raised a question as to whether any of Licensee's purported
30 reasons for not attending would excuse his actions.
31

32 Licensee's primary argument at hearing for not attending the CPEP evaluation was that
33 the Board had failed to provide medical documents to Licensee or his attorney. Licensee argued
34 that he did not have to obey the Board's order if the Board had not provided the documents.
35 However, the record fails to show how that delay would excuse Licensee from following the
36 Board's order in this case.¹¹ Licensee cites no rule, statute, or case law in support of his decision
37 to defy the Board.
38

39 More importantly, the content of the refusal letter shows that there were other reasons for
40 his refusal:
41
42
43
44

45 ¹¹ The Board correctly points out, and Licensee admits, that he received the documents within the 90 days
46 he had to schedule the CPEP evaluation. He could have changed his mind after receiving the documents,
47 but did not.

- 1 • Licensee believed that the money spent to be evaluated and attend CPEP would
2 be "money down the toilet" because the Board already had its mind made up
3 about his professional fate;
4 • Licensee believed his confidentiality had been violated by the Board because the
5 Board erroneously sent letters to him, "personal and confidential," at the Voter
6 Power address rather than at his clinic;
7 • Licensee believed the order was "political." "You don't think I know this is
8 political? I am in trouble with the Medical Board because I was willing to sign a
9 statement for individuals that stated that medical marijuana may be beneficial for
10 their medical condition."
11 • Licensee considered the Board to be "incompetent" at best, and "corrupt" at
12 worst, engaging in a "witch hunt" followed by a "kangaroo court" followed by a
13 "lynch mob."
14

15 (Ex. A8).

16
17 None of Licensee's reasons, even if true, justify his refusal to attend the evaluation that
18 the Board requested. The ALJ found that the Board established that Licensee violated ORS
19 677.190(17).
20

21 **The Sanctions**

22
23 As previously noted, at the hearing the Board sought to revoke Licensee's medical
24 license, to impose a \$10,000 civil penalty, and to require him to pay the costs of the litigation.
25 The Board's authority to impose sanctions is found in ORS 677.205, which states in part:
26

27 **Grounds for discipline; action by board; penalties.** (1) The Oregon Medical
28 Board may discipline as provided in this section any person licensed, registered or
29 certified under this chapter who has:
30

31 (a) Admitted the facts of a complaint filed in accordance with ORS 677.200 (1)
32 alleging facts which establish that such person is in violation of one or more of
33 the grounds for suspension or revocation of a license as set forth in ORS 677.190;
34

35 (b) *Been found to be in violation of one or more of the grounds for disciplinary*
36 *action of a licensee as set forth in this chapter;*
37

38 * * * * *

39
40 (2) In disciplining a licensee as authorized by subsection (1) of this section, *the*
41 *board may use any or all of the following methods:*
42

43 (a) Suspend judgment.
44

45 (b) Place the licensee on probation.
46
47

1 (c) Suspend the license.
2

3 (d) Revoke the license.
4

5 (e) Place limitations on the license.
6

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

11 * * * * *

12
13 (4) If the board places any licensee on probation as set forth in subsection (2)(b)
14 of this section, the board may determine, and may at any time modify, the
15 conditions of the probation and may include among them any reasonable
16 condition for the purpose of protection of the public or for the purpose of the
17 rehabilitation of the probationer, or both. Upon expiration of the term of
18 probation, further proceedings shall be abated if the licensee has complied with
19 the terms of the probation.
20

21 (5) If a license issued under this chapter is suspended, the holder of the license
22 may not practice during the term of suspension. Upon the expiration of the term
23 of suspension, the license shall be reinstated by the board if the conditions for
24 which the license was suspended no longer exist.
25

26 (Emphasis added). Every one of the sanctions the Board seeks to impose is within its authority
27 under this statute.
28

29
30 **Proposed Sanctions.** The ALJ found that the Board's assessment of a civil penalty and
31 the requirement to pay costs of the hearing and investigation are reasonable and appropriate, and
32 are accepted without further comment. The ALJ did, however, comment on the Board's desire to
33 revoke Licensee's license.
34

