

Oregon Medical Board  
**BOARD ACTION REPORT**  
**January 15, 2015**

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between December 16, 2014 and January 15, 2015.

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

Printed copies of the Board Orders not provided with this report are available to the public. To obtain a printed copy of a Board Order not provided in this report, please complete a Service Request Form (<http://egov.oregon.gov/BME/PDFforms/VerDispMalFillin.pdf>) found under the Licensee Information Request Form link on the Board's web site, submit it with the \$10.00 fee *per licensee* and mail to:

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

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

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**\*Anderson, Lance Emanuel, MD; MD22975; Portland, OR**

On January 8, 2015, the Board issued a Default Final Order for unprofessional or dishonorable conduct; gross or repeated negligence in the practice of medicine; willfully violating any provision of the Board's statute, rule, board order or board request; refusing an invitation for an informal interview with the Board; violating the federal Controlled Substances Act; prescribing a controlled substance 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; and practicing medicine without a license. This Order revokes Licensee's medical license.

**\*Boespflug, Randolph Roy, MD; MD15363; Florence, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order reprimands Licensee; assesses a civil penalty of \$3,000; requires Licensee to complete pre-approved courses on medical documentation and opiate prescribing; places Licensee on probation; prohibits Licensee from treating chronic pain; and limits Licensee's prescribing of Schedule II stimulant medications.

**\*Dempsey, Jackson Tyler, MD; MD15946; Grants Pass, OR**

On January 8, 2015, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's October 3, 2013, Stipulated Order.

**\*Druzdel, Maciej Janusz, MD; MD18563; Gold Beach, OR**

On December 19, 2014, Licensee entered into an Interim Stipulated Order to voluntarily cease the treatment of chronic pain within 90 days, with the exception of hospice patients, pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**\*Dyson, Robert Duane, MD; MD11274; Portland, OR**

On January 8, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved update course on gynecology and work under a pre-approved proctor for ten gynecologic surgery cases who will then submit a report to the Board regarding Licensee's clinical judgment and surgical skills.

**\*Fitzsimons, Josephine Marie, MD; MD17657; Bend, OR**

On January 8, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's April 3, 2014, Corrective Action Agreement.

**\*Fortune, Michael Arthur, MD; MD14008; Adair Village, OR**

On January 8, 2015, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's January 9, 2014, Consent Agreement.

**\*Jackson, Larry Arthur, MD; MD08513; Springfield, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated acts of negligence. This Order assesses a \$5,000 civil penalty (\$4,000 held in abeyance), places Licensee on probation; requires Licensee to enroll in CPEP and complete any education plan; prohibits Licensee from treating chronic pain; and requires Licensee to complete a pre-approved prescribing course.

**\*Mazur, Dennis John, MD; MD15399; Wheeler, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional conduct, and fraud or misrepresentation in applying for or procuring a license to practice in this state, or in connection with applying for or procuring registration. This Order retires Licensee's medical license while under investigation.

**\*Meeker, Stephen Randall, LAc; AC00127; Lake Grove, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and willfully violating the terms of a board order. This Order reprimands Licensee; assesses a \$5,000 civil penalty; requires practice site approval; allows for no-notice practice site audits; requires Licensee to comply with recommendations made by a board-approved healthcare professional; requires that Licensee practice in compliance with the NCCAOM Code of Ethics; and requires that Licensee keep accurate records of each patient visit; places Licensee on probation.

**Morehouse, Samuel Huntington, PA; PA00881; Portland, OR**

On January 13, 2015, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to specific requirements regarding supervision and chart review

from his supervising physician, that his supervising physician would submit reports to the Board regarding his progress in his return to the practice of medicine, and to practice only in settings pre-approved by the Board.

**\*Muller, Christopher Martin, MD; MD16728; Coos Bay, OR**

On January 8, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 11, 2013, Corrective Action Agreement.

**\*Nelson, Stephen Lanier, MD; MD18996; Medford, OR**

On December 24, 2014, Licensee entered into an Amended Interim Stipulated Order which allows for an exception for hospice patients.

**\*Perry, Bruce Edgar, MD; MD16305; Grants Pass, OR**

On January 8, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's April 3, 2014, Corrective Action Agreement.

**\*Purtzer, Thomas John, MD; MD12880; Murphy, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; willfully violating any rule adopted by the Board or any Board order or any Board request; violation of the federal Controlled Substance Act; and prescribing controlled substances without a legitimate medical purpose, or prescribing without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping. This Order surrenders Licensee's medical license while under investigation.

**\*Queeley, Philip William, LAc; AC00862; Portland, OR**

On January 8, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete pre-approved courses on professional conduct and ethics, and medical record keeping.

**\*Roddy, Timothy James, MD; MD14358; Vancouver, WA**

On January 8, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 10, 2014, Corrective Action Agreement.

**\*Rowley, Mark Calvin, MD; MD18314; Silverton, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence in the practice of medicine. This Order places Licensee on probation; and requires Licensee to complete the CPEP Education Plan and pre-approved courses on medical documentation and fetal monitoring.

**\*Sharma, Bhanoo, MD; MD150955; Hazel Crest, IL**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated negligence in the practice of medicine. This Order revokes Licensee's medical license, however the revocation is stayed; reprimands Licensee; assesses a \$10,000 civil penalty; requires Licensee to complete a pre-approved course in charting and 25 hours of pre-approved CME in perioperative management; requires Board approval for all practice settings; requires that all outpatient surgeries be performed in facilities accredited by the Accreditation Association for Ambulatory Healthcare; and requires that Licensee report any surgical complications to the Board for any Oregon patient.

**\*Stapleton, Joseph Paul, MD; MD13551; Happy Valley, OR**

On January 8, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 12, 2012, Corrective Action Agreement.

**\*Stapleton, Joseph Paul, MD; MD13551; Happy Valley, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order reprimands Licensee; assesses a civil penalty of \$6,000; requires that Licensee complete a pre-approved course on medical ethics; requires Licensee to submit charts to a pre-approved practice consultant who will provide quarterly reports to the Board; requires Licensee to implement a protocol to address the risk of wrong-site surgery; and allows the Board to conduct no-notice audits of Licensee's practice.

**\*Thomas, Harold Andrew, Jr., MD; MD14766; Lake Oswego, OR**

On January 8, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional conduct. This Order retires Licensee's medical license while under investigation.

**\*Van Winkle, Jenny Kathleen, LAc; AC155499; Ashland, OR**

On January 8, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's June 29, 2011, Corrective Action Agreement.

**\*White, Keith Allen, MD; MD10976; Independence, OR**

On January 8, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete courses in boundaries and pain management, and 40 hours of pre-approved CME in chronic pain management; conduct a risk assessment of all chronic pain patients; meet monthly for 12 months with a pain specialist for the purpose of chart review of chronic pain patients; and open his practice to random chart audits of chronic pain patients after 12 months.

**\*Williams, Ryan Elizabeth, DO; DO154545; Welches, OR**

On January 8, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course in chronic pain and 20 hours of pre-approved CME; and bi-monthly meetings with a pre-approved physician for the purpose of chart review of chronic pain patients.

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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 practice group address, which is the last known address provided by Licensee to the Board. Each  
2 licensee of the Board has an obligation to notify the Board in writing within 30 days of any  
3 change in residence address, practice location or mailing address, OAR 847-008-0060. Licensee  
4 did not submit a request for a hearing.

5 3.

6 NOW THEREFORE, after considering the Board's file relating to this matter, the Board  
7 enters the following Order.

8 FINDINGS OF FACT

9 Licensee is a psychiatrist who most recently practiced medicine in Portland, Oregon. The  
10 acts and conduct by Licensee that violated the Medical Practice Act as set forth in paragraph 2  
11 (above) are:

12 3.1 The Board conducted a review of charts for patients (Patients A – F), which  
13 revealed a pattern of inappropriate prescribing for patients of stimulants, opioids and  
14 benzodiazepines that was not medically indicated. Licensee failed to support many of his  
15 diagnoses with data that would satisfy the diagnostic criteria, and prescribed combinations of  
16 opioids and benzodiazepines for patients that were at high risk of dependence or abuse.  
17 Licensee's pattern of prescribing combinations of controlled substances put patients at risk of  
18 harm. Licensee also prescribed opioids and benzodiazepines to treat chronic pain without  
19 documenting the following: an adequate history or physical examination prior to prescribing for  
20 chronic pain; material risk notification and informed consent; periodic urine drug screening tests;  
21 medication verification and coordination of care with other providers; and maintaining a current  
22 medication list or other means of documenting the ongoing medications and dosages that his  
23 patients were taking throughout the course of treatment.

