

Oregon Medical Board  
**BOARD ACTION REPORT**  
**July 15, 2011**

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between June 16, 2011 and July 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.

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](#) 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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**\*Bhatt, Kiran, Lata Pathak, MD; Applicant; Palo Alto, CA**

On June 16, 2011, the Oregon Medical Board issued a Final Order which denied the application for licensure and imposed a civil penalty.

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

On July 7, 2011, the Board issued an Order of Emergency Suspension due to concerns regarding Licensee's ability to safely and competently practice medicine.

**Depweg, Ethan, Reed, LAc; AC00376; Corvallis, OR**

The Board issued an Order Terminating Corrective Action Agreement on June 20, 2011. This Order terminates Licensee's May 23, 2011 Corrective Action Agreement.

**\*Friedlander, Jeffrey, MD; MD14269; Celebration, FL**

The Board issued a Default Final Order on April 7, 2011. This Order revoked Licensee's Oregon medical license, assessed a civil penalty of \$10,000, and imposed costs of a scheduled contested case hearing.

**\*Gambee, John, Edwin, MD; MD09526; Junction City, OR**

On July 7, 2011, the Board issued a Final Order. This Order revoked Licensee's Oregon medical license and imposed costs related to the disciplinary action.

**Greeder, Glenn, Alan, MD; MD14605; Portland, OR**

Licensee entered into a Corrective Action Agreement with the Board on July 7, 2011. In this

This is not a disciplinary action.

**Keller, Michael, Edgar, LAc; AC00839; Portland, OR**

The Board issued an Order Terminating Corrective Action Agreement on July 8, 2011. This Order terminates Licensee's April 8, 2011 Corrective Action Agreement.

**\*Nielsen, Erik, William, MD; MD12909; Portland, OR**

Licensee entered into an Interim Stipulated Order with the Board on 7/7/11. In this Order, Licensee agreed to withdraw from practice pending completion of the Board's investigation into his ability to safely and competently practice medicine.

**Olds, Julie, Ann, MD; MD27412; Hillsboro, OR**

Licensee entered into a Corrective Action Agreement with the Board on July 7, 2011. In this Agreement Licensee agreed to obtain a Preceptor with whom she shall meet on an ongoing basis for case and chart review. Licensee will also complete a Board approve CME course. This is not a disciplinary action.

**\*Pettersen, Jon, Eric, MD; MD11174; Baker City, OR**

The Board issued an Order Terminating Stipulated Order on July 7, 2011. This Order terminates Licensee's December 7, 2006 Stipulated Order.

**\*Sasaki, Aaron, Takuji Fumiyuki, MD; MD26759; Astoria, OR**

The Board issued an Order Terminating Stipulated Order on July 7, 2011. This Order terminates Licensee's May 7, 2009, Stipulated Order.

**\*Skotte, Daniel, Mark, DO; DO13485; Sunriver, OR**

The Board issued an Order Modifying Stipulated Order on July 7, 2011. This Order replaces section 5 of Licensee's July 10, 2008 Stipulated Order.

In this Modification Order Licensee is placed on 10 years probation; reprimanded; subject to random chart audits by Board consultant, and must provide a copy of Order to his Commander in the Air National Guard.

**\*Thomson, Kathryn, Mary Donoghue, DO; DO13836; Salem, OR**

Licensee entered into an Interim Stipulated Order with the Board on 6/17/11. In this Order, Licensee agreed to withdraw from practice pending completion of the Board's investigation into her ability to safely practice medicine.

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

Licensee entered into a Corrective Action Agreement with the Board on June 29, 2011. In this agreement, Licensee agreed to complete a mentorship as a condition of her licensure.

**\*Weiner, Marcus, Ira, DO; DO29163; Portland, OR**

On June 22, 2011, the Board issued an Order of Emergency Suspension due to concerns regarding Licensee's ability to safely and competently practice medicine.

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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.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

IN THE MATTER OF:            )  
  )  
**KIRAN L. BHATT, MD**        ) **FINAL ORDER**  
Applicant                        )  
  )

**HISTORY OF THE CASE**

On April 28, 2010, the Oregon Medical Board (Board) issued a Notice of Intent to Deny License Application (Notice) to Kiran L. Bhatt, MD, proposing to deny Dr. Bhatt's application for a license to practice as a physician in Oregon. The Notice also proposed imposing a monetary penalty against Dr. Bhatt, as well as an assessment of the costs of the proceedings. On June 1, 2010, Dr. Bhatt requested an administrative hearing. On June 15, 2010, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned Senior Administrative Law Judge Jennifer H. Rackstraw to preside over the case.

On August 31, 2010, a pre-hearing conference was held. Senior Assistant Attorney General (AAG) Warren Foote represented the Board. Dr. Bhatt represented herself.

A hearing was held on January 25, 2011, at the Board's Offices in Portland, Oregon. Senior AAG Katharine M. Lozano represented the Board. Dr. Bhatt represented herself. The following witnesses testified for the Board: Dr. Bhatt; Netia Miles, a Board Physician Licensing Specialist; Greta Matus, a Board Investigator; and Monique Malbrough, a Deputy Parole Officer with the Orange County, California Probation Department. Dr. Bhatt also testified on her own behalf. In addition, Kadavil Satyanarayan, MD, testified for Dr. Bhatt. Also present at the hearing were Dennis Dalton, Protection Specialist; Kristi Lamont, Protection Specialist; Jenny Pedersen, Board Investigations Coordinator; Larry Bennett, Protection Specialist; and Michele Lucas, Court Reporter. The evidentiary record closed at the conclusion of the hearing.

On January 26, 2011, the Board submitted a written closing argument. On January 27, 2011, the Board submitted a corrected written closing argument. On January 28, 2011, Dr. Bhatt submitted a written response. On February 3, 2011, Dr. Bhatt submitted an email containing additional argument, as well as additional evidence. The additional evidence was excluded because the evidentiary record closed on January 25, 2011. On February 16, 2011, the OAH received a written transcript of the hearing. The hearing record closed on that date. On February 22, 2011, Dr. Bhatt submitted another email containing additional evidence. That evidence was also excluded due to the closure of the evidentiary record.

The ALJ issued a Proposed Order on March 25, 2011. Dr. Bhatt filed no exceptions.

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## ISSUES

1. Whether the Board may deny Dr. Bhatt's application for a license to practice as a physician in Oregon based on one or more violations of the Medical Practice Act and a lack of good moral character. ORS 677.190(1)(a), (7), (8), (15), and (17); 677.100(1)(d).
2. Whether the Board may impose \$10,000 of assessed costs and \$5,000 in civil penalties, totaling a \$15,000 assessment, against Dr. Bhatt. ORS 677.265.

## EVIDENTIARY RULINGS

The Board offered Exhibits A1 through A15. Exhibits A1 and A2, and A5 through A13 were admitted into the record without objection. Exhibits A3, A4, A14, and A15 were admitted into the record over Dr. Bhatt's reliability objections.

Dr. Bhatt offered Exhibits R1 through R13. Page 2 of Exhibit R4 and Exhibit R12 were admitted into the record without objection. Exhibit R2 was admitted into the record over the Board's relevancy objection. The Board's relevancy objections to Exhibits R1, R3, page 1 of Exhibit R4, R5 through R11, and R13 were sustained and those exhibits were not admitted into the record.

## CREDIBILITY DETERMINATION

One of an administrative law judge's responsibilities in a contested case is to assess the credibility of witnesses. ORS 44.370 provides, in part:

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

Moreover, a determination of witness credibility can be based on a number of factors, other than the manner of testifying. These factors include the inherent probability of the evidence, whether or not the evidence is corroborated, whether the evidence is contradicted by other testimony or evidence, whether there are internal inconsistencies, and "whether human experience demonstrates that the evidence is logically incredible." *Tew v. DMV*, 179 Or App 443, 449 (2002), citing *Lewis and Clark College v. Bureau of Labor*, 43 Or App 245, 256 (1979) *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part, dissenting in part).

At hearing, Dr. Bhatt repeatedly failed to answer the specific questions posed to her by the Board's counsel and the administrative law judge. Her responses were often illogical, disjointed, and rambling. Her explanations with regard to her criminal record and certain events surrounding her criminal history were logically incredible, and her testimony often directly contradicted information contained in police and FBI reports. The ALJ did not find Dr. Bhatt to be a credible witness. Where Dr. Bhatt's testimony conflicted with other evidence, the ALJ accorded greater weight to the other evidence.

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## FINDINGS OF FACT

1. On April 10, 1982, Dr. Bhatt received her Oregon medical license. Her license became inactive on October 31, 1985, lapsed on January 1, 1996, and expired on January 19, 2006. (Ex. A1 at 2, 5; Tr. at 39.) She has held medical licenses in California and Washington. (Exs. A3 at 1-2, A4 at 4, A5 at 1-3; Tr. at 52.)

2. Dr. Bhatt's practice specialty is physical medicine and rehabilitation, and her subspecialty is spinal cord injury. (Ex. A1 at 5; Tr. at 120.) She was an assistant clinical professor in the Physical Medicine and Rehabilitation Department at the University of California, Irvine (UCI) from August 1980 to April 1982. (Ex. R2 at 2, 4.) In March 1983, she became a clinical assistant professor in the Department of Neurology at the Oregon Health Sciences University School of Medicine. (*Id.* at 3.) She held various medical positions in other states during the next two decades, with time off work (*i.e.* not practicing medicine) from May 1984 to July 1985, June 1988 to June 1990, July 1993 to April 1994, and 1998 to January 2003. (Ex. A2 at 4.)

3. From 1982 to 1984, Dr. Bhatt worked at Kaiser Permanente with Kadavil Satyanarayan, MD. Dr. Satyanarayan has not had contact with Dr. Bhatt since 1984. (Tr. at 34-35.)

4. On June 13, 1997, Dr. Bhatt was involuntarily committed to the Santa Clara Medical Center's psychiatric unit for four days. (Exs. A3 at 5, A10 at 9, 14; Tr. at 83.) Prior to the involuntary hospitalization, Dr. Bhatt had repeatedly harassed staff at the Stanford University Medical Center and engaged in personally threatening behavior. For example, in one three-hour period she made 37 telephone calls to University staff. The phone calls included rambling and disoriented speech, as well as threatening statements. (Exs. A3 at 5, A10 at 9, 14.)

5. On March 10, 1998, the Medical Board of California (California Board) ordered Dr. Bhatt to undergo a psychiatric examination to determine whether Dr. Bhatt was mentally ill to such an extent that it might affect her ability to safely practice medicine. After Dr. Bhatt failed to appear for a psychiatric examination scheduled for April 1, 1998, the California Board determined that she failed to comply with a board order. (Ex. A3 at 3-5.)

6. On July 22, 1998, psychiatrist David J. Sheffner, MD, evaluated Dr. Bhatt for two and one-fourth hours. Dr. Sheffner diagnosed Dr. Bhatt with a paranoid psychotic condition and opined that she was "in immediate need of regular treatment with anti-psychotic medications" and treatment by a psychiatrist for the indefinite future. (Ex. A3 at 5-6.)

7. On September 18, 1998, a California administrative law judge issued a Proposed Decision, finding that Dr. Bhatt had failed to comply with a board order and that her ability to practice medicine safely was impaired due to mental illness. The administrative law judge recommended revocation of Dr. Bhatt's California medical license. (Ex. A3 at 5-9.) By order dated December 15, 1998, the California Board revoked Dr. Bhatt's medical license, effective January 14, 1999. (*Id.* at 1.)

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1 8. Effective July 20, 1999, Dr. Bhatt was excluded from participation as a provider  
2 in Medicare, Medicaid, and all other federal health care programs. (Ex. A12 at 2.) As of the  
3 date of hearing, the exclusion had not been lifted. (Tr. at 65.)  
4

5 9. On October 29, 1999, the Washington Medical Quality Assurance Commission  
6 (Washington Medical Commission) revoked Dr. Bhatt's Washington medical license based on  
7 the revocation of her California medical license. (Ex. A4 at 6-9.)  
8

9 10. On November 8, 1999, Dr. Bhatt was arrested in California for Unauthorized  
10 Practice of Medicine. She pled not guilty to the offense, but was convicted in a jury trial. She  
11 received five years of supervised probation on January 24, 2001. She was subsequently  
12 arraigned for probation violations three times. (Exs. A7 at 1.)  
13

14 11. On several occasions between June 19, 2000, and July 31, 2000, Dr. Bhatt visited  
15 the Anaheim Veterans Health Clinic (VA Clinic) and engaged in behavior that included  
16 demanding to use the phone, fax, and copy machine, becoming upset and irate when not allowed  
17 to use clinic equipment, loudly threatening to sue the clinic and the Veterans Administration  
18 (VA), refusing to leave the premises when directed to do so, and throwing a piece of paper  
19 through the reception window. (Ex. A9 at 1-15.)  
20

21 12. On June 19, 2000, Dr. Bhatt came to the VA Clinic twice. In response, clinic  
22 staff called the Anaheim Police Department. The police informed Dr. Bhatt that if she returned  
23 to the clinic she would be arrested for Trespass. Dr. Bhatt returned to the VA Clinic less than  
24 two hours later, but left before the police returned to the scene. (Ex. A9 at 2, 6-7.)  
25

26 13. On June 20, 2000, the Anaheim Police Department responded to a "mental case  
27 call" at the VA Clinic. (Ex. A9 at 1.) A clinic employee reported to police that Dr. Bhatt had  
28 entered the clinic that morning, thrown a crumpled piece of paper containing anti-discrimination  
29 statements through the reception window, then exited the clinic. (*Id.*)  
30

31 14. On June 21, 2000, Lawrence C. Stewart, director of the VA Long Beach  
32 Healthcare System, mailed a certified letter to Dr. Bhatt. The letter stated, in part:  
33

34 [Y]ou have made several unnecessary visits to the Anaheim Veterans  
35 Health Clinic. Your visits have been reported to be very disruptive to the  
36 clinic staff and patients. You are not a veteran nor an employee of the  
37 Department of Veterans Affairs, and you have no business to conduct at  
38 the Anaheim Veterans Health Clinic. Your visits must cease immediately.  
39

40 (Ex. A9 at 10.) Dr. Bhatt replied to the letter with her own letter, dated July 8, 2000, and  
41 asserted, among other things, that "two black male clerks made threats" against her on June 19,  
42 2000. (*Id.* at 11.)  
43

44 15. On July 27, 2000, Dr. Bhatt entered the waiting room of the VA Clinic and began  
45 "rambling loudly" that clinic staff were treating her badly by not allowing her to use their  
46 equipment. (Ex. A9 at 5, 8.) Dr. Bhatt "yelled" that she was going to direct the FBI to  
47 investigate the clinic and was going to sue them for discrimination. (*Id.* at 5.) Dr. Bhatt refused  
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1 to leave when clinic staff directed her to do so, but she left once she saw and heard clinic staff  
2 calling the police. (*Id.*)  
3

4 16. On July 31, 2000, Dr. Bhatt again entered the VA Clinic and “ranted loudly about  
5 being discriminated against by clinic employees.” (Ex. A9 at 5.) Dr. Bhatt refused to leave the  
6 premises until she became aware that clinic staff were calling the police. (*Id.*)  
7

8 17. Based on her conduct at the VA Clinic, Dr. Bhatt was subsequently arrested and  
9 charged with Obstructing/Intimidating Business/Customers and Entering Land to Interfere with  
10 Lawful Business. The Entering Land charge was subsequently withdrawn. On February 28,  
11 2001, Dr. Bhatt entered a plea of *nolo contendere* to the Obstruction/Intimidating offense. She  
12 received three years of informal probation. (Exs. A7 at 2, A6 at 4.)  
13

14 18. On November 19, 2001, Dr. Bhatt’s Drug Enforcement Agency (DEA) Certificate  
15 of Registration was revoked, based on the revocation of her California medical license. (Ex.  
16 A11.) As of the date of hearing, her DEA registration had not been restored. (Tr. at 64.)  
17

18 19. On September 2, 2009, Dr. Bhatt submitted to the Board an application for  
19 reactivation of her Oregon medical license. (Ex. A2.) The application instructed Dr. Bhatt to  
20 answer several questions by checking either a “yes” or “no” box for each question. In response  
21 to the question “Have you ever had any disciplinary or adverse action imposed against any  
22 professional license or certification, or were you ever denied a professional license or  
23 certification, \* \* \* or have you ever been notified of any complaints or investigations related to  
24 any license or certification?” Dr. Bhatt failed to check either box. (*Id.* at 5.) Instead, she wrote  
25 “Victim of Identity theft case #03-58507.” (*Id.*) In response to the question, “Have you ever  
26 been denied approval to prescribe controlled substances, \* \* \* or been asked to surrender your  
27 DEA number?” Dr. Bhatt checked the “no” box. (*Id.*) In response to the question, “Have you  
28 ever been arrested, convicted of, or pled guilty or ‘nolo contendere’ to ANY offense in any state  
29 in the United States \* \* \*, other than minor traffic violations?” Dr. Bhatt failed to check either  
30 box. (*Id.*) In response to the question “Have you ever been contacted by or asked to make a  
31 response to any governmental agency in any jurisdiction regarding any criminal or civil  
32 investigation of which you are the subject, whether or not a charge, claim or filing with a court  
33 actually occurred?” Dr. Bhatt checked the “no” box. (*Id.*) In response to the question, “Have  
34 you interrupted the practice of your health care profession for one year or more, or ceased the  
35 practice of your specialty?” Dr. Bhatt failed to check either box. (*Id.*) In response to the  
36 compound question “Do you currently, or have you had within the past 5 years, any physical,  
37 mental, or emotional condition which impaired, or does impair your ability to practice your  
38 health care profession safely and competently? Has there been any type of inquiry into your  
39 physical, mental, or emotional health within the past 5 years?” Dr. Bhatt checked the “no” box.  
40 (*Id.* at 6.)  
41

42 20. Upon review of Dr. Bhatt’s application, Board licensing staff noted several items  
43 of concern, including Dr. Bhatt’s admission that she had previously failed licensing examinations  
44 or portions thereof and her failure to respond to questions regarding any adverse licensing  
45 history, criminal history, and interruptions of her practice or specialty. (Ex. A2 at 5; Tr. at 40-  
46 42.)  
47  
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1           21. In October 2009, as part of the application process, Dr. Bhatt submitted  
2 fingerprints to the Board. Using those fingerprints, Board staff conducted a routine background  
3 and criminal check through the FBI database. The Board discovered that Dr. Bhatt had five  
4 criminal arrests in California between 1999 and 2004, including three arrests for the  
5 unauthorized practice of medicine. (Exs. A1 at 2, A6 at 1-5; Tr. at 43-43, 56-58, 74, 104-107.)  
6

7           22. By letter dated January 5, 2010, Dr. Bhatt requested that the Washington Medical  
8 Commission vacate the October 29, 1999, order that revoked her medical license in that state.  
9 The Washington Medical Commission construed the request to vacate the order as a request for  
10 reinstatement of her license and informed Dr. Bhatt that reinstatement of her medical license  
11 would require a personal appearance before the Washington Medical Commission and proof that  
12 her California medical license had been reinstated. (Ex. R4 at 2.) As of the date of hearing,  
13 there is no evidence that Dr. Bhatt has appeared before the Washington Medical Commission.  
14 (See Evidentiary Record.) As of the date of hearing, Dr. Bhatt's Washington and California  
15 medical licenses have not been reinstated. (Tr. at 54.)  
16

17           23. As of at least January 2010, Dr. Bhatt was employed at the Pinnacle  
18 Healthcare/Yakima, Washington Sleep Center and actively conducting and interpreting  
19 EMG/NCV testing. (Ex. A1 at 3.)  
20

21           24. By letter dated February 3, 2010, Jerome S. Tobis, MD, recommended that the  
22 California Medical Board reinstate Dr. Bhatt's medical license. He wrote that he had known Dr.  
23 Bhatt for 30 years, and that they previously worked together at UCI. He also wrote that he had  
24 maintained intermittent contact with Dr. Bhatt professionally since she left UCI employment.  
25 (Ex. R2 at 1.) At the time Dr. Tobis wrote the letter of support for Dr. Bhatt, he believed she  
26 held active medical licenses in both Oregon and Washington and that she was actively practicing  
27 medicine in both states. (Ex. A1 at 4-5.)  
28

29           25. During a telephone conversation on February 8, 2010, Dr. Bhatt informed Ms.  
30 Matus that she was seen by a psychiatrist, Dr. Saghal, for an evaluation in 2004. Ms. Matus  
31 requested that Dr. Bhatt provide a copy of the evaluation to the Board. (Ex. A1 at 4.) As of the  
32 date of hearing, Dr. Bhatt had not provided a copy of the evaluation to the Board. (Tr. at 72.)  
33

34           26. On March 4, 2010, at the Board's request, Dr. Bhatt participated in an interview  
35 with the Board's investigative committee. (Ex. A10.) During the interview, she stated that she  
36 had only been to the VA Clinic in Anaheim once, that she had never received any warnings from  
37 the clinic regarding disruptive behavior, that she had never been involved in a jury trial, and that  
38 she had only been arrested on one occasion—for reasons unknown to her, but possibly having to  
39 do with police not believing that she was a doctor and a U.S. citizen. During the interview, Dr.  
40 Bhatt admitted that in 1997 she was involuntarily hospitalized for four days at Santa Clara  
41 Medical Center and that her DEA license has been inactive since 2002. She also stated that she  
42 saw a psychiatrist, Dr. Saghal, on one occasion, and that he informed her that she did not need  
43 medication for any psychiatric condition. (*Id.* at 6-11, 14.) When asked why she failed to  
44 answer "yes" or "no" on her license reinstatement application regarding whether she had ever  
45 been arrested, Dr. Bhatt responded, "Maybe because I didn't want to incriminate myself until the  
46 whole story came out with the detective's report." (*Id.* at 13.) When asked why she failed to  
47 answer "yes" or "no" on her license reinstatement application regarding whether her practice had  
48 been interrupted for more than one year, Dr. Bhatt admitted to not practicing medicine since

1 1998. However, she added that because she had worked in a clinic setting since that time,  
2 considering her practice to have been interrupted was "like splitting hairs." (*Id.*) Following that  
3 interview, the committee recommended that Dr. Bhatt's application for licensure be denied. (Ex.  
4 A1 at 1.)

5  
6 27. On April 14, 2010, Dr. Bhatt sent an email to Board staff that stated, in part:

7  
8 I will never forget the heartless cruelty of the Oregon medical board  
9 decision[.]

10  
11 Why didn't you come yourself to shoot me with your gun yesterday?

12  
13 \* \* \* \* \*

14  
15 You will see me die and my death will remain on your conscious  
16 forever[.]

17  
18 Give me an answer!

19  
20 (Ex. A14.) During interactions with Board staff from 2009 to 2011, Dr. Bhatt has displayed  
21 volatile, irrational, erratic, and paranoid behavior. (*See* Exs. A10, A14, A15; Tr. at 71.) Dr.  
22 Bhatt's responses to inquiries from Board staff have frequently been evasive, incomplete, and  
23 immaterial. (Tr. at 44-46, 70-71.)

24  
25 28. As of the date of hearing, Dr. Bhatt was under investigation for practicing  
26 medicine without a license in Washington and California. (Tr. at 55.)

27  
28 29. There is no evidence that Dr. Bhatt is currently being treated with anti-psychotic  
29 medications, or that she is currently under the care of a psychiatrist. (*See* Evidentiary Record.)

### 30 31 CONCLUSIONS OF LAW

32  
33 1. The Board may deny Dr. Bhatt's application for a license to practice as a  
34 physician in Oregon based on violations of the Medical Practice Act and a lack of good moral  
35 character.

36  
37 2. The Board may impose a total civil penalty of \$15,000 against Dr. Bhatt.

### 38 39 OPINION

#### 40 41 1. Denial of application for licensure

42  
43 Pursuant to the Medical Practice Act, the Board is authorized by ORS 677.190 to refuse  
44 to grant a license to practice in Oregon for any of several delineated reasons. The Board has  
45 proposed denying Dr. Bhatt's application for licensure based on the following statutory  
46 provisions:

47  
48 (1)(a) Unprofessional or dishonorable conduct.

1 \* \* \* \* \*

2  
3 (7) Impairment as defined in ORS 676.303.

4 \* \* \* \* \*

5  
6  
7 (8) Fraud or misrepresentation in applying for or procuring a license to  
8 practice in this state, or in connection with applying for or procuring  
9 registration.

10 \* \* \* \* \*

11  
12  
13 (15) Disciplinary action by another state of a license to practice, based  
14 upon acts by the licensee similar to acts described in this section. A  
15 certified copy of the record of the disciplinary action of the state is  
16 conclusive evidence thereof.

17 \* \* \* \* \*

18  
19  
20 (17) Willfully violating any provision of this chapter or any rule adopted  
21 by the board, board order, or failing to comply with a board request  
22 pursuant to ORS 677.320.<sup>1</sup>

23  
24 In addition, the Board contended that it may deny Dr. Bhatt's application for licensure  
25 pursuant to ORS 677.100(1)(d) because Dr. Bhatt has failed to prove that she possesses good  
26 moral character. ORS 677.100(1)(d) states, in part:

27  
28 An applicant for a license to practice medicine in this state \* \* \* must  
29 possess the following qualifications:

30 \* \* \* \* \*

31  
32  
33 (d) Have provided evidence sufficient to prove to the satisfaction of the  
34 board that the applicant is of good moral character. For purposes of this  
35 section, the lack of good moral character may be established by reference  
36 to acts or conduct that reflect moral turpitude or to acts or conduct which  
37 would cause a reasonable person to have substantial doubts about the  
38 individual's honesty, fairness and respect for the rights of others and for  
39 the laws of the state and the nation. The acts or conduct in question must  
40 be rationally connected to the applicant's fitness to practice medicine.

41  
42 <sup>1</sup> The Board also alleged a violation of ORS 677.190(25) in its Notice, but later conceded that section (25)  
43 only applies to licensees, and not applicants. See Board's Corrected Closing Argument at 12. Thus, it is  
44 unnecessary to determine whether Dr. Bhatt, an applicant for licensure, committed the conduct described  
45 in ORS 677.190(25) ("Failure by the licensee to report to the board any adverse action taken against the  
46 licensee by another licensing jurisdiction or any peer review body, health care institution, professional or  
47 medical society or association, governmental agency, law enforcement agency or court for acts or conduct  
48 similar to acts or conduct that would constitute grounds for disciplinary action as described in this  
section.").

1 As the proponent of the position that Dr. Bhatt's application should be denied, the Board  
2 has the burden of coming forward with reliable, probative, and substantial evidence to support its  
3 position. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a  
4 contested case rests on the proponent of the fact or position"). If the Board meets its burden,  
5 then the burden shifts to Dr. Bhatt to present reliable, probative, and substantial rebutting  
6 evidence. If she does so, then all credible evidence, and all reasonable and permissible  
7 inferences drawn from that evidence, are weighed to determine which propositions are more  
8 probably true than false. See *Metcalf v. AFSD*, 65 Or App 761, 765 (1983) (in the absence of  
9 legislation specifying a different standard, the standard of proof in an administrative hearing is  
10 preponderance of the evidence); *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402  
11 (1987) (proof by a preponderance of the evidence means the fact finder is persuaded the facts  
12 asserted are more likely than not true). If the evidence appears to be equally balanced, then the  
13 Board must resolve the evidentiary question against the party upon whom the burden of proof  
14 (*i.e.* persuasion) rests. See *In the Matter of Callow*, 171 Or App 175, 179 (2000). Under ORS  
15 677.100(1)(d), Dr. Bhatt has the burden of proving that she possesses the requisite moral  
16 character to be licensed by the Board.

17  
18 **A. Unprofessional or dishonorable conduct**

19  
20 ORS 677.190(1)(a) allows the Board to deny an application for licensure for  
21 "unprofessional or dishonorable conduct." ORS 677.188(4) states, in part:

22  
23 "Unprofessional or dishonorable conduct" means conduct unbecoming a  
24 person licensed to practice medicine or podiatry, or detrimental to the best  
25 interests of the public, and includes:

26  
27 (a) Any conduct or practice contrary to recognized standards of ethics of  
28 the medical \* \* \* profession or any conduct or practice which does or  
29 might constitute a danger to the health or safety of a patient or the public  
30 or any conduct, practice or condition which does or might adversely affect  
31 a physician's \* \* \* ability safely and skillfully to practice medicine[.]