35 The ALJ found that the Board has the authority to revoke his license based upon the
36 violations it has proved in this case. However, the ALJ proposed a different set of sanctions that
37 contain the possibility of restoring Licensee to the practice of medicine but allow the Board to
38 revoke his license if he fails to make appropriate changes.
39

40 The record shows that Licensee failed to meet the standard of care in the way he
41 performed and charted the examinations at the Voter Power clinic. The ALJ noted that no
42 evidence was presented to show whether any problems arose from his practice in Portland. The
43 Board will draw no inference from that observation because that issue was not identified in the
44 Board's Notice nor addressed at the hearing. The ALJ found that the Board should discipline
45 Licensee for his violations, but should consider a plan to allow him to keep his license.
46
47

1 The ALJ did find that there were certain factors that might lead the Board to reject his
2 proposal (discussed in detail below), which were evident throughout the record of this case. The
3 ALJ found that Licensee is arrogant, he is angry at the Board, and he tends to see conspiracies
4 where none have been shown to exist. Licensee can see no wrong in himself, and cannot admit
5 he is wrong. (The ALJ noted that Licensee's testimony insisting that Dr. LeClair's name was
6 really St. Claire, despite evidence to the contrary, is a minor example of this trait. Another is his
7 belief that a record mix-up at the clinic would be "impossible."). Thus, the question exists
8 whether Licensee would be willing to abide by the proposal even if the Board agreed.
9 Nevertheless, the ALJ proposed the following:

- 10
- 11 • That Licensee's license be revoked, but that revocation be held in abeyance;
- 12 • That Licensee be suspended from the practice of medicine for two years, to begin from
- 13 the date of a Final Order in this case;
- 14 • That Licensee be required to undergo an evaluation at CPEP and to follow all
- 15 requirements set by that program, at his own cost, and that the two year suspension be
- 16 extended, if necessary, until he has so complied;
- 17 • That Licensee agree to any further educational or practice-oriented training that the Board
- 18 requires;
- 19 • That Licensee pay a civil penalty of \$10,000; and
- 20 • That Licensee pay the costs of the investigation and hearing, in an amount to be
- 21 determined in the Final Order of this proceeding;
- 22 • That the revocation be imposed without further need for hearing if Licensee fails to
- 23 follow through on any part of this discipline, and that it be withdrawn following
- 24 successful completion of the discipline.
- 25

26 The ALJ stated that his proposal was intended to give Licensee the opportunity to rebuild his
27 relationship with the Board and to gain and apply the skills necessary to meet the standard of
28 care. It would place the onus of his professional future on him. If he refuses to follow through,
29 the revocation could be re-imposed. If he is successful, his patients and his family would benefit
30 from his success.

31 32 **FINAL ORDER**

33
34 The Board issues the following order:

35
36 The Board adopts the ALJ's findings of fact and conclusions of law, finding that
37 Licensee engaged in unprofessional conduct and repeated negligence, and that he violated a
38 Board order by refusing the CPEP evaluation. The Board has considered the ALJ's proposed
39 sanctions, but concludes that Licensee's refusal to accept responsibility for his conduct, his
40 refusal to comply with a Board order, and his continued defiant attitude make him a poor
41 candidate for rehabilitation. Licensee should be disciplined in the manner set forth above.

- 42
- 43
- 44 1. The license of Dr. Dover to practice medicine in Oregon is revoked.
- 45
- 46 2. Dr. Dover must pay a civil penalty of \$10,000 due within 60 days from the date this
- 47 Order is signed by the Board Chair.

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3. Dr. Dover is assessed the full costs of this disciplinary action. Costs shall be due within 90 days from the date the Board issues its Bill of Costs.
 4. Licensee must notify all patients seen within the previous two years of the change in his license status and how patients may access or obtain their medical records. Notifications must be in writing and sent by regular mail to each patient's last known address within 45 days of the change in licensee's status.