24 3.2 Specific concerns in regard to individual patient care for Patients A - F include the  
25 following:

26 a. Patient A, a 51-year-old male, initially presented to Licensee in May of  
27 2008 with an ongoing prescription of duloxetine (Cymbalta, an anti-depressant) from another

1 therapist. Patient A reported a history of depression, alcohol and drug abuse and attention  
2 deficit disorder (ADD). Licensee initiated treatment of ADD with methylphenidate (Ritalin,  
3 Schedule II) 10 mg, ½ - 2 tablets, twice a day, without establishing the basis for the diagnosis in  
4 the chart. Licensee increased the dosage on May 28, 2008 to 20 mgs, and on July 2, 2008  
5 introduced clonazepam (Klonopin, Schedule IV) .5 mg, 1/2 – 2 tablets twice a day. In 2010,  
6 Licensee increased the dosage for Ritalin to 20 mg, 3 tablets every afternoon Licensee  
7 increased Ritalin dosage in May of 2012 to 20 mg, 3 tablets three times a day, without explaining  
8 the medical indications, other than some comments about ongoing fatigue and difficulty with  
9 concentration. Licensee maintained Patient A on this dosage through December of 2012. This  
10 dosage of Ritalin was excessive and was not medically indicated. Licensee continued to  
11 authorize prescription refills with infrequent patient follow-up visits to the clinic. On December  
12 12, 2012, Licensee received a credible report that Patient A was “crushing up Ritalin and  
13 snorting it” and that he had diverted Ritalin prescribed for his partner for his own use. Licensee  
14 failed to follow up on this report, and failed to document that he informed Patient A of the risks  
15 associated with taking prescribed habit forming medications such as Klonopin and Ritalin for a  
16 patient with a history of substance abuse and dependence, and failed to monitor Patient A’s  
17 compliance with the treatment plan.

18           b.       Patient B, a 50-year-old male, initially presented to Licensee in early  
19 2006. Licensee’s assessment included obsessive-compulsive disorder (OCD), severe; major  
20 depressive disorder, recurrent, severe; and a history of alcohol abuse vs. dependence. Licensee’s  
21 progress notes reflect prescriptions of different controlled substances, to include diazepam  
22 (Valium, Schedule IV) and alprazolam (Xanax, Schedule IV) (both are benzodiazepines),  
23 without documented medical indications. There are chart references to methylphenidate (Ritalin,  
24 Schedule II) and naltrexone, but without a supporting assessment, treatment plan, or informed  
25 consent. In April 2011, Patient B underwent inpatient treatment for alcohol dependence. On  
26 March 28, 2012, Licensee noted that methylphenidate (Ritalin, Schedule II) was helping Patient  
27 B’s OCD. On April 10, 2012, Licensee’s chart notes make reference to hip pain and a discussion

1 of using “Norco to see if it is enough.” On May 7, 2012, Licensee added hydrocodone and  
2 acetaminophen (Norco, Schedule III) as an adjunct treatment for OCD. On May 10<sup>th</sup>, Licensee  
3 switched Norco to oxycodone (Schedule II). In mid-2012, Licensee noted that Patient B’s  
4 gambling and drinking “are better.” On July 12, 2012, Licensee listed the following medications  
5 that were prescribed for Patient B in the chart: sertraline (Zoloft, an anti-depressant), 400 mg;  
6 aripiprazole (Abilify) 45 mg; oxycodone 5 mg; and dextroamphetamine (Adderall XR 30,  
7 Schedule II). On June 11, 2013, the medication regimen included Zoloft 400mg; Abilify 45;  
8 Oxycontin (Schedule II); lorazepam (Ativan, Schedule IV) “occasionally,” and methylphenidate  
9 (Concerta, Schedule II). Licensee often failed to chart dosage information for the medications  
10 that he was prescribing; and Licensee failed to chart his medical rationale for treating Patient B  
11 with opiate medications in combination with benzodiazepines. In addition, Licensee did not  
12 employ urine drug screening tests to assess patient compliance with the treatment plan. Although  
13 Licensee charted patient responses such as the medication was “helpful” or made him “sleepy;”  
14 he did not conduct ongoing assessments of patient response to the medication regimen.

15 c. Patient C, a 28-year-old adult female, first presented to Licensee in 2010  
16 with a history of depression and post-traumatic stress disorder. Licensee charted a diagnosis of  
17 attention deficit disorder (ADD), but failed to document data that would support this conclusion.  
18 Licensee’s chart notes make it difficult to follow the medication dosages that he prescribed, or  
19 the medical indications and patient response to the treatment regimen. On March 1, 2010,  
20 Licensee prescribed Adderall XR 20 mg, twice a day, #60. A progress note for November 30,  
21 2011, notes that Patient C had recent surgery and was “running out of oxycodone from taper  
22 after surgery...” and to continue Adderall, Zoloft and lorazepam. Licensee apparently agreed to  
23 assume responsibility for prescribing narcotic medications for pain. Licensee maintained Patient  
24 C on a dosage of oxycodone, 10 mg, 1 – 2 tablets every 4 hours. A chart entry dated February 6,  
25 2012, indicates that Licensee was prescribing Adderall XR, 20 mg, 2 times a day. On November  
26 13, 2013, Licensee prescribed Xanax, .5 mg, 1 – 2 tablets twice a day; oxycodone 10 mg, 1 – 2  
27 tablets every 4 hours; oxycodone HCL, 30 mg, 1 – 2 tablets 5 times per day; and Adderall 30 mg

1 4 tablets per day. Licensee's evaluation of Patient C lacked sufficient information to support a  
2 diagnosis of ADD or the subsequent treatment with Adderall. Licensee also prescribed large  
3 amounts of opioid medications (oxycodone) without an adequate history, physical examination,  
4 or formulation of the pain issues or follow-up on the treatment plan, and failed to provide proper  
5 oversight and monitoring, to include use of random urine drug screens.

6 d. Patient D, an 18-year-old female, initially presented to Licensee on March  
7 13, 2008, with a history of depression, PTSD, chronic pain secondary to motor vehicle accident,  
8 and panic attacks. Licensee noted that Patient D was 7 months pregnant and was taking  
9 oxycodone (Oxycontin) and was trying to decrease clonazepam (Klonopin, Schedule IV).  
10 Licensee's charting for January 13, 2011, refers to Patient D working on a plan to taper opiates  
11 and clonazepam. Chart notes in 2012 indicate that Licensee assumed responsibility for providing  
12 chronic pain medications. In March of 2013, Licensee was prescribing Oxycontin, 60 mg a day,  
13 and clonazepam, 2 mg, 4 times a day. Licensee prescribed opioid medications in combination  
14 with a benzodiazepine (clonazepam) without conducting an adequate physical examination to  
15 determine the cause of Patient D's pain, failed to provide chart notes where the dosage and  
16 patient response to treatment can be followed, and failed to provide proper oversight and  
17 monitoring, to include use of random urine drug screens or a pain contract.

18 e. Patient E, a 42-year-old female, initially presented to Licensee in April of  
19 2011. Licensee charted a diagnosis on April 22, 2011, of Obsessive Compulsive Disorder  
20 (OCD), noting "compulsive traits at least, shoplifting." Licensee did not chart sufficient  
21 information to support a diagnosis of OCD. On May 14, 2012, Licensee noted "continue  
22 Effexor" and he charted that he could cover her prescriptions for Vicodin (Schedule III) and  
23 benzodiazepines for a short term. At this time, Patient E's regimen included clonazepam, 2 mg  
24 daily; diazepam (Valium, Schedule IV) 20 mg daily; hydrocodone & acetaminophen (Vicodin,  
25 Schedule III) 7.5/325 mg, 3 tablets daily; and carisoprodol (Soma, Schedule IV). Licensee  
26 continued this pattern of prescribing into 2013. In May of 2013, Licensee was prescribing the  
27 following combination of medications: clonazepam, 2 mg #120; Oxycontin (Schedule II) 40 mg

1 #60; oxycodone (Schedule II) 15 mg #90; and carisoprodol 350 mg #180. Licensee assumed  
2 responsibility for prescribing chronic pain medications without establishing the medical  
3 justification to support his prescribing. Licensee also failed to chart the dosage and patient  
4 response to treatment, failed to provide proper oversight and monitoring, to include use of  
5 random urine drug screens or a pain contract.