32  
33 The Board contended that Dr. Bhatt has engaged in unprofessional or dishonorable  
34 conduct, as defined in ORS 677.188(4)(a), by practicing medicine without a license and by  
35 engaging in disruptive and volatile behavior that did, or had the potential to, negatively affect  
36 patient care.

37  
38 First, the record establishes that Dr. Bhatt engaged in the practice of medicine without a  
39 license in California, an act that constituted a crime of which she was ultimately convicted. The  
40 practice of medicine without a license is prohibited in Oregon by ORS 677.080(4)("No person  
41 shall \* \* \* practice medicine in this state without a license required by this chapter."). Moreover,  
42 the act has been criminalized by ORS 677.990(2)("Any person who practices medicine without  
43 being licensed under this chapter as prohibited in ORS 677.080(4) commits a Class C felony.").  
44 The Board is persuaded that practicing medicine without a license is contrary to recognized  
45 standards of ethics in the medical profession. Thus, by engaging in the unlicensed practice of  
46 medicine, Dr. Bhatt engaged in unprofessional or dishonorable conduct.

47 ///  
48 ///

1 Second, the record establishes that Dr. Bhatt engaged in disruptive and volatile behavior  
2 in a healthcare setting. Her conduct on repeated occasions at the VA Clinic in Anaheim led to  
3 her arrest and subsequent conviction for Obstructing/Intimidating Business/Customers. The  
4 Board contended that disruptive behavior in a healthcare setting, especially when such behavior  
5 rises to the level of a violation of the law, is conduct that is contrary to recognized standards of  
6 ethics in the medical profession. The American Medical Association (AMA) has stated that  
7 “[e]thical values and legal principles are usually closely related, but ethical obligations typically  
8 exceed legal duties.” AMA Ethics Opinion 1.02 (2010). The AMA has described disruptive  
9 behavior by a physician as “[p]ersonal conduct, whether verbal or physical, that negatively  
10 affects or that potentially may negatively affect patient care.” AMA Ethics Opinion 9.45(1)  
11 (2010). The evidence establishes that Dr. Bhatt shouted, threw objects, and threatened medical  
12 staff at the VA clinic. The Board is persuaded that such conduct had the potential to negatively  
13 affect patient care. Moreover, her conviction for Obstructing/Intimidating Business/Customers  
14 demonstrates that her conduct did, more likely than not, negatively affect clinic patients and their  
15 health care experience. Thus, her conduct constitutes “disruptive behavior,” which is contrary to  
16 recognized standards of ethics in the medical profession.  
17

18 As set forth above, Dr. Bhatt engaged in “unprofessional or dishonorable conduct,” as  
19 defined in ORS 677.188(4)(a). This constitutes a violation of ORS 677.190(1)(a), and provides  
20 the Board with sufficient grounds upon which to deny Dr. Bhatt’s application for licensure.  
21

### 22 *B. Impairment*

23  
24 ORS 677.190(7) allows the Board to deny an application for licensure for “impairment.”  
25 ORS 676.303(1)(b) defines “impairment,” in part, as “an inability to practice with reasonable  
26 competence and safety due to \* \* \* a mental health condition.”  
27

28 The most recent available medical documentation shows that psychiatrist Dr. David J.  
29 Sheffner diagnosed Dr. Bhatt with a paranoid psychotic condition in 1998 and recommended  
30 immediate and regular treatment with anti-psychotic medications, as well as treatment by a  
31 psychiatrist for an indefinite duration. Also in 1998, the California Medical Board determined  
32 that Dr. Bhatt was unable to practice medicine safely because she was impaired due to mental  
33 illness. There is no evidence to indicate that Dr. Bhatt has undergone treatment with anti-  
34 psychotic medications since that time, or otherwise taken action to treat any mental or  
35 psychiatric condition. While Dr. Bhatt denies having a mental illness, the Board has presented  
36 sufficient evidence to establish that, more likely than not, she does have an untreated paranoid  
37 psychotic condition. The Board contended that Dr. Bhatt therefore cannot practice medicine  
38 safely or competently. The California Medical Board came to that conclusion in 1998, and Dr.  
39 Bhatt has offered no compelling evidence to refute the conclusion. In fact, her conduct since that  
40 time supports the California Medical Board’s determination. The Board may deny Dr. Bhatt’s  
41 application for licensure under ORS 677.190(7).  
42

### 43 *C. Fraud or misrepresentation in applying for licensure*

44  
45 ORS 677.190(8) allows the Board to deny an application for licensure based on “[f]raud  
46 or misrepresentation in applying for or procuring a license to practice in this state.” ORS  
47 677.188(1) states, in part:  
48

///

1 "Fraud or misrepresentation" means the intentional misrepresentation or  
2 misstatement of a material fact, concealment of or failure to make known  
3 any material fact, or any other means by which misinformation or a false  
4 impression knowingly is given.  
5

6 First, despite the 2009 Board license application's specific instructions to answer various  
7 questions in either the affirmative or the negative, Dr. Bhatt did not provide "yes" or "no"  
8 responses to the questions relating to adverse licensing actions, arrests, convictions, guilty/*nolo*  
9 *contendere* pleas, and interruption of her practice or specialty. In failing to answer those  
10 questions, Dr. Bhatt concealed and failed to make known the material facts of her license  
11 revocation in two states, her arrests and convictions in California, her *nolo contendere* plea, and  
12 her cessation of the lawful practice of her specialty or profession since 1999. During her  
13 interview with the Board's investigative committee, Dr. Bhatt admitted that she had intentionally  
14 misled the Board regarding her arrest history because she did not want to incriminate herself.  
15 She also admitted to the committee that she misled the Board regarding the cessation of her  
16 practice, and referred to it as "splitting hairs." The Board is persuaded that, more likely than not,  
17 Dr. Bhatt intentionally concealed or failed to make known material facts on her application for  
18 licensure, and therefore committed fraud or misrepresentation.  
19

20 Second, in response to the question regarding adverse licensing actions, in lieu of  
21 answering "yes" or "no" on the application, Dr. Bhatt wrote "Victim of Identity theft case #03-  
22 58507." Exhibit A2 at 5. By so responding, Dr. Bhatt gave the false impression that any adverse  
23 licensing action[s] to which she might have been subject were against a person who had stolen  
24 her identity and/or were due to conduct committed by a person who had stolen her identity. The  
25 evidence does not support either of those scenarios. Rather, Dr. Bhatt's California license  
26 revocation was based on her refusal to comply with a California Board order and a determination  
27 that she was unable to safely practice medicine due to mental impairment, and her Washington  
28 revocation was based on her California revocation. The Board is persuaded that Dr. Bhatt, on  
29 her application, intentionally gave a false impression that any adverse licensing actions were due  
30 to her being the victim of identity theft, and that she therefore committed fraud or  
31 misrepresentation.  
32

33 Third, Dr. Bhatt denied on her application that she was ever required to surrender her  
34 DEA number, that she was ever contacted or asked to respond to any governmental agency  
35 regarding a criminal or civil investigation of which she was the subject, and that she currently  
36 has or in the past five years has had any physical, mental, or emotional condition that impaired or  
37 impairs her ability to practice medicine. By so denying, Dr. Bhatt misstated material facts  
38 because the evidence establishes that she was, in fact, required to surrender her DEA number,  
39 that she has been contacted by and asked to respond to government agencies regarding  
40 investigations of which she was the subject, and that she has had a mental health condition for  
41 several years, including the past five, which arguably has impaired or would impair her ability to  
42 safely practice medicine. During her interview with the Board's investigative committee, Dr.  
43 Bhatt admitted to knowing that she had been required to surrender her DEA license. At hearing,  
44 she admitted to denying contact by government agencies regarding investigations of which she  
45 was the subject, when she should have admitted it on her application. (Transcript at 118-119.)  
46 With respect to the matters of DEA licensing and contact from governmental agencies, the Board  
47 is persuaded that Dr. Bhatt intentionally misrepresented material facts on her application for  
48 licensure, and therefore committed fraud or misrepresentation. Because Dr. Bhatt does not

1 believe or recognize that she has any mental or psychiatric conditions, the Board is not persuaded  
2 that she intended to misrepresent the current state of her mental or psychiatric health to the  
3 Board.

4  
5 As set forth above, Dr. Bhatt committed fraud or misrepresentation in applying for  
6 licensure, in violation of ORS 677.190(8), and the Board may deny her license application on  
7 that ground.

8  
9 ***D. Disciplinary action by another state***

10  
11 ORS 677.190(15) allows the Board to deny an application for licensure based on  
12 “[d]isciplinary action by another state of a license to practice, based upon acts by the licensee  
13 similar to acts described in this section.” Thus, a violation of ORS 677.190(15) is established  
14 when a person has been subject to license discipline in another state and that discipline was  
15 based on acts similar to those that would have subjected the person to discipline in Oregon.

16  
17 In 1998, the California Medical Board revoked Dr. Bhatt’s medical license for failure to  
18 comply with a California Board order and for an inability to safely practice medicine due to  
19 mental illness. In Oregon, ORS 677.190(17) subjects a licensee to discipline for willfully  
20 violating any provision under ORS chapter 677, any Board rule, or any Board order. ORS  
21 677.190(14) and 677.420<sup>2</sup> authorize the Board to require mental competency examinations from  
22 subject licensees, and ORS 677.190(7) and (14) subject a licensee to discipline for mental health  
23 “impairment” and “incapacity to practice medicine,” respectively. Thus, the evidence establishes  
24 that Dr. Bhatt was disciplined in California for acts that would have subjected her to discipline in  
25 Oregon.

26  
27 In 1999, the Washington Medical Commission revoked Dr. Bhatt’s medical license  
28 because of the California revocation. ORS 677.190(15) subjects a licensee to license revocation  
29 in Oregon based on license revocation in another state. Thus, the evidence establishes that Dr.  
30 Bhatt was disciplined in Washington for an act that would have subjected her to discipline in  
31 Oregon.

32  
33  
34 <sup>2</sup> ORS 677.190(14) allows the Board to discipline a licensee for “[i]ncapacity to practice medicine,” and  
35 allows the Board to “order a licensee to submit to a standardized competency examination” if the Board  
36 has evidence that indicates incapacity.

37  
38 ORS 677.420 provides, in part:

39  
40 (1) [The] Board may at any time direct and order a mental, physical or medical  
41 competency examination or any combination thereof, and make such investigation,  
42 including the taking of depositions or otherwise in order to fully inform itself with respect  
43 to the performance or conduct of a licensee.

44  
45 (2) If the board has reasonable cause to believe that any licensee is or may be unable to  
46 practice medicine or podiatry with reasonable skill and safety to patients, the board shall  
47 cause a competency examination of such licensee for purposes of determining the fitness  
48 of the licensee to practice medicine or podiatry with reasonable skill and safety to  
patients.

1 For the reasons set forth above, the Board may deny Dr. Bhatt's application for licensure  
2 under ORS 677.190(15).

3  
4 *E. Willful violation of Board statute, rule, order, or request*  
5

6 ORS 677.190(17) allows the Board to deny an application for licensure for "[w]illfully  
7 violating any provision of this chapter or any rule adopted by the board, board order, or failing to  
8 comply with a board request pursuant to ORS 677.320."  
9

10 The Board contended that Dr. Bhatt willfully violated ORS 677.190(1)(a) and (8). As  
11 previously set forth, the preponderance of the evidence establishes that Dr. Bhatt willfully  
12 engaged in unprofessional or dishonorable conduct and willfully committed fraud or  
13 misrepresentation when applying for licensure by the Board. Thus, it was proven that Dr. Bhatt  
14 willfully violated one or more provisions of ORS Chapter 677.  
15

16 The Board further contended that Dr. Bhatt willfully violated ORS 677.320 by failing to  
17 cooperate with the Board's investigation. ORS 677.320 provides, in part:  
18

19 (1) [The] Board may investigate any alleged violation of this chapter[.]

20  
21 (2) In the conduct of investigations, the board or its designated  
22 representative may:

23 (a) Take evidence;

24 (b) Take the depositions of witnesses, including the person charged;

25  
26 (c) Compel the appearance of witnesses, including the person charged;

27  
28 (d) Require answers to interrogatories; and  
29

30 (e) Compel the production of books, papers, accounts, documents and  
31 testimony pertaining to the matter under investigation.  
32  
33  
34

35 The Board contended, and the evidence established, that Dr. Bhatt routinely failed to  
36 provide direct and relevant responses to inquiries from Board staff during the Board's  
37 investigation. Also, the Board contended that Dr. Bhatt failed to cooperate with the investigation  
38 by failing to produce a 2004 psychiatric evaluation report from Dr. Saghal that would allegedly  
39 show that she had no psychiatric diagnoses. Dr. Bhatt's explanations for her inability to obtain  
40 the report were inconsistent<sup>3</sup> and lead to the conclusion that, more likely than not, she willfully  
41 failed to take the necessary steps to produce the report for the Board.  
42

43 As set forth above, Dr. Bhatt violated ORS 677.190(17), and the Board may deny her  
44 application for licensure on that ground.  
45

46  
47 <sup>3</sup> For example, she informed the Board's investigative committee that she did not know Dr. Saghal's  
48 phone number (Ex. A10 at 11), yet she testified at hearing that she left him three phone messages  
requesting her medical records (Tr. at 101).

1                    *F. Good moral character under ORS 677.100(1)(d)*  
2

3                    To reiterate, ORS 677.100(1)(d) requires that an applicant seeking licensure by the Board  
4 provide “evidence sufficient to prove to the satisfaction of the board that the applicant is of good  
5 moral character.” Dr. Bhatt chiefly attempted to establish that she possesses good moral  
6 character by arguing that her identity was stolen and that the alleged identity theft somehow  
7 contributed to her convictions or provided proof that she was wrongly convicted. Dr. Bhatt’s  
8 allegations of identity theft were not proven and, even if true, are not exculpatory and do not  
9 establish that, more likely than not, she possesses good moral character. Dr. Bhatt also offered  
10 testimony from a former colleague, Dr. Satyanarayan, to establish that she possesses good moral  
11 character. While Dr. Satyanarayan testified that during the time he worked with Dr. Bhatt he  
12 knew her to be of good moral character, he admitted that he has not had contact with her since  
13 1984. As such, his testimony does not tend to prove that, more likely than not, Dr. Bhatt  
14 *currently* possesses good moral character. Dr. Bhatt also offered a letter of support from a  
15 colleague, Dr. Tobis, with whom she worked many years ago and has maintained a limited  
16 degree of professional contact. However, Dr. Tobis’ letter of support for the reinstatement of Dr.  
17 Bhatt’s California medical license carries little weight in this matter given the current limited  
18 contact between Drs. Tobis and Dr. Bhatt and the fact that Dr. Tobis was not even aware that Dr.  
19 Bhatt currently lacks licensure to practice medicine in any state. In sum, Dr. Bhatt failed to  
20 establish that she possesses good moral character, as required for Board licensure under ORS  
21 677.100(1)(d)  
22

23                    Under ORS 677.100(1)(d), the Board may establish a *lack* of good moral character as  
24 follows:  
25

26                    [T]he lack of good moral character may be established by reference to acts  
27 or conduct that reflect moral turpitude or to acts or conduct which would  
28 cause a reasonable person to have substantial doubts about the individual’s  
29 honesty, fairness and respect for the rights of others and for the laws of the  
30 state and the nation. The acts or conduct in question must be rationally  
31 connected to the applicant’s fitness to practice medicine.  
32

33                    The record contains overwhelming evidence to support the Board’s allegations with  
34 respect to Dr. Bhatt’s convictions, her conduct leading to those convictions, her  
35 misrepresentations when applying for licensure in Oregon, her failure to fully cooperate with the  
36 Board during its investigation, and her disciplinary history by medical boards in other states. Dr.  
37 Bhatt’s convictions for the unlicensed practice of medicine and for obstruction/intimidation are  
38 based on conduct that would cause a reasonable person to have doubts regarding Dr. Bhatt’s  
39 respect for the rights of others and for the law. Her misrepresentations to the Board, both on her  
40 application for licensure and during the investigatory process, and her failure to fully cooperate  
41 with the Board would cause a reasonable person to have substantial doubts about her honesty.  
42 Her convictions were related to the practice of medicine and to disruptive and intimidating  
43 behavior in a healthcare setting—conduct that is rationally connected to her fitness to practice  
44 medicine. Her misrepresentations to the Board were related to her criminal history, disciplinary  
45 history by other state boards, the cessation of her practice, and whether she had any mental or  
46 psychological impairments—all matters that are rationally connected to her fitness to practice  
47 medicine. The Board finds that Dr. Bhatt’s lack of good moral character has been established.  
48

///

1 **2. Civil penalty**

2  
3 Under ORS 677.265, the Board may, in addition to denying an application for licensure,  
4 impose fines and assess the costs of proceedings to an applicant. ORS 677.265 provides, in part:

5  
6 [T]he Oregon Medical Board may:

7  
8 \* \* \* \* \*

9  
10 (2) Issue, deny, suspend and revoke licenses and limited licenses, assess  
11 costs of proceedings and fines and place licensees on probation as  
12 provided in this chapter.

13  
14 The Board has established sufficient grounds for denial of Dr. Bhatt's application for  
15 licensure. In addition, the Board proposed assessing a total civil penalty of \$15,000 against Dr.  
16 Bhatt—including \$5,000 in fines (\$1,000 per each of the five violations proven) and \$10,000 for  
17 the costs of the proceeding. The costs of the proceeding were incurred as follows: Department of  
18 Justice (4/10-4/11) - \$9,595.50, Transcription Fees - \$822.20, Hearings Officer - \$3,570.91, and  
19 Security - \$750.00. Pursuant to ORS 677.265(2), it is within the scope of the Board's authority to  
20 impose the \$5,000 fine against Dr. Bhatt and to assess the costs of the proceeding, for a total  
21 civil penalty of \$15,000.

22  
23 **ORDER**

24  
25 The Board adopts the ALJ's findings of fact and conclusions of law, finding that Dr.  
26 Bhatt violated the Medical Practice Act on numerous occasions and lacks good moral character.  
27 Dr. Bhatt's should be disciplined as follows:

- 28  
29 1. Dr. Kiran L. Bhatt's application for a license to practice as a physician in Oregon  
30 is **denied**.  
31  
32 2. Dr. Kiran L. Bhatt must pay a **total assessment of \$15,000**, including \$10,000 of  
33 the assessed costs of the proceedings and a \$5,000 civil penalty.

34  
35 IT IS SO ORDERED this 16<sup>th</sup> day June, 2011

36  
37 OREGON MEDICAL BOARD  
38 State of Oregon

39  
40  
41 **(SIGNATURE REDACTED)**

42 ~~RALPH A. YATES, DO~~  
43 Board Chair  
44

45 **NOTICE OF RIGHT TO APPEAL:** You are entitled to seek judicial review of this order. To seek  
46 judicial review, you must file a petition for review with the Oregon Court of Appeals within sixty  
47 (60) days from the service of the Final Order. If this order was mailed to you, the date of service is  
48 the day it was mailed, not the day you received it. See ORS 183.480 et seq.



1 677.188(4)(a). This Order placed Licensee on career length probation and required him to  
2 undergo a Board approved evaluation, along with other terms and conditions.

3 2.4 Pursuant to the 2010 Stipulated Order, Licensee underwent an evaluation at the  
4 Keystone Center, which issued a report, dated November 11, 2010. In the report, Licensee was  
5 found to present with many boundary issues, but that he: “may still be safe to practice under  
6 monitoring....His behaviors seem to be significant mostly because he does not understand the  
7 possible damage or unethical nature of them (e.g. prescribing medications to someone who is not  
8 a patient.)” The report recommended that the Board “gain clarity on his prescribing practices  
9 and whether they do fall out of the standard of care.” During this evaluation, Licensee disclosed  
10 that he had prescribed controlled substance medications to a small number of patients in  
11 emergency situations without conducting one or more of the following: intake and evaluation,  
12 physical examination, records review, assessment, documentation and follow up.

13 2.5 Beginning in 2008, Licensee practiced medicine at the Men’s Addictionology  
14 clinic in Portland. The Board opened an investigation into Licensee’s medical practice at this  
15 clinic after receiving the information in the Keystone Center report that Licensee had prescribed  
16 Suboxone (Schedule III, Buprenorphine and Nalaxone) to a patient’s mother without conducting  
17 an evaluation or reviewing her medical records. Further, Licensee authorized this prescription  
18 after learning that the mother had diverted some of her son’s medications for her own use.

19 2.6 On January 11, 2011, Licensee and the Board entered into an Interim Stipulated  
20 Order, in which Licensee voluntarily withdrew from the practice of medicine. This action was  
21 taken as a result of the concerning information from the Keystone Center evaluation and in the  
22 context of the two active Stipulated Orders.

23 2.7 On February 17, 2011, Licensee and the Board entered into an Amended Interim  
24 Stipulated Order, which allowed Licensee to return to the practice of medicine with Licensee  
24 voluntarily limiting his practice of medicine to male patients only while the Board continued the  
25 investigation. The investigation continued with a detailed review of Licensee’s medical charts.

26 ///

3.

The Board to date has reviewed six charts for patients for whom Licensee has prescribed Suboxone in crisis circumstances and 11 additional charts that were selected at random to reflect Licensee's normal clinical practice. In each of the reviewed cases, the Board has identified significant concerns regarding Licensee's ability to safely and competently provide care and treatment to this vulnerable patient population.

The Board has determined from the evidence available at this time that Licensee's continued practice of medicine would pose an immediate danger to the public and to his patients. Licensee treats many patients suffering from narcotics addiction with Suboxone (Schedule III, Buprenorphine and Nalaxone). The Board's chart review, conducted by a Medical Consultant, reveals that Licensee's manner of practice does not conform to the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. In addition, Licensee's chart notes are extremely difficult to read, and do not record an adequate assessment (to include patient history, physical examination with objective findings, and appropriate laboratory testing) to support a diagnosis and treatment plan. The Medical Consultant's review identified significant deficiencies in Licensee's practice of Addiction Medicine. The Medical Consultant opined that the deficiencies in Licensee's chart notes reflect a manner of practice that does not conform to the standard of care and subjects his patients to the risk of harm.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days from the date of the mailing of this Notice to Licensee, pursuant to 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 practical.

///

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5.

The Board orders that pursuant to ORS 677.205(3), the license of Robert Perry Campbell, MD, be suspended on an emergency basis and that Licensee immediately cease the practice of medicine until otherwise ordered by the Board.

IT IS SO ORDERED THIS 7<sup>th</sup> day of July, 2011.

OREGON MEDICAL BOARD

(SIGNATURE REDACTED)

~~RALPH WATERS, DO~~  
BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
JEFFREY FRIEDLANDER, MD )  
LICENSE NO. MD 14269 ) DEFAULT FINAL ORDER

1.

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

2.

2.1 On December 28, 2010, the Board issued an Order of License Suspension against the medical license of Licensee pursuant to ORS 677.225(1)(b) based upon Licensee's incarceration in a Federal Correctional Institution in Jesup, Georgia. On January 20, 2011, the Board issued a Complaint and Notice of Proposed Disciplinary Action in regard to allegations that Licensee had engaged in acts of misconduct. The Board's Notice designated the Board's file on this matter as the record for purposes of a default order and granted Licensee an opportunity for a hearing, if requested in writing within 21 days of service of the Notice. This Notice was sent by Certified Mail to Licensee at the address provided by Licensee. On February 5, 2011, Licensee submitted a handwritten letter to the Board requesting a contested case hearing. Senior Administrative Law Judge (ALJ) Bernadette House was assigned to preside at hearing. A prehearing conference was convened on April 4, 2011, at which time the relevant deadlines and the hearing dates were set.

2.2 Licensee is currently incarcerated at the Federal Correctional Institution (FCI) in Jesup, Georgia. In a letter dated June 2, 2011, the Board's counsel sent a letter to the Warden of the



1 which he pled guilty to a single count of conspiracy to knowingly and intentionally distribute and  
2 dispense, and cause distribution and dispensing of controlled substances, primarily Oxycodone  
3 (Schedule II), Morphine (Schedule II), Hydrocodone (Schedule III), and Alprazolam (Schedule  
4 IV) and a single count of conspiracy to commit Medicare fraud. Both offenses are felonies.  
5 Court documents indicate that Licensee allowed the prescribing of controlled substances to  
6 patients by unauthorized employees without his presence, participation and adequate supervision.  
7 Licensee knowingly and intentionally caused the distribution and dispensing of controlled  
8 substances not for a legitimate medical purpose, and not in the usual course or professional  
9 practice in one or more of the following manners: without adequate verification of the patient's  
10 identity or medical complaint; without adequate and reliable patient medical history; without  
11 conducting adequate mental or physical examinations; without establishing a true diagnosis;  
12 without using appropriate diagnostic or laboratory testing; without sufficient dialogue with the  
13 patient regarding treatment options and risks and benefits of such treatments; without  
14 establishing a treatment plan; without considering or discussing alternative treatment options;  
15 without referral of patients to specialists in an effort to identify and correct the cause of pain;  
16 without any assessment of risk of abuse for individual patients; without provision of a means to  
17 follow up with a patient or to monitor patient response to medication or compliance with  
18 medication usage; and without maintaining true, accurate and complete medical records.

19       3.2     On October 15, 2010, subsequent to his plea of guilty, the Licensee was sentenced  
20 in the U.S. District Court for the Middle District of Florida to one hundred eight (108) months  
21 confinement and ordered to forfeit \$317,047.13. The Licensee is currently incarcerated at the  
22 Federal Correctional Institution in Jesup, Georgia.

23       3.3     Licensee practiced medicine in the state of Florida, primarily out of a medical  
24 business known as "Neurology and Pain Center Clinics," which offered clinics at the following  
25 cities in Florida: Tampa, Sarasota, Lakeland, Orlando, Jacksonville, and St. Petersburg. These  
26 clinics were investigated by state and federal authorities. This investigation found that Licensee

1 distributed and dispensed controlled substances to patients through clinic employees who lacked  
2 prescribing authority. Licensee engaged in a pattern of misconduct in which he signed blank  
3 prescription forms prepared by clinic employees in advance of patient visits, who in turn  
4 distributed these signed prescriptions to patients without any meaningful interaction between  
5 patient and a physician. Many of these prescriptions were issued for controlled substances to  
6 patients without the benefit of a physical examination, a proper diagnosis or consideration  
7 alternative treatment options. Licensee also caused the submission of false claims to Medicare  
8 for reimbursement for services that had not been performed.

9           3.4     On April 16, 2010, the Board of Medicine for the state of Florida accepted  
10 Licensee's offer to voluntarily relinquish his license to practice medicine in the state. This was  
11 considered to be a disciplinary action. Licensee agreed never to reapply for licensure as a  
12 medical doctor in the state of Florida.

13           3.5     In the Board's Complaint and Notice of Proposed Disciplinary Action dated  
14 January 20, 2011, the Board informed Licensee that it intended to take disciplinary action against  
15 him based upon violations of the Medical Practice Act, as follows: ORS 677.190(1)(a)  
16 unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a); ORS 677.190(6)  
17 conviction of any offense punishable by incarceration in a Department of Corrections institution  
18 or in a federal prison; and ORS 677.190(15) disciplinary action by another state of a license to  
19 practice, based upon acts by the licensee similar to acts described in the Medical Practice Act;  
20 ORS 677.190(23) violation of the federal Controlled Substances Act; and ORS 677.190(24)  
21 prescribing controlled substances without a legitimate medical purpose, or prescribing controlled  
22 substances without following accepted procedures for examination of patients, or prescribing  
23 controlled substances without following accepted procedures for record keeping.

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5.

**ORDER**

IT IS HEREBY ORDERED THAT the license of Jeffrey Friedlander, MD, to practice medicine is revoked. In addition, Jeffrey Friedlander, MD, is assessed a \$10,000 civil penalty, to be paid in full within 60 days from the date of this Order, and is assessed the costs of the hearing.

DATED this 7<sup>th</sup> day of July, 2011.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURES REDACTED

[Signature]  
RALPH A. ATTS, DO  
BOARD CHAIR

**Right to Judicial Review**

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

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

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IN THE MATTER OF:                    )  
  )  
JOHN EDWIN GAMBEE, MD            ) FINAL ORDER  
License No. MD09526                )  
  )

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**HISTORY OF THE CASE**

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On May 11, 2010, the Oregon Medical Board (Board) issued a Complaint and Notice of Disciplinary Action to John Edwin Gambée, MD (Licensee). On May 25, 2010, Licensee, by and through counsel, William G. Wheatley, Attorney at Law, requested a hearing.