DATED this 14th day of January, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

LISA A. CORNELIUS, DPM
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.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
FREDERICK STERLING EY, MD)
LICENSE NO. MD14443) INTERIM STIPULATED ORDER
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. FREDERICK STERLING EY, MD (Licensee) is a licensed physician in the state of Oregon.

2.

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

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

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

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

1
2 4.

3 At the conclusion of the Board's investigation, Licensee's status will be reviewed in an
4 expeditious manner. Following that review, if the Board determines that Licensee shall not be
5 permitted to return to the practice of medicine, Licensee may request a hearing to contest that
6 decision.

7 5.

8 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
9 of protecting the public, and making a complete investigation in order to fully inform itself with
10 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
11 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are
12 confidential and shall not be subject to public disclosure, nor shall they be admissible as
13 evidence in any judicial proceeding. However, as a stipulation this Order is a public document.

14 6.

15 This Order becomes effective the date it is signed by the Licensee.

16
17 IT IS SO STIPULATED THIS 10 day of January, 2011.

18
19 Signature Redacted

20 FREDERICK STERLING EY, MD

21
22 IT IS SO ORDERED THIS 11 day of January, 2011.

23 State of Oregon
24 OREGON MEDICAL BOARD

25 Signature Redacted

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27 KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

JAN 03 2011

In the Matter of)
JEFFREY FRIEDLANDER, MD) ORDER OF LICENSE SUSPENSION
LICENSE NO. MD14269)
)

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. Jeffrey Friedlander, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On October 8, 2009, the Licensee was indicted by the US Attorney for the Middle District of Florida for several felony charges involving the unlawful distribution of controlled substances and healthcare fraud. The Licensee subsequently pled guilty on March 15, 2010, to a single count of conspiracy to unlawfully distribute controlled substances (Oxycodone and Alprazolam) and a single count of conspiracy to commit Medicare fraud. Both offenses are felonies. Court documents indicate that Licensee allowed the prescribing of controlled substances to patients by unauthorized employees without his presence, participation and adequate supervision. Many of these prescriptions were issued for controlled substances to patients without conducting adequate physical examinations, making proper diagnosis or considering alternative treatment options.

3.

On October 15, 2010, subsequent to his March 2010 plea, the Licensee was sentenced in the US District Court for the Middle District of Florida to one hundred eight (108) months confinement and ordered to forfeit \$317,047.13. The Licensee is currently incarcerated at the Federal Correctional Institution in Jesup, Georgia.

1
2 4.

3 ORS 677.225(1)(b) provides that a licensee's medical license is suspended automatically
4 if the licensee is an inmate in a penal institution.

5 5.

6 The license of Licensee to practice medicine is suspended, pursuant to ORS
7 677.225(1)(b). This suspension is effective the date this Order is signed by the Board Chair.
8 This suspension will remain in effect until Licensee presents satisfactory evidence to the Board
9 that Licensee is no longer incarcerated and the Board is satisfied with due regard to the public
10 interest that Licensee's privilege to practice medicine may be restored.

11
12 IT IS SO ORDERED this 28th day of December, 2010.

13 OREGON MEDICAL BOARD
14 State of Oregon

15 Signature Redacted

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17 _____
18 LISA A. CORNELIUS, DPM
19 BOARD CHAIR
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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
CASEY JACOB MAUL, PA)
LICENSE NO. PA00970) INTERIM STIPULATED ORDER
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physician assistants, in the state of Oregon. Casey Jacob Maul (Licensee) is a licensed physician assistant in the state of Oregon.

2.

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

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective the date this Order is signed by the Licensee:

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

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

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4.

At the conclusion of the Board's investigation, Licensee's status will be reviewed in an expeditious manner. If the Board determines, following that review, that Licensee shall not be permitted to return to the practice of medicine, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.265(2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this order is a public document.

6.

This Order becomes effective the date it is signed by the Licensee.

IT IS SO STIPULATED THIS 5 day of January, 2011.