6 f. Patient F, a 59-year-old male, initially presented to Licensee in November  
7 of 2012. Licensee's assessment included PTSD, OCD, ADD, and pain secondary to a motor  
8 vehicle accident, but failed to document the medical indications that would support these  
9 diagnoses. Licensee placed Patient F on a regimen of bupropion (Wellbutrin XL) 150 mg, 3  
10 tablets daily; Celexa 80 mg; Adderall XR 30 mg 3 tablets daily; Adderall IR 30 mg daily;  
11 clonazepam 2 mg, as needed; Oxycontin 80 mg daily; oxycodone 5 mg, as needed but not to  
12 exceed 6 tablets per day. No urine drug screens or pain contract were used. Licensee  
13 occasionally noted the need to refer Patient F to a pain clinic, but this was never accomplished,  
14 he also noted the desire to reduce the medications, but this was not done either. For instance, on  
15 February 26, 2013, Licensee noted "Continue to look for pain clinic. On oxycodone for pain and  
16 for disabling OCD – but dose based on pain." Licensee continued to prescribe oxycodone HCL  
17 30 mg #280 on April 6, 2013. In April- May of 2013, Licensee also prescribed amphetamine  
18 salts (Schedule II) 30 mg #150 and D-Amphetamine ER (Schedule II) 10 mg #150, apparently  
19 for ADD.

20 3.3 On November 14, 2013, the Board issued an Interim Stipulated Order (ISO) in  
21 which Licensee agreed to voluntarily withdraw from the practice of medicine pending  
22 completion of the Board's investigation into his ability to safely and competently practice  
23 medicine. On June 16, 2014, Licensee wrote prescriptions for oxycodone (Schedule II),  
24 dextroamphetamine (Dexedrine, Schedule II) and bupropion (Wellbutrin) for a patient that  
25 attempted to fill the prescriptions. On March 24, 2014, Licensee posted a tweet in which he  
26 wrote the following: "HAVING Q'S ABOUT DIAGNOSES OR MEDS USED?? 14 yrs  
27 experience in advanced psychopharmacology in Portland. I love doing 2<sup>nd</sup> opinions." These

1 actions constitute the practice of medicine. Licensee violated the terms of the ISO by writing  
2 prescriptions and by soliciting patients after he had agreed to withdraw from the practice of  
3 medicine. Licensee also violated the federal Controlled Substances Act and its implementing  
4 regulation 21 CFR § 1306.03 by writing prescriptions for controlled substances when he lacked  
5 the legal authority to do so.

6 3.4 In a letter dated July 17, 2014, Licensee was invited to appear before the Board's  
7 Investigative Committee on August 7, 2014, for an informal interview, pursuant to ORS  
8 677.320(5). The Board subsequently received a post card that was postmarked July 23, 2014,  
9 from Newport Beach, California, in the handwriting of Licensee stating the following: "Beach  
10 bound, not sure I can make it back." Licensee failed to appear on August 7, 2014, for the  
11 interview, violating ORS 677.190(17) and ORS 677.190(22).

12 3.5 In 2013, Licensee maintained Patient G, a 33-year-old male, on a course of  
13 clonazepam (Klonopin, Schedule IV) and escitalopram (Lexapro). On July 12, 2013, Patient G  
14 called the pharmacy to refill his prescription for clonazepam. The pharmacy informed Patient G  
15 that the refills had "run out." Patient G asked the pharmacy to send a refill request to Licensee.  
16 Patient G subsequently called Licensee's clinic and left a message requesting a refill. Patient G  
17 ran out of clonazepam on July 15, 2013. Patient G repeatedly called Licensee's clinic (the  
18 voicemail box was full) and the pharmacy, asking for refill. On July 17, 2013, the pharmacy  
19 indicated that they had sent refill requests to Licensee's clinic, but had not received a response.  
20 In the late afternoon of July 17, 2013, Patient G began to experience negative physical  
21 symptoms, to include dizziness, inability to focus, loss of balance and nausea, which were likely  
22 attributable to clonazepam withdrawal. On July 19, 2013, Patient G continued to experience  
23 profound discomfort. He finally received a refill order from Licensee in the late afternoon of  
24 that day. Licensee's failure to provide a timely refill order or to timely respond to Patient G's  
25 requests for assistance constituted patient abandonment and subjected Patient G to unnecessary  
26 discomfort.

27 ///



1 677.190(23) violating the federal Controlled Substances Act; ORS 677.190(24) prescribing a  
2 controlled substance without a legitimate medical purpose, or prescribing controlled substances  
3 without following accepted procedures for examination of patients, or prescribing controlled  
4 substances without following accepted procedures for record keeping; and ORS 677.080(4)  
5 practicing medicine without a license by engaging in the practice of medicine after he signed the  
6 Interim Stipulated Order in which he withdrew from the practice of medicine.

7 5.

8 **ORDER**

9 The Board has the statutory duty to protect the public from the practice of medicine from  
10 the unprofessional conduct by persons licensed to practice medicine, ORS 677.015. Licensee  
11 has engaged in various acts of unprofessional or dishonorable conduct that subjected his patients  
12 to the risk of harm; engaged in multiple acts of gross or repeated acts of negligence; willfully  
13 violated the Board's rules and the terms of the Interim Stipulated Order; violated the Federal  
14 Controlled Substances Act; refused to respond to investigative demands for the production of  
15 documents; and refused to appear for an interview with the Board's Investigation Committee. In  
16 order to protect the public and appropriately address his conduct, his license must be revoked.

17 IT IS HEREBY ORDERED THAT the license of Lance Emanuel Anderson, M.D., to  
18 practice medicine is revoked.

19 The Interim Stipulated Order of November 14, 2013, terminates when the revocation of  
20 Licensee's medical license goes into effect.

21 DATED this 8 day of January, 2015.

22 OREGON MEDICAL BOARD  
23 State of Oregon

24 **SIGNATURE REDACTED**

25 \_\_\_\_\_  
26 DONALD GIRARD, MD  
27 BOARD CHAIR

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**CERTIFICATE OF MAILING**

On January 13, 2015, I mailed the foregoing Default Final Order regarding Lance Emanuel Anderson, MD to the following parties:

**By: First Class Certified/Return Receipt U.S. Mail**  
**Certified Mail Receipt # 7014 2120 0001 8296 4953**

Lance Emanuel Anderson, MD  
3583 NE Broadway Street  
Portland, OR 97232

**By: UPS GROUND**

Warren Foote  
Department of Justice  
1162 Court St NE  
Salem OR 97301

Beverly Loder  
Beverly Loder  
Investigations Secretary  
Oregon Medical Board

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
RANDOLPH ROY BOESPFLUG, MD ) STIPULATED ORDER  
LICENSE NO. MD15363 )

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. Randolph Roy Boespflug MD (Licensee) is a licensed physician in the state of Oregon.

2.

On July 15, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that Licensee engaged in the conduct described in paragraph 2 above and that this conduct violated

1 ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(13); and ORS 677.190(24).  
2 Licensee understands that this Order is a public record and is a disciplinary action that is  
3 reportable to the National Data Bank and the Federation of State Medical Boards.

4 4.

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

7 4.1 Licensee is reprimanded.

8 4.2 Licensee must pay a civil penalty of \$3,000. Licensee may make payments of no  
9 less than \$250 at intervals of his choosing with the final payment being made no later than 180  
10 days from the signing of this Order by the Board Chair.

11 4.3 Within 180 days from the signing of this Order by the Board Chair, Licensee must  
12 successfully complete a course on medical documentation and a course on opiate prescribing that  
13 are pre-approved by the Board's Medical Director.

14 4.4 Licensee is placed on probation for five years. Licensee must report in person to  
15 the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a  
16 probationer interview unless directed to do otherwise by the Board or its Compliance Officer.  
17 After two years of compliance with this Order, and completion of terms 4.2 and 4.3 of this  
18 Order, Licensee may submit a written request to modify this term.