47  
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On August 10, 2010, the Board referred the hearing request to the Office of Administrative Hearings (OAH). Administrative Law Judge (ALJ) Samantha Fair was initially assigned to preside at hearing. A prehearing conference was convened on September 23, 2010, at which time the relevant deadlines and the hearing dates were set. The case was later reassigned to Senior ALJ A. Bernadette House.

A hearing was held beginning December 13 continuing through December 17, 2010, in Portland, Oregon. Licensee appeared, accompanied by counsel, and testified. The Board was represented by Warren Foote, Senior Assistant Attorney General. The Board called the following witnesses in addition to Licensee: Patient A; David Cook, MD; Anne Nedrow, MD; Terry Lewis, Board Investigator; and David Esrig, MD, who appeared by telephone.

Licensee called the following witnesses: Kathleen Haley, Board Executive Director; Kenneth Welker, MD; Patient E; Patient G; Jay Harvey Mead, MD; David Grube, MD; Patient F; and John A. Green, MD. The record closed following oral arguments on December 17, 2010.

List of acronyms and terms used

To aid in the reading of the proposed order, the following is a list of acronyms used in the Order<sup>1</sup>

- AACE – American Association of Clinical Endocrinologists  
CME – Continuing Medical Education  
DRE – Digital Rectal Examination  
FDA – Food and Drug Administration  
HRT – Hormone Replacement Therapy

<sup>1</sup> The source of the definitions used was primarily from testimony, if provided, or secondarily, from *Taber's Donal Venes, ed., Cyclopedic Medical Dictionary, (21st Ed. 2009),* unless otherwise noted.

1 JCE&M – Journal of Clinical Endocrinology & Metabolism  
2 NEJM – New England Journal of Medicine  
3 PSA – prostate-specific antigen  
4 PCP – primary care physician  
5 TSH – thyroid-stimulating hormone  
6

7 Units of Measurement

8 ng/mL – nanogram/milliliter, unit of measurement used in expressing test results for testosterone  
9 and PSA levels.

10 pg/mL – picogram/milliliter, unit of measurement used in expressing test results for levels of free  
11 testosterone.

12 uIU/mL – micro-international units per milliliter, unit used in expressing test results for levels of  
13 TSH.

14  
15 **ISSUES**  
16

17 1. Whether the Board's Order Modifying the Stipulated Order of January 15, 2004 (2004  
18 Modified Stipulated Order) and the Interim Stipulated Order of March 18, 2010 (2010 ISO) were  
19 outside the Authority of the Board to impose and thus void.  
20

21 2. Whether Licensee treated patients H, I, J, K, and L with thyroid medication or with  
22 testosterone in a manner that violated the terms of the 2010 ISO, effective March 18, 2010.  
23

24 3. If so, whether Licensee's treatment of the five patients above, while the Board was  
25 investigating Licensee's on-going pattern of medical practice, also constituted repeated disregard  
26 of prior Board Orders, unprofessional or dishonorable conduct and constituted gross or repeated  
27 negligence, in violation of ORS 677.190(1)(a), ORS 677.188(4)(a), (b) and (c), ORS  
28 677.190(13), and ORS 677.190(17).  
29

30 4. If so, whether such conduct posed an immediate danger to the public and his patients,  
31 and required the immediate suspension of Licensee's license, pursuant to ORS 677.205(3), as  
32 alleged in the Order of Emergency Suspension, dated September 8, 2010.  
33

34 5. Whether Licensee, when treating certain patients, willfully disobeyed a Board order  
35 by failing to comply with the terms of paragraph 5.5 of the 2004 Modified Stipulated Order,  
36 failing to utilize appropriate endocrine testing to diagnose hypothyroidism and to monitor patient  
37 response to treatment, and by relying upon patient requests or inadequate clinical findings to  
38 justify his decision to initiate or to continue treatment with thyroid replacement therapy.  
39

40 6. If so, whether Licensee's conduct constitutes unprofessional or dishonorable conduct  
41 and gross or repeated negligence that exposed his patients to harm, in violation of ORS  
42 677.190(1)(a), ORS 677.188(4)(a), (b) and (c), ORS 677.190(13), and ORS 677.190(17).  
43

44 7. Whether Licensee prescribed testosterone when not medically indicated and failed to  
45 set forth in the patient charts the clinical basis for diagnosing and treating hypogonadism.  
46  
47  
48

1 8. If so, whether Licensee's conduct breached the standard of care, and unprofessional or  
2 dishonorable conduct and constituted gross or repeated negligence. ORS 677.190(1)(a), ORS  
3 677.188(4)(a), (b) and (c), and ORS 677.190(13)  
4

5 6. Whether the Board may impose disciplinary sanctions against Licensee, including  
6 sustaining the Order of Emergency Suspension and revoking of Licensee's license to practice  
7 medicine, assessing a civil penalty in the amount of \$10,000, and assessing the costs of the  
8 hearing. ORS 677.205.  
9

## 10 EVIDENTIARY RULINGS

11  
12 Record documents, marked P1 through P11 were made part of the record. Prior to  
13 hearing, Licensee submitted Licensee's Trial Brief, which has been marked P12, for the record.  
14 In addition, the Board referred to a chart, outlining the Board's summary of patients and facts for  
15 the purposes of closing argument, a copy of which was provided to opposing counsel and the  
16 ALJ. The Board's chart has been marked P13 for purposes of the record.  
17

18 Exhibits A1 through A29, A31 through A33, and A35 through A37, offered by the Board,  
19 were admitted into evidence without objection. The Board offered a chart of Patient G's PSA  
20 lab values with the duplicate exhibit number A37. Licensee had no objection to the exhibit and it  
21 was admitted into evidence. To correct the duplicate numbering, the exhibit has been  
22 renumbered as A38.  
23

24 Licensee's objection to A30, based on relevancy was sustained. Licensee's objection to  
25 A34 for lack of foundation was overruled. Exhibit A34 was admitted into evidence.  
26

27 Exhibits marked R1 through R9, R10 pages 1 through 4, R12 through R23, R25 through  
28 R38, R40 through R51, R53 through R73, R75 through R81, R83 through R84, R87 through  
29 R110, R113 through R115, and R117 through R123, R125 through R129, offered by Licensee,  
30 were entered into evidence without objection.  
31

32 The Board's objection to R10, pages 5 through 8, of an electronic mail (e-mail) between  
33 Licensee and Abraham Morgantaler, MD, was sustained for lack of proper foundation,  
34 relevancy, and reliability. The Board withdrew its objection to R11, as to the apparent  
35 incompleteness of the exhibit, when Licensee provided the missing first page. R11, pages one  
36 and two, were then admitted without objection. The Board did not object to the following  
37 exhibits but noted that Exhibit R5 was a duplicate of A14, and R25 was duplicative of the first  
38 four pages of R10. R82 was duplicative of pages five through eight of R10 and R24, and was  
39 therefore excluded from the evidence record.  
40

41 The Board objected to what was marked as R85 on the basis that the document was  
42 incomplete and therefore, unreliable, unless the remainder of the document were introduced.  
43 Licensee failed to provide the remainder of the document prior to the close of the record and,  
44 therefore, the Board's objection to R85 is hereby sustained. The Board objected to R86, R111  
45 and R116 on the basis of lack of proper foundation and relevancy. The foundations for R86 and  
46 R116 were not established at hearing; the Board's objections are hereby sustained. The  
47 foundation and relevance of R111 was not established at hearing; the Board's objection is hereby  
48 ///

1 sustained. The Board's objection to Exhibit R112, on the basis of relevancy and foundation,  
2 were overruled, and Exhibit R112 was admitted into evidence.

3  
4 The Board objected to Exhibit R124 offered by Licensee at hearing, due to lack of notice.  
5 Exhibit R124, a copy of 54 pages of a power-point presentation referred to, and relied upon, by  
6 witness Dr. Welker in offering his expert testimony, was not provided on or before the  
7 November 24, 2010 deadline set for receipt of exhibits, or thereafter anytime prior to Dr.  
8 Welker's appearance at the hearing. The 54-page exhibit included multiple pages of  
9 bibliographical references and detailed content regarding the use of testosterone therapy and  
10 thyroid replacement therapy. Licensee provided no evidence of circumstances that prevented the  
11 timely discovery of the exhibit to the Board. The Board's objection to the entry of documents  
12 into the record, for the truth of the matters asserted therein, was sustained. Exhibit R124 was  
13 admitted for the limited purpose of establishing that Dr. Welker had read material regarding the  
14 referenced therapies to support his qualification as an individual with specialized knowledge or  
15 expertise in the area of testosterone and thyroid replacement therapies.

## 16 17 **FINDINGS OF FACT**

18  
19 1. Licensee graduated with a doctorate in medicine from Oregon Health Sciences  
20 University in 1966 and practiced urology in another state for approximately 9 years. Licensee  
21 returned to Oregon and became licensed to practice medicine in the State of Oregon in 1975.  
22 (Test. of Licensee, tr. at 48; Ex. A11 at 3.)

23  
24 2. Licensee is certified by the American Board of Urology. (Ex. A11 at 3.) Licensee has  
25 practiced "alternative" or "complimentary" medicine since becoming licensed in Oregon.  
26 Licensee defines his practice as complimenting treatments a patient may be doing on his own or  
27 with another practitioner. He uses alternative treatments that are not available generally and  
28 which may not be taught in medical school but which may be used by other physicians and  
29 which have a basis in science to some degree. (Test. of Licensee; Ex. A11 at 6-8.)

30  
31 3. Licensee attends continuing medical education (CME) conferences in his specialty  
32 area of practice which is sometimes referred to as "functional medicine." (Test. of Licensee, Ex.  
33 A11 at 6-8.) He has not participated in a fellowship nor has he had formal training in alternative  
34 or naturopathic medicine. (Test. of Licensee, tr. at 48, 49; Ex. A11 at 9.) Licensee relies  
35 primarily on his own reading for practicing testosterone and thyroid replacement therapies. Prior  
36 to the current emergency suspension of his license, Licensee practiced as a sole-practitioner in  
37 Junction City. He employs approximately six people, including a licensed massage therapist  
38 (LMT) and a licensed practical nurse (LPN). (Test. of Licensee, tr. at 48-51.)

39  
40 4. The Board revoked Licensee's medical license in 1994. (Ex. A1.) Licensee applied  
41 for, and was granted, reinstatement of his license pursuant to a Stipulated Final Order of  
42 Licensure Pursuant to Request for Voluntary Limitation dated April 1, 1997 (the 1997 Stipulated  
43 Order). (Ex. A2.) The 1997 Stipulated Order reinstated Licensee's license expressly contingent  
44 upon compliance with paragraph 5 of the Order, which included, among others, the following  
45 requirements:

46  
47 All patients treated by Licensee were required to sign an informed consent agreement  
48 stating that:

- 1 a) Licensee is not a primary care physician;
- 2 b) the patient must have a primary care physician prior to Licensee treating the patient;
- 3 c) the patient must give authorization for Licensee to release medical records to all
- 4 primary care and specialty physicians.

5  
6 (Ex. A2 at 3, 4.) Licensee signed a letter voluntarily accepting the limitations of the 1997  
7 Stipulated Order. (Ex. A2 at 2.)

8  
9 5. The terms of the 1997 Stipulated Order included a provision that evidence of a  
10 violation or violations of the terms of the 1997 Stipulated Order constituted grounds for  
11 discipline. (Ex. A2 at 3.)

12  
13 6. On March 14, 2002, the Board opened an investigation into Licensee's then-current  
14 manner of practicing medicine. On September 12, 2003, Licensee submitted a request to amend  
15 the 1997 Stipulated Order, including the language for proposed restrictions to be included in the  
16 amendments to the existing order. On November 28, 2003, Licensee signed an Order Modifying  
17 the Stipulated Order (2004 Order) which was then issued by the Board on January 15, 2004.  
18 (Ex. A3.)

19  
20 7. The 2004 Modified Stipulated Order included a statement that Licensee understood  
21 his right to a contested case hearing regarding the matters under investigation, and fully and  
22 finally waived his right to a contested case hearing and any further appeals. (Ex. A3 at 1.) In  
23 consideration for resolution of the matters under investigation by the Board, Licensee agreed as  
24 follows:

25  
26 Licensee shall use thyroid function blood tests (with appropriate documentation in the  
27 patient charts), to include blood tests that measure the amount of thyroid hormone (free  
28 T4) and thyroid-stimulating hormone (TSH) in conjunction with the history and physical  
29 findings in making the decision whether to use thyroid medication. Licensee will not use  
30 thyroid medication in treatment unless the blood tests find a TSH level greater than the  
31 normal range and a free T4 below the normal range on a test. While treating patients  
32 with thyroid medication, Licensee shall periodically retest the TSH level of his patients'  
33 blood no later than six weeks after initiating treatment with thyroid medication and no  
34 less than annually thereafter. Licensee shall reduce the level of thyroid medication if the  
35 level of TSH falls below the normal range.

36  
37 (Ex. A3 at 2.) The 2004 Modified Stipulated Order did not change the remaining terms of the  
38 1997 Stipulated Order, which remained in full force and effect. (Id.)

39  
40 8. On September 9, 2009, the Board notified Licensee that based upon a patient  
41 complaint from Patient A, it had opened an investigation. (Ex. A9.) Included with her  
42 complaint, Patient A provided the Board with information she had been given by Licensee, both  
43 at the time of her visit to his office and later through the mail. (Test. of Lewis, tr. at 549, 550,  
44 and Patient A, tr. at 81-84; Ex. A35.)

45  
46 9. The Board began an investigation of the following allegations: Licensee had  
47 recommended thyroid medication to Patient A although her laboratory tests revealed that her  
48 thyroid levels were within normal limits; Licensee recommended that Patient A obtain thyroid

1 medication from Mexico through an on-line source without providing appropriate dosing  
2 recommendations; Licensee had diagnosed Patient A with hormone imbalance as a result of her  
3 not having had children; and Licensee told Patient A that her health would improve if she were  
4 to become pregnant and give birth. (Id.; test. of Lewis)  
5

6 10. Prior to receiving the complaint by Patient A, Terry Lewis, Board Investigator, was  
7 assigned to perform on-going monitoring of Licensee for compliance with the previous orders.  
8 Following the receipt of Patient A's complaint, Lewis was also assigned to that investigation.  
9 (Test. of Lewis, tr. at 544, 545.) As part of the investigation, the Board requested Licensee's  
10 summary on the treatment of, and all patient records for, Patient A. (Ex. A9.) Licensee provided  
11 the requested records. (Ex. A10.)  
12

13 11. Following review of the records for Patient A, the Board held an informal  
14 investigative interview with Licensee on February 4, 2010. (Test. of Lewis, tr. at 545; Ex. A11.)  
15 After the interview but prior to any further contact from the Board, Licensee, by letter dated  
16 February 5, 2010, proposed to the Board that he would further restrict his use of thyroid and  
17 testosterone in treating patients. (Test. of Lewis, tr. at 546; Ex. A12.)  
18

19 12. The Board adopted Licensee's proposed voluntary limitations and issued an Interim  
20 Stipulated Order (2010 ISO) stipulated to and signed by Licensee, on March 18, 2010. The  
21 Board immediately signed and issued the 2010 ISO, also on March 18, 2010. (PL 1.) The 2010  
22 ISO set, in part, the following limitations on Licensee's practice of medicine:  
23

24 3.1 Licensee will not recommend, prescribe, or direct any patient to take thyroid  
25 unless patient TSH levels exceed 10 uIU/mL, except that Licensee may recommend,  
26 prescribe or direct a patient to take thyroid supplementation if patient TSH levels are  
27 between 5 and 10 uIU/mL and the patient has also been diagnosed with goiter or positive  
28 anti-thyroid peroxidase antibodies (or both).  
29

30 3.2 Licensee will require any patient taking thyroid from a non-prescription source to  
31 undergo thyroid blood tests on a regular basis (at least every 6 months) and that Licensee  
32 will direct such patients to adjust their dose to bring their TSH level into the range  
33 recommended by the American Association of Clinical Endocrinologists (the target TSH  
34 level is between 0.3 and 3.0 uIU/mL). If any patient declines to follow this direction,  
35 Licensee will provide 30 day prior written notice to the patient and then terminate the  
36 physician-patient relationship.  
37

38 3.3 In the event Licensee decides to prescribe, recommend, direct a patient to take  
39 testosterone, or to follow a patient taking testosterone, Licensee must comply with the  
40 guidelines recommended in the article "Risks of Testosterone Replacement Therapy and  
41 Recommendations for Monitoring," published in the New England Journal of Medicine,  
42 350:5, January 29, 2004. Specifically, Licensee will ensure that either he or another  
43 physician has conducted and documented a recent digital rectal examination and that at a  
44 minimum, blood tests for baseline testosterone and PSA levels have been performed.  
45 Licensee must not prescribe, recommend, or direct a patient to take testosterone for  
46 patients with a PSA level above 4.0 ng/mL as well as patients with a yearly PSA increase  
47 of 1.5 ng/mL or more, or 0.75 ng/mL per year or more over two years. If any patient  
48 insists that they want to take testosterone in the face of such PSA levels, Licensee will

1 provide 30 day prior written notice to the patient and then terminate the physician-patient  
2 relationship.

3  
4 3.4 Licensee must make appropriate and timely chart entries to demonstrate that he is  
5 complying with the terms of this Order.

6  
7 (PL 1.)

8  
9 13. The 2010 ISO also advised Licensee that the Board would continue its investigation  
10 and that the 2010 ISO terms would remain in effect unless and until the Board determined they  
11 should be lifted. (PL 1.)

12  
13 14. Following issuance of the 2010 ISO, the Board continued to investigate the matter  
14 regarding Patient A and Licensee's compliance with its prior orders. On May 11, 2010, the  
15 Board issued a Complaint and Notice of Proposed Disciplinary Actions. (PL 2.) Licensee  
16 timely requested a contested case hearing. (PL 3.)

17  
18 15. The Board continued its investigation and monitoring of Licensee for compliance  
19 with the 2010 ISO. Lewis made an unannounced visit to Licensee's office and requested a list of  
20 Licensee's patients who Licensee had treated with either testosterone or thyroid or both within  
21 the last 12 months. From the list, Lewis randomly selected five patient charts. (Test. of Lewis,  
22 tr. at 546, 547.)

23  
24 16. Licensee provided the charts for the five patients: H, I, J, K, and L. Lewis then gave  
25 those charts to the Board's medical director, Jim Peck, MD. along with a copy of the 2010 ISO.  
26 Lewis asked Dr. Peck to review the charts and to give his medical opinion on whether, based on  
27 the charts, Licensee was in compliance with the terms of the 2010 ISO. (Test. of Lewis, tr. at  
28 547, 548.) Dr. Peck found that Licensee was not in compliance with the 2010 ISO. (Ex. A13.)

29  
30 17. After its review of the investigation results and the patient charts, the Board issued an  
31 Order of Emergency Suspension, dated September 8, 2010, based on its determination that  
32 Licensee's continued practice of medicine would pose an immediate danger of risk to the public  
33 and to his patients. (PL 6.)

34  
35 18. On September 20, 2010, the Board issued an Amended Complaint and Notice of  
36 Proposed Disciplinary Action (Amended Complaint). (PL 8.) Licensee's hearing request along  
37 with the Amended Complaint and the Emergency Suspension Order were referred for a contested  
38 case hearing. (PL 9.)

39  
40 19. David Cook, MD is an expert in endocrinology including the diagnosis and treatment  
41 of hypothyroidism and hypogonadism. Dr. Cook acted as the Board's consultant on the previous  
42 investigation of Licensee. After Dr. Peck's review and response, the same five patients' records  
43 and a copy of the 2010 ISO were submitted to Dr. Cook for his review as to whether Licensee's  
44 treatment of the five patients at issue complied with the terms of the 2010 ISO. (Test. of Lewis,  
45 tr. at 548.) Dr. Cook reviewed the charts in addition to the records for Patient A, and he heard  
46 her testimony at hearing. Dr. Cook concluded that Licensee had failed to meet the standard of  
47 care in his treatment of Patient A and the other patients whose charts he had reviewed. (Test. of  
48 Dr. Cook, tr. at 150, 151.)

1 **Background facts related to the standard of care for treatment of hypothyroidism.**  
2

3 20. The guidelines set out by the AACE for the evaluation and treatment of  
4 hyperthyroidism and hypothyroidism are accepted as authoritative in the diagnosis and treatment  
5 of thyroid disease. The Endocrine Society is a second, equally authoritative source regarding  
6 information and guidelines for the practice of endocrinology. The standard of care for doctors  
7 diagnosing and treating thyroid disease in Oregon reflects the guidelines set by AACE and the  
8 Endocrine Society. Dr. Cook teaches medical students according to those guidelines and follows  
9 them when diagnosing and treating patients with thyroid disease. (Test. of Dr. Cook, tr. at 114-  
10 116; Ex. A16.)  
11

12 **21. Blood tests for TSH levels are required for the diagnosis of thyroid deficiency.**  
13 (Test. of Drs. Cook, tr. at 126, 126, and Nedrow, tr. at 388, 389.) The total TSH level is the  
14 focus for the standard of care in diagnosing and treating thyroid deficiency. (Test. of Dr. Cook,  
15 tr. at 476.) Chronic or sub-clinical hypothyroidism may be present in a patient who is not  
16 showing clinical signs and symptoms of hypothyroidism but whose TSH level is within the range  
17 that should be treated. A TSH level is a prerequisite for diagnosing sub-clinical hypothyroidism;  
18 clinical symptoms are not. (Test. of Cook, tr. at 246, 247; Ex. A16 at 8.) On-going, frequent  
19 TSH testing is also necessary to monitor efficacy of on-going treatment. (Test. of Cook, tr. at  
20 497.)  
21

22 22. Further testing for specific thyroid antibodies, free T4 and free-T3, provides  
23 complimentary information for the primary diagnosis of hypothyroidism, or low production of  
24 thyroid by the thyroid gland. The relationship between TSH levels and thyroid is inverse; the  
25 higher the TSH levels, the lower the amount of thyroid that is being produced by the body. A  
26 high TSH level indicates too little thyroid is being produced. (Test. of Dr. Cook, tr. at 127-129.)  
27

28 23. The normal target range for TSH is from .3 uIU/mL to 3.0 uIU/mL. A TSH above  
29 the normal range, in general, is an indication for treatment with thyroid hormone to bring the  
30 number within the normal range. Clinical indications for detecting hypothyroidism are very  
31 nonspecific because, in part, every cell in the body is affected to some extent by thyroid  
32 hormone. (Test. of Dr. Cook, tr. at 130, 131 and Dr. Nedrow, tr. at 540.) For purposes of  
33 diagnosing hypothyroidism, a basal temperature test is a very crude analysis of the body's  
34 metabolic rate<sup>2</sup> and is usually out of the normal range when a patient has either extremes of  
35 hypo- or hyper-thyroidism. (Test. of Dr. Cook, tr. at 131, and Dr. Nedrow, tr. at 540, 541.)  
36

37 24. The level of free T4 shows the total amount of thyroid that is in the blood that is  
38 biologically active or available (bioavailability), hence the term "free" T4. The T4 level is more  
39 accurate than a measurement of the total thyroid because the level of total thyroid hormone  
40 available can be influenced by many factors that may make it read high or low. (Test. of Dr.  
41 Cook, tr. at 132-133.)  
42

43 ///  
44

45 \_\_\_\_\_  
46 <sup>2</sup> Basal metabolic rate: the metabolic rate as measured 12 hr. after eating, after a restful sleep, no exercise  
47 or activity preceding testing, elimination of emotional excitement, and in a comfortable temperature, tr. at  
48 246.

1           25. Secondary hypothyroidism is diagnosed only in a patient with a known pituitary  
2 injury or disease in addition to TSH levels that show a normal TSH but a low T4. Secondary  
3 hypothyroidism is rare. (Test. of Dr. Cook, tr. at 488.) A patient with an abnormal TSH but  
4 without secondary symptoms is still diagnosed and treated as hypothyroid. (Id. at 489, 490.)  
5

6           26. Common medications used to treat hypothyroidism include L-Thyroxine, a brand-  
7 name hormone, the hormone contents of which are regulated by the FDA. Both the AACE and  
8 the Endocrine Society have published recommendations on medications, including the use of L-  
9 Thyroxine, and have recommended that a prescription for treatment utilize the same brand name  
10 of hormone because the FDA does not regulate the bioavailability of the hormone specific to  
11 each brand. (Test of Dr. Cook, tr. at 132, 133.)  
12

13           27. Hypogonadism is a clinical condition in which low levels of serum testosterone are  
14 found in association with specific signs and symptoms, including diminished libido and sense of  
15 vitality, erectile dysfunction, reduced muscle mass and bone density, depression, and anemia.  
16 (Ex. A14 at 7.) The guidelines for treatment of hypogonadism, incorporated into the 2010 ISO  
17 from the New England Journal of Medicine, presuppose that a patient has been accurately  
18 diagnosed with hypogonadism. (Test. of Dr. Cook, tr. at 218, 219.)  
19

20           28. An accurate diagnosis of hypogonadism is a predicate for recommending  
21 testosterone replacement therapy. A blood test to establish a baseline testosterone serum level is  
22 required, in association with other specific signs and symptoms, to make the diagnosis of  
23 hypogonadism. The New England Journal of Medicine article entitled, "Risks of Testosterone  
24 Replacement Therapy and Recommendations for Monitoring," published January 29, 2004, (Ex.  
25 A14) provides recommendations regarding treatment with testosterone replacement therapy  
26 assuming a patient has been correctly diagnosed with hypogonadism. (Test. of Dr. Cook, tr. at  
27 224, 225.) Pre-treatment screening for older men being considered for testosterone replacement  
28 therapy should include a DRE, measurement of the PSA level, and evaluation of risk factors for  
29 prostate cancer. (Test. of Dr. Cook, tr. at 524; Exs. A14 at 7, R3 at 1.)  
30

31           29. PSA, a glycol-protein based in the prostate cells, is a marker or monitor for prostate  
32 health and for prostate cancer. PSA levels are determined by blood tests. An elevated PSA  
33 correlates directly with the risk for prostate cancer. The range for a normal PSA is age  
34 dependent and it rises as a male ages. Prostate cancer is very common in males in the United  
35 States. (Test. of Dr. Cook, tr. at 143, 144.)  
36

37           30. Prostate cancer varies in its level of development according to the grade of the  
38 cancer. Some cancers are relatively benign and indolent, do not metastasize, and remain in the  
39 prostate. Others are extremely lethal where the patient may be dead within a year. A DRE is  
40 also a common means of diagnosing prostate cancer. (Test. of Dr. Cook, tr. at 145.)  
41

42           31. Testosterone replacement therapy is linked to exposing underlying cancers and to  
43 accelerating tumor growth. Treatment with testosterone therapy for men with an abnormal DRE,  
44 elevated PSA level or rapidly increasing PSA levels is not within the standard of care, and is  
45 contra-indicated. (Test. of Dr. Cook, tr. at 524, 525.)  
46

47           32. Although there is controversy regarding the cause and effect relationship between  
48 testosterone replacement therapy and prostate tumor growth, the current standard of care for

1 allowing testosterone therapy replacement in men with a history of prostate cancer is a disease-  
2 free interval, meaning no recurrence of prostate cancer, of five years. Treatment with  
3 testosterone would not be considered for an individual with a PSA in excess of 4.0 under either  
4 the AACE or the Endocrine Society guidelines and doing so constitutes a breach of the standard  
5 of care. (Test. of Dr. Cook, tr. at 146, 148.)  
6

7 33. A patient with a history of cancer may be treated with testosterone replacement  
8 therapy according to the medical standard of practice. Treatment may be indicated if the patient  
9 is seeking the strength, stamina and libido associated with testosterone replacement therapy but it  
10 would be necessary to consult with, and to have the patient's treating oncologist's approval, prior  
11 to starting testosterone therapy, in addition to the patient having been cancer-free for the prior  
12 five-years. (Test. of Dr. Cook, tr. at 146, 148.)  
13