Signature Redacted

IT IS SO ORDERED THIS 6th day of January, 2011.

State of Oregon
OREGON MEDICAL BOARD

Signature Redacted

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

DEC 7 2011

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
LESLIE ARTHUR PLISKIN, MD) STIPULATED ORDER
LICENSE No. MD12017)
)

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. Leslie Arthur Pliskin, MD (Licensee) is a licensed board certified emergency medicine physician in the state of Oregon.

2.

2.1 In a Complaint and Notice of Proposed Disciplinary Action (Notice) dated September 23, 2010, the Board proposed taking disciplinary action 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 by ORS 677.188(4)(a); ORS 677.190(13) gross or repeated negligence in the practice of medicine; and ORS 677.190(14) incapacity to practice medicine.

2.2 Licensee practices at an urgent care center in Oregon's mid-Willamette Valley, where he has seen a high volume of patients. The Board conducted a review of his medical charts pertaining to Patients A - L that revealed practice concerns that are described in the Board's Notice. Licensee also underwent an assessment of his medical knowledge and clinical judgment at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado, to evaluate his practice of urgent care medicine. CPEP is an independent facility used by state licensing agencies, public and private hospitals, malpractice insurance companies, and other

///

1 medical groups to evaluate the practice and competency of physicians nationwide. The findings
2 of the CPEP team of medical evaluators are set forth in the Board's Notice.

3 3.

4 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
5 Licensee understands that he has the right to a contested case hearing under the Administrative
6 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
7 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
8 Order in the Board's records. Licensee neither admits or denies but the Board finds that he
9 engaged in the conduct referenced in paragraph 2 and that this conduct violated ORS
10 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a); ORS
11 677.190(13) gross or repeated negligence in the practice of medicine.

12 4.

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

15 4.1 Licensee is reprimanded.

16 4.2 Licensee is placed on probation for a minimum of five years and will report in
17 person to the Board at each of its quarterly meetings at the scheduled times for a
18 probation interview, unless otherwise directed by the Board's Compliance Officer
19 or its Investigative Committee.

20 4.3 Licensee must pay a fine of \$2,500 within 60 days from the signing of this Order
21 by the Board Chair.

22 4.4 Within 30 days from the approval of this Order, Licensee must sign an agreement
23 with CPEP to complete the CPEP Education Plan, which must be pre-approved by
24 the Board's Medical Director before it goes into effect. Licensee must
25 successfully complete the CPEP Education Plan within 24 months from the date
26 this Order is signed by the Board Chair. Licensee must also sign all necessary
27 releases to authorize full ongoing communication between the Board and CPEP,

1 and Licensee will ensure that periodic progress reports, interim reports and the
2 final written evaluation report from CPEP are provided promptly to the Board.

3 4.5 Licensee will sign and fully cooperate with CPEP in the completion of the written
4 education plan. Licensee will cause CPEP to send a copy of the signed, written
5 Education Plan to the Board. The Education Plan will not go into effect until it is
6 reviewed and approved by the Board's Medical Director.

7 4.6 Licensee will successfully complete the educational activities set out in the
8 Education Plan, including any final evaluation, within the time set out by CPEP,
9 but in no event, more than two years from the effective date of this Order. All
10 instructions made by CPEP will constitute terms of this Order and will be
11 complied with within the time periods set out by CPEP.

12 4.7 Reports by CPEP of late compliance or non-compliance with the terms of the
13 Education Plan will constitute grounds for discipline.

14 4.8 At the conclusion of the Education Plan, Licensee must cause CPEP to submit a
15 final written evaluation report to the Board. This report will include
16 recommendations concerning Licensee's medical knowledge, medical judgment,
17 and his ability and willingness to practice safely and competently.

18 4.9 Licensee's practice, to include his charts, will be subject to no notice compliance
19 audits by the Board's designee.

20 4.10 Licensee will provide a copy of this Order to any employer in the health care
21 field.