19 4.5 Licensee must not treat chronic pain. For the purposes of this Order, chronic pain  
20 is defined as pain that persists or progresses over a period of time greater than 30 days. Licensee  
21 must not prescribe any medication for pain for any one patient in excess of 30 days for any one  
22 year period and never in conjunction with any benzodiazepine (Schedule IV).

23 4.6 Licensee may only prescribe Schedule II stimulant medications for a patient if a  
24 psychiatrist licensed in the state of Oregon has diagnosed a well-recognized health condition  
25 (such as attention deficit disorder) that is treatable with Schedule II stimulant medications.  
26 Documentation of the health condition diagnosis must be recorded in Licensee's patient charts.

27 4.7 Licensee stipulates and agrees that this Order becomes effective the date it is  
28 signed by the Board Chair.

1           4.8    Licensee must obey all federal and Oregon state laws and regulations pertaining  
2 to the practice of medicine.

3           4.9    Licensee stipulates and agrees that any violation of the terms of this Order shall  
4 be grounds for further disciplinary action under ORS 677.190(17).

5  
6                   IT IS SO STIPULATED THIS 19<sup>th</sup> day of December, 2014.

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8                                   SIGNATURE REDACTED  
9                                   RANOLDPH ROY BOESPFLUG, MD

10                   IT IS SO ORDERED THIS 8 day of January, 2015.

11                                   OREGON MEDICAL BOARD  
12                                   State of Oregon

13                                   SIGNATURE REDACTED  
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15                                   DONALD GIRARD, MD  
16                                   BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
JACKSON TYLER DEMPSEY, MD ) ORDER TERMINATING  
LICENSE NO. MD15946 ) STIPULATED ORDER  
 )

1.

On October 3, 2013, Jackson Tyler Dempsey, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On October 14, 2014, Licensee submitted a written request to terminate term 4.2 of this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the October 3, 2013, Stipulated Order in its entirety, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 8 day of January, 2015.

OREGON MEDICAL BOARD  
State of Oregon

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DONALD GIRARD  
Board Chair

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of

MACIEJ JANUSZ DRUZDZEL, MD  
LICENSE NO. MD18563

)  
)  
) INTERIM STIPULATED ORDER  
)  
)

1.

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

2.

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

3.

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

3.1 Licensee must not treat chronic pain. For the purposes of this Order, chronic pain is defined as pain that persists or progresses over a period of time greater than 30 days. Licensee must not prescribe any medication for pain for any one patient in excess of 30 days for any one year period. This term is effective 90 days from the date Licensee signs this Order.



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

3 IT IS SO STIPULATED THIS 19 day of Dec, 2014

4 SIGNATURE REDACTED

5  
6 MACIEJ JANUSZ DRUZDZEL, MD /

7 IT IS SO ORDERED THIS 22<sup>nd</sup> day of December, 2014.

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9 OREGON MEDICAL BOARD  
10 State of Oregon

11 SIGNATURE REDACTED

12 KATHLEEN HALEY, JD U  
13 EXECUTIVE DIRECTOR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of

ROBERT DUANE DYSON, MD  
LICENSE NO. MD11274

}  
CORRECTIVE ACTION AGREEMENT  
}

1.

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

2.

On April 11, 2013, the Board issued a Complaint and Notice of Proposed Disciplinary Action. On October 2, 2014, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action. Licensee is a board certified obstetric and gynecologic (OB-GYN) physician. Licensee has informed the Board that he no longer is performing myomectomies.

3.

In regard to the above-referenced matter, Licensee and the Board desire to settle this matter by entry of this agreement. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this agreement in the Board's records. The Board agrees to close the current investigation and makes no finding in regard to any violation of the Medical Practice Act. This agreement is a public document and is not a disciplinary action, but is reportable to the National Data Bank and the Federation of State Medical Boards.

4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree to the following terms:





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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
MICHAEL ARTHUR FORTUNE, MD )  
LICENSE NO. MD14008 ) ORDER TERMINATING  
CONSENT AGREEMENT )

1.

On January 9, 2014, Michael Arthur Fortune, MD, (Licensee) entered into a Consent Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On October 13, 2014, Licensee submitted written correspondence that he wished to retire his Oregon medical license. Licensee has not completed the terms of the Agreement.

2.

In view of Licensee's retirement from medical practice, the Board does hereby order that the January 9, 2014, Consent Agreement be terminated effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 8 day of January, 2015.

OREGON MEDICAL BOARD  
State of Oregon

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DONALD GIRARD, MD  
Board Chair

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
)  
LARRY ARTHUR JACKSON, MD ) STIPULATED ORDER  
LICENSE NO. MD08513 )  
)

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. Larry Arthur Jackson, MD (Licensee) holds, and at all relevant times held, an active license to practice medicine in the state of Oregon.

2.

On February 14, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions pursuant to ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee is a non-board certified family medicine physician in solo private practice in Springfield, Oregon. The acts and conduct alleged to violate the Medical Practice Act follow:

3.1 Patient A is a 36-year-old male, transferred from Licensee's care at Prime Med Medical Clinic to Licensee's solo practice. Patient A complained of low back pain and knee pain. Etiology of the back pain is not documented in six months of Licensee records. Licensee referred Patient A to an orthopedic clinic for knee pain in February of 2013, but Patient A attended no orthopedic appointments. Licensee ordered Magnetic Resonance Imaging (MRI) in April and again in May of 2013 to diagnose Patient A's knee pain, but an MRI was not

1 performed. Licensee failed to attempt a non-opioid based therapy plan, but addressed Patient A's  
2 complaints of pain by prescribing oxycodone (Schedule II) 120 mg daily, amitriptyline and,  
3 although Patient A reported no depression, citalopram (Celexa). Patient A consistently refilled  
4 only the oxycodone prescription, and consistently refilled 30 day prescriptions of oxycodone in  
5 less than 30 days. Licensee did not complete a Material Risk Notice (MRN) for Patient A, and  
6 did not require that Patient A undergo urine drug screening tests (UDS). There was no evidence  
7 of improved functionality from Patient A's opiate treatment.

8       3.2     Patient B is a 33-year-old male, transferred from Licensee's care at Prime Med  
9 Medical Clinic to Licensee's solo practice. Patient B complained of a 13 year history of chronic  
10 mandibular pain, the cause of which Licensee conditionally presumed but never diagnosed.  
11 Licensee referred Patient B to OHSU dental clinic in June of 2013, for potential diagnosis of the  
12 source of mandibular pain, but Patient B did not attend any appointments at the clinic. Licensee  
13 failed to attempt an initial trial of non-opioid based therapy plan and addressed Patient B's  
14 complaints of pain by prescribing oxycodone (Schedule II) 30 mg, 4 to 5 tablets daily. Patient B  
15 occasionally refilled a 30 day prescription of oxycodone in less than 30 days. On December 3,  
16 2012, Licensee obtained a UDS from Patient B which revealed benzodiazepines and  
17 amphetamines in his urine, demonstrating substance abuse. Patient B's Prescription Drug  
18 Monitoring Program (PDMP) report obtained by Licensee in July 2013, does not document a  
19 prescription for either amphetamines or benzodiazepines prior to the December 2012 UDS. At  
20 his next visit on January 2, 2013, Patient B reports that he ran out of his medications two days  
21 early and Licensee notes Patient B's recent amphetamine use, but did not address the positive  
22 benzodiazepine test result. Licensee made no modifications of Patient B's treatment and refilled  
23 his oxycodone. Licensee completed no MRN on Patient B and made no assessment of improved  
24 functionality from Patient B's opiate treatment.