14 34. Additional risks of having excess testosterone are prostate hypertrophy and  
15 hyperplasia, and possible urinary tract obstruction. (Test. of Dr. Cook, tr. at 148.) If a patient  
16 who has a diagnosis of prostate cancer insists on receiving testosterone replacement therapy, it is  
17 the duty of the provider to decline to prescribe the treatment. (Id., tr. at 150.)  
18

19 35. The Journal of Clinical Endocrinology & Metabolism, published by The Endocrine  
20 Society in 2006, found the following:  
21

22 In a systematic review of 19 randomized trials to determine the risks of adverse events  
23 associated with testosterone therapy in older men, the combined rate of all prostate events  
24 was significantly greater in testosterone-treated men than in placebo-treated men.  
25

26 (Ex. A34 at 15.)  
27

28 36. In addition, the Endocrine Society recommended not to treat asymptomatic older  
29 men with age-related decline in testosterone levels. The Society placed "a lower value on the  
30 unproven, potential benefits of testosterone replacement therapy and a higher value on avoiding  
31 the burdens of testosterone administration, monitoring, and cost, as well as on unknown long-  
32 term risks." (Ex. A34 at 16; see also Ex. A30 at 8.)  
33

34 37. When the Endocrine Society published its journal in June 2010, it did not change the  
35 guidelines from those in 2006. (Ex. A30 at 18.) Evidence supporting the recommendation to not  
36 treat men with documented testosterone deficiency and prostate cancer with testosterone  
37 replacement therapy has been found overwhelming and valid. (Ex. R10 at 3.)  
38

39 38. Publications by proponents of testosterone replacement therapy do not unequivocally  
40 support testosterone therapy replacement for men with a diagnosis of prostate cancer. (Ex. R120  
41 at 166). Some proponents of the treatment acknowledge that "no large studies yet exist to assess  
42 the safety of [testosterone] therapy in men with [prostate cancer.]" (Ex. R10 at 2.)  
43

44 **Background facts related to the standard of care for diagnosis and treatment of**  
45 **hypothyroidism.**  
46

47 39. At the request of the Board, Anne Nedrow, MD, an expert in integrative medicine  
48 which includes alternative medical treatments, reviewed the patient charts for PATIENTS A, B,

1 C, D, E, F, and G for hypothyroidism. She concluded that Licensee failed to meet the standard  
2 of care for the treatment of all seven patients. In general, Licensee's diagnosis of androgen  
3 deficiency or hypothyroidism did not fall within the category of alternative medicine. Further,  
4 the treatments prescribed by Licensee, either with injectable testosterone or oral thyroid, were  
5 standard conventional therapies, not alternative medical practices. (Test. of Dr. Nedrow, tr. at  
6 385-387.)  
7

8 40. Dr. Nedrow graduated from OHSU in 1983. She is certified by the American Board  
9 of Internal Medicine and is an associate professor at OHSU. Dr. Nedrow currently serves as the  
10 Director for Women's Primary Care and for Integrative Medicine at the Center for Women's  
11 Health, OHSU, and maintains a patient practice there. Dr. Nedrow completed an internship in  
12 Integrative Medicine at the University of Arizona College of Medicine in 2002. She also teaches  
13 as adjunct faculty at Western States Chiropractic College. (Test. of Dr. Nedrow, tr. at 377-379;  
14 Ex. A32.)  
15

16 41. Dr. Nedrow teaches the entire curriculum for medical students in integrative  
17 medicine at OSHU, including all training in alternative medicine. Dr. Nedrow is a member of  
18 both the National and International Consortiums of Academic Health Centers for Integrative  
19 Medicine, and she has been published in ten publications over the last five years. (Test. of Dr.  
20 Nedrow, tr. at 379; Ex. A32.)  
21

22 42. The study of integrative medicine encompasses both conventional (allopathic)  
23 medicine and alternative medicine. Alternative medicine includes areas such as traditional  
24 Chinese medicine, or ayurvedic medicine, as well as naturopathic and homeopathic medicine.  
25 The study of alternative medicine in traditional allopathic medical schools is relatively new.  
26 Only about 50 percent of traditional medical schools in the United States offer formal training in  
27 alternative medicine. OSHU began its program in 2001. (Test. of Dr. Nedrow, tr. at 380, 381.)  
28

29 43. Alternative medicine incorporates five specific areas: mind-body medicine; body-  
30 based medicine, like chiropractic and osteopathic; energy medicine, which can range from  
31 magnets to cranio-sacral; whole systems, like Chinese medicine; and biologically based, which is  
32 usually botanical and supplements. The standard of practice may vary between the practice of  
33 alternative medicine and allopathic medicine. Alternative medicine relies more heavily on  
34 traditional or historical treatments where allopathic medicine is more evidence or scientifically  
35 based, at least by perception. There is a strong movement to integrate evidence-based medicine  
36 into alternative medicine. The basic tenet of "do no harm" applies equally to practitioners of  
37 alternative medicine as well as those of allopathic medicine. (Test. of Dr. Nedrow; tr. at 382,  
38 383, 384.)  
39

40 44. Overall, Licensee's treatment failed to meet the standard of care for allopathic  
41 medicine. Licensee provided treatment to patients based on the patients' reported feelings of  
42 well-being despite there being well-known risks associated with the treatments. In addition,  
43 Licensee lacked diagnostic criteria to make accurate diagnoses, which is necessary in practicing  
44 the conventional medicine demonstrated in the charts of the patients at issue. (Test. of Dr.  
45 Nedrow, tr. at 387.)  
46

47 45. The standard of care for treating a patient with hypothyroidism requires an initial  
48 diagnosis based upon a TSH blood test in addition to a clinical examination and history. (Test.

1 of Dr. Nedrow, tr. at 388, 389.) TSH levels should be checked, at a minimum, yearly and after  
2 every dosing change to monitor the patient's reaction to the exogenous thyroid. Risks to a  
3 patient from prescribing excess thyroid include accelerated bone density loss, or osteopenia,  
4 cardiac complications including cardiac arrhythmia, and developing hyperthyroidism, which may  
5 increase the risk for hypertension. (Id., tr. at 402 - 404.)  
6

7 **Facts related to specific patients.**  
8

9 Patient A  
10

11 46. Patient A, a 23-year old female at the time, consulted with Licensee on June 25,  
12 2009. (Ex. A17 at 5.) She had been seeing a new PCP, Timothy Ueng, MD, since January 2009.  
13 (Ex. A17 at 6.) Dr. Ueng had treated her for depression/anxiety, and chronic irritable bowel  
14 syndrome (IBS) and constipation. Patient A had an office visit with Dr. Ueng's on June 18,  
15 2009, prior to her visit with Licensee. (Ex. A17 at 9-11.)  
16

17 47. On June 25, 2009, Patient A came to Licensee's office with the completed medical  
18 history forms, which Licensee's office sent to her prior to the visit. Patient A was seeking relief  
19 from chronic health problems, mainly gastrointestinal problems, chronic pelvic and abdominal  
20 pain, and menstrual bleeding. (Test. of Patient A, tr. at 79, Ex. A17 at 1-5, 86.) Patient A had  
21 been told by her PCP that her thyroid levels were normal. She brought her lab results with her to  
22 Licensee's office. (Test. of Patient A at 79, 83.)  
23

24 48. Licensee conducted a standard examination on Patient A, including blood pressure  
25 and pulse rate. Licensee also tested Patient A's acupuncture points and allergies. Following the  
26 examination, Licensee told Patient A that although her thyroid levels were normal, her symptoms  
27 indicated that she had problems with her thyroid. Licensee told Patient A that her IBS symptoms  
28 were probably more of a result of allergies and hormone imbalances. He also indicated that  
29 Patient A should take iodine and thyroid. (Test. of Patient A, tr. at 80-83.)  
30

31 49. Licensee provided Patient A with information regarding the positive aspects of  
32 thyroid replacement therapy, he told her during the visit how to get thyroid from the Internet  
33 from a source from Mexico, and he told her if she started taking thyroid, to start with the smallest  
34 dose to see how she felt. During the office visit, Licensee did not tell Patient A about dangers or  
35 side-effects associated with taking thyroid. (Test. of Patient A, tr. at 90-93, 106, 107.) Licensee  
36 did not tell Patient A at that time that he could not prescribe thyroid. (Test. of Patient A, tr. at  
37 93.)  
38

39 50. Licensee also told Patient A that her body had been designed to have children by the  
40 age of 17 and that failure to have had children by her age could be contributing to her health  
41 issues, specifically hormone imbalances and menstrual issues. (Test. of Patient A, tr. at 89; Ex.  
42 A8.)  
43

44 51. After her visit, Patient A received information flyers from Licensee in the mail,  
45 regarding thyroid supplements available through the Internet. (Test. of Patient A, tr. at 90-93.)  
46

47 52. Patient A was upset that Licensee had referred her to a source for medicine that was  
48 from the Internet and from out-of-country. She was also offended by Licensee's implication that

1 her lack of having had children by her age had contributed to her health issues. (Test. of Patient  
2 A, tr. at 89, 106; Ex. A7.)  
3

4 53. Patient A wrote a follow-up letter to Licensee telling Licensee of her concerns and  
5 requesting a refund of the insurance co-payment amount that she had paid for the visit. (Ex. A7.)  
6

7 54. Licensee responded to Patient A's letter with further suggested readings on  
8 hypothyroidism. Licensee told Patient A that he could not prescribe thyroid but reiterated that he  
9 had provided information about where she could get a safe, reliable source from the Internet.  
10 Licensee also reiterated his theory regarding the age at which females are designed to reproduce  
11 but apologized if his remarks had offended her. He also refunded Patient A's co-payment as she  
12 had requested. (Ex. A8.)  
13

14 55. Dr. Ueng saw Patient A on July 29, 2009, following her visit with Licensee. Dr.  
15 Ueng noted that Patient A had a family history of thyroid issues that she had gotten labs every 6  
16 months, and he ordered lab tests. (Ex. A17 at 7, 8.) Patient A's blood test results showed her  
17 TSH was at .93 uIU/mL with a reference range of .27 to 4.20 uIU/mL<sup>3</sup>, and her free T4 was level  
18 was 1.15 ng/dL, within the reference range of 0.85-1.71 ng/dL. (Ex. A17 at 21.)  
19

20 56. Thyroid therapy was not indicated for Patient A. Patient A had test results indicating  
21 a TSH of 1.3 in January 2009 and .93 in July 2009, which are well within the normal range.  
22 (Test. of Dr. Cook, tr. at 151, 152; Ex. A17 at 21, 22.) Licensee diagnosed Patient A based upon  
23 clinical symptoms, including chiefly irregular menstrual cycles, fatigue, depression, and  
24 abdominal pain. (Test. of Licensee, tr. at 64, 65.) The clinical symptoms relied upon by  
25 Licensee in his diagnosis are so non-specific that they could be, and most likely are, unrelated to  
26 thyroid disease. (Test. of Dr. Cook, tr. at 151.)  
27

28 57. Licensee lacked criteria to assess Patient A for thyroid treatment. In addition,  
29 Licensee's suggestion in his follow-up letter to Patient A that a normal thyroid level does not  
30 always preclude the need for thyroid treatment placed Patient A at risk. In addition to the normal  
31 risks associated with unnecessary thyroid treatment, Patient A, as a 23-year old female, was at  
32 the age critical for building bone and critical not to incur bone loss, which could have resulted if  
33 Patient A had taken thyroid as Licensee suggested. (Test. of Dr. Nedrow, tr. at 390.)  
34

35 58. Licensee placed Patient A at risk when he suggested that Patient A could acquire  
36 thyroid through an Internet source from out-of-country. Medications that are acquired from out-  
37 of-country may include other ingredients that place a patient at risk of serious harm or death and  
38 may not contain the stated amount or any amount at all of the medication the patient is seeking.  
39 (Test. of Dr. Nedrow, tr. at 394-395.)  
40

41 59. Licensee's statement to Patient A, about the normalcy of childbirth at age 17, and  
42 suggesting pregnancy as a means of improving her health, was unfounded and was inappropriate  
43 within the context of the doctor-patient relationship. (Test. of Dr. Nedrow, tr. at 392, 393.)  
44

45 <sup>3</sup> For clarity and simplicity, the unit of measurement for each test level will be set out at the time of the  
46 first reference. Throughout the rest of the Order, TSH levels are understood to be measured in the  
47 standard unit of uIU/mL, free T4 or T3 are understood to be measured in the standard unit of pg/dL, and  
48 PSA levels are understood to be measure in the standard unit of ng/mL.

1           60. Thyroid medication obtained from a non-FDA approved source, such as an out-of-  
2 country resource like that suggested by Licensee's literature, which he provided to Patient A and  
3 to other patients, subjected Patient A to an increased risk of harm. The risk stems from dosing  
4 that may be inconsistent and that may not be able to be titrated or administered in order to  
5 achieve consistent absorption levels. As a result, the patient may develop hyperthyroidism; bone  
6 damage, and cardiac arrhythmia (rhythm disturbance) most commonly called atrial fibrillation.  
7 (Test. of Dr. Cook; tr. at 134-137, 154.)  
8

9           61. Licensee's care of Patient A, by diagnosing Patient A with hypothyroidism based  
10 solely on clinical findings when Patient A had a normal TSH level, by informing Patient A of the  
11 availability of thyroid medication from the Internet through an out-of-country source, in addition  
12 to failing to recommend a minimum or any particular dosing, constituted gross negligence.  
13 (Test. of Dr. Cook; tr. at 154, 155.)  
14

15           Patient B  
16

17           62. Licensee first saw Patient B, a female, on December 9, 2008. Patient B presented  
18 with a history of osteoporosis and symptoms associated with menopause. Patient B told  
19 Licensee that she had initiated the visit to discuss vitamin/mineral assessment and to ask  
20 Licensee's opinion about her diagnosis of osteoporosis, about vitamin D and about possible  
21 HRT. Patient B had a slightly elevated FSH (follicle-stimulating hormone) level, a value related  
22 to menopause. Based on Patient B's history and Licensee's clinical observations, Licensee  
23 initially diagnosed Patient B with osteoporosis, menopause, probable hormone imbalance, and  
24 vitamin D deficiencies. He also requested that Patient B regularly take and report her basal  
25 temperature (BT). (Test. of Licensee; tr. at 70-72; Ex. A18 at 2.) Patient B did not take and  
26 report her BTs as ordered because she had become ill sometime after the visit. (Ex. A18 at 2.)  
27

28           63. On Patient B's visit of February 18, 2009, Licensee noted that Patient B "has a  
29 source for thyroid an[d] wants to try that." At that time, Licensee noted that Patient B was  
30 continuing to take iodine pills. (Ex. A18 at 3.) Following Patient B's visit of April 15, 2009,  
31 Licensee noted that Patient B had "done some research and ordered some thyroid. She began  
32 taking one a day and has no symptoms of excess." Patient B had not reported her BTs as of that  
33 date. Following the April 15th visit, Licensee added hypothyroidism to Patient B's diagnoses.  
34 Licensee's plan included continuing Patient B on thyroid and watching for symptoms of excess,  
35 and to monitor blood tests. (Id.)  
36

37           64. On August 27, 2009, Licensee saw Patient B for an office visit. At the time, Patient  
38 B was taking 2 grains of thyroid and Licensee noted that she was tolerating it well. Her  
39 "symptom score" was 10 and her BTs at 97.3 degrees Fahrenheit (F). (Ex. A18 at 4.) There  
40 were no documented visits with Licensee by Patient B following the August 27th visit. Licensee  
41 ordered blood tests for Patient B which were drawn on April 10, 2010. As of that date, Patient B  
42 had a TSH level of 1.66, normal range for that lab was .40- 4.00. (Ex. A29 at 12.)  
43

44           65. Licensee's treatment of Patient B failed to meet the standard of care for the following  
45 reasons: there was no evidence that Patient B had thyroid deficiency and no indication for  
46 thyroid treatment. Licensee's treatment of Patient B with thyroid despite Patient B's history of  
47 low bone density/osteoporosis, constituted a major bone risk factor to Patient B. Treating Patient  
48 B with thyroid without a basis for thyroid treatment also placed Patient B at risk for

1 hyperthyroidism. (Test. of Dr. Cook, tr. at 155-159, and Dr. Nedrow, tr. at 393, 394.)  
2 Licensee's method and choice of prescription, Armour thyroid, a brand-name thyroid which is  
3 dosed in grains, is no longer the standard or usual choice for thyroid prescriptions. The most  
4 common form is now Levothyroxine (L-Thyroxine) which is prescribed in micrograms or  
5 milligrams. (Id., at 396, 397.)  
6

7 Patient C  
8

9 66. Patient C, a female, saw Licensee on August 27, 2008. Among other things, Patient  
10 C had a documented history of, and was being treated for, osteopenia. Patient C had a family  
11 history of hypothyroidism and presented with cold hands and cold feet. Patient C told Licensee  
12 that she probably needed thyroid based on her family history. Licensee did not test Patient C for  
13 thyroid levels at that time. Among other things, Licensee gave Patient C a diagnosis of probable  
14 hypothyroid type 2. He recommended TSH and T4 testing. No follow up notes document that  
15 the testing was performed. (Ex. A19 at 2.)  
16

17 67. On April 7, 2009, Licensee sent Patient C a letter, noting that he had not seen her  
18 after her initial visit. Among other information, Licensee told Patient C that inadequate doses of  
19 thyroid accelerate aging. (Ex. A19 at 5.)  
20

21 68. Regarding Patient C, Licensee failed to establish a diagnosis of hypothyroidism.  
22 Licensee based his diagnosis on clinical symptoms, including cold hands and feet, general  
23 symptoms which are common to thyroid problems but to many other issues as well. Nothing  
24 else in Patient C's chart established a basis for Licensee's diagnosis of hypothyroidism in Patient  
25 C. (Test. of Dr. Nedrow, tr. at 398, 399.)  
26

27 Patient D  
28

29 69. Licensee first saw Patient D, a 57-year old female, beginning June 24, 1993.  
30 Licensee did not have documentation or indications of Patient D having had thyroid treatment.  
31 (Ex. A20 at 1.) At Patient D's second visit, on December 15, 1997, Licensee observed that  
32 Patient D was "no longer taking thyroid" and "may have thyroid problems." There was no  
33 documentation of Patient D's TSH levels. (Id.)  
34

35 70. Licensee began prescribing thyroid to Patient D. She did not see Licensee on a  
36 regular basis. (Ex. A20 at 2-9.) At a visit of November 4, 1998, Patient D was not currently  
37 taking thyroid, and her basal temperatures were 97. Licensee prescribed 1 grain thyroid. (Ex.  
38 A20 at 2.) At a visit in May 1999, Licensee noted that Patient D was taking 1 grain thyroid, was  
39 "tolerating it well" and that she denied any symptoms of excess. (Id.) Licensee prescribed  
40 Armour thyroid at 1 grain on February 2, 1999. Licensee saw Patient D on March 22, 1999,  
41 noted that she was feeling much better on thyroid, and that she had not done basal temperatures  
42 but that she denied any symptoms of excess. He prescribed 2 grains on March 23, 1999. In May  
43 1999, Patient D's thyroid prescription was reduced to 1 grain Armour thyroid. (Id. at 20, 21.)  
44

45 71. Licensee again prescribed 1 grain Armour thyroid for Patient D on January 11, 2000,  
46 without noting an office visit. From January 2000 to January 2003, Licensee's charts do not  
47 document any visits with Patient D. Licensee saw Patient D on January 24, 2003, at which time  
48 Patient D was no longer taking thyroid and had not done basal temperatures recently. (Ex. A20

1 at 3.) Licensee did not document restarting Patient D on thyroid at that time. On July 30, 2003,  
2 and November 17, 2003, Licensee prescribed Armour thyroid, 1 grain, for Patient D. (Ex. A20  
3 at 4.)  
4

5 72. On December 22, 2003, Licensee saw Patient D for the first time in a year. She was  
6 not taking thyroid at that time. Licensee prescribed Armour thyroid, 1 grain, on December 30,  
7 2003. (Ex. A20 at 4.)  
8

9 73. Licensee's next documented office visit with Patient D was on August 4, 2004, and  
10 Licensee noted that patient D's physician had prescribed thyroid. Patient D was taking  
11 Levothyroxine. She returned to Licensee in September 2004 to request a return to Armour  
12 thyroid and Licensee did so. (Ex. A20 at 4.) Per test ordered by Dr. O'Reilly, Patient D's TSH,  
13 as of May 19, 2004, was 6.016, above the normal range of .350-5.500 for that lab, and her T4  
14 was .95, within the normal range of .61-1.76 for that lab. (Ex. A20 at 16.) Licensee noted that  
15 Patient D's TSH was "OK" on November 23, 2004. (Id.) Results from tests ordered by Dr.  
16 O'Reilly documented Patient D with a TSH level of 1.005, within the normal range, as of  
17 November 24, 2004. (Ex. A20 at 19.)  
18

19 74. On January 5, 2005, Patient D reported feeling better on one grain thyroid. Licensee  
20 noted that her TSH was "apparently normal but we don't have copies of that." (Ex. A20 at 5.)  
21

22 75. Patient D continued on prescription thyroid from Licensee, with office visits to  
23 Licensee in December 7, 2005, and May 1, 2006. (Ex. A20 at 6.) At the December visit,  
24 Licensee noted at the end of the chart that "Patient D consents to this plan." (Id.) At the end of  
25 the chart notes for the rest of Patient D's office visits, Licensee made the same notation. (Id. at 6  
26 -9.)  
27

28 76. A test on May 22, 2006, showed Patient D had a TSH level of 2.83, within normal  
29 range, with no T4 value. Licensee's note on the test result stated that the TSH "should be  
30  $\leq 2$ ...Continue thyroid use 2 x daily." (Ex. A20 at 22.) Patient D continued on prescription  
31 Armour thyroid. Licensee refilled the prescription for Patient D on July 27, 2006, but did not  
32 have an office visit with Patient D on that date. (Ex. A20 at 6.)  
33

34 77. On October 9, 2006, Licensee saw Patient D and noted that she was taking 1-2 grains  
35 of thyroid, sporadically, depending on how she felt. Her TSH had dropped from 2.83 in May to  
36 0.76. Patient D denied symptoms of excess. Licensee, among other things, continued Patient D  
37 on 1-2 grains of thyroid. (Ex. A20 at 7.)  
38

39 78. After the October 2006 visit, Licensee charted prescription refills, including Armour  
40 thyroid, 1 grain, on April 24, 2007, and on June 26, 2007, but had no office visits with Patient D  
41 until October 1, 2007. Patient D was taking 1 grain thyroid, b.i.d. (twice daily) at that time and  
42 she reported that her latest TSH test had been in May. Patient D had taken thyroid at the  
43 increased dose for 1-2 months until she felt better and then Patient D decreased the dose.  
44 Licensee did not note the most recent TSH result in the chart notes for the October 1, 2007, visit.  
45 Licensee recommended that Patient D increase her thyroid dosage to twice a day, to watch for  
46 signs of excess, and to repeat her TSH tests after she had done "this for awhile." (Ex. A 20 at 8.)  
47  
48

1 79. On July 14, 2009, Licensee saw Patient D for the first visit in 16 months. She had  
2 been treated by her PCP in the interim. Patient D was taking 1 grain of thyroid and was  
3 tolerating it well. (Ex. A20 at 8.) On September 3, 2009, Licensee saw Patient D for a follow-up  
4 visit. Patient D was complaining that she did not feel as energetic as she would have liked.  
5 Patient D continued to take 1 grain Armour thyroid and showed no signs of excess. Licensee  
6 advised D to consider increasing the dose of thyroid and reviewed the signs of excess with the  
7 patient. (Id., at 9.)  
8

9 80. September 21, 2009, test results showed Patient D's TSH level at 3.29 and her free  
10 T4 at 0.9, both within normal ranges. Licensee's handwritten note to Patient D on the September  
11 21, 2009, lab report read, "You need  more thyroid. Use in AM & PM and see how you feel!"  
12 (Ex. A20 at 32.)  
13

14 81. Licensee had no documented clear indication for treating Patient D with thyroid prior  
15 to initiating thyroid treatment. (Test. of Dr. Nedrow, tr. at 400, 401; Exs A20 at 1, A29 at 15.)  
16 Patient D's lab values on February 9, 1998, of TSH at 3.10 and T4 at 7.3, when Licensee first  
17 documented Patient D's thyroid levels, were within the normal range. (Ex. A29 at 15.)  
18 Licensee's treatment subjected Patient D, a female patient with a history of osteopenia, to the  
19 risk of accelerated osteopenia based on the prescription of thyroid, especially without  
20 documenting that thyroid treatment was medically indicated. In addition, Patient D's lab results  
21 revealed an increased cardiac risk due to her high cholesterol readings, complicated by Patient  
22 D's apparent hypertension. (Test. of Dr. Nedrow, tr. at 402- 404.) The Board adds that during  
23 Patient D's testimony at the hearing, she acknowledged that she had been diagnosed with  
24 osteopenia in the past two years (tr. at 1121).  
25

26 82. Licensee failed to test Patient D's TSH level at least yearly and after each dosage  
27 change. Licensee's dosage changes from 1 to 2 grains should have been more graduated,  
28 especially in an elderly patient such as Patient D due to risk of coronary disease. (Test. of Dr.  
29 Nedrow, tr. at 405, 406.) Licensee was not practicing to the standard of care when he continued  
30 to prescribe thyroid to drive Patient D's TSH level below 3. Some practitioners of naturopathic  
31 medicine may attempt to drive the TSH level to below 3, which varies from the traditional  
32 approach, but in both naturopathic and alternative medicine, a TSH of up to 5.5 is considered  
33 within the normal range. In the case of Patient D, there was no documented basis for Licensee to  
34 diagnose Patient D with hypothyroidism. (Id., tr. at 408, 409.)  
35

36 83. By medicating Patient D with thyroid based on the patient's report of how she felt,  
37 unsubstantiated by TSH levels outside the normal range, and failing to test TSH levels on an on-  
38 going yearly basis, and after each dosage change, constituted a breach of the standard of care and  
39 created a risk of harm to Patient D. (Test. of Dr. Nedrow, tr. at 410.)  
40

41 Patient E  
42

43 84. Licensee began seeing Patient E, a female, as a patient on October 20, 2005. Patient  
44 E was complaining of, among other things, fatigue, fibromyalgia, and irritable bowel syndrome  
45 (IBS). Patient E told Licensee that, although her testing had been normal in the past, she had  
46 believed for many years that she had hypothyroidism. Patient E's prior history showed that, as  
47 of August 2005, her TSH was 6.29, in September 2005 it was 2.58 and she was taking 0.25mg of  
48 Levothroxine at that time. Patient E reported feeling somewhat better on thyroid but, based on

1 her own reading, she believed many of her problems were still related to thyroid deficiency. (Ex.  
2 A21 at 1.)  
3

4 85. Licensee diagnosed Patient E with hypothyroidism and switched her to Armour  
5 thyroid at her request. Licensee noted that "pros and cons were discussed; questions answered;  
6 patient agreed to treatment." (Ex. A21 at 1.) As of the office visit of November 30, 2005,  
7 Licensee noted Patient E was tolerating Armour thyroid well. Licensee's plan included  
8 continuing the thyroid and monitoring Patient E's temperatures. He did not order TSH testing.  
9 (Ex. A21 at 2.)  
10

11 86. As of the office visit of January 12, 2006, Patient E had continued taking 1 grain of  
12 Armour thyroid and was observed to be tolerating it well. Patient E's temperatures were less  
13 than 96 degrees Fahrenheit and she had not been able to lose weight, despite using a low-  
14 carbohydrate diet. Licensee increased her thyroid to twice daily and continued to treat Patient E.  
15 (Ex. A21 at 2.)  
16

17 87. As of her visit of March 14, 2006, Patient E had "obtained thyroid" and was taking it  
18 twice a day. Patient E was also taking iodine twice a day. She reported a "pounding sensation"  
19 in her chest when she went to bed at night. Patient E also asked Licensee about the use of low-  
20 dose cortisone because she had been reading about it and felt it would help her with a variety of  
21 complaints, including her back, allergies, and weight. Licensee discussed the "pros and cons" of  
22 her request and then prescribed Cortef 5 mg QID and instructed her on its use. He discontinued  
23 her use of iodine. Licensee continued Patient E on thyroid without dosage adjustments. (Ex.  
24 A21 at 3.)  
25