22 4.11 Licensee will obey all federal and Oregon State laws and regulations pertaining to
23 the practice of medicine.

24 4.12 Licensee stipulates and agrees that any violation of the terms of this Order will be
25 grounds for further disciplinary action under ORS 677.190(17).

26 ///

27 ///

5.

Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards. This Order becomes effective the date it is signed by the Board Chair.

IT IS SO STIPULATED this 15th day of December, 2010.

Σ Signature Redacted

LESLE ARTHUR PLISKEN, MD

IT IS SO ORDERED this 13th day of January, 2011. L.A.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

LISA A. CORNELIUS, DPM
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
DIANE HENNACY POWELL, MD) STIPULATED ORDER
LICENSE No. MD25438)
)

I.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including physicians, in the state of Oregon. Diane Hennacy Powell, MD, (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is a board-certified solo practitioner in Medford, Oregon. The Board initiated an investigation of Licensee's practice involving Patient A, who is a 59-year-old male patient with a long history of serious mental health conditions, multiple psychiatric admissions, suicidal ideation, and chemical dependency. A review of Licensee's practice and medical records show that Licensee was treating some patients living outside of Oregon primarily by telephone sessions and that Licensee's charting of other in-state patients did not comply with community standards. On October 8, 2010, the Board issued an Order of Emergency Suspension.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. 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 Order in the Board's records. Licensee neither admits or denies but the Board finds that she

1 engaged in the conduct described in paragraph 2 and that this conduct violated ORS
2 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a)(b); and
3 ORS 677.190(13) gross or repeated acts of negligence. Licensee understands that this Order is a
4 public record and is reportable to the National Practitioner Data Bank, Healthcare Integrity and
5 Protection Data Bank, and the Federation of State Medical Boards.

6 4.

7 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order.
8 Effective the date this Order is signed by the Board Chair, Licensee's Order of Emergency
9 Suspension from October 8, 2010, is terminated and Licensee is returned to practice subject to
10 the following terms and conditions:

11 4.1 Licensee will not conduct therapy or treatment sessions by telephone with any
12 patient except when a patient has a medical emergency requiring changes involving medications
13 or refills; and/or coordinating any continuity of care with other health care providers.
14 Subsequent to any telephone session occasioned by a medical emergency or changes involving
15 medications or refills, Licensee will meet with the patient face-to-face within a reasonable time
16 thereafter.

17 4.2 Licensee must complete a charting course that is pre-approved by the Board's
18 Medical Director within six months from the date that this Order is signed by the Board chair.

19 4.3 Licensee must have monthly chart review and mentoring by a board-certified
20 psychiatrist, who is pre-approved by the Board's Medical Director. This chart review and
21 mentorship shall last for six continuous months with the psychiatric mentor submitting monthly
22 reports to the Board's Medical Director. Any costs involving this mentorship shall be borne by
23 Licensee.

24 4.4 Licensee's practice setting and patient records may be subject to no-notice
25 inspections by the Board's Compliance Officer or investigative staff to ensure compliance with
26 the terms of this Order.

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
DAVID WHITMAN SHOEMAKER, MD) ORDER TERMINATING
LICENSE NO. MD17620) FINAL ORDER
)

1.

On August 2, 2007, The Oregon Medical Board (Board) entered into a Final Order with David Whitman Shoemaker, MD (Licensee). This Order imposed sanctions, which included suspension of Licensee's Oregon medical license. On July 10, 2008, the Board modified the Final Order, which lifted the license suspension and granted Licensee a Limited License for the purpose of entering a re-training program.

2.

Having fully considered Licensee's successful compliance with the terms of this Order, to include training program completion and Board certification in radiology, the Board does hereby order that the August 2, 2007 Final Order, and all subsequent Orders Modifying Final Order, be terminated effective the date this Order is signed by the Board Chair. Licensee will be granted an unlimited license to practice medicine in Oregon.

IT IS SO ORDERED this 13th day of January, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

LISA A. CORNELIUS, DPM
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
EDUARDO RODOLFO VALENZUELA, PA) STIPULATED ORDER
LICENSE NO PA00950)
)

1.
2.