25       3.3     Patient C is a 44-year-old female who first presented at Licensee's practice in  
26 January of 2013, complaining of headaches, neck pain, and low back pain with intermittent  
27 radicular symptoms, but reflexes and sensory exams were normal. At Patient C's initial visit,  
28 Licensee referenced Patient C's prior x-ray films, but did not obtain them. Licensee noted the

1 need for an MRI during visits on February 11 and 26, 2013. On or about March 20, 2013,  
2 Licensee ordered an MRI for Patient C, but it was not completed. In May of 2013, Licensee  
3 ordered neurology consultation and electroencephalography (EEG) for Patient C, but these were  
4 not completed. Licensee failed to attempt a non-opioid based therapy plan and addressed Patient  
5 C's complaints of pain by prescribing oxycodone (Schedule II) - initially 10 mg, 3 tablets daily,  
6 quickly escalating to 15 mg, 5 tablets daily, and then 30 mg, 4 to 5 tablets daily. Patient C  
7 consistently obtained early refills of oxycodone. On April 1, 2013, Patient C forged a fax from  
8 her prior employer to obtain an early refill of her opioids while allegedly working in California.  
9 This forged fax indicated that Patient C was to return to Roseburg on May 10. Patient C returned  
10 to Licensee's clinic on April 10, 2013, reporting that she was present during a minor fire at her  
11 residence in Roseburg on April 4, 2013. Patient C produced a partial copy of the Roseburg Fire  
12 Department report and a fire damaged medication bottle as justification for her request for an  
13 early refill. Licensee did not inquire into Patient C's presence in Roseburg when she had  
14 claimed to be working in California, and instead increased her dose of Oxycodone from 120  
15 tablets of Oxycodone 15 mg to 120 tablets of Oxycodone 30 mg. Licensee required no UDSs  
16 from Patient C. Licensee made no assessment of functionality improvement from opiate  
17 treatment of Patient C.

18 3.4 Patient D is a 54-year-old female that first presented at Licensee's practice in  
19 February of 2013, complaining of neck pain related to a 1980 motor vehicle accident and a 1990  
20 boating accident, as well as knee pain that was exacerbated by her work as a caregiver, but there  
21 is no documented cause of pain in her records. Patient D also complained of depression,  
22 insomnia, fatigue and anxiety. Licensee failed to attempt a non-opioid based therapy plan to treat  
23 Patient D's pain, and instead addressed Patient D's complaints of pain by prescribing oxycodone  
24 (Schedule II) 30 mg, 4 tablets daily. Licensee addressed Patient D's complaints of depression,  
25 insomnia, fatigue and anxiety with amitriptyline and citalopram. On Patient D's February 15,  
26 2013 visit to Licensee, Patient D reported that she had been out of oxycodone for two days. A  
27 Prescription Drug Monitoring Program (PDMP) query obtained by Licensee in June 2013  
28 revealed that Patient D had obtained oxycodone - acetaminophen 5/325 mg # 20 on February 14,

1 2013 from a different provider. Patient D's April 2013 drug screen tested positive for alcohol,  
2 blood alcohol content (BAC) = .072. Licensee made no modification to Patient D's treatment.  
3 Licensee made no assessment of functionality improvement from opiate treatment of Patient D,  
4 but did report improvement of symptoms of depression, insomnia, fatigue and anxiety, due to  
5 amitriptyline treatment.

6 3.5 Patient E is a 27-year-old male, transferred to Licensee's solo practice from  
7 Licensee's care at the Prime Med Medical Clinic. Patient E complained of chronic neck and back  
8 pain from motor vehicle and dirt bike accidents that had occurred in 2009 and 2011, but the only  
9 documentation is a normal appearing back film from July of 2012. Patient E reported working as  
10 a fire fighter. Licensee conducted no verification through collateral sources and ordered no  
11 consultations to investigate the cause of Patient E's back pain. Licensee addressed Patient E's  
12 complaints of pain by prescribing oxycodone (Schedule II) 120 mg daily. Patient E's UDS, in  
13 December of 2012, returned with positive results for benzodiazepines, which the Licensee had  
14 not prescribed. Licensee prescribed carvedilol (Coreg) for Patient E's high blood pressure, but  
15 Licensee's chart notes reflect that Patient E reports he lost this medication in May 2013 and  
16 stopped taking them in July 2013. Additionally, Licensee was contacted by a pharmacy in July  
17 2013 reporting that Patient E only wanted the opioid medications filled. Patient E received early  
18 refills of extra oxycodone medication for out of state travel for family and work. Patient  
19 reported pain going down both legs to his feet, but no readily discernible pain mechanism was  
20 documented.

21 3.6 Patient F is a 31-year-old male, transferred to Licensee's solo practice from  
22 Licensee's care at the Prime Med Medical Clinic. Patient F complains of low back pain from a  
23 motor vehicle accident in 2000. Patient F's records include a plain film showing a narrowing of  
24 T11-T12 and diagnosed degenerative disc disease. The only physical exam abnormality was  
25 tenderness. Licensee failed to attempt a non-opioid based therapy plan, and addressed Patient F's  
26 complaints of pain by prescribing oxycodone (Schedule II) 75 mg daily. Licensee also prescribed  
27 Patient F Adderall (Schedule II), 15 mg twice a day, to treat ADHD, but there is no  
28 documentation of an ADHD evaluation and diagnosis. Licensee saw Patient F on December 10,

1 2012 and continued his monthly prescription of oxycodone and Adderall. Patient F's December  
2 10, 2012, UDS was negative for oxycodone and Adderall but positive for marijuana. During his  
3 January 9, 2013, visit Patient F reported losing his pills prior to the December 2012 UDS.  
4 Licensee did not modify Patient F's treatment to address the inconsistent UDS results. Licensee  
5 prepared no MRN or controlled substance use agreement for Patient F, and made no PDMP  
6 queries on Patient F until after he was notified of the current Board investigation.

7 3.7 Patient G is a 42-year-old male who first presented at Licensee's practice in  
8 January of 2013. Patient G complained of back and shoulder pain from sports injuries. Licensee  
9 referred Patient G to a neurosurgeon and ordered an MRI for Patient G in March of 2013, for  
10 pain radiating down Patient G's legs, but Patient G did not complete the evaluation and the MRI  
11 was not obtained. Licensee referred Patient G to a neurosurgeon again in July of 2013, and also  
12 referred Patient G to an orthopedist for his shoulder pain, when Patient G's records end. After  
13 several months of prescribing both methadone and oxycodone, Licensee discontinued Patient G's  
14 methadone prescription without providing a rationale, and treated Patient G's complaints of pain  
15 by prescribing oxycodone (Schedule II) 180 mg daily. Two weeks after his initial visit, Patient G  
16 requested an early refill of oxycodone, reporting his oxycodone prescription had been stolen at a  
17 church youth group retreat. Licensee replaced the missing oxycodone with hydrocodone 10  
18 mg/acetaminophen 325 mg (Norco). Licensee made no assessment of improved functionality for  
19 Patient G with opiate therapy. Licensee provided no MRN, entered into no controlled substance  
20 treatment agreement with Patient G, and required no UDSs of Patient G.

21 3.8 Patient H, a 39-year-old male, first presented to Licensee in March of 2013,  
22 complaining of low back and shoulder pain from a 2005 fall and humeral head replacement, and  
23 a motor vehicle accident occurring approximately two weeks before his initial appointment with  
24 Licensee. Licensee requested Patient H's prior medical records, but did not receive them. On  
25 June 13, 2013, Licensee referred Patient H to physical therapy and orthopedics. Patient H did  
26 not attend these treatments. At the same visit, Licensee recorded a price quote of \$488 for an  
27 MRI, but did not order an MRI. Licensee failed to attempt a non-opioid based therapy plan for  
28 Patient H's pain, and treated Patient H's complaints of pain by prescribing oxycodone (Schedule

1 II) 50 mg daily. Licensee prescribed nortriptyline for insomnia and citalopram to Patient H for  
2 “masked depression.” At Patient H’s first visit, he reported to Licensee that he had received  
3 oxycodone 10 days prior at another facility for the motor vehicle accident. However, the PDMP  
4 report obtained by Licensee in July 2013, documents no such prior prescription. The July 2013  
5 PDMP report also documents that Patient H received oxycodone and Vicodin prescriptions from  
6 another provider in June 2013. Patient H’s only recorded UDS, from April of 2013, was  
7 negative for oxycodone, indicating possible diversion. Licensee notes Patient H’s non-  
8 compliance but did not modify Patient H’s treatment.