26 88. Licensee continued a doctor-patient relationship, with office visits with Patient E on  
27 June 6, 2006, and November 7, 2006, but made no notes related to Patient E's thyroid or thyroid  
28 medication. (Ex. A21 at 3-5.)  
29

30 89. On August 8, 2006, Patient E had blood tests done on Licensee's orders. Her TSH  
31 was at 0.020, with the normal reference range of 0.40-4.6. (A21 at 22.)  
32

33 90. Patient E's next office visit was January 7, 2008, at which time Patient E was taking  
34 1 grain of thyroid 2 times per day. Patient E told Licensee that she felt she needed more thyroid.  
35 Licensee's treatment plan for Patient E included continuing to watch for signs of excess thyroid  
36 and to tell Patient E to watch for symptoms of excess "if she chooses to increase her dose." (Ex.  
37 A21 at 6.)  
38

39 91. As of an office visit on May 14, 2008, Patient E reported taking 4 grains of thyroid a  
40 day and discontinuing her iodine. Licensee did not note discussing a change or reduction in the  
41 level of thyroid Patient E was taking, any treatment plans or other discussion regarding thyroid  
42 issues. (Ex. A21 at 7.)  
43

44 92. On the office visit of July 2, 2008, Patient E reporting taking 3 grains of thyroid  
45 daily. No other chart notes, other than the on-going diagnosis of hypothyroidism, address  
46 thyroid symptoms or treatment. (Ex. A21 at 7.)  
47

48 ///

1 93. On July 16, 2009, at the time of an Outpatient Medication Profile review of Patient  
2 E's medications, Patient E was taking ". . . Amour Thyroid Tab, 65 (sic) mg. one tablet by mouth  
3 3 x daily." A comment on the profile noted that Patient E did not know the dose of the thyroid  
4 she was taking. (Ex. A21 at 35.)  
5

6 94. On August 26, 2008, Patient E visited Licensee. Licensee noted that her basal  
7 temperatures remained "too low on 3 grains of thyroid." Patient E had lab results for T4 and T3  
8 which were within normal limits but she had not had a TSH level checked. Licensee reduced her  
9 dosage of thyroid by 1 grain a day.  
10

11 95. On October 6, 2009, a chart note documented Patient E's prescription of thyroid was  
12 changed to 1 grain QD, #204 to replace the previous prescription. The pharmacy where the  
13 prescription was being filled did not have the 2 grain dosage. (Ex. 21 at 9.)  
14

15 96. On September 29, 2009, Patient E saw Licensee for an office visit. She was taking 3  
16 grains of desiccated thyroid and denied symptoms of excess. Patient E reported not feeling as  
17 well as she did when she was taking 4-5 grains daily about a year before. She reports reducing  
18 her dose when her pulse rate went up "a bit." (Ex. 21 at 9.)  
19

20 97. As of November 16, 2009, Patient E's TSH was 0.02 on 3 grains of thyroid and her  
21 free T4 was 0.94, within the normal reference range of 0.61-1.27. Patient E's TSH of 0.020 was  
22 low for the normal reference range of 0.40-4.6. Licensee's handwritten note to Patient E on the  
23 lab report stated that the results suggested that Patient E was taking too much thyroid, that she  
24 should take 2 grains and call him. (Ex. A21 at 9, 42.) As of May 17, 2010, Patient E continued  
25 on thyroid and her TSH was 1.07, within the normal reference range of 0.40-4.6 and Licensee  
26 recommended that she continue to take thyroid. (Ex. A29 at 20.)  
27

28 98. Regarding his treatment of Patient E, Licensee did not meet the standard of care for  
29 the following reasons: Patient E came to Licensee already taking a low dose of Synthroid.  
30 Licensee could not establish a primary diagnosis of hypothyroidism without stopping thyroid,  
31 which was not done. Lab results in 2009, three and half years after Patient E began treatment  
32 with Licensee, indicated that Patient E was hyperthyroid and had been since first coming to see  
33 Licensee. (Ex. A21 at 22, 42; test. of Dr. Nedrow, tr. at 412, 413.) Waiting six months to retest  
34 Patient E following her lab result on November 13, 2009, did not meet the standard of care and  
35 placed Patient E at risk. (Test. of Dr. Nedrow, tr. at 1368.) Patient E was placed at additional  
36 risk because Licensee was also treating Patient E with cortisone. Cortisone combined with  
37 Patient E's chronic hyperthyroid state was very toxic for Patient E's bone health. (Id., tr. at 414.)  
38

39 Patient F  
40

41 99. Patient F, a male patient, saw both his PCP and Licensee for medical treatment  
42 concurrently for a period of time. Patient F had seen his PCP, David Grube, MD, Board  
43 Certified family physician, for over 35 years. Patient F has known Licensee for over 25 years  
44 and has seen Licensee as a patient for approximately 15 years. (Test. of F, tr. at 1127, 1128.)  
45 Patient F's wife has worked for Licensee in the past for a period of about 15 years. (Test. of F,  
46 tr. at 1137.)  
47

48 100. Patient F had a history of hypertension. (Ex A22 at 18-20.)

1 101. Patient F talked with friends and read about testosterone therapy for issues with low  
2 sex drive and lack of energy. Patient F saw Dr. Grube for some issues but felt more comfortable  
3 talking with Licensee about others. (Test. of F, tr. at 1120, 1128-1130.) As of February 19,  
4 2007, Patient F's PSA level was .92 ng/mL, within the normal reference range of 0.0-4.0 ng/mL.  
5 (Ex. A22 at 24.)  
6

7 102. On December 20, 2007, Patient F had an office visit with Licensee and discussed  
8 taking testosterone. (Ex. A22 at 1.) Patient F's lab results revealed a PSA of 0.63 ng/mL, within  
9 the normal reference range of 0.0 - 4.0 ng/mL, a total testosterone of 450 ng/dL, within the  
10 reference range of 350-890 mg/dL, and a free testosterone of 78 pc/mL, within the reference  
11 range of 47-244 pg/mL. (Id. at 6-9.)  
12

13 103. Licensee reviewed Patient F's recent lab results, performed a DRE, and diagnosed  
14 Patient F with hypogonadism. Licensee noted that Patient F had reviewed the "Medical Clinics  
15 article" and said that he would like to begin testosterone therapy. Licensee discussed the "pros  
16 and cons and theoretical risks of prostate cancer" with Patient F, noted that he understood the  
17 risks of prostate cancer and wanted to proceed with treatment. Licensee gave him a testosterone  
18 injection. (Ex. 22 at 1.)  
19

20 104. Licensee charted a second note for the December 20, 2007, visit, repeating some of  
21 the same information, excluding the notes as to the discussion of the Medical Clinics article from  
22 the first chart note, and noting that [Patient F] read about the CV and metabolic benefits of  
23 testosterone. Following a repetition of the lab results, Licensee noted, "This suggests  
24 aromatization so we discussed various approaches" and his plan included beginning 100 mg of  
25 testosterone every other week. These notes were copied to Dr. Grube. (Ex. A22 at 2.)  
26

27 105. Patient F continued with injections of testosterone and then switched to a cream  
28 form, and then to a sublingual form. Patient F saw Licensee on a fairly regular basis and  
29 Licensee performed DRE's on each office visit. (Test. of Patient F, tr. at 1131, 1132.) A PSA  
30 test performed on March 6, 2008 was 0.68, within the normal reference range of 0.0-4.0. (Ex.  
31 A22 at 14.)  
32

33 106. Testing on March 6, 2008, showed a free testosterone level of 24.9, abnormal for  
34 the normal reference range of 47-244. Licensee's handwritten note to Patient F on the lab report  
35 asked Patient F if he were taking testosterone. (Ex. A22 at 13.) On Patient F's visit with  
36 Licensee on April 14, 2008, Licensee had discontinued Patient F's injections of testosterone  
37 following the drop in Patient F's free testosterone level. Patient F had not noticed any difference  
38 in the way that he felt. Licensee switched Patient F to testosterone in a gel form. (Ex. A22 at 2.)  
39

40 107. Saliva test results from August 14, 2008, revealed that Patient F's testosterone level  
41 had risen to 600. (Ex. A22 at 21.) Patient F felt more energetic, more flexible and like he had  
42 more endurance, but his sex drive was not as good as he would have liked. (Test. of Patient F, tr.  
43 at 1132.)  
44

45 108. On February 2, 2010, Dr. Grube called Patient F and ordered him to stop taking  
46 testosterone. Dr. Grube followed up the telephone call with a letter, telling Patient F to stop  
47 taking testosterone because his test results showing that he had "way too much testosterone." Dr.  
48 Grube instructed Patient F to talk to Licensee about the level, a result of 1430, high from the

1 normal reference range of 72-623. (Ex. R81 at 21, 22.) Patient F was taking sublingual  
2 testosterone at the time. (Test. of F, tr. at 1139.)  
3

4 109. Dr. Grube, based on his 35 year history of treating Patient F, does not believe that  
5 Patient F has symptoms, a history, or test results that support a diagnosis of hypogonadism.  
6 (Test. of Dr. Grube, tr. at 1023.)  
7

8 110. Patient F discontinued the testosterone as instructed but resumed it later at a  
9 reduced dosage, once every other day, under Licensee's care until Licensee's license was  
10 suspended. Following Licensee's suspension, Patient F then saw Dr. Welker who again  
11 prescribed the sublingual testosterone on a daily basis. Patient F was a patient of Dr. Welker's at  
12 the time of the hearing. (Test of Patient F at 1139.)  
13

14 111. Over two days, December 12 and 13, 2010, Patient F had his testosterone levels  
15 tested three times, at his own expense, at the request of Dr. Welker. The purpose of the three  
16 tests was to simulate the testing done on February 10, 2010, in preparation for Licensee's  
17 defense in the current contested case matter. (Test. of Patient F, tr. at 1140, 1141, and Dr.  
18 Welker, tr. at 678; Ex. R125.) For normal therapeutic testing, only one test would be ordered.  
19 The time of the test would be between noon and 4:00 p.m. to provide a realistic level of the  
20 patient's testosterone level when taking sublingual testosterone in the morning. (Test. of Dr.  
21 Welker, tr. at 678, 679.)  
22

23 112. Patient F was subjected to two additional tests at his own expense that were not  
24 necessary for his treatment but were done for purposes of providing evidence for the hearing.  
25 (Test. of Dr. Welker, tr. at 675, 676, 678, 679.)  
26

27 113. Licensee did not meet the standard of care in his treatment of Patient F for the  
28 following reasons: Licensee failed to establish a diagnosis of low testosterone for Patient F  
29 before beginning testosterone replacement therapy; Licensee changed the administration method;  
30 and increased the dose of testosterone for Patient F without a documented medical basis, thus  
31 increasing the risks of taking testosterone without establishing a medical deficiency. (Test. of  
32 Dr. Nedrow, tr. at 417.)  
33

34 114. Patient F was subjected to an unnecessary test and was placed at risk, based on the  
35 level of testosterone administered to a man with high blood pressure, for the purpose of  
36 providing evidence in defense of Licensee for the hearing. (Test. of Dr. Grube, tr. at 1018.)  
37

#### 38 Patient G

39

40 115. Patient G, a male born on April 17, 1933, (Ex. A33 at 20), was seen at the Eugene  
41 Clinic on December 1994, at his request to have his prostate evaluated. Patient G had, at that  
42 time, already consulted with other physicians and had a history of slightly elevated PSAs for  
43 approximately 2 years and positive biopsies showing a minimal amount of prostate cancer on the  
44 biopsy specimens. (Ex. A33 at 119.)  
45

46 116. Patient G's biopsy report to Dennis Ellison, MD, of McKenzie Urology, from  
47 September 25, 1992, showed a Gleason grade 2-3 adenocarcinoma as diagnosed by L. Samuel  
48 Vickers, MD, pathologist. Per note by Dr. Vickers, five other pathologists had reviewed the

1 biopsies, one agreed with Dr. Ellison, one found the adenocarcinoma diagnosis in only one of the  
2 specimen samples and the other three interpreted the atypical glands in specimen numbers 2 and  
3 3 as suspicious for adenocarcinoma but non-diagnostic. (Ex. A36 at 1.)  
4

5 117. On January 19, 1993, a second biopsy ordered by Dr. Ellison, resulted in a  
6 diagnosis of a Gleason grade 2-3 adenocarcinoma. (Ex. A36 at 2.)  
7

8 118. At the December 1994 Eugene Clinic visit, Patient G told the treating physician that  
9 he was refusing to have any kind of treatment for prostate cancer, whether it was drugs, radiation  
10 or surgery. (Ex. A33 at 119.)  
11

12 19. Patient G, 66 years of age at the time, presented to Licensee in November 1999 with  
13 a history that included the presence of a prostate nodule for over 10 years. (Ex. A23 at 1.)  
14 Patient G chose to see Licensee based on his personal experience with friends who had similar  
15 diagnoses. Patient G was given Licensee's name by a friend who had had good results. (Test. of  
16 Patient G, tr. at 778, 779.)  
17

18 120. Patient G had a PSA of 14.8 at the time of his first visit with Licensee. Patient G  
19 told Licensee that his doctor had wanted to do a bone scan and then to consider either radical  
20 surgery or implants. Patient G told Licensee that he was adamantly opposed to those options.  
21 Licensee did not perform a DRE at that time because Patient G had had them multiple times in  
22 the past. (Ex. A23 at 1.)  
23

24 121. On a follow-up visit of December 6, 1999, Licensee began Patient G on thyroid  
25 replacement with a prescription for 1 grain thyroid, noting that Patient G's basal temperatures  
26 were below 97 degrees. (Ex. A23 at 1.)  
27

28 122. On December 20, 1999, Patient G's testosterone was elevated at 58, and, among  
29 other things, he was taking 60 mg of thyroid. Licensee prescribed increasing the thyroid to 120  
30 mg. and planned for Patient G to be tested for PSA levels in one month. (Ex. A23. at 1.)  
31

32 123. On January 17, 2000, Licensee wanted Patient G to have his PSA levels checked.  
33 Licensee knew that Patient G was being followed by a urologist for PSA levels at that time and  
34 ordered lab results to be forwarded to the urologist. (Ex. A23 at 1.)  
35

36 124. On Patient G's next visit on December 5, 2000, Licensee noted that Patient G had  
37 cancer of the prostate. Licensee's most recent record showed a PSA of 14 in January 2000.  
38 Patient G continued taking thyroid as prescribed by Licensee. (Ex. A23 at 1.)  
39

40 125. On the January 22, 2001, office visit, Patient G brought recent PSA test results (Ex.  
41 A23 at 2) which showed a current PSA of 10.0, high from the normal reference range of 0.0-4.0.  
42 The January 1, 2001, lab report included Patient G's history of PSA levels which were as  
43 follows:  
44

45 11/2000 - 16.5 (handwritten result added to printed report)

46 ///

47 ///

48 ///

1 Patient G's history reflects the following PSA values:  
2

3 9/8/92 – 4.2

4 5/13/93 – 5.9

5 10/20/93 – 5.4

6 11/08/95 – 8.1

7 8/06/96 – 7.6

8 8/11/97 – 7.1  
9

10 (Ex. A23 at 17.) Patient G brought a note from his urologist who had recommended that Patient  
11 G take anti-testosterone substances but Patient G was refusing to do so. Patient G also told  
12 Licensee that he would not do any more biopsies. (Ex. A23 at 2.)  
13

14 126. Licensee continued to see Patient G and to follow Patient G's PSA levels. On the  
15 visit of July 16, 2001, Licensee referred Patient G to OHSU for a "rectal exam, etc." and asked  
16 Patient G to make a decision on whether he wished to continue "watchful waiting" regarding his  
17 prostate and PSA levels. Patient G's response was not noted. (Ex. A23. at 2.)  
18

19 127. Throughout 2001 and 2002, Licensee continued to prescribe thyroid for Patient G.  
20 Patient G's next office visit with Licensee was on January 2, 2003. Patient G's PSA had gone up  
21 and he was scheduled to see a specialist about it but Patient G continued to be opposed to any  
22 invasive procedure. (Ex. A23 at 2.)  
23

24 128. Patient G's PCP at the time was Michael Boespflug, MD. Dr. Boespflug referred  
25 Patient G to David Esrig, MD, a Board Certified urologist of 15 years, for evaluation, and for  
26 medical or surgical treatment of his prostate cancer. (Ex. A33 at 140, 141; test. of Dr. Esrig, tr.  
27 at 1378.) Dr. Esrig's partner had performed Patient G's biopsies. When the partner retired, Dr.  
28 Esrig assumed the care of Patient G. Dr. Esrig recommended the standard care, which includes  
29 surgery, radiation, and hormonal deprivation therapy to Patient G, but Patient G repeatedly  
30 declined those options. (Test. of Dr. Esrig, tr. 1380, 1386)  
31

32 129. There are risks associated with the standard treatments, which include the  
33 following: related to surgery, bleeding, infection, injury to adjacent structures in the body,  
34 urinary incontinence, erectile dysfunction, pulmonary complications; related to radiation,  
35 urethral ulcer, bowel or urine incontinence, and urethral obstruction or strictures; and related to  
36 hormonal deprivation therapy, cognitive changes, decreased bone marrow density, hot flashes,  
37 decreased energy level, and possibly some cardiac abnormalities. (Test. of Dr. Esrig, tr. at 1392,  
38 1393.)  
39

40 130. Licensee's next office visit with Patient G was on April 21, 2004. Patient G's PSA  
41 was at 19, a rise from the one taken the prior year. Patient G had not seen his urologist since his  
42 biopsy and was refusing surgery or radiation or hormone blockage. Licensee noted that Patient  
43 G "has the Dr. Wright book and has been reading about testosterone therapy. He'll do that."  
44 Licensee's treatment plan included having Patient G read the material about testosterone and  
45 prostate cancer and to decide if he wanted to proceed in that direction. (Ex. 23. at 4.)  
46

47 131. By the time of Patient G's next office visit with Licensee on October 18, 2004,  
48 Patient G had consulted with his PCP. The Board observes that Licensee's chart noted on this

1 date Patient G's PSA was at 31.9 (Ex. A23 at 4). Patient G had lost about 18 lbs since March  
2 which Patient G attributed to his attempts to lose weight. He was scheduled for a bone scan but  
3 expressed hesitancy and would not consider chemotherapy. Patient G, at that time, indicated he  
4 might consider radiation and/or hormone manipulation. Licensee performed a DRE which  
5 revealed a firm, small nodule on the left of the prostate. Licensee's assessment of Patient G at  
6 that exam was prostate cancer. (Ex. A23. at 4.)  
7

8 132. Licensee continued to prescribe thyroid for Patient G but did not see him again for  
9 an office visit until October 24, 2005. Licensee's chart note for this date states that Patient G's:  
10 "PSA had gone up from 26 in 10/04 to 31 currently." (Ex. A23 at 4.) The Board notes that the  
11 apparent discrepancy between Licensee's two chart entries regarding PSA readings in 2004 (see  
12 paragraph 131 above) and the chart entry for 10/25/05 probably reflects a charting error by  
13 Licensee. This supposition is confirmed by the lab final report that reflects a PSA of 26.1 on  
14 10/12/04 and a PSA of 31.7 on 10/12/05. (Ex. A23 at 33.) Patient G continued to refuse any  
15 treatment. Patient G reported continuing to be asymptomatic and the results of a bone scan had  
16 been negative. (Ex. A23 at 4)  
17

18 133. At Patient G's next office visit with Licensee on April 11, 2006, Patient G's recent  
19 PSA level was 25.8. Licensee noted that Patient G reported a recent DRE and that Patient G did  
20 not feel another was necessary. Licensee's assessment noted "most likely prostate cancer" and  
21 following the write-up of the treatment plan, including having another PSA in six months.  
22 Licensee noted that Patient G "consents to this plan." (Ex. A23 at 5.)  
23

24 134. Patient G next saw Licensee on October 25, 2006. Patient G's TSH was 4.8. Patient  
25 G's PSA had elevated from 25.8 to 29.7. Patient G reported feeling quite vigorous in his  
26 exercise and lifestyle, competing in the Master's Competition in running. Patient G continued to  
27 believe that his prostate was not a problem and he had been reading about testosterone to help  
28 with andropause (male menopause) and to help improve the quality of his life. Patient G  
29 reported having had a biopsy that he did not want another rectal exam, and he continued to refuse  
30 any traditional intervention with his prostate. (Ex. A23 at 6.)  
31

32 135. Patient G and Licensee then discussed testosterone therapy. Patient G wanted to  
33 start testosterone therapy with Licensee. Licensee prescribed Androgel, a brand name gel-form  
34 of testosterone, for Patient G and scheduled a discussion with Patient G in six weeks. (Ex. A23.  
35 at 6.)  
36

37 136. As of 2005, Patient G had been seen for approximately four to five years by Dr.  
38 Esrig. Patient G stopped seeing Dr. Esrig in 2005. Dr. Esrig was never informed by Licensee or  
39 Patient G that he had prescribed testosterone for Patient G. (Test. of Dr. Esrig, tr. at 1378.)  
40

41 137. From October 2006 to the next office visit with Patient G, Licensee continued to  
42 prescribe testosterone in the form of Androgel for Patient G. On the next office visit of April 24,  
43 2007, Patient G reported that he felt excellent. He was using the testosterone and his PSA levels  
44 were elevated. Licensee noted that he had discussed the potential risks of testosterone therapy  
45 with Patient G in the past and that Patient G "accepts this based on the quality of life he feels  
46 testosterone is giving him." (Ex. A23 at 7.) Patient G's most recent PSA levels were 29.7 and  
47 31.5. A DRE revealed a firm, smooth gland which Licensee noted "[without] knowing his PSA I  
48 might feel it was suspicious." (Id.)

1 138. On June 28, 2007, Patient G and Licensee spoke by telephone. Patient G's PSA  
2 had risen from 31 to 37. Licensee did not want to continue prescribing testosterone but did so at  
3 Patient G's request. Patient G agreed to sign a consent letter prepared by Licensee. Patient G  
4 wanted to continue taking testosterone because he felt so good while taking it. (Ex. A23 at 7.)  
5

6 139. On the next office visit of September 26, 2007, Patient G's PSA had come down  
7 from 37 to 32.7 and he reported remaining asymptomatic. Patient G had been inconsistent but  
8 was still taking thyroid. Patient G had had some obstructive symptoms, mainly nocturia at 1-2  
9 times (per night) but Patient G attributed that to drinking a lot. Patient G's DRE revealed a very  
10 suspicious result; the gland was nodular and had a couple of areas of induration (hardened mass  
11 or formation). Licensee's assessment noted "very likely prostate cancer." (Ex. A23 at 8.)  
12 Licensee and Patient G discussed the traditional contraindication of continuing with testosterone  
13 therapy considering Patient G's condition but Licensee continued prescribing testosterone  
14 because Patient G wanted it. (Id.)  
15

16 140. The consent that Patient G signed for Licensee, entitled "Prostate Cancer Disclosure  
17 and Consent" on August 27, 2007, read as follows:  
18

19 I understand the controversy regarding the use of testosterone in the presence of prostate  
20 cancer. I have read the summary of the Medical Clinics Supplement regarding  
21 Testosterone Replacement Therapy (TRT).

22 Dr. Gambee has answered my questions regarding TRT in patients with prostate cancer.  
23 In using TRT I understand the need for having regular prostate examinations and tests to  
24 measure my PSA and testosterone levels and consent to having these done.

25 I understand that I can discontinue TRT at any time.  
26

27 (Ex. A23 at 12.)  
28

29 141. The Medical Clinic Supplement that Patient G read and that was referred to in the  
30 signed consent form was written by authors who believed that research showed that if an  
31 individual's testosterone gets too low, the individual is more likely to get cancer. Licensee told  
32 Patient G what "other people thought" but Patient G did not want to "go in that direction." (Test.  
33 of Patient G, tr. at 784, 785.) Patient G, as of the time of the hearing, continued to question the  
34 value of the PSA level as accurate regarding the presence or progress of prostate cancer. (Id.)  
35

36 142. In March 2008, Patient G visited Licensee and reported feeling great. His PSA  
37 level was 31.8, down from 34.7. Patient G and Licensee again discussed the contraindications  
38 for continuing with testosterone but again, Licensee agreed to continue prescribing testosterone  
39 because Patient G wanted him to do so. Licensee increased the testosterone level from 100 mg  
40 every other week to 100 mg every week because, based on literature Licensee had read, he had  
41 concluded that Patient G's testosterone level was too low. (Ex. A23 at 9.)  
42

43 143. As of Patient G's next office visit with Licensee on May 20, 2008, Patient G  
44 reported feeling great. He was taking 100mg testosterone every other week. Licensee performed  
45 a DRE and noted that the results showed the prostate as firm and nodular, still suspicious. (Ex.  
46 A23 at 9.)  
47

48 ///

1 144. In October 2009, Patient G's PSA was 47. As of February 2010, Patient G's PSA  
2 level was 46. (Ex. A29 at 43.)  
3

4 145. Patient G has been unable to get testosterone replacement therapy from any other  
5 provider in the time since Licensee has been restricted from providing it to him. Patient G  
6 stopped seeing his urologist and his primary care doctor while he was seeing Licensee and has  
7 not resumed care under either since Licensee has been suspended from the practice of medicine.  
8 (Test. of Patient G, tr. at 790, 792.)  
9

10 146. Licensee subjected Patient G to a substantial risk of harm and did not meet the  
11 standard of care in treating Patient G. (Test. of Dr. Cook, tr. at 192, Dr. Esrig, tr. at 1381, and  
12 Dr. Nedrow, tr. at 422.) Beginning testosterone treatment without a confirmation of low  
13 testosterone, as Licensee did for Patient G, was not medically indicated. In view of Patient G's  
14 PSA levels, history of biopsies positive for prostatic cancer, and the results of Patient G's DRE's,  
15 Licensee's treatment of Patient G with testosterone replacement therapy was contraindicated and  
16 constituted gross negligence. (Test of Dr. Cook, tr. at 186, 192.)  
17

18 147. Licensee did not tell Dr. Esrig, Patient G's most recent treating urologist, that he  
19 was prescribing testosterone for Patient G. (Test. of Dr. Esrig, tr. at 1380.) It is standard  
20 practice for a treating urologist to communicate with a patient's primary treating physician,  
21 especially in regards to treating prostate cancer. (Test. of Dr. Cook, tr. at 188.) Dr. Esrig would  
22 have opposed the treatment had he been made aware of it. (Test. of Dr. Esrig, tr. at 1380, 1381.)  
23

24 148. Licensee violated his ethical obligation to "do no harm" when he continued to treat  
25 Patient G with testosterone, despite Patient G's rising PSA levels, the changes noted in Patient  
26 G's prostate through DRE's, and Licensee's own doubts and wishes regarding discontinuing the  
27 therapy. (Test. of Dr. Cook, tr. at 189.) Licensee placed Patient G at risk by supporting Patient  
28 G in not seeking curative treatment for his prostate cancer and in increasing the risk that the rate  
29 and speed of growth of Patient G's cancer would result in a fatal outcome in a relatively young  
30 man. (Test. of Dr. Nedrow, tr. at 422.)  
31

32 149. Licensee did not meet the standard of care because he provided information on a  
33 highly controversial treatment, supporting the proposition that a patient with prostate cancer can  
34 benefit from treatment with testosterone, to a patient who had a diagnosis of prostate cancer and  
35 who was refusing to pursue standard treatments. The patient would most likely be confused by  
36 such information. (Test. of Dr. Esrig, tr. at 1391, and test. of Dr. Nedrow, tr. at 426, 1374.)  
37 Standard treatment following a diagnosis of prostate cancer, especially metastatic cancer, would  
38 include withdrawing testosterone. Providing or approving testosterone treatment to a patient  
39 with rising PSA levels is contraindicated and is against the standard of care. (Test. of Dr. Esrig,  
40 at 1381, test. of Dr. Nedrow at 426.)  
41

42 150. A cancer of a Gleason level 5 in Patient G does not indicate, by itself, an aggressive  
43 cancer. However, that level, combined with rising PSAs such as Patient G had, suggest strongly  
44 that the cancer had spread beyond the prostate gland itself. The lives of patients with very  
45 aggressive metastatic prostate cancer have been prolonged by withdrawing testosterone or  
46 decreasing its production in the body. (Test. of Dr. Esrig, tr. at 1389.)  
47

48 ///

1 151. Patient G's signature on Licensee's consent form was inadequate to establish  
2 informed consent. Patient G was given insufficient information regarding the risks of continuing  
3 testosterone therapy, necessary to make an informed decision. (Test. of Dr. Nedrow, tr. at 426.)  
4

5 **Facts related to Licensee's alleged violation of 2010 ISO resulting in the Order of**  
6 **Emergency Suspension.**  
7

8 Patient H  
9

10 152. Patient H, a 64 year old female, saw Licensee on May 27, 2009, complaining of  
11 fatigue and weight problems. Laboratory tests of April 23, 2009, ordered by an internist at  
12 another clinic, showed Patient H's TSH level at 1.84, within a reference range of .40-5.00 and  
13 her testosterone at less than 0.2, within a reference range of 0.0 to 0.8. (Ex. A24, at 1, 6.)  
14

15 153. Patient H's thyroid result from the April 23, 2009, lab test was within the normal  
16 range. (Test. of Dr. Cook, tr. at 193.)  
17

18 154. On June 25, 2009, Patient H was still complaining of some fatigue. Licensee  
19 provided Patient H with information about thyroid deficiencies. (Ex. A24 at 1.)  
20

21 155. On July 15, 2009, Licensee spoke with Patient H by telephone and noted that she  
22 had started thyroid. (Ex. A24 at 2.)  
23

24 156. On September 29, 2009, during an office visit, Patient H was no longer feeling  
25 fatigued. She was taking 1 grain of thyroid, which she reported getting on-line. Licensee  
26 observed that Patient H seemed to be tolerating the thyroid well. Licensee discussed the possible  
27 risks of thyroid with Patient H and provided her with a list of the side effects. (Ex. A24 at 2.)  
28

29 157. On January 28, 2010, Patient H saw Licensee for an office visit. She reported taking  
30 1 to 2 grains of thyroid and Licensee observed that Patient H seemed to be tolerating it well.  
31 Patient H was losing weight and felt more energetic. Licensee noted that Patient H was getting  
32 her thyroid from an on-line source and that it appeared to be desiccated thyroid. Her list of  
33 current medications included Armour thyroid. (Ex. A24 at 2.)  
34

35 158. On February 16, 2010, Patient H's lab tests showed her TSH level was low at 0.007  
36 and her free T4 was 1.07. Licensee wrote on the lab result, with a line drawn to the TSH level,  
37 "suggests too much thyroid" and with a line drawn to the free T4 level, wrote "suggests the right  
38 amount." (Ex. A24 at 9.) Licensee noted the results of the TSH test in Patient H's chart and sent  
39 her the results with a note instructing her to decrease her dose to 1 grain 5 to 6 times per week,  
40 instead of taking it daily. (Id at 3.)  
41

42 159. Patient H's next office visit with Licensee was on June 16, 2010. Patient H was  
43 continuing to take Armour thyroid, which she was getting from Mexico, at the reduced dosage  
44 recommended by Licensee in February. Licensee had no follow up with Patient H from the time  
45 he received the lab results in February until this office visit. Licensee scheduled her to get a  
46 follow up TSH/T4 done in August. Licensee's assessment and plan for Patient H noted a  
47 diagnosis of hypothyroidism. (Ex. A24 at 3.)  
48

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1 160. TSH levels that have been suppressed, unlike other hormones from the pituitary,  
2 take time to recover following a change in thyroid medication. Licensee's treatment of Patient H  
3 on June 16th consisted of monitoring Patient H's reaction to Licensee's February 2010  
4 recommendation to lower her thyroid dosing. Licensee's treatment of Patient H on June 16,  
5 2010, was consistent with attempting to bring Patient H's TSH level to within a target range of .3  
6 to 3.0 TSH. (Test. of Dr. Cook, tr. at 210, 211.)  
7

8 Patient I  
9

10 161. On May 10, 2004, Licensee saw Patient I, 55 year-old male, who was complaining  
11 of fatigue. His PSA level at that time was .79. His total testosterone level was 345 and his free  
12 T4 was at 57.9. (Ex. A29 at 61, 64.) Patient I's testosterone levels were within normal limits  
13 and did not support a diagnosis of, and treatment for, hypogonadism. (Test. of Dr. Cook, tr. at  
14 520.)