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

3.

In a Complaint and Notice of Proposed Disciplinary Action, dated October 21, 2010, the Board proposed to take disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.080(4) engaging in the unlicensed practice of medicine; ORS 677.190(1)(a), unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or repeated negligence in the practice of medicine; ORS 677.190(17) willfully failing to comply with any Board statute or rule or failing to comply with a Board request and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

4.

3.1 Licensee was terminated for cause from his practice in the emergency department at Mercy Medical Center in Roseburg, Oregon, on February 8, 2010. Licensee failed to report this official action, incident or event within ten days as required by ORS 677.415. Additionally, Licensee failed to report the termination of his relationship with a supervising physician within

1 fifteen days in accordance with OAR 847-050-0050. The Board placed Licensee on inactive
2 status on February 9, 2010.

3 On May 4, 2010, the Board opened an investigation after receiving credible information
4 that Licensee was under investigation by the police department in Florence, Oregon, regarding
5 allegations that Licensee was prescribing medications for patients without legal authority. On
6 May 5, 2010, Licensee entered into an Interim Stipulated Order in which Licensee agreed to
7 cease the practice of medicine until the investigation was completed.

8 3.2 A review of selected patient charts (Patients A – R) reveals a pattern of
9 substandard care, poor chart documentation and disregard of legal and ethical standards.

10 Specific examples of this pattern of conduct include the following:

11 a. Patient A, a 61-year-old male, was seen by Licensee in the Mercy Medical Center
12 Emergency Room (ER) on September 6, 2009. Patient A had a history of myocardial
13 infarctions and was on Coumadin (Warfarin, an anti-coagulant). Patient A complained of
14 continuing hip pain, having fallen the week previous and injuring his left hip. Patient A
15 had extensive bruising around the left hip area. Patient A's laboratory studies reflected a
16 hematocrit of 20.1, hemoglobin of 6.9 and INR (International Normalized Ratio) of 3.66.
17 A CT scan was negative for fracture. Licensee failed to note Patient A's anemia and did
18 not document a plan for follow-up.

19 b. Patient B, a 4-year-old male, presented at the ER on August 24, 2009,
20 complaining of a peanut wedged in his right ear. Licensee unsuccessfully attempted to
21 remove the peanut with forceps, resulting in bleeding and complaints of pain. Three days
22 later, another health care provider observed that Patient B's eardrum was ruptured.

23 c. Patient C, a 47-year-old female, presented to Licensee at the ER on November 21,
24 2009, complaining of vaginal pain sustained from a sexual assault with trauma to the
25 pelvic area. Licensee's notes are illegible and failed to document whether he performed a
26 pelvic examination on this patient.

27 ///

1 d. Patient D, an adult male, attempted to fill a prescription written by Licensee for
2 Oxycodone (Schedule II) at the Rite Aid pharmacy in Florence, Oregon on April 27,
3 2010. Licensee did not have the legal authority to write a prescription at this time,
4 because his license was inactive and he did not have a Board approved practice
5 description or supervising physician. Upon questioning, Licensee acknowledged to the
6 Board that he had previously written monthly prescriptions of hydrocodone &
7 acetaminophen (Vicodin, Schedule III) for this patient. Licensee failed to maintain a
8 medical record for this patient. Licensee has admitted that he lied to the pharmacist
9 attempting to fill this prescription when asked to confirm the validity of the prescription.

10 e. Beginning in 2008 and continuing until April 24, 2010, Licensee provided
11 medical care to a number of friends, family members and associates in a non-clinical
12 setting without a supervising physician, to include prescribing both controlled and non-
13 controlled medications for them (Patients D – R). Licensee has acknowledged to the
14 Board that he did not maintain medical records for any of these patients. Licensee's
15 above described conduct after the inactivation of his license by the Board on February 9,
16 2010, constituted the unlicensed practice of medicine and is grounds for discipline as
17 expressed in ORS 677.080(4) and OAR 847-050-0035.