9 3.9 Patient I, a 27-year-old male, transitioned from Licensee’s prior practice at Prime  
10 Med Medical Center to Licensee’s solo practice. Patient I complained of low back pain from  
11 being hit by a car in 2010. Licensee failed to attempt a non-opioid based therapy plan, and  
12 treated Patient I’s complaints of pain by prescribing oxycodone (Schedule II) 120 mg daily.  
13 Licensee later learned that Patient I filled oxycodone prescriptions at both Prime Med Medical  
14 Center and Licensee’s solo practice in January of 2013. Licensee prescribed oxycodone 30 mg #  
15 120 at Patient I’s first visit on January 28, 2013; however the PDMP indicates that this  
16 prescription was filled for 200 tablets. Patient I’s UDS in May 2013 was positive for  
17 amphetamines. Patient I reported using dextroamphetamine & amphetamine (Adderall, Schedule  
18 II) from an old prescription to explain the presence of amphetamines in his urine. Licensee asked  
19 Patient I to bring in the bottle of Adderall, but Patient I did not, and Patient I’s July UDS was  
20 also positive for amphetamines, specifically methamphetamine. Licensee dismissed Patient I  
21 from his practice in July of 2013.

22 3.10 The Board’s review of Licensee’s charts in regard to these nine chronic pain  
23 patients demonstrated a pattern of negligent practice that breached the standard of care. Licensee  
24 maintained Patients A-I on opioid treatment while failing to comply with clinical guidelines.  
25 Licensee failed to address aberrant behavior; failed to consistently or timely execute material risk  
26 notices; prescribed large doses of opiates and other medications without appropriate diagnoses  
27 and without objective evidence of improved function or pain control; prescribed large doses of  
28 opiates when signs of substance abuse were present and prescribing early refills; failed to

1 conduct or document a comprehensive musculoskeletal examination (at the outset) or serial  
2 examinations (in follow-up); and failed to try alternative therapies or trials with non-opiate  
3 medications.

4 4.

5 Licensee and the Board desire to settle this matter by entry of this Stipulated Order, and  
6 Licensee enters this Stipulated Order of his volition, without any coercion or duress. Licensee  
7 understands that he has the right to a contested case hearing under the Administrative Procedures  
8 Act (Chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a  
9 contested case hearing and any appeal therefrom by the signing of this Order in the Board's  
10 records. Licensee admits that he engaged in the conduct described in paragraph 3, and that this  
11 violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS  
12 677.188(4)(a); and ORS 677.190(13) gross or repeated acts of negligence. Licensee understands  
13 that this Order is a public record and is a disciplinary action that is reportable to the National  
14 Data Bank and the Federation of State Medical Boards.

15 5.

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

18 5.1 Licensee must pay a civil penalty of \$5,000, of which \$4,000 will be held in  
19 abeyance contingent on Licensee complying with all the terms and conditions of this Order. The  
20 remaining \$1,000 is due and payable in full within 60 days from the effective date of this Order.

21 5.2 Licensee is placed on probation for a minimum period of five years and shall  
22 report in person to the Board at each of its quarterly meetings at the scheduled times for a  
23 probation interview, unless otherwise directed by the Board's Compliance Officer or its  
24 Investigative Committee.

25 5.3 Within 180 days from the signing of this Order by the Board Chair, Licensee must  
26 at his own expense enroll in and complete a physician assessment at the Center for Personalized  
27 Education for Physicians (CPEP). Licensee must sign all necessary releases to allow full  
28 communication and exchange of documents and reports between the Board and CPEP. Licensee

1 must timely and successfully complete the recommended CPEP Education or Remediation Plan,  
2 if any, at Licensee's expense. This plan must be reviewed and approved by the Board's Medical  
3 Director prior to implementation.

4 5.4 Licensee must not treat chronic pain. For the purposes of this Order, chronic pain  
5 is defined as pain that persists or progresses for more than thirty (30) days. Licensee may only  
6 treat acute pain, however, Licensee must not prescribe more than 30 days of medications to any  
7 one patient over a period of one year.

8 5.5 Within 12 months from the signing of this Order by the Board Chair, Licensee  
9 must complete a prescribing course pre-approved by the Board's Medical Director.

10 5.6 Licensee stipulates and agrees that this Order becomes effective the date it is  
11 signed by the Board Chair.

12 5.7 Licensee must obey all federal and Oregon state laws and regulations pertaining  
13 to the practice of medicine.

14 5.8 Licensee stipulates and agrees that any violation of the terms of this Order shall  
15 be grounds for further disciplinary action under ORS 677.190(17).

16  
17 IT IS SO STIPULATED THIS 19 day of December, 2014.

18  
19 SIGNATURE REDACTED

20 LARRY ARTHUR JACKSON, MD

21  
22 IT IS SO ORDERED THIS 8 day of January, 2015.

23 OREGON MEDICAL BOARD  
24 State of Oregon

25 SIGNATURE REDACTED

26 DONALD GIRARD, MD  
27 BOARD CHAIR  
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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
DENNIS JOHN MAZUR, MD ) STIPULATED ORDER  
LICENSE NO. MD15399 )

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. Dennis John Mazur, MD (Licensee) is a licensed physician in the State of Oregon.

2.

Licensee is a board-certified internal medicine physician. On November 18, 2013, the Board opened an investigation after receiving information regarding potential violations of the Medical Practice Act.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to retire his license while under investigation, consistent with the terms of this Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies but the Board finds that Licensee engaged in conduct that violated the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional conduct, as defined in ORS 677.188(4)(a), and ORS 677.190(8) fraud or misrepresentation in applying for or procuring a license to practice in this state, or in connection with applying for or procuring registration. Licensee understands that this document is a public record and is reportable to the National Databank and the Federation of State Medical Boards.

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4.

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

4.1 Licensee retires his license to practice medicine while under investigation. This retirement of license becomes effective the date the Board Chair signs this Order.

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

IT IS SO STIPULATED this 21 day of October, 2014.

SIGNATURE REDACTED  
\_\_\_\_\_  
DENNIS JOHN MAZUR, MD

IT IS SO ORDERED this 8th day of January, 2015.

OREGON MEDICAL BOARD  
State of Oregon  
SIGNATURE REDACTED  
\_\_\_\_\_  
DONALD E. GIRARD, MD  
BOARD CHAIR





1           4.4     Licensee must practice in compliance with the Code of Ethics promulgated by the  
2 National Certification Commission for Acupuncture and Oriental Medicine.

3           4.5     Licensee must keep accurate records of each patient’s history and treatment and  
4 must record every treatment in each patient’s chart.

5           4.6     Licensee must remain on probation for the duration of his professional license  
6 (either inactive or active) to practice acupuncture and must report in person to the Board at each  
7 of its quarterly meetings at the scheduled times for a probation interview, unless otherwise  
8 directed by the Board’s Compliance Officer or its Investigative Committee. After five years of  
9 demonstrated compliance with the terms of this Order, Licensee may submit a written request to  
10 modify the terms of his probation.

11          4.7     Licensee has completed an evaluation by a health professional that was pre-  
12 approved by the Board’s Medical Director. Licensee must comply with all treatment  
13 recommendations until his Board approved health professional submits a recommendation to the  
14 Board’s Medical Director to modify any terms, and that recommendation is approved in writing.

15          4.8     In the event Licensee receives an active license, Licensee and his practice  
16 location(s) are subject to no-notice audits by the Board’s Compliance Officer throughout the  
17 period of probation.

18          4.9     Licensee stipulates and agrees that this Order becomes effective the date it is  
19 signed by the Board Chair.

20          4.10    This Stipulated Order replaces the Stipulated Order of March 3, 2011.

21          4.11    Licensee must obey all federal and Oregon state laws and regulations pertaining  
22 to the practice of acupuncture.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
STEPHEN LANIER NELSON, MD ) AMENDED INTERIM STIPULATED  
LICENSE NO. MD18996 ) 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. Stephen Lanier Nelson, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

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

3.

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

3.1 Licensee must not treat chronic pain with any DEA scheduled medications. For the purposes of this Order, chronic pain is defined as pain that persists or progresses over a period of time greater than 30 days. Licensee must not prescribe any medication for pain for any one patient in excess of 30 days for any one year period. This term is effective 90 days from the date Licensee signs this Order.



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

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IT IS SO STIPULATED THIS 24 day of December, 2014.

SIGNATURE REDACTED  
\_\_\_\_\_  
STEPHEN LANIER NELSON, MD

IT IS SO ORDERED THIS 29<sup>th</sup> day of December, 2014.