15 162. On June 2, 2004, Licensee diagnosed Patient I's PSA level as being low and his  
16 total testosterone level as low. Licensee began him on testosterone replacement therapy. (Ex.  
17 A29 at 61.)  
18

19 163. On June 6, 2007, Patient I's total testosterone was 318, low for the reference range  
20 of 350-890, and his free testosterone was 51, within the reference range of 47-244. (Ex. R123.)  
21 The mid-range for the total testosterone, for the reference range for the June 6th test, was 620.  
22 (890, the high range, minus 350, the low range = 540, divided by two = 270, added to the low of  
23 350 = 620 for the mid-range.) (Test. of Dr. Cook, tr. at 476 to 479.)  
24

25 164. Patient I's PSA on April 22, 2009, was 0.96, within the normal range. His  
26 testosterone level was 436, within the reference range of 350-720. (Ex. A25 at 4.) Patient I  
27 visited Licensee on June 4, 2009. Licensee continued treating him for a diagnosis of  
28 hypogonadism. Patient I's PSA was stable at less than 1. Licensee performed a DRE, noting the  
29 result was benign and non-tender. Licensee increased his testosterone dose to 4 percent. (Ex.  
30 A25 at 1.)  
31

32 165. On March 2, 2010, Patient I's PSA level was 0.9, which was within the normal  
33 range. (Ex. A25 at 8.)  
34

35 166. On May 24, 2010, Patient I's lab tests showed his testosterone level at 477, which  
36 was within the reference range of 350-720. (Ex. A25 at 9.)  
37

38 167. On June 7, 2010, Licensee saw Patient I at the office. He was taking his  
39 testosterone "a little sporadically," was not feeling as well and wanted to increase his dose.  
40 Licensee noted that Patient I's PSA was within normal limits. Licensee performed a DRE,  
41 noting the results as "benign and non-tender, a somewhat nodular gland." Licensee directed  
42 Patient I to continue taking testosterone and to increase his dosage to 40 mg. daily. (Ex. A25 at  
43 2.)  
44

45 168. On the visit of June 7, 2010, Licensee continued to treat Patient I under an active  
46 diagnosis of hypogonadism because he was directing Patient I to continue taking testosterone,  
47 and to increase the dosage. (Test. of Dr. Cook, tr. at 219, 228.)  
48

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1 169. It is within the clinical judgment of the treating physician to prescribe testosterone  
2 for a patient whose testosterone level was close to the lower level of normal combined with  
3 clinical symptoms. Licensee's treatment of Patient I, based on his total testosterone level,  
4 combined with his clinical symptoms, was within the standard of care set out under the AACE  
5 guidelines. Evaluating the patient's response to treatment is within the clinical judgment of the  
6 treating physician based upon the method of delivery of the testosterone, the timing of the  
7 dosing, and the patient's history. (Test. of Dr. Cook, tr. at 481, 482.)  
8

9 Patient J  
10

11 170. Patient J, a female patient of Licensee's, was tested for TSH levels on March 16,  
12 2009. At that time, her TSH level was under .003, low for the reference range of 0.465-4.680.  
13 (Ex. A26 at 4.) As of June 22, 2009, Patient J was on thyroid replacement therapy, which was  
14 addressed during the visit along with other complaints. Patient J was taking 1 grain of thyroid  
15 and tolerating it well. Licensee continued Patient J on thyroid but changed it to Naturthroid.  
16 (Ex. A26 at 1.)  
17

18 171. As of March 16, 2010, Patient J's TSH was 50.400, high for the reference range of  
19 .465-4.680. (Ex. A26 at 3.) Licensee continued thyroid treatment for Patient J. During an office  
20 visit of June 16, 2010, Licensee noted the increase in Patient J's TSH levels from March of 2009  
21 to March of 2010. Patient J showed no signs of excess and very few symptoms of deficiency. In  
22 his assessment and plan, Licensee continued treatment for hypothyroidism, increased Patient J's  
23 Naturthroid to 60mg BID and ordered a repeat TSH. (Ex. A26 at 1.)  
24

25 172. Licensee's treatment of Patient J was appropriate under the 2010 ISO because her  
26 TSH was above 10 according to a recent TSH test. (Test. of Dr. Cook, tr. at 471, 472.)  
27

28 Patient K  
29

30 173. Patient K, a female patient of Licensee's, was seen at the office on January 14,  
31 2010, for migraines. Patient K was taking thyroid at the time. (Ex. A27 at 1.)  
32

33 174. Patient K visited the office of Licensee on February 22, 2010, for an un-related  
34 issue and her current medications at that time included thyroid. (Ex. A27 at 1, 2.)  
35

36 175. Licensee continued to prescribe thyroid for Patient K. (Ex. A27 at 2.) On March  
37 8, 2010, her TSH level was 14.3, high for the reference range of 0.40-4.6, and her free T4 was  
38 0.71, within the reference range of 0.61-1.27. Licensee's handwritten note on Patient K's lab  
39 result instructed Patient K to take thyroid in the morning and afternoon and to repeat the TSH  
40 test in two months. (Ex. A27 at 5.)  
41

42 176. Licensee's treatment of Patient K was appropriate and was within the restrictions of  
43 the 2010 ISO. (Test. of Dr. Cook, tr. at 470.)  
44

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1 Patient L

2  
3 177. Patient L, a 56 year old male, began seeing Licensee in May 2006. Patient L's PCP  
4 was Terry Cooperman, MD. (Ex. A29 at 86.) When Patient L first saw Licensee, Patient L was  
5 already being treated with testosterone based on low testosterone levels. (Id.)  
6

7 178. As of March 26, 2007, Patient L's total testosterone was at 271.0, low for the  
8 reference range of 350-890 for males in the 40-59-year age group. (Ex. A29 at 92.)  
9

10 179. Licensee continued to treat Patient L with testosterone as of the office visit of April  
11 2007. Licensee performed a DRE, with benign results and noted that Patient L's PSA was  
12 continuing to drop, from a high of 1.3 in July of 2005 to 0.8 at the time of the visit. (Ex. A29 at  
13 88, 89.)  
14

15 180. During an office visit of July 8, 2008, Licensee noted that Patient L was taking  
16 thyroid which he and his wife had found from an independent source. Patient L had not had  
17 blood work performed regarding his thyroid function. Licensee reviewed the symptoms of  
18 excess thyroid with Patient L and he denied having any symptoms. Licensee charted a diagnosis  
19 of hypothyroidism for Patient L as of the July 8th visit. (Ex. A29 at 89.)  
20

21 181. Patient L's PSA level as of July 1, 2009, was 1.8. It had been 1.5 in 2008. (Ex.  
22 A28 at 1.) During an office visit of July 8, 2009, Licensee performed a DRE, noting a benign  
23 and non-tender result. Patient L continued to complain of erectile dysfunction. At that time  
24 Patient L continued taking testosterone, originally prescribed by another provider before  
25 Licensee first saw Patient L, and desiccated thyroid at 2 grains. (Ex. A28 at 1.)  
26

27 182. In lab results for Patient L on June 29, 2009, his screening PSA was 1.8, within the  
28 reference range of 0.0-4.0. His testosterone level was 790.06. Per the lab report, Patient L's  
29 testosterone level was high for Patient L's age, the reference range for a 60+ male being 350-  
30 720. (Ex. A28 at 5, 7.) His free T4 was within the normal reference age for his age group. (Id.  
31 at 8.) On October 15, 2009, Patient L's diagnostic PSA was at 1.3, within the reference range of  
32 0.0-4.0. (Id. at 5.)  
33

34 183. Patient L's only documented TSH level was 2.13, within the reference range of  
35 0.40-4.6, on April 27, 2010. (Ex. A28 at 2, 14.) On April 28, 2010, Licensee prescribed  
36 desiccated thyroid for Patient L. (Ex. A28 at 2.)  
37

38 184. Licensee saw Patient L on May 26, 2010. Patient L had been taking 3 grains of  
39 thyroid at the time and his TSH level was 2.13 as of the April 28th lab test. Licensee continued  
40 Patient L on the thyroid. (Ex. A28 at 2.)  
41

42 185. Patient L saw Licensee on June 10, 2010. Patient L had not gotten a recent TSH  
43 level with his other lab work. Patient L reported feeling better and having less erectile  
44 difficulties. Licensee performed a DRE with benign and non-tender results. There were no  
45 recent PSA test results. Licensee continued Patient L on testosterone injections and thyroid.  
46 (Ex. A28 at 2, 3.)  
47

48 ///

1 186. Patient L's TSH of May 26, 2010, was well within the normal range. Licensee's  
2 direction to Patient L on June 10, 2010, was reasonable in that it continued a course of treatment,  
3 for a patient currently taking thyroid whose TSH was 2.13 in May. The treatment was designed  
4 to maintain the patient's TSH within the normal limits of .3 to 3.0. (Test. of Dr. Cook, tr. at 229,  
5 230.)  
6

7 187. Patient L's chart does not include a diagnosis for goiter or positive anti-thyroid  
8 peroxidase antibodies. (Ex. A28 at 1-14, A29 at 86-102.)  
9

10 **Additional facts related to witness qualification, alternative practical practice**  
11 **organizations, and opinion testimony.**  
12

13 188. Dr. Cook holds certifications from the American Board of Internal Medicine in both  
14 Endocrinology and Metabolism and Internal Medicine. He teaches at, and is the current Interim  
15 Division Chief, Division of Endocrinology, for Oregon Health Sciences University, Portland  
16 (OHSU). Dr. Cook has published, among other things, multiple professionally-related peer-  
17 reviewed papers, books and book chapters, and abstracts. His curriculum vitae includes a  
18 lengthy history of speaking as an invited lecturer, conference presenter or professor, nationally  
19 and internationally, and multiple awards of grants or scholarships related to his medical  
20 specialty, endocrinology. (Test. of Dr. Cook, tr. at 112, 113; Ex. A31.)  
21

22 189. Dr. Cook's work in endocrinology has encompassed the diagnosis and treatment of  
23 thyroid disease as well as testosterone therapy. Endocrinology is the study of hormones and  
24 glands, basically secretions which enter the bloodstream and which have an effect on target  
25 organs of the body. Some hormones are more focused and affect specific organs, rather than all  
26 of the body's tissues. (Test. of Dr. Cook, tr. at 113; Ex. A31.)  
27

28 190. John A. Green, MD, is certified by the International Board of Environmental  
29 Medicine. He has practiced, among other areas, in emergency room medicine and in general  
30 family practice including the treatment of hypothyroidism, with a focus on environmental causes  
31 for disease. Since 1999, Dr. Green has specialized in special needs children in the context of  
32 environmentally-related disease. Dr. Green considers himself an alternative medical provider  
33 and had testified in support of the amendments to the law in 1995 to allow for alternative  
34 medical treatments. (Test. of Dr. Green, tr. at 1307-1310.)  
35

36 191. In diagnosing and treating hypothyroidism, Dr. Green relies more on findings of  
37 low basal temperatures, patient history of symptoms related to low thyroid, such as deep-vein  
38 thrombosis, fatigue, depression, severe constipation, menstruation problems, rather than the  
39 patient's TSH level. Dr. Green believes the TSH level is affected by multiple factors and that it  
40 is not an effective diagnostic tool for hypothyroidism. Rather than conduct further testing, it is  
41 Dr. Green's practice, for a patient he suspects is hypothyroid, to run a patient trial on thyroid  
42 because it is less invasive and costly than further testing. (Test. of Dr. Green, tr. at 1315-1319,  
43 1328, 1329.)  
44

45 192. Licensee provided the charts of the patients, A-E, named in the Amended  
46 Complaint and a copy of the Amended Complaint to Dr. Green. Dr. Green was asked to review  
47 the charts and the Amended Complaint and provide his opinion as to whether Licensee met the  
48 standard of care for treatment of those patients. (Test. of Dr. Green, tr. at 1313, 1314.)

1 193. In Dr. Green's opinion, Licensee had an objective basis to believe that the treatment  
2 he provided had a reasonable probability of being effective. (Test. of Dr. Green, tr. at 1315.)  
3

4 194. Jay Harvey Mead, MD, is certified by the American Board of Pathology, in  
5 pathology and in anatomic, clinical, and blood banking specialties. He has a patient practice as  
6 well as practicing pathology, and is the Medical Director of Labrix Clinical Services, a testing  
7 lab in Oregon City. (Test. of Dr. Mead, tr. at 818, 819.) Tests ordered by Licensee for Patient  
8 D (Ex. A20 at 24), Patient E (Ex. A21 at 15), and Patient F (A22 at 15) were performed at Labrix  
9 Clinical Services.

10  
11 195. Dr. Mead maintains his continuing medical education and attends classes in  
12 pathology. (Test. of Dr. Mead, tr. at 818, 819.) Dr. Mead also attends conferences on topics  
13 related to male and female health and hormone balancing, including those sponsored by the  
14 A4M. He is unfamiliar with the clinical practice guidelines put forth by the Endocrine Society.  
15 (Id., tr. at 827, 828, 830.)  
16

17 196. In Dr. Mead's opinion, there is no risk associated with treating a patient with a  
18 diagnosis of prostate cancer with testosterone. Following his review of the charts for Patients F  
19 and G, Dr. Mead concluded that Licensee's treatment met the qualifications for the practice of  
20 alternative medical treatment and posed no greater risk to either patient than the generally  
21 recognized treatment. (Test. of Dr. Mead, tr. at 826, 828.)  
22

23 197. Kenneth Welker, MD, received his medical degree from the University of  
24 Washington, Seattle in 1982. Dr. Welker's training and area of practice is in general surgery.  
25 (Test. of Dr. Welker, tr. at 643, 645.) Dr. Welker has acquired additional specialized knowledge  
26 in the field of endocrinology by pursuit of independent study. He also completed a fellowship in  
27 "functional" or anti-aging medicine, through different organizations, and the American  
28 Association of Anti-Aging Medicine (A4M), a non-ABMS course of study. (Id. at 646)  
29

30 198. Prior to moving to Oregon, Dr. Welker practiced general surgery in Idaho. As the  
31 result of a Stipulation and Order that he entered into with the Idaho State Board of Medicine, Dr.  
32 Welker was required, among other things to attend an additional two (2) years of accredited  
33 supervised training. (Test. of Dr. Welker, tr. at 861; Ex. A37.) Within the Order, Dr. Welker  
34 admitted that the Board had good cause to institute an investigation but denied the allegations  
35 and denied any violations. The Idaho Board believed it had sufficient evidence that Dr. Welker  
36 had, in the past, provided care that did not meet the standard for medical care. (Ex. A37.)  
37

38 199. Dr. Welker did not pursue reinstatement of his privileges at the two Idaho hospitals  
39 involved in the underlying investigation that led to the Order. (Test. of Dr. Welker, tr. at 888.)  
40 Dr. Welker completed the required training at Oregon Health Sciences University. Following  
41 completion of that training, Dr. Welker practiced bariatric surgery at Sacred Heart Hospital until  
42 2004. At that time, a dispute arose regarding Dr. Welker's relationship with surgical staff. As a  
43 result, Dr. Welker left the staff position and no longer has admitting privileges at Sacred Heart  
44 Hospital. He has since engaged in studying functional medicine and opened a private practice in  
45 functional medicine while performing locum tenens general surgery work approximately one  
46 weekend a month. (Id, tr. at 865-870.)  
47

48 ///

1 200. After Licensee's license was suspended, Dr. Welker became aware of the  
2 suspension through profession-related materials. Previously, Dr. Welker had not been  
3 acquainted with Licensee. Following the suspension, Dr. Welker began volunteering one day a  
4 week to cover Licensee's practice, when not otherwise engaged, sometime in October or  
5 November 2010. Dr. Welker's wife, a Family Nurse Practitioner (FNP) also volunteers one day  
6 a week to work at Licensee's practice. (Test. of Dr. Welker, tr. at 871-873, 871.)  
7

8 201. Dr. Welker was asked to review the 12 patient charts at issue and to provide an  
9 opinion regarding whether Licensee's treatment of those patients met the standard of care. In  
10 general, Dr. Welker concluded Licensee's treatment was very reasonable, that he had an  
11 objective basis to believe that testosterone therapy for Patients G and F and the thyroid treatment  
12 for patients Patients A, B, C, D, and E, had a reasonable probability for effectiveness. (Test. of  
13 Dr. Welker, tr. at 656.)  
14

15 202. Dr. Welker also found that Licensee's treatment of Patients G, F, A, B, D, C, and E  
16 did not increase the risk of harm to the patients than the generally recognized treatment. (Test.  
17 of Dr. Welker; tr. at 656. 657.)  
18

19 203. Regarding Licensee's treatment of Patient F, Dr. Welker saw Patient F as a patient  
20 after he could no longer be seen by Licensee. Dr. Welker was not concerned with the test result  
21 for testosterone levels of 1450 for Patient F because the dosing was sublingual. Sublingual  
22 dosing can result in a high spike in the testosterone level during the one-to-two hours following  
23 the administration before the level returns to a more realistic level. (Test. of Dr. Welker, tr. at  
24 670-673.)  
25

26 204. In Dr. Welker's own practice, Dr. Welker tests his patients, with few exceptions, by  
27 ordering lab blood-work, prior to prescribing thyroid, in order to establish a baseline. Dr.  
28 Welker would also order follow-up tests to evaluate the effectiveness of the treatment, in  
29 addition to considering the initial, or any changes, in a patient's clinical symptoms. Dr. Welker  
30 would most likely retest a patient taking thyroid within six weeks if the patient experienced  
31 symptoms such as tachycardia and it was necessary to reduce the thyroid dose in order to  
32 evaluate for further treatment. (Test. of Dr. Welker, tr. at 880, 881.)  
33

34 205. Patient F asked Dr. Welker to resume treatment with testosterone therapy. Dr.  
35 Welker agreed. In addition, Dr. Welker requested Patient F to repeat the testosterone level test in  
36 the same sequence as he had previously when under the care of Dr. Grube, for purposes of  
37 preparing for the current contested case hearing. Patient F consented to do so at his own  
38 expense. (Test. of Dr. Welker, tr. at 674-677, and F, tr. at 1140.)  
39

40 206. Licensee treated patients for hypothyroidism based on the clinical presentation of  
41 the patient as the primary basis for diagnosis. He does not consider the blood test to measure  
42 thyroid stimulating hormone (TSH) to be a primary tool for diagnosis nor does he believe it to be  
43 critical for establishing the diagnosis or for treatment of the disease. (Test. of Licensee, tr. at 52-  
44 54.)  
45

46 207. The American Association of Anti-aging Medicine (A4M) is not a respected  
47 institution by doctors practicing in academic medicine. The A4M is considered to promote  
48 potentially harmful treatment such as the use of growth hormone, is considered to be fairly

1 profit-based, and it raises concerns of conflict of interest because it sells products connected with  
2 its preferred treatment modalities. (Test. of Dr. Nedrow, tr. at 1363.)  
3

4 208. The Institute for Functional Medicine is more respected within academic circles.  
5 The Institute, although still considered a fringe organization, is solidly based in biochemical  
6 knowledge of nutrition. (Test. of Dr. Nedrow, tr. at 1363, 1364.)  
7

8 209. Dr. Nedrow is a member of the Consortium of Academic Health Centers for  
9 Integrative Medicine. The group is working with 44 medical schools to develop formal  
10 competencies for training medical doctors in the field of integrative medicine. The criteria is  
11 projected to take 18 months to complete and will result in a nationally recognized certification,  
12 one that does not currently exist. (Test. of Dr. Nedrow, tr. at 1364.)  
13

#### 14 CONCLUSIONS OF LAW

15  
16 1. The Board's 2004 Modified Stipulated Order and the 2010 ISO were within the  
17 Authority of the Board to enter into with Licensee, and are valid.  
18

19 2. Licensee's treatment of patients H, J and K did not violate the parameters of treatment  
20 within subparagraph 3 of the Interim Stipulated Order, effective March 18, 2010. Licensee's  
21 treatment of Patient L for hypothyroidism, without establishing thyroid levels under  
22 subparagraph 3.1 which would have allowed treatment, violated the 2010 ISO. Additionally,  
23 Licensee's treatment of Patient I violated the terms of the Interim Stipulated Order, effective  
24 March 18, 2010, specifically the portion of subparagraph 3.3 regarding testosterone treatment by  
25 treating a patient with testosterone who did not have an abnormal testosterone level.  
26

27 3. Licensee's treatment of Patient L and Patient I above, while the Board was  
28 investigating Licensee's on-going pattern of medical practice, constituted a repeated disregard of  
29 prior Board Orders, unprofessional or dishonorable conduct, and gross or repeated negligence.  
30 As such, Licensee's conduct posed an immediate danger to the public and to his patients, and  
31 required the immediate suspension of Licensee's license.  
32

33 4. When treating Patients A, B, C, D, and E, Licensee willfully disobeyed a Board order  
34 by failing to comply with the terms of paragraph 5.5 of the 2004 Modified Stipulated Order as  
35 alleged. As such, Licensee's conduct constituted unprofessional or dishonorable conduct and  
36 gross or repeated negligence that exposed his patients to harm.  
37

38 5. When treating Patients F and G, Licensee prescribed testosterone when not medically  
39 indicated, and failed to set forth in the patient charts the clinical basis for diagnosing and treating  
40 hypogonadism. Licensee's conduct breached the standard of care, and constituted  
41 unprofessional or dishonorable conduct and gross or repeated negligence.  
42

43 6. The Board may revoke Licensee's license to practice medicine as proposed in the  
44 Amended Complaint. The ALJ opined that the Board may not assess the additional civil  
45 penalties or the costs of the proceeding as proposed at hearing. The Board rejects that opinion,  
46 and assesses costs.  
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## OPINION

The Board proposed to take disciplinary action against Licensee pursuant to ORS 677.205 for violations of ORS Chapter 677, referred to as the Medical Practice Act. The Board has the burden of proving its allegations, and Licensee has the burden to prove any affirmative defenses. ORS 183.450(2); *Gallant v. Board of Medical Examiners*, 159 Or App 175, 183 (1999). Specifically, the Board determined that Licensee's treatment of patients with thyroid and testosterone replacement therapy breached the standard of care for medical practitioners practicing within the specialization of endocrinology and hormone replacement. Licensee denies the allegations. The Board must establish the standard of care that applies to Licensee's practice and that standard is established by expert testimony. *Spray v. Bd. of Medical Examiners*, 50 Or. App. 311 (1981).<sup>4</sup>

### Expert Testimony

The Board is charged with determining "whether the licensee used that degree of care, skill and diligence that is used by ordinarily careful physicians \* \* \* in the same or similar circumstances in the community of the physician \* \* \* or a similar community. ORS 677.265(1)(c).

Although the current matter involves proposed disciplinary action by the Board against Licensee's license to practice medicine, civil law applies a similar standard to establish the standard of care. The applicable standard is that medical care which is reasonable practice in the community. *Getchell v. Mansfield*, 260 Or. 174 (1971).<sup>5</sup>

There were contradictory expert opinions regarding whether Licensee's treatment of patients with thyroid and with testosterone met the standard of care or whether it constituted unprofessional or dishonorable conduct and gross and repeated negligence that exposed his patients to the risk of harm. In weighing which opinion is the more reliable, it is critical to look to the scientific validity of the general propositions utilized by the expert. *State v. O'Key*, 321 Or 285, 291, 292 (1995)

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<sup>4</sup> In *Spray*, the Court held that the Board could determine on a case by case basis what is inappropriate or unnecessary medical treatment if it ascertains the treatment necessary or appropriate in the particular case. The determination must be based on findings of fact on the practice of the medical community as established by expert testimony and supported by substantial evidence. *Spray*, 50 Or. App. at 321.

<sup>5</sup> In *Getchell*, the court found that, in medical malpractice actions, most charges of negligence against professional persons require expert testimony to establish what the reasonable practice is in the community.

The conduct of the defendant professional is adjudged by this standard. Without such expert testimony a plaintiff cannot prove negligence. The reason for this rule is that what is reasonable conduct for a professional is ordinarily not within the knowledge of the usual jury.

*Getchell*, 260 Or at 179.