18 4.

19 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
20 Licensee understands that he has the right to a contested case hearing under the Administrative
21 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
22 right to a contested case hearing and any appeal rights by the signing of and entry of this Order
23 in the Board's records. Licensee understands that this Order is a disciplinary action and is
24 reportable to the Federation of State Medical Boards, National Practitioner Data Bank (NPDB)
25 or the Healthcare Integrity and Protection Data Bank (HIPDB). Licensee understands that this
26 Order is a public document. Licensee stipulates that he engaged in the conduct described in
27 section 3. Licensee stipulates and the Board finds this conduct violated ORS 677.080(4)

1 engaging in the unlicensed practice of medicine; ORS 677.190(1)(a), unprofessional or
2 dishonorable conduct, as defined by ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or
3 repeated negligence in the practice of medicine; ORS 677.190(17) willfully failing to comply
4 with any Board statute or rule or failing to comply with a Board request and ORS 677.190(24)
5 prescribing controlled substances without a legitimate medical purpose, or prescribing controlled
6 substances without following accepted procedures for examination of patients, or prescribing
7 controlled substances without following accepted procedures for record keeping.

8 5.

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

11 5.1 Licensee is reprimanded.

12 5.2 Licensee surrenders his license to practice medicine while under investigation.

13 5.3 The Interim Stipulated Order of May 5, 2010 is terminated.

14 5.4 Licensee agrees not to apply for an active license for a period of two (2) years
15 from the date this Order is signed by the Board Chair.

16 5.5 Licensee stipulates and agrees that any violation of the terms of this Order shall
17 be grounds for further disciplinary action under ORS 677.190(17).

18
19 IT IS SO STIPULATED this 27 day of Dec, 2010.

20 Signature Redacted

21 EDUARDO VALENZUELA, PA

22
23 IT IS SO ORDERED this 13th day of January, 2011.

24 OREGON MEDICAL BOARD
25 State of Oregon

26 Signature Redacted

27 LISA A. CORNELIUS, DPM
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of
YORAM YAKIMOVSKY, MD
LICENSE NO. MD12635

} 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. Yoram Yakimovsky, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On November 4, 2010, the Board proposed taking disciplinary action 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).

3.

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

3.1 On November 3, 2009, Licensee provided general anesthesia in the operating room (OR) at Legacy Emanuel Medical Center in Portland, Oregon, to Patient A, an adult male who was undergoing surgery to repair a ruptured forearm tendon. Patient A was sedated with Midazolam (Versed, Schedule IV) and Fentanyl (Schedule II) drips to Patient A in the Intensive Care Unit (ICU) by the trauma team. In preparation for surgery, Licensee transported Patient A to the OR at about 1445, where Licensee continued the Versed and Fentanyl drips, and supplemented them with Desflurane gas using the anesthesia ventilator. At about 1510, Licensee administered Rocuronium (Zemuron), a neuromuscular blocking agent, to Patient A. At about the same time, Licensee received several calls from a nurse in regard to another patient, Patient B, who was downstairs in the post anesthesia care unit (PACU) recovering from surgery. This nurse informed Licensee that

Yoram Yakimovsky
11/10/11

1 Data Bank and the Federation of State Medical Boards.

2 5.

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

5 5.1 Licensee is reprimanded.

6 5.2 License is fined \$2,500 payable within 90 days from the date this Order is signed
7 by the Board Chair.

8 5.3 Licensee stipulates and agrees that any violation of the terms of this Order shall
9 be grounds for further disciplinary action under ORS 677.190(17).

10 6.

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

12

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14 IT IS SO STIPULATED this 10th day of January 2011.

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Signature Redacted

17

YORAM YAKIMOVSKY, MD

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20 IT IS SO ORDERED this 13th day of January 2011.

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OREGON MEDICAL BOARD
State of Oregon

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Signature Redacted

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LISA A. CORNELIUS, DPM
Board Chair

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