OREGON MEDICAL BOARD  
State of Oregon

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KATHLEEN HALEY, JD  
EXECUTIVE DIRECTOR



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
THOMAS JOHN PURTZER, MD ) STIPULATED ORDER  
LICENSE NO. MD12880 )  
)

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. Thomas John Purtzer, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On February 14, 2013, the Board opened an investigation upon receipt of credible information regarding Licensee. Subsequent to this, the Board opened a second investigation on June 11, 2013. On September 24, 2013, Licensee signed an Interim Stipulated Order in which he agreed to withdraw from the treatment of chronic pain within 30 days. On October 23, 2013, the Board opened a third investigation, and on November 8, 2013, Licensee signed an Interim Stipulated Order in which he voluntarily agreed to withdraw from the practice of medicine pending the completion of the Board's investigations.

3.

On February 3, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action. On April 3, 2014, the Board withdrew this notice and issued an Amended Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, 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), (b) and (c); ORS

1 677.190(13) gross or repeated acts of negligence; ORS 677.190(17) willfully violating any rule  
2 adopted by the Board or any Board order or any Board request; ORS 677.190(23) violation of  
3 the federal Controlled Substance Act; and ORS 677.190(24) prescribing controlled substances  
4 without a legitimate medical purpose, or prescribing without following accepted procedures for  
5 examination of patients, or prescribing controlled substances without following accepted  
6 procedures for record keeping.

7 4.

8 Licensee and the Board agree to close this investigation with this Stipulated Order in  
9 which Licensee agrees to permanently surrender his license while under investigation, consistent  
10 with the terms of this Order. Licensee understands that he has the right to a contested case  
11 hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and  
12 fully and finally waives the right to a contested case hearing and any appeal therefrom by the  
13 signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but  
14 the Board concludes that Licensee engaged in conduct detailed in the Amended Complaint and  
15 Notice of Disciplinary Action and that conduct violated ORS 677.190(1)(a) unprofessional or  
16 dishonorable conduct, as defined in ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or  
17 repeated acts of negligence; ORS 677.190(17) willfully violating any rule adopted by the Board  
18 or any Board order or any Board request; ORS 677.190(23) violation of the federal Controlled  
19 Substance Act; and ORS 677.190(24) prescribing controlled substances without a legitimate  
20 medical purpose, or prescribing without following accepted procedures for examination of  
21 patients, or prescribing controlled substances without following accepted procedures for record  
22 keeping. Licensee understands that this document is a public record and is reportable to the  
23 National Data Bank, and the Federation of State Medical Boards.

24 5.

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

27 ///

1           5.1    Licensee permanently surrenders his license to practice medicine while under  
2 investigation. Licensee further agrees that he will never apply for a license to practice medicine  
3 in the state of Oregon. This surrender of license becomes effective the date the Board Chair  
4 signs this Order.

5           5.2    This order terminates the Interim Stipulated Orders of September 24, 2013, and  
6 November 8, 2013, effective the date the Board chair signs this Order.

7           5.3    Licensee stipulates and agrees that any violation of the terms of this Order would  
8 be grounds for further disciplinary action under ORS 677.190(17).

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IT IS SO STIPULATED this 30<sup>th</sup> day of December, 2014.

SIGNATURE REDACTED  
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THOMAS JOHN PURTZER, MD

IT IS SO ORDERED this 8 day of January, 2015.

OREGON MEDICAL BOARD  
State of Oregon

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DONALD E. GIRARD, MD  
BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
PHILIP WILLIAM QUEELEY, LAc ) CORRECTIVE ACTION AGREEMENT  
LICENSE NO. AC00862 )

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including acupuncturists, in the State of Oregon. Philip William Queeley, LAc (Licensee) is a licensed acupuncturist in the state of Oregon.

2.

The Board opened an investigation in 2011 after receiving information that raised concerns in regard to Licensee's ability to safely and competently practice as a licensed acupuncturist. The Board and Licensee entered into a Corrective Action Agreement on October 6, 2011. The Board reopened this matter when Licensee's compliance with the terms of that Agreement came into question. Licensee and the Board now desire to settle this matter by entry of this agreement. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this agreement in the Board's records. The Board agrees to close the current investigation and does not make a finding in regard to any violation of the Medical Practice Act. This agreement is a public document; however, it is not a disciplinary action. This document is reportable to the National Data Bank and the National Certification Commission for Acupuncture and Oriental Medicine.

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3.

In regard to the above-referenced matter, Licensee neither admits nor denies a violation of the Medical Practice Act. In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

3.1 Within 6 months from the date this Agreement is signed by the Board Chair, Licensee will successfully complete Continuing Medical Education (CME) on professional conduct and ethics that is pre-approved by the Board's Medical Director.

3.2 Within 6 months from the date this Agreement is signed by the Board Chair, Licensee will successfully complete a documentation course on medical records and charting that is pre-approved by the Board's Medical Director.

3.3 This Agreement supersedes and terminates the Corrective Action Agreement of October 6, 2011.

3.4 Licensee must initiate contact with a telephone conversation or confirmed email with the Board's Compliance Officer and provide an update on his compliance with the terms of this Agreement on the first day of each month. If the first day of the month falls on a holiday or weekend, then the first work day thereafter.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
TIMOTHY JAMES RODDY, MD ) ORDER TERMINATING  
LICENSE NO. MD14358 ) CORRECTIVE ACTION AGREEMENT  
 )

1.

On July 10, 2014, Timothy James Roddy, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On August 22, 2014, Licensee submitted documentation that he has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the July 10, 2014, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 8 day of January, 2015.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURE REDACTED

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DONALD GIRARD, MD  
Board Chair



1 ultrasound on August 10, 2012, which suggested a “2 cm lesion of the uterus with distortion of  
2 endometrial stripe.” Licensee did not have Patient A undergo a pregnancy test. Licensee  
3 discussed options for treatment with Patient A, and recommended dilation and curettage (D & C)  
4 with ablation. Licensee noted that Patient A would call his office to schedule the procedure.  
5 Patient A called Licensee’s office on November 1, 2012, to report that her pelvic bleeding was  
6 continuing with cramping. She received a prescription of hydrocodone & acetaminophen,  
7 (Vicodin, Schedule III) for pain. She returned to Licensee’s clinic on November 5, 2012, for  
8 laboratory studies, but no examination or pregnancy test. Patient A was admitted on November  
9 7, 2012, for the planned D & C with ablation. After Licensee dilated the cervix, sounding of the  
10 uterus showed an enlarged uterus. A hysteroscopy showed a smooth endometrium. Licensee  
11 attempted to do an endometrial ablation, but noted that the uterus was too large (“14 week’s  
12 size.”) A small biopsy of the posterior wall revealed a normal proliferative endometrium.  
13 Licensee discontinued the procedure. One week later, Patient A reported that her pelvic bleeding  
14 was heavier. The next day, she came to the clinic and was examined. An umbilical cord was  
15 seen protruding from her vagina. A pelvic ultrasound revealed a nonviable fetus that was 16  
16 weeks in age. Patient A was admitted on November 15, 2012, and underwent an induced labor  
17 to deliver the fetus as well as a D & C to remove the placenta. Licensee failed to rule out  
18 pregnancy prior to attempting to perform an endometrial ablation, which resulted in harm to  
19 Patient A and the demise of her 4 month old fetus.

20       3.2     The Board conducted a review of charts for adult female patients ranging in age  
21 from 32 to 35 years old (Patients B – E) that Licensee treated for abnormal uterine bleeding in  
22 2012. Licensee’s work-up and treatment of these patients closely resembled that of Patient A,  
23 but without the adverse outcome of fetal demise. Licensee failed to order a pregnancy test in his  
24 work-up of these patients and quickly proceeded to perform an endometrial ablation without  
25 trying hormonal therapy. Licensee’s work-up and treatment of these patients failed to comply  
26 with the standard of care and the usual algorithm workup to objectively identify the cause of  
27 abnormal uterine bleeding.



1 reports, interim reports and the final written evaluation report from CPEP are provided promptly  
2 to the Board.

3 5.4 Licensee must provide the Board with written proof from CPEP upon successful  
4 completion of the recommended Education program, including successful completion of the  
5 Post-Education Evaluation, as defined above.

6 5.5 Licensee must successfully complete courses on medical documentation and fetal  
7 monitoring. These courses must be American Medical Association Category 1, and pre-  
8 approved by the Board's Medical Director.

9 5.6 Licensee stipulates and agrees that this Order becomes effective the date it is  
10 signed by the Board Chair.

11 5.7 Licensee must obey all federal and Oregon state laws and regulations pertaining  
12 to the practice of medicine.