1 Because more weight is given to an expert opinion that is well reasoned and based on  
2 complete information, it is necessary to evaluate the reasoning and basis for each expert's  
3 opinion. OAR 459-015-0010(5); *Somers v. SAIF*, 77 Or App 259, 263 (1986), see also *Roseburg*  
4 *Forest Products v. Glenn*, 155 Or App 318 (1998). (The persuasiveness of a medical opinion  
5 depends not on the form in which the opinion is given, but on the completeness and  
6 thoroughness of its factual basis and the force of its reasoning.)  
7

8 Dr. Cook, testifying on behalf of the Board, among other qualifications, is a Board  
9 Certified Endocrinologist, a professor at, and the Interim Medical Director of, the Division of  
10 Endocrinology at OHSU. His opinion was based on his experience practicing, teaching,  
11 studying, and writing in the area of endocrinology, specifically on matters related to the  
12 diagnosis and treatment of thyroid disease and the use of testosterone replacement therapy. He  
13 relies upon guidelines, published by both the AACE and the Endocrine Society, and accepted in  
14 the field of endocrinology as authoritative.  
15

16 Dr. Nedrow qualified as an expert by education and certification in integrative care which  
17 encompasses both conventional or allopathic medicine as well as alternative medicine. Dr.  
18 Nedrow is also a professor at OHSU, teaching in the area of alternative medical practices, in  
19 addition to her other qualifications. Dr. Nedrow is a member of the National and International  
20 Consortiums of Academic Health Centers for Integrative Medicine which are currently working  
21 towards creating nationally accepted criteria for proficiency in alternative medicine for medical  
22 doctors.  
23

24 Licensee offered Dr. Welker as an expert in endocrinology and the Board objected.  
25 Following testimony by Dr. Welker as to his areas of expertise, the ALJ concluded that Dr.  
26 Welker has specialized knowledge in the area of endocrinology, including thyroid and  
27 testosterone replacement therapies. However, as discussed below, Dr. Welker was not qualified  
28 to testify to the standard of medical care in practice in the community of endocrinologists or  
29 integrative medicine practitioners in the treatment of patients with thyroid disease using hormone  
30 replacement therapy or hypogonadism or prostate cancer using testosterone replacement therapy.  
31

32 Dr. Welker's formal education and medical training is as a general surgeon. Dr. Welker  
33 has gained specialized knowledge in alternative theories of the use of conventional treatments in  
34 patients with hormone and thyroid deficiencies. Dr. Welker is studying alternative theories for  
35 using conventional treatments and is a member of what has been termed a fringe organization,  
36 the A4M. He is not qualified as a medical expert by education, training, or experience to testify  
37 to the standard of care for the diagnosis and treatment of endocrine system diseases, including  
38 hypothyroidism and hypogonadism.  
39

40 In addition, the Board's argument that Dr. Welker's past history of disciplinary action in  
41 Idaho and loss of hospital privileges in Idaho and in Oregon demonstrates that Dr. Welker's  
42 medical judgment is less reliable than the Board's experts, was supported by the evidence. As  
43 such, Dr. Welker's opinion, where it contradicts those of the Board's experts, is given less  
44 weight, since the evidence shows that Dr. Welker's opinion was not well-founded in training,  
45 experience, or judgment. Therefore, the findings of fact reflect the opinion of Drs. Cook and  
46 Nedrow where there was a conflict with the opinion testimony of Dr. Welker.  
47  
48

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1 Jay Harvey Mead, MD, testified as an expert regarding hormones and the endocrine  
2 system. Dr. Mead's formal medical education and training is as a pathologist, which includes the  
3 study of glands and the hormone system for purposes of pathology. Dr. Mead's opinion was  
4 contrary to Drs. Cook and Nedrow regarding the standard of medical care for treatment of  
5 thyroid deficiency and hypogonadism. Dr. Mead was unaware of the clinical guidelines for  
6 testosterone therapy published by the Endocrine Society but agreed with Licensee's testosterone  
7 treatment for a patient with a diagnosis of prostate cancer. Dr. Mead is the medical director of  
8 one of the commercial labs where patients receive, and pay for, testing services ordered by  
9 Licensee. Thus, there is a business relationship between Dr. Mead and Licensee.

10  
11 Drs. Cook and Nedrow are highly qualified by education, experience, past and current  
12 teaching positions and practices, and their opinions were supported by authoritative sources in  
13 the evidence record. Dr. Mead is trained as and practices as a pathologist; he does not hold a  
14 permanent or on-going position in a medical university, and his opinion relied upon resources  
15 considered less reliable than those relied upon by Drs. Cook and Nedrow. In addition, it may be  
16 inferred that Dr. Mead is biased due to the business relationship between Licensee and Dr. Mead.  
17 Based on balancing all of the factors discussed above, Dr. Mead's expert opinion is given less  
18 weight. The findings of fact reflect the standard of care in the medical community as testified to  
19 by Drs. Cook and Nedrow.

20  
21 **Burden of proof and statutory authority of the Board to act.**

22  
23 Pursuant to ORS 677.265, the Board is vested with the authority to regulate the practice  
24 of medicine in Oregon. ORS 677.265, setting out the general powers of the Board, provides, in  
25 relevant parts:

26  
27 In addition to any other powers granted by this chapter, the Oregon Medical Board may:

28  
29 (1) Adopt necessary and proper rules for administration of this chapter including but not  
30 limited to:

31  
32 \* \* \* \* \*

33  
34 (b) Establishing standards and tests to determine the moral, intellectual, educational,  
35 scientific, technical and professional qualifications required of applicants for licenses  
36 under this chapter.

37  
38 (c) Enforcing the provisions of this chapter and exercising general supervision over the  
39 practice of medicine and podiatry within this state. In determining whether to discipline a  
40 licensee for a standard of care violation, the Oregon Medical Board shall determine  
41 whether the licensee used that degree of care, skill and diligence that is used by ordinarily  
42 careful physicians or podiatric physicians and surgeons in the same or similar  
43 circumstances in the community of the physician or podiatric physician and surgeon or a  
44 similar community.

45  
46 (2) Issue, deny, suspend and revoke licenses and limited licenses, assess costs of  
47 proceedings and fines and place licensees on probation as provided in this chapter.

48  
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1 Licensee's license to practice medicine was reinstated, following a prior revocation,  
2 under a series of stipulated orders which restricted Licensee's practices in specific areas of  
3 medicine. The Board currently proposes to revoke Licensee's license to practice medicine  
4 based on alleged conduct that it contends violated prior Board orders and which constituted  
5 unprofessional or dishonorable conduct and gross or repeated negligence. The Board may  
6 suspend, revoke or refuse to grant a license, registration or certification for any of the reasons set  
7 out in ORS 677.190. ORS 677.190 provides in relevant parts:

8  
9 The Oregon Medical Board may refuse to grant, or may suspend or revoke a license to  
10 practice for any of the following reasons:

11  
12 (1)(a) Unprofessional or dishonorable conduct.

13  
14 (b) For purposes of this subsection, the use of an alternative medical treatment shall not  
15 by itself constitute unprofessional conduct. For purposes of this paragraph:

16  
17 (A) "Alternative medical treatment" means:

18  
19 (i) A treatment that the treating physician, based on the physician's professional  
20 experience, has an objective basis to believe has a reasonable probability for  
21 effectiveness in its intended use even if the treatment is outside recognized scientific  
22 guidelines, is unproven, is no longer used as a generally recognized or standard treatment  
23 or lacks the approval of the United States Food and Drug Administration;

24  
25 (ii) A treatment that is supported for specific usages or outcomes by at least one other  
26 physician licensed by the Oregon Medical Board; and

27  
28 (iii) A treatment that poses no greater risk to a patient than the generally recognized or  
29 standard treatment.

30  
31 ORS 677.205 sets out the grounds for which the Board may take disciplinary action taken  
32 against a licensee and the penalties it may impose. ORS 677.205 provides, in relevant  
33 parts:

34  
35 (1) The Oregon Medical Board may discipline as provided in this section any person  
36 licensed, registered or certified under this chapter who has:

37  
38 (a) Admitted the facts of a complaint filed in accordance with ORS 677.200 (1) alleging  
39 facts which establish that such person is in violation of one or more of the grounds for  
40 suspension or revocation of a license as set forth in ORS 677.190;

41  
42 (b) Been found to be in violation of one or more of the grounds for disciplinary action of  
43 a licensee as set forth in this chapter;

44  
45 \* \* \* \* \*

46  
47 (2) In disciplining a licensee as authorized by subsection (1) of this section, the board  
48 may use any or all of the following methods:

1           \* \* \* \* \*

2  
3           (b) Place the licensee on probation.

4  
5           \* \* \* \* \*

6  
7           (d) Revoke the license.

8  
9           (e) Place limitations on the license.

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

14  
15           (3) In addition to the action authorized by subsection (2) of this section, the board may  
16 temporarily suspend a license without a hearing, simultaneously with the commencement  
17 of proceedings under ORS 677.200 if the board finds that evidence in its possession  
18 indicates that a continuation in practice of the licensee constitutes an immediate danger to  
19 the public.

20  
21           There are two actions at issue in this matter: the Board's Order of Emergency  
22 Suspension of Licensee's license to practice medicine, issued September 8, 2010, and the  
23 Board's September 20, 2010 Amended Complaint proposing revocation of Licensee's license. In  
24 the first action, the Board suspended Licensee's medical license by Order of Emergency  
25 Suspension because it determined that Licensee continued to violate its prior Orders and that  
26 Licensee's ongoing pattern of violations and his practice of medicine at issue in the Orders  
27 created an immediate danger to the public. ORS 677.205(3).

28  
29           In the second action, as set out in the Amended Complaint, the Board also proposes to  
30 revoke Licensee's license to practice medicine based upon the following allegations: that  
31 Licensee's treatment of the patients as set out in the Amended Complaint constituted  
32 unprofessional conduct, in violation of ORS 677.190(1)(a), and gross or repeated acts of  
33 negligence, in violation of ORS 677.190(13); that Licensee's treatment of certain patients posed  
34 a greater risk to those patients than did the generally recognized or standard treatment in  
35 violation of ORS 677.190(1) (b)(iii); and that his treatment of those patients was a willful  
36 violation of the terms of previous Board Orders, in violation of ORS 677.190(17). At hearing,  
37 the Board proposed, in addition to revoking Licensee's license, to assess the costs of the  
38 disciplinary proceedings, and to assess a civil penalty of \$10,000.00, under the authority granted  
39 by ORS 677.205(1)(f).

40  
41           Initially, Licensee contends that the Board lacked the authority to have imposed the  
42 emergency suspension because he denies that his practice of medicine created an immediate  
43 danger to the public. In attacking the Board's allegation that he continued to violate prior Board  
44 orders as a portion of its basis for the emergency suspension order, Licensee argues that the prior  
45 orders were beyond the scope of the Board's authority and were, therefore, invalid. In the  
46 alternative, Licensee argues that the Board failed to show that he violated the prior orders as  
47 alleged. Secondly, Licensee also denies that the Board has grounds to take disciplinary measures  
48 under the Amended complaint. Licensee argues that the Board exceeded its authority when it

1 imposed limitations on his practice of medicine under the 2004 Stipulated Order and the 2010  
2 ISO. Licensee contends that, even if the previous Orders were valid, he did not engage in  
3 unprofessional or dishonorable conduct, he did not engage in repeated or gross acts of  
4 negligence, he did not violate the standards set out in ORS 677. 190(b) in his practice of  
5 alternative medical treatments, and he did not violate the Board's previous Orders as alleged.

6  
7 **Board's authority to limit Licensee's practice according to stipulated agreement.**

8  
9 The ALJ addressed the arguments in turn, beginning with Licensee's challenge to the  
10 Board's authority to have entered into the 2004 Stipulated Order and the 2010 ISO with  
11 Licensee. Licensee argues that the prior Stipulated Orders are void because the Board  
12 overreached its authority by imposing arbitrary limitations on Licensee that did not apply to all  
13 treating physicians using alternative medical treatments. Licensee argues therefore, as a matter  
14 of law, that the Board could not contract with a private party to take away a public benefit, the  
15 rights to access alternative medical treatment from their treating physicians, granted by the  
16 Legislature to the general public.

17  
18 The ALJ found, and the Board agrees, that a review of the enabling statutes and the case  
19 law does not support Licensee's arguments, either that the Board's limitations were arbitrary or  
20 that they were overreaching, and thus void. The evidence record supports the Board's contention  
21 that the 2004 Stipulated Order and the 2010 ISO are valid and binding upon Licensee.

22  
23 Licensee looks to case law to support a finding that the Board and Licensee could not, by  
24 private contract, limit a statutory right conferred upon Licensee for the benefit of the public.  
25 First, Licensee's arguments address an agency's right to engage in rulemaking that exceeds the  
26 authority granted to the agency by statute. (P13 beginning at 21.) In particular, Licensee relies  
27 upon the holding in *Oregon Newspaper Publishers Assoc. v. Peterson*, 244 Or 116 (1966).

28  
29 At issue in *Oregon Newspaper* was the authority of the Oregon State Board of Pharmacy  
30 to adopt rules prohibiting the advertising of prescription drugs. In that case, the Court placed the  
31 burden on the agency to show that its regulation prohibiting such advertising fell within a clearly  
32 defined statutory grant of authority, and found that the agency did not meet that burden. Noting  
33 that the "Legislative Assembly presumably could enact statutes concerning the public promotion  
34 and advertisement of poisons and dangerous drugs [and] delegate that power to an agency of its  
35 own creation," the Court found that it had not done so in that case. *Oregon Newspaper*, 244 Or  
36 at 123. The *Oregon Newspaper* Court further supported its determination by analyzing the  
37 Legislature's decision to grant the authority to regulate advertising, the specific activity at issue,  
38 to other professional licensing boards. *Oregon Newspaper*, 244 Or at 124-5. Because the power  
39 to regulate advertising had been statutorily granted to some agencies but not to others, the Court  
40 found that the Legislature had not intended to authorize such regulation by the Board of  
41 Pharmacy. (Id.)

42  
43 The holding in *Oregon Newspaper* is distinguishable from the current case for two  
44 reasons: Licensee has failed to identify a rule promulgated by the Board that it contends is  
45 contrary to its Legislative authority, and the regulation of the practice of medicine is clearly  
46 within the authority of the Board to regulate.

47 ///

1 Licensee equates the restrictions on Licensee's practice of medicine under the 2004  
2 Stipulated Order and the 2010 ISO as regulations or rules adopted or promulgated by the Board  
3 regarding the use of an alternative medical treatment under ORS 677.190(b)(1)(A). Licensee's  
4 argument is not persuasive. First, the Orders impose restrictions only upon Licensee and  
5 Licensee freely entered into both Orders with the Board. Although counsel for Licensee argued  
6 that Licensee entered into both agreements under duress, in order to avoid a lengthy hearing  
7 process, to avoid additional costs, and for other reasons, there was no evidence to support that  
8 supposition. To the contrary, Licensee proposed the limitations that were incorporated into the  
9 Stipulated Orders in each instance. The Board then agreed to and incorporated those limitations  
10 into the Stipulated Orders. Licensee's reasons for first proposing, and then agreeing to, the terms  
11 of each order are largely irrelevant.

12  
13 The Board regulates the practice of medicine and promulgates rules as directed by the  
14 Legislature. ORS 677.417,<sup>6</sup> ORS 677.265.<sup>7</sup> The Board's statutory authority includes the  
15 authority to discipline a licensee for specific conduct, including unprofessional conduct as  
16 defined in ORS 677.188. ORS 677.188 sets out the definitions for ORS 677.190 "unless the  
17 context requires otherwise" in relevant part as follows:

18  
19 (4) "Unprofessional or dishonorable conduct" means conduct unbecoming a person  
20 licensed to practice medicine or podiatry, or detrimental to the best interests of the public,  
21 and includes:

22  
23  
24 <sup>6</sup> ORS 677.417, entitled "Medical incompetence, unprofessional conduct, physical incapacity,  
25 impairment; rules[,]" provides that:

26  
27 The Oregon Medical Board shall determine by rule what constitutes medical  
28 incompetence, unprofessional conduct, physical incapacity or impairment for the  
29 purposes of ORS chapter 677.

30  
31 <sup>7</sup> ORS 677.265, entitled "Powers of board generally; rules; fees; physician standard of care[,]" provides,  
32 in relevant part:

33  
34 In addition to any other powers granted by this chapter, the Oregon Medical Board may:  
35 (1) Adopt necessary and proper rules for administration of this chapter including but not  
36 limited to:

37 \* \* \* \* \*

38 (b) Establishing standards and tests to determine the moral, intellectual,  
39 educational, scientific, technical and professional qualifications required of  
40 applicants for licenses under this chapter.

41 (c) Enforcing the provisions of this chapter and exercising general supervision  
42 over the practice of medicine and podiatry within this state. In determining  
43 whether to discipline a licensee for a standard of care violation, the Oregon  
44 Medical Board shall determine whether the licensee used that degree of care,  
45 skill and diligence that is used by ordinarily careful physicians or podiatric  
46 physicians and surgeons in the same or similar circumstances in the community  
47 of the physician or podiatric physician and surgeon or a similar community.

48 (2) Issue, deny, suspend and revoke licenses and limited licenses, assess costs of proceedings and  
49 fines and place licensees on probation as provided in this chapter

1 (a) Any conduct or practice contrary to recognized standards of ethics of the medical or  
2 podiatric profession or any conduct or practice which does or might constitute a danger to  
3 the health or safety of a patient or the public or any conduct, practice or condition which  
4 does or might adversely affect a physician's or podiatric physician and surgeon's ability  
5 safely and skillfully to practice medicine or podiatry;

6  
7 (b) Willful performance of any surgical or medical treatment which is contrary to  
8 acceptable medical standards; and

9  
10 (c) Willful and repeated ordering or performance of unnecessary laboratory tests or  
11 radiologic studies; administration of unnecessary treatment; employment of outmoded,  
12 unproved or unscientific treatments; failure to obtain consultations when failing to do so  
13 is not consistent with the standard of care; or otherwise utilizing medical service for  
14 diagnosis or treatment which is or may be considered inappropriate or unnecessary.

15  
16 Under the rules promulgated by the Board, OAR 847-010-0073 provides that a licensee  
17 may be reported for, among other things:

18  
19 (b) Unprofessional conduct: Unprofessional conduct includes the behavior described in  
20 ORS 677.188(4) and is conduct which is unbecoming to a person licensed by the Board  
21 of Medical Examiners or detrimental to the best interest of the public and includes:

22  
23 (A) Any conduct or practice contrary to recognized standards of ethics of the medical,  
24 podiatric or acupuncture professions or any conduct which does or might constitute a  
25 danger to the public, to include a violation of patient boundaries.

26  
27 (B) Willful performance of any surgical or medical treatment which is contrary to  
28 acceptable medical standards.

29  
30 (C) Willful and repeated ordering or performance of unnecessary laboratory tests or  
31 radiologic studies, administration of unnecessary treatment, employment of outmoded,  
32 unproved, or unscientific treatments, except as allowed in ORS 677.190(1)(b), failing to  
33 obtain consultations when failing to do so is not consistent with the standard of care, or  
34 otherwise utilizing medical service for diagnosis or treatment which is or may be  
35 considered unnecessary or inappropriate.

36 \* \* \* \* \*

37 (F) Any conduct related to the practice of medicine that poses a danger to the public  
38 health or safety.

39  
40 Licensee also challenged that the application of the Board's determination of  
41 "unprofessional conduct" as applied to Licensee's use of testosterone and thyroid replacement  
42 therapies as a violation of ORS Chapter 677, also known as the Medical Practice Act (Act), the  
43 Board's enabling statute, as amended by ORS 677.190(1)(b).

44  
45 In defense of his use of both thyroid and testosterone replacement therapies, Licensee  
46 argues that those therapies constitute an alternative medical treatment under OAR 677.190(1)(b)  
47 and that his use of those treatments cannot be regulated by the Board. Licensee posited that the  
48 Board is restricted from reviewing the practice of a physician if the particular practice at issue

1 falls under the alternative medical practices provision as set out in ORS 677.190(b)(A). Licensee  
2 looks to the wording of the statute, to the legislative history of the enactment of ORS  
3 677.190(b)(A) and to case law in support of his argument. As discussed below, the ALJ did not  
4 find Licensee's argument persuasive. The Board concurs.  
5

6 First, expert opinion in this case established that the treatments at issue are not  
7 "alternative medical practices" under ORS 677.190(1)(b). It is the opinion of the expert in  
8 alternative medical practices that Licensee's treatments at issue, using hormone replacement  
9 therapy for thyroid deficiencies and testosterone replacement therapy for hypogonadism are  
10 conventional treatments for conventional diagnoses. Whether Licensee's use of the conventional  
11 therapy in a non-conventional manner meets the standard of care for that special area of medical  
12 expertise was the issue in this case. Additionally, the Licensee's argument, that the Board has  
13 exceeded the limitations to regulate by rulemaking contrary to the powers granted under its  
14 enabling statute, is unsupported. The Board has regulated Licensee and brought charges against  
15 Licensee under ORS Chapter 677, the Board's enabling statute. The applicable OAR essentially  
16 restates the language of the enabling statute. The Board has not promulgated rules that expand  
17 the wording of that statute pertinent to the matters at issue in this contested case hearing. All of  
18 the alleged violations in this matter are related to the standards set under the Act.  
19

20 Although not specifically articulated by Licensee, it is true that an agency may engage in  
21 rulemaking through the contested case procedure, *see Larsen V. Adult & Family Services*  
22 *Division*, 34 Or App 615 (1978). Even if Licensee is arguing that the Board overreached its  
23 regulatory authority, by creating a general rule when it applied specific limitations to Licensee's  
24 treatment of patients through the agreed upon prior Orders, Licensee failed to prove that  
25 argument. As discussed above, the Board has the authority to enter into stipulated orders with  
26 those it regulates, as it did with Licensee. The provisions of those orders regulate Licensee's  
27 practice of a particular area of medicine by agreement, based on specific concerns about  
28 Licensee's practice in those areas of medicine with specific patients. The Stipulated Orders did  
29 not propose to set rules which would be applicable to other providers.  
30

31 In this case, Licensee's proposition that the Board may not regulate where a physician is  
32 practicing medicine that falls within the provisions of ORS 677.190(b)(A) is also unpersuasive.  
33 Licensee specifically argues that the Board may not set the standard for the third element of the  
34 rule (i.e., "no greater risk") by "arbitrary standard," as Licensee contends the Board did when  
35 issuing the stipulated orders. The 2004 Stipulated Order restricted Licensee's use of thyroid  
36 medication and the 2010 ISO further restricted Licensee's use of thyroid and of testosterone,  
37 both of which, Licensee argues, limit a recognized use of alternative medicine. Thus, Licensee  
38 contends that such limitations constitute overreaching by the Board, contrary to the plain  
39 meaning, and to the legislative history, of the statute.  
40

41 Licensee offered evidence on the legislative hearings leading up to the enactment of the  
42 amendments to ORS Chapter 677 regarding alternative medical treatments. The evidence  
43 pointed towards concern that the Board not seek to impose additional regulations or a different  
44 standard on doctors who provide alternative medical treatments as opposed to other health  
45 services providers who provide alternative medical treatments. Licensee seems to argue that the  
46 Legislature intended to prevent the Board from determining the standard of whether an  
47 alternative medical treatment provided by a medical doctor meets the standard that it "\* \* \*  
48 poses no greater risk to a patient than the generally recognized or standard treatment." ORS

1 677.190(b)(iii). However, Licensee does not articulate who, under the statutory scheme, may set  
2 that standard if not the Board.

3  
4 In looking to the standard of care established under ORS 677.190(b)(iii), it is necessary to  
5 look to the plain text and context of the statute. ORS 174.010 provides that:

6  
7 The office of the judge is simply to ascertain and declare what is, in terms or in  
8 substance, contained therein, not to insert what has been omitted, or to omit what has  
9 been inserted and where there are several provisions or particulars such construction is, if  
10 possible, to be adopted as will give effect to all.

11  
12 Previously, under the *PGE* methodology, if the meaning of the text and context of the statute is  
13 clear and unambiguous, the inquiry stopped there. *PGE v. Bureau of Labor and Industries*, 317  
14 Or 606, 859 P2d 1143 (1993). In 2001, the Legislature amended ORS 174.020 to include the  
15 consideration of the intention of the legislature even if the court finds no ambiguity in the  
16 statutory language. ORS 174.020 amended by 2001 Or Laws 2001, c. 438 § 1. As amended,  
17 ORS 174.020 provides:

18  
19 (1)(a) In the construction of a statute, a court shall pursue the intention of the legislature  
20 if possible.

21  
22 (b) To assist a court in its construction of a statute, a party may offer the legislative  
23 history of the statute.

24  
25 (2) When a general and particular provision are inconsistent, the latter is paramount to the  
26 former so that a particular intent controls a general intent that is inconsistent with the  
27 particular intent.

28  
29 (3) A court may limit its consideration of legislative history to the information that the  
30 parties provide to the court. A court shall give the weight to the legislative history that the  
31 court considers to be appropriate.

32  
33 Following the 2001 amendments to ORS 174.020, the legislative history may be  
34 considered even without identifying an ambiguity but a court need only give the weight to that  
35 history “for what it’s worth – and what it is worth is for the court to determine.” *State v. Gaines*,  
36 346 Or 160, 170-171 (2009). In the current case at hearing, the legislative history provided does  
37 not support Licensee’s argument because Licensee failed to show that the treatments at issue fall  
38 under the provisions of ORS 677.190(1)(b). Furthermore, even if it were determined that they  
39 did, the evidence, as discussed below, shows that the Board met its burden of proof regarding the  
40 risk to patients of the treatment given versus the standard or recognized treatment, or even no  
41 treatment at all.