13 5.8 Licensee stipulates and agrees that any violation of the terms of this Order shall  
14 be grounds for further disciplinary action under ORS 677.190(17).

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IT IS SO STIPULATED THIS 16 day of December, 2014.

SIGNATURE REDACTED  
MARK CALVIN ROWLEY, MD

IT IS SO ORDERED THIS 8 day of January, 2015.

OREGON MEDICAL BOARD

SIGNATURE REDACTED  
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DONALD GIRARD, MD  
BOARD CHAIR



1 engaged in conduct as described, however the Board finds that Licensee violated ORS  
2 677.190(1)(a), as defined by ORS 677.188(4)(a), (b) and (c); and ORS 677.190(13).  
3 Licensee understands that this Order is a public record and is a disciplinary action that is  
4 reportable to the National Data Bank and the Federation of State Medical Boards.

5 4.

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

8 4.1 The license of Licensee to practice medicine is revoked, but the revocation is  
9 stayed.

10 4.2 Licensee is reprimanded.

11 4.3 Licensee must pay a civil penalty of \$10,000, payable in four installments of  
12 \$2,500 each. Installments are due 60 days, 120 days, 180 days, and 240 days from the  
13 effective date of this Order.

14 4.4 Within 240 days from the effective date of this Order, Licensee must  
15 successfully complete a charting course pre-approved by the Board's Medical Director.

16 4.5 Within 12 months from the effective date of this Order, Licensee must  
17 complete 25 hours of CME in perioperative management pre-approved by the Board's  
18 Medical Director.

19 4.6 Licensee may only practice medicine in Oregon in a setting that has been pre-  
20 approved in writing by the Board's Medical Director.

21 4.7 Licensee may only perform outpatient surgeries in Oregon at facilities which  
22 have been accredited by the Accreditation Association for Ambulatory Healthcare.

23 4.8 Any complications of surgery performed in Oregon or on a patient that resides  
24 in Oregon by Licensee must be reported to the Oregon Medical Board in writing within ten  
25 days from the date of the complication. Complications include: surgical related death,  
26 emergency transfer of the surgical patient to the hospital from a non-hospital setting,

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anesthetic or surgical event requiring cardiopulmonary resuscitation (CPR) or any  
unscheduled hospitalization related to the surgery.

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

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

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

IT IS SO STIPULATED THIS 18th day of December, 2014

**SIGNATURE REDACTED**

BHANOO SHARMA, MD

IT IS SO ORDERED THIS 8 day of January, 2015

OREGON MEDICAL BOARD

**SIGNATURE REDACTED**

DONALD GIRARD, MD  
BOARD CHAIR





1 4.

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

4 4.1 Licensee is reprimanded.

5 4.2 Licensee must pay a civil penalty of \$6,000. The first payment of \$2,000 is  
6 payable within 60 days from the effective date of this Order. The second payment of \$2,000 is  
7 payable within 120 day from the effective date and the third and final payment of \$2,000 is  
8 payable within 180 days.

9 4.3 Within 270 days from the signing of this Order by the Board Chair, Licensee must  
10 successfully complete a course on medical ethics that is pre-approved by the Board's Medical  
11 Director.

12 4.4 Licensee must submit his charts for ongoing chart review with a practice  
13 consultant that is pre-approved by the Board's Medical Director. Licensee is responsible to  
14 ensure that the practice consultant reviews at least 20% of his charts on a monthly basis. After  
15 three months, the Board's Medical Director may reduce the chart review requirement to 10% of  
16 charts upon the recommendation of the practice consultant. The practice consultant shall provide  
17 the Board with quarterly reports, with a particular focus on how Licensee is addressing the  
18 practice and documentation issues that were identified in the present case. All costs associated  
19 with the practice consultant are the responsibility of Licensee. After one year of demonstrated  
20 compliance with the terms of this Order, and upon written recommendation of the practice  
21 consultant, Licensee may submit a written request to modify this term.

22 4.5 Licensee must implement a protocol to address the risk of wrong-site surgery or  
23 procedures that includes the following elements (which are documented in the medical chart): (1)  
24 preoperative verification process; (2) marking the surgical site; and (3) leading a "time out" to  
25 verify patient identification, the planned procedure and the surgical site prior to starting any  
26 surgery.

27 4.6 Licensee's medical charts and the clinic where he practices are subject to no-  
28 notice audits by the Board's designees.



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
HAROLD ANDREW THOMAS JR., MD ) STIPULATED ORDER  
LICENSE NO. MD14766 )

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. Harold Andrew Thomas, Jr., MD (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is a board-certified emergency medicine physician. On June 4, 2014, the Board opened an investigation related to possible violations of the Medical Practice Act, after receiving credible information regarding Licensee.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to retire his license while under investigation, consistent with the terms of this Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds, that Licensee engaged in conduct that violated the Medical Practice Act, to wit ORS 677.190(1)(a) unprofessional conduct. Licensee understands that this document is a public record and is reportable to the National Databank and the Federation of State Medical Boards.

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4.

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

4.1 Licensee permanently retires his license to practice medicine while under investigation. This retirement of license becomes effective the date the Board Chair signs this Order.

4.2 Licensee may not re-apply for any license status with the Oregon Medical Board.

4.3 The Interim Stipulated Order of September 25, 2014, terminates effective the date Board Chair signs this Order.

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

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

IT IS SO STIPULATED this 26 day of OCTOBER, 2014.

**SIGNATURE REDACTED**  
HAROLD ANDREW THOMAS JR., MD

IT IS SO ORDERED this 8 day of January, 2015

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**  
DONALD E. GIRARD, MD  
BOARD CHAIR





4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree to the following terms:

4.1 Licensee completed a professional boundaries course and a pain management course prior to entering into this Agreement. The Board accepts the completion of these courses as part of the resolution in this matter.

4.2 Within 18 months from the signing of this Agreement by the Board Chair, Licensee must complete 40 hours of continuing medical education in chronic pain management, pre-approved by the Board's Medical Director.

4.3 Licensee must assess all of his chronic pain patients, conduct a risk assessment for each such patient, and determine how many times per year each chronic pain patient will undergo a random urine screen. Random urine screens must occur a minimum of once a year for each of these patients.

4.4 For 12 consecutive months, Licensee must meet monthly with a pain specialist pre-approved by the Board's Medical Director to review charts for his chronic pain patients. The pain specialist must provide quarterly written reports to the Board on the quality of Licensee's care, to include his adherence to nationally recognized opioid treatment standards.

4.5 Upon Licensee's completion of term 4.4 of this Agreement, the Board may, at its discretion, conduct random chart audits of chronic pain patients in Licensee's medical practice. Audits may continue until this Agreement is terminated.

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

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
RYAN ELIZABETH WILLIAMS, DO )  
LICENSE NO. DO154545 ) CORRECTIVE ACTION AGREEMENT  
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1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including osteopathic physicians, in the state of Oregon. Ryan Elizabeth Williams, DO (Licensee) holds an active license to practice medicine in the state of Oregon.

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2.

Licensee is a board certified family physician practicing in Sandy, Oregon. The Board opened an investigation after receiving a complaint in regard to the manner in which Licensee prescribed high doses of controlled substances with multiple refills to treat patients complaining of chronic pain.

3.

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

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4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree to the following terms:

4.1 Within 12 months from the signing of this Agreement by the Board Chair, Licensee must successfully complete a course on chronic pain management that is pre-approved by the Board's Medical Director.

4.2 Upon completion of term 4.1 of this Agreement and within 18 months from the signing of this Agreement by the Board Chair, Licensee must complete 20 hours of additional continuing education that is pre-approved by the Board's Medical Director.

4.3 For six consecutive months, Licensee must meet at least twice a month with a physician with an active practice that includes managing chronic pain patients that is pre-approved by the Board's Medical Director for the purpose of reviewing the charts of chronic pain patients. This mentoring physician must provide quarterly written reports to the Board on the quality of Licensee's care; to include her adherence to nationally recognized opioid treatment standards.

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

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

IT IS SO STIPULATED THIS 17 day of December, 2014.

**SIGNATURE REDACTED**

RYAN ELIZABETH WILLIAMS, DO

IT IS SO ORDERED THIS 8 day of January, 2015.

OREGON MEDICAL BOARD

**SIGNATURE REDACTED**

DONALD GIRARD, MD  
BOARD CHAIR