#### 42 43 **Alleged Violations of the 2010 ISO.**

44  
45 Patient H

46  
47 The 2010 ISO limited Licensee’s ability to recommend, prescribe, or direct a patient to  
48 take thyroid after March 18, 2010, the effective date of the ISO. Under paragraph 3.1, Licensee

1 could only recommend, prescribe or direct a patient to take thyroid if the patient had a TSH level  
2 in excess of 10 uIU/mL, or had a TSH level between 5 and 10 uIU/mL, and had a diagnosis of  
3 goiter or positive anti-thyroid peroxidase antibodies (or both).  
4

5 Under paragraph 3.2, for any patient taking thyroid from a non-prescription source,  
6 Licensee was required to conduct thyroid tests on a regular basis (at least every 6 months) and to  
7 direct patients to adjust their thyroid dose to bring their TSH levels into the range recommended  
8 by the AACE (the target level is between 0.3 and 3.0).  
9

10 The Board alleged that Licensee's treatment of Patient H, violated the terms of the 2010  
11 ISO because he "recommended, prescribed, or directed" Patient H to take thyroid when Patient H  
12 did not fall within those limitations.  
13

14 Licensee argued that because Patient H had acquired her thyroid from a non-prescription  
15 source, his treatment of Patient H fell under the parameters of paragraph 3.2 and that he was in  
16 compliance with the terms of that paragraph. The evidence supports Licensee's position. Patient  
17 H had initially acquired and continued to take thyroid she found on her own. Licensee was  
18 monitoring the dosage. In February 2010, when Patient H's TSH levels were too low, suggesting  
19 she was taking too much thyroid, Licensee directed her to lower her dose to bring her TSH levels  
20 up.  
21

22 Licensee's treatment of Patient H was, according to Dr. Cook, appropriate because he  
23 was monitoring Patient H's reaction to a dosing change which required time for Patient H to  
24 adjust to in order to gauge the effectiveness of the change. Licensee's treatment of Patient H  
25 after the effective date of 2010 ISO did not violate the terms of the ISO.  
26

#### 27 Patient J

28

29 The Board alleged that Licensee violated the 2010 ISO regarding the medical care  
30 provided to Patient J. Licensee disputed the Board's allegations. The evidence at hearing  
31 established that Patient J's TSH was at 50.400 when tested most recently prior to the office visit  
32 of June 16, 2010, a level allowing Licensee to treat Patient J under paragraph 3.1 of the March  
33 18th ISO. During the office visit of June 16, 2010, Licensee noted the rise in TSH levels,  
34 changed the type of thyroid Patient J was taking, and ordered a repeat TSH. The record supports  
35 Licensee's argument that his treatment of Patient J on June 16, 2010 did not violate the terms of  
36 the ISO.  
37

#### 38 Patient K

39

40 The Board failed to meet its burden to prove that Licensee's treatment of Patient K,  
41 following March 18, 2010, violated the terms of the ISO. Dr. Cook opined that as of May 3,  
42 2010, the visit following the effective date of the ISO, Licensee's treatment of K was appropriate  
43 and did not violate the ISO. Patient K's most recent TSH result was 14.3, and treatable by  
44 Licensee under the ISO. Licensee's direction to Patient K to continue taking thyroid as directed  
45 and to repeat the TSH lab test in two months was in accord with the ISO restrictions.  
46

47 ///

48 ///

///

1 Patient L

2  
3 Patient L was a male being treated by Licensee for both hypothyroidism and  
4 hypogonadism. The findings of fact support the Board's determination that Licensee was  
5 treating Patient L with thyroid outside the restrictions of the 2010 ISO. Specifically, Licensee's  
6 treatment violated paragraph 3.1 of the 2010 ISO.  
7

8 The single TSH level documented in Patient L's chart, from a test on April 27, 2010, was  
9 2.13, within the normal reference range, not above 10, the level at which Licensee was allowed  
10 to treat patients with thyroid. The test was approximately one year after Licensee noted that  
11 Patient L had begun thyroid replacement therapy on his own. Licensee subsequently diagnosed  
12 Patient L with hypothyroidism and had begun monitoring and then prescribing thyroid for  
13 Patient L. Licensee had not diagnosed Patient L with goiter or positive anti-thyroid antibodies.  
14 Therefore, Licensee prescribed for, and directed LS to take, thyroid when Patient L had TSH  
15 levels that did not exceed 10 nor did Patient L's TSH level fall between 5 and 10 with a  
16 diagnosis of goiter or positive anti-thyroid peroxidase antibodies. Licensee's treatment of  
17 Patient L violated paragraph 3.1 of the 2010 ISO as alleged in the Order of Emergency  
18 Suspension.<sup>8</sup>  
19

20 Treating Patient L with thyroid in a manner that violated paragraph 3.1 of 2010 ISO was  
21 also a violation of the 2004 Modified Stipulated Order, paragraph 5.5. Licensee failed to use  
22 thyroid function blood tests, appropriately documented in the patient's chart, for TSH and free  
23 T4 levels in conjunction with the history and physical findings when making the decision to treat  
24 Patient L with thyroid. When a TSH test was performed, after Patient L had started thyroid, the  
25 levels were within the normal range. Thus, Licensee's treatment of Patient L in violation of the  
26 2010 ISO and the 2004 Modified Stipulated Order showed a repeated disregard for the terms of  
27 the Board's orders that were designed to protect the public. Expert testimony established the  
28 risks to patients of using thyroid replacement therapy without establishing a baseline and without  
29 documenting the need for the treatment. The evidence supports the Board's conclusion that  
30 allowing Licensee to continue to practice medicine while it continued its investigation would  
31 subject Licensee's current patients and the public, who might become patients, to the risk of  
32 harm.  
33

34 Patient L was also being treated for hypogonadism with injections of testosterone.  
35 Licensee performed a DRE on Patient L on the office visit after the effective date and in accord  
36 with the terms of the ISO. Licensee's charts documented abnormal testosterone and the  
37 diagnosis of hypogonadism levels for Patient L. Licensee's treatment of Patient L with  
38 testosterone did not violate the terms of the ISO.

39 ///  
40 ///

41  
42  
43 <sup>8</sup> In the opinion of Dr. Cook, Licensee appropriately directed LS to take and maintain an appropriate  
44 dosage of thyroid in order to maintain LS's TSH level as of the effective date of the ISO. However, the  
45 narrow legal issue regarding the basis for the emergency suspension was whether Licensee's treatment  
46 complied with the terms of the ISO, which it did not. Overall, it is of note that Dr. Cook's opinion was  
47 that it is necessary to establish an abnormal TSH level prior to beginning thyroid treatment to support a  
48 diagnosis of hypothyroidism, which was not done in the case of LS.

1 Patient I

2  
3 The Board also issued the emergency suspension because it alleged that Licensee had  
4 violated the terms of the 2010 ISO by treating Patient I with testosterone when he did not have  
5 abnormal levels of testosterone and by failing to conduct recent DRE's for Patient I while he was  
6 taking testosterone under Licensee's direction and supervision. Licensee denied the allegations.  
7

8 Paragraph 3.3 of the 2010 ISO, as set out in the findings of fact, required Licensee,  
9 among other things, to comply with the guidelines published in the referenced article from the  
10 NEJM for testosterone replacement therapy. Additionally, if testosterone was prescribed under  
11 those guidelines, Licensee was required to comply with the additional restrictions set out in that  
12 paragraph.  
13

14 According to Dr. Cook, treatment under the NEJM guidelines presupposes that a patient  
15 has been properly diagnosed for hypogonadism. The evidence revealed that Patient I presented  
16 to Licensee with normal testosterone levels and there was no evidence that Patient I developed  
17 abnormal testosterone levels. Although Licensee had performed a DRE in compliance with the  
18 ISO, there was no evidence to support Licensee's diagnosis of hypothyroidism for Patient I. The  
19 Board met its burden of proof to show that Licensee treated Patient I, who did not have abnormal  
20 testosterone levels, with testosterone in violation of the terms of the 2010 ISO. Thus he was  
21 exposed to the risks of treatment for an unsupported diagnosis.  
22

23 The 2004 Modified Stipulated Order did not address Licensee's treatment of patients with  
24 testosterone. However, Licensee's treatment of Patient I did not comply with the 2010 ISO and,  
25 combined with violations of the Board's orders evidenced by his treatment of Patient I,  
26 supported the basis of the Order of Emergency Suspension. Licensee demonstrated a pattern of  
27 violating Board orders designed to protect the public. The Board met its burden to prove that  
28 allowing Licensee to continue to practice medicine while Licensee was under investigation  
29 created a risk of immediate danger to the public and to his patients.  
30

31 In summary, Licensee's treatment of Patients H, J, and K did not violate the terms of the  
32 2010 ISO as alleged in the Order of Emergency Suspension. However, Licensee's treatment of  
33 Patients L and I violated the terms of 2010 ISO and supports the Board's action in issuing the  
34 Order of Emergency Suspension.  
35

36 **Conduct related to the allegations in the Amended Complaint of September 2010.**

37  
38 In the Amended Complaint, the Board alleged that Licensee's treatment of Patient A, B,  
39 C, D, and E demonstrated a pattern of practice that willfully violated the 2004 Amended  
40 Stipulated Order and which constituted unprofessional or dishonorable conduct and gross or  
41 repeated negligence that exposed his patients to harm, in violation of ORS 677.188(4)(a)(b) and  
42 (c), ORS 677.190(13) and ORS 677.190(17).  
43

44 The allegations involved Licensee's use of thyroid replacement therapy and testosterone  
45 replacement therapy. For those patients being treated with thyroid, the Board alleges that  
46 Licensee failed to utilize appropriate endocrine testing to diagnose hypothyroidism and to  
47 monitor patient response to treatment. In addition, the Board alleged that Licensee failed to set  
48 forth in the charts the clinical basis for diagnosing and treating hypothyroidism and relied upon

1 patient requests or inadequate clinical findings to justify his decision to initiate or to continue  
2 treatment with thyroid supplements.  
3

4 Patient A  
5

6 The Board alleged that Licensee failed to meet the standard of care as follows: Licensee  
7 diagnosed Patient A with hypothyroidism without TSH blood tests in violation of the prior  
8 Order, and in violation of the standard of care for thyroid treatment; Licensee made inappropriate  
9 remarks regarding Patient A's age and lack of having had children as a contributing factor to her  
10 health issues; and Licensee recommended that Patient A procure thyroid from an out-of-country  
11 source through the Internet without providing information on proper dosing and without giving  
12 Patient A sufficient information regarding the risks associated with thyroid replacement therapy.  
13

14 Licensee denied the alleged violations. Licensee argued that his single visit with Patient  
15 A did not constitute treatment and that his assessment that Patient A had possible  
16 hypothyroidism did not constitute a diagnosis. Licensee also argued that he did not recommend  
17 thyroid to Patient A, rather he merely advised her to educate herself regarding the issue and then  
18 provided resources for Patient A to acquire thyroid if she decided to do so on her own.  
19 Licensee's arguments were not supported by the evidence record.  
20

21 Expert testimony established that Licensee's treatment of Patient A did not meet the  
22 standard of care for doctors who treat hypothyroidism. Licensee's assessment and information  
23 given to Patient A constituted a diagnosis of hypothyroidism without the necessary lab data to  
24 support the diagnosis and was contrary to the medical standard of care. The follow up letter to  
25 Patient A suggesting that a normal thyroid level did not preclude a diagnosis of hypothyroidism  
26 put Patient A at risk for bone loss if she were to have taken thyroid unnecessarily as she was  
27 directed by Licensee. Patient A was at an age where it is critical to avoid risk of bone loss from  
28 excess thyroid. Also, suggesting that Patient A acquire thyroid from an out-of-country  
29 unregulated source placed Patient A at risk. Licensee's care of Patient A violated the 2004  
30 Modified Stipulated Order, constituted misconduct and unprofessional conduct and constituted  
31 gross negligence.  
32

33 Patient B  
34

35 Expert testimony confirmed the Board's allegation that Licensee's treatment of Patient B  
36 violated the terms of the 2004 ISO and constituted unprofessional or dishonorable conduct.  
37 There was no evidence that Patient B had thyroid deficiency and no basis to support starting  
38 thyroid treatment. Additionally, based on Patient B's history of low bone density, treating her  
39 with thyroid put Patient B at major risk for bone damage. And, treating a patient without  
40 documenting hypothyroidism places a patient at risk for developing hyperthyroidism. The Board  
41 met its burden of proof that Licensee failed to meet the standard of care for the diagnosis and  
42 treatment of hypothyroidism, thereby subjecting Patient B to unnecessary health risks. By  
43 treating Patient B in violation of a prior Board order designed to protect the public and by  
44 subjecting Patient B to unnecessary additional health risks due to substandard care, Licensee's  
45 care of Patient B constituted gross or repeated acts of negligence.  
46  
47  
48

1 Patient C

2  
3 Licensee failed to meet the requirements of the 2004 Modified Stipulate Order and failed  
4 to meet the standard of care when treating Patient C. Expert opinion determined that Licensee  
5 diagnosed Patient C with hypothyroidism without establishing her TSH levels through blood  
6 tests. He diagnosed Patient C based on physical symptoms that are common to many conditions  
7 and are not specific to hypothyroidism. Because Patient C had a documented history of, and  
8 treatment for, osteopenia, Licensee's recommendation that she take thyroid placed Patient C at  
9 additional risk for bone damage or disease. The Board met its burden of proof regarding the  
10 allegations related to Licensee's care of Patient C.

11  
12 Patient D

13  
14 The Board also met its burden of proof regarding Licensee's diagnosis and treatment of  
15 Patient D according to the expert opinion at hearing. Although Patient D initially saw Licensee  
16 after she had begun taking thyroid, Licensee failed to follow through with tests to document that  
17 Patient D was hypothyroid. At the time Licensee documented TSH levels for Patient D, the  
18 levels were normal. Patient D had a history of osteopenia, which contraindicated thyroid  
19 replacement therapy. He based his treatment decisions on Patient D's reports of how she was  
20 feeling without corroborating medical data. Patient D had high cholesterol readings, and  
21 apparent hypertension which were also contraindications for thyroid replacement therapy due to  
22 an increased cardiac risk. Licensee failed to meet the standard of care when he failed to  
23 regularly test Patient D's TSH levels on an annual basis and after each change in dosing.  
24 Licensee's conduct constituted a willful violation of the 2004 Modified Stipulated Order,  
25 unprofessional or dishonorable conduct, and gross or repeated acts of negligence.

26  
27 Patient E

28  
29 Licensee's treatment of Patient E also violated the Board's prior order, and constituted  
30 unprofessional or dishonorable conduct, and gross or repeated acts of negligence. When  
31 Licensee first saw Patient E, she was already taking thyroid. According to expert opinion,  
32 Licensee could not have established the basis for a diagnosis of hypothyroidism without a  
33 baseline TSH level prior to treatment or without stopping thyroid for a period of time to establish  
34 Patient E's baseline TSH. There was no evidence of either source for a baseline TSH on which  
35 to diagnose Patient E with hypothyroidism. In addition, lab results three years after Patient E  
36 started seeing Licensee indicated that Patient E was hyperthyroid, and had been since coming to  
37 Licensee, which exposed Patient E to the risks associated with that condition. Also, Licensee  
38 was treating Patient E with cortisone, which, combined with Patient E's chronic hyperthyroid  
39 state, presented a toxic combination for Patient E's bone health. The Board met its burden of  
40 proof regarding its allegations against Licensee involving the treatment of Patient E.

41  
42 Patient F

43  
44 In the Amended Complaint, the Board also alleged that Licensee treated patients,  
45 specifically Patients F and G, with testosterone replacement therapy that was not medically  
46 indicated and which exposed the patients to harm. The Board met its burden of proof regarding  
47 Licensee's alleged violations in his care of both patients.

48 ///

1 Licensee failed to establish a diagnosis of low testosterone prior to beginning his  
2 treatment of Patient F with testosterone. He changed the administration method for the  
3 testosterone and increased the dosage for Patient F, again without documenting an accepted  
4 medical basis for doing so. Patient F's own PCP directed Patient F to stop taking testosterone  
5 following a test result which the PCP concluded showed that Patient F, at the time of the test,  
6 was taking too much testosterone. Evidence established that the risks associated with excessive  
7 testosterone are accelerated growth of an occult prostate cancer, prostate hypertrophy and  
8 hyperplasia, and possible urinary tract obstruction. Licensee exposed Patient F to such risks  
9 without establishing that Patient F had a testosterone deficiency.

10  
11 There was evidence that the high level of testosterone was the result of the time of the  
12 test in relation to the time and method of dosing and did not indicate an on-going excessively  
13 high level of testosterone. However, Patient F was asked to, and did, submit to unnecessary  
14 testing, at his own expense, to replicate the test results for evidence to be used in Licensee's  
15 defense during this contested case hearing. To request that a patient submit to an unnecessary  
16 test for such purposes constituted unprofessional conduct under ORS 677.188(4)(c).

17  
18 The evidence supports a finding that Licensee's treatment failed to meet the medical  
19 standard of care for establishing and treating hypogonadism, and subjected Patient F to  
20 unnecessary testing, conduct which constituted unprofessional or dishonorable conduct and gross  
21 or repeated negligence.

22  
23 Patient G

24  
25 The evidence also supports a finding that Licensee's treatment of Patient G also  
26 constituted unprofessional conduct and gross negligence. Patient G presented to Licensee with a  
27 history of elevated PSA levels, and a prior biopsy that indicated Patient G had a Gleason 5 grade  
28 adenocarcinoma. Patient G refused to pursue the alternative suggested by his primary care  
29 urologist. Licensee started Patient G on thyroid based on Patient G's basal temperatures.  
30 According to the Board's expert witnesses and Patient G's treating urologist, Licensee treated  
31 Patient G with testosterone replacement therapy without establishing the medical necessity for  
32 the treatment. In Dr. Cook's opinion, treating Patient G with testosterone in the face of a known  
33 diagnosis of prostate cancer, rising PSA levels, and DRE's which yielded suspicious results, was  
34 contraindicated and constituted gross negligence.

35  
36 In addition, Licensee failed to notify Patient G's treating physician that he was  
37 prescribing testosterone for Patient G, contrary to the standard of care for communication  
38 between specialists and treating physicians. Patient G was also at risk because he was less likely  
39 to seek approved or standard treatment because Licensee provided him with information that  
40 supported giving testosterone to a patient with a diagnosis of prostate cancer. The proposition of  
41 giving testosterone to a patient with prostate cancer is highly controversial and is not within the  
42 accepted standard of medical care for specialists treating hormonal diseases including prostate  
43 abnormalities. Patient G's Gleason 5 tumor, in addition to his rising PSA levels, suggested that  
44 the cancer had spread beyond the prostate. Licensee's treatment not only increased the risk of  
45 growth of the cancer but it discouraged Patient G from seeking alternative treatments which have  
46 the potential to extend his life.

47 ///

48 ///

1 Licensee also failed to provide sufficient information to Patient G regarding the risks  
2 associated with testosterone replacement therapy. Therefore, Patient G could not have given  
3 Licensee informed consent for testosterone therapy because he lacked sufficient information  
4 upon which to make his decision. Licensee's treatment of Patient G constituted unprofessional  
5 conduct and gross negligence.  
6

### 7 **Summary**

8  
9 The Board met its burden of proof to sustain the Order of Emergency Suspension based  
10 on his care of Patients L and I. More than that, the Board produced ample evidence that  
11 Licensee has a history of violating prior Board orders designed to protect the public, and the  
12 terms of which the Licensee, in part, proposed as part of stipulated agreements. The Licensee's  
13 continued violations and his pattern of medical treatment for patients he diagnosed with  
14 hypothyroidism and/or hypogonadism, without sufficient medical bases, constituted on-going  
15 unprofessional conduct and gross and repeated negligence.  
16

17 To the extent that the experts determined that Licensee's thyroid and testosterone  
18 replacement therapies were not alternative medical treatments but were conventional treatments  
19 for conventional diagnoses treated in a manner that was outside the standard of medical care, the  
20 provisions of ORS 677.190(1)(b) do not apply. The standard was that of the practice of those  
21 physicians who treat diseases of the endocrine systems. Licensee did not meet that standard for  
22 the specific patients as set out above.  
23

24 Even if it were determined that Licensee was using alternative medical treatments for  
25 purposes of ORS 677.190(1)(b), the Board met its burden to show, as set out in the analysis  
26 above, that Licensee's treatment posed a greater risk of harm to his patients than the standard or  
27 recognized treatment, contrary to the provisions of ORS 677.190(1)(b)(A)(iii).  
28

### 29 **Proposed sanctions.**

30  
31 In its Amended Complaint and Notice of Proposed Disciplinary Action, the Board  
32 proposes to revoke Licensee's license to practice medicine. At hearing, the Board also proposed  
33 to impose a civil penalty of \$10,000, and to assess the costs of the contested case hearing,  
34 pursuant to ORS 677.205(2).  
35

### 36 **Revocation.**

37  
38 Based on the findings of fact and the analysis above, the record supports the proposed  
39 revocation. Licensee repeatedly violated prior Board orders. He has a history of a prior  
40 revocation and reinstatement. Considering Licensee's history and the evidence of the conduct  
41 supporting the current proposed revocation, Licensee has demonstrated that he will not practice  
42 medicine in the areas of thyroid and testosterone replacement therapies in a safe manner.  
43 Licensee has been undeterred by prior Board orders. He maintains that his practice in these areas  
44 is safe and argues that his view is supported by recent reliable analysis and expert  
45 recommendations. Licensee's sources did not withstand scrutiny as to the safety of the position  
46 taken by those whose recommendations regarding thyroid and testosterone treatments practices  
47 Licensee follows. The revocation of Licensee's license to practice medicine is appropriate.  
48

///

1 **Civil penalty and assessment of costs.**  
2

3 The Board has the statutory authority to assess civil penalties and costs of contested case  
4 hearings under ORS 677.205(2). At hearing, the Board requested that Licensee be assessed a  
5 \$10,000 penalty and the cost for the hearing, pursuant to ORS 677.205(2)(f). In addition to those  
6 portions of ORS 677.205 cited above, ORS 677.205(7) provides in additional relevant part:  
7

8 Civil penalties under this section shall be imposed as provided in ORS 183.745.  
9

10 ORS 183.745 provides, in part:  
11

12 (1) Except as otherwise provided by law, an agency may only impose a civil penalty as  
13 provided in this section.  
14

15 (2) A civil penalty imposed under this section shall become due and payable 10 days  
16 after the order imposing the civil penalty becomes final by operation of law or on appeal.  
17 A person against whom a civil penalty is to be imposed shall be served with a notice in  
18 the form provided in ORS 183.415. Service of the notice shall be accomplished in the  
19 matter provided by ORS 183.415.  
20

21 (3) The person to whom the notice is addressed shall have 20 days from the date of  
22 service of the notice provided for in subsection (2) of this section in which to make  
23 written application for a hearing. The agency may by rule provide for a longer period of  
24 time in which application for a hearing may be made. If no application for a hearing is  
25 made within the time allowed, the agency may make a final order imposing the penalty.  
26 A final order entered under this subsection need not be delivered or mailed to the person  
27 against whom the civil penalty is imposed.  
28

29 Here, the ALJ opined that the Board's Amended Complaint and Notice of Proposed  
30 Disciplinary Action does not contain a statement that the Board may assess Licensee with a civil  
31 penalty and/or with the cost for the disciplinary proceeding. The Notice apprises Licensee of his  
32 right to request a hearing as provided by the Administrative Procedures Act and that he may be  
33 represented by counsel at the hearing. The Notice states that "failure by Licensee to request a  
34 hearing or failure to appear at any hearing scheduled by the Board will constitute waiver of the  
35 right to a contested case hearing and will result in a default order by the Board, including the  
36 assessment of such penalty and costs as the Board deems appropriate under ORS 677.205." (See  
37 Pleading 8.) The Notice does not apprise Licensee that he may be assessed the cost of the  
38 proceeding if he requests a contested case hearing and does appear for such hearing.  
39

40 The ALJ stated that ORS 183.745(2) specifically provides that a person against whom a  
41 civil penalty is to be imposed shall be served with a notice. ORS 183.745(3) provides that the  
42 person to whom the notice is addressed shall have 20 days from the date of service in which to  
43 make written application for a hearing. The ALJ found that the Board failed to put Licensee on  
44 notice that it sought to assess him with the cost of the disciplinary proceeding if he requested and  
45 appeared for a hearing. As such, the ALJ found that the Board has failed to comply with the  
46 requirements set forth in ORS 183.745(2) and may not assess Licensee with either a civil penalty  
47 of \$10,000.00 or with the cost of the disciplinary proceeding or both as civil penalties.  
48

///

1 The Board does not adopt the ALJ's conclusion of law in this regard. Consistent with  
2 ORS 183.745, the Board did provide notice in the form provided in ORS 183.415, which states  
3 that:  
4

5 (1) The Legislative Assembly finds that persons affected by actions taken by state  
6 agencies have a right to be informed of their rights and remedies with respect to the  
7 actions.  
8

9 (2) In a contested case, all parties shall be afforded an opportunity for hearing after  
10 reasonable notice, served personally or by registered or certified mail.  
11

12 (3) Notice under this section must include:  
13

14 (a) A statement of the party's right to hearing, with a description of the procedure  
15 and time to request a hearing, or a statement of the time and place of the hearing;  
16

17 (b) A statement of the authority and jurisdiction under which the hearing is to be  
18 held;  
19

20 (c) A reference to the particular sections of the statutes and rules involved;  
21

22 (d) A short and plain statement of the matters asserted or charged; and  
23

24 (e) A statement indicating whether and under what circumstances an order by  
25 default may be entered.  
26

27 The Board's Amended Complaint and Notice of Proposed Disciplinary Action, paragraph  
28 2, states that:  
29

30 The Board proposes to take disciplinary action pursuant to ORS 677.205 against Licensee  
31 for violations of the Medical Practice Act, to wit, ORS 677.190(1)(a) unprofessional or  
32 dishonorable conduct, as defined in ORS 677.188(4)(a), (b), and (c); ORS 677.190(13)  
33 gross or repeated acts of negligence; and ORS 677.190(17) willfully disobeying a board  
34 order.  
35

36 ORS 677.205(2) states:  
37

38  
39 (1) The Oregon Medical Board may discipline as provided in this section any person  
40 licensed, registered or certified under this chapter who has:  
41

42 (a) Admitted the facts of a complaint filed in accordance with ORS 677.200 (1)  
43 alleging facts which establish that such person is in violation of one or more of  
44 the grounds for suspension or revocation of a license as set forth in ORS 677.190;  
45

46 (b) Been found to be in violation of one or more of the grounds for disciplinary  
47 action of a licensee as set forth in this chapter;  
48

1 (c) Had an automatic license suspension as provided in ORS 677.225; or

2  
3 (d) Failed to make a report as required under ORS 677.415.

4  
5 (2) In disciplining a licensee as authorized by subsection (1) of this section, the board  
6 may use any or all of the following methods:

7  
8 (a) Suspend judgment.

9  
10 (b) Place the licensee on probation.

11  
12 (c) Suspend the license.

13  
14 (d) Revoke the license.

15  
16 (e) Place limitations on the license.

17  
18 (f) Take such other disciplinary action as the board in its discretion finds proper,  
19 including assessment of the costs of the disciplinary proceedings as a civil penalty  
20 or assessment of a civil penalty not to exceed \$10,000, or both.  
21

22  
23 The Board's reference to ORS 677.205 complied with the requirements of ORS  
24 183.415, and put Licensee on notice that he faced all the sanctions listed in ORS 677.205. And  
25 as the ALJ noted, paragraph 6 of the Amended Notice states in part that: "Failure by Licensee to  
26 request a hearing or failure to appear at any hearing scheduled by the Board will constitute  
27 waiver of the right to a contested case hearing and will result in a default order by the Board,  
28 including the assessment of such penalty and costs as the Board deems appropriate under ORS  
29 677.205." The Board also notes that the Board's counsel announced that the Board was seeking  
30 revocation, costs, and a \$10,000 civil penalty during opening statement (tr. at 27) and at closing  
31 argument of the contested case hearing. This was also stated by Board counsel during the pre-  
32 hearing conference call of September 23, 2010, that included Licensee's counsel and ALJ  
33 Samantha Fair.  
34

### 35 **Exceptions.**

36  
37 Licensee through counsel submitted a document that was captioned: "LICENSEE'S  
38 EXCEPTIONS TO PROPOSED ORDER", which was dated March 10, 2011. In this document,  
39 Licensee set forth 107 exceptions for the Board to consider. According to Licensee, his  
40 exceptions "focus primarily on factual and legal issues essential to a just determination of the  
41 proceeding."  
42

43 In exception 8, Licensee correctly notes that the conclusion of law on page 35 found that  
44 the ISO in paragraph 3.1 refers to testosterone, which must be a typographical error. He  
45 correctly points out that it is paragraph 3.3 of the ISO that refers to testosterone. The Board will  
46 make the necessary correction in this Order.  
47

48 The Board has reviewed the remaining exceptions and finds them to lack merit.

1 Pursuant to the Board's modification of the ALJ's Proposed Order, Licensee was allowed  
2 to submit written exceptions to the specific modifications.  
3

4 Licensee through counsel submitted a document that was captioned: "LICENSEE'S  
5 EXCEPTIONS TO PROPOSED ORDER", which was dated June 29, 2011. In this document,  
6 Licensee set forth two additional exceptions regarding the assessment of a civil penalty and/or  
7 assessment of costs for the hearing, which the Board has considered but finds to lack merit.  
8  
9

10  
11  
12 **FINAL ORDER**

13  
14 The Oregon Medical Board issues the following Final Order:  
15

16 Licensee's Oregon medical license is hereby REVOKED. Licensee is assessed the costs  
17 of this hearing, as set forth in the Addendum to Final Order – Bill of Costs. Costs shall be due  
18 within 90 days from the date the Board issues its Bill of Costs.  
19

20 DATED this 7<sup>th</sup> day of July, 2011.

21  
22 OREGON MEDICAL BOARD  
23

24  
25 SIGNATURES REDACTED

26 RALPH A. YATES, DO  
27 Board Chair  
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32 **APPEAL**

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34 If you wish to appeal the Final Order, when it is issued, you must file a petition for  
35 review with the Oregon Court of Appeals within 60 days after the Final Order is served upon  
36 you. See ORS 183.480 et seq.  
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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
ERIK WILLIAM NIELSEN, MD ) INTERIM STIPULATED ORDER  
LICENSE NO. MD12909 )

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9.

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. Erik William Nielsen, 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 immediately 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 all of the following conditions, effective the date this Order is signed by Licensee:

3.1 Licensee voluntarily and immediately 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. 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 and reportable to both the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank.

IT IS SO STIPULATED THIS 7<sup>th</sup> day of July, 2011.

SIGNATURES REDACTED  
ERIK WILLIAM NIELSEN, MD

IT IS SO ORDERED THIS 7<sup>th</sup> day of July, 2011.

State of Oregon  
OREGON MEDICAL BOARD

SIGNATURES REDACTED  
KATHLEEN HALEY, JD  
EXECUTIVE DIRECTOR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
)  
JON ERIC PETTERSON, MD ) ORDER TERMINATING  
LICENSE NO. MD11174 ) STIPULATED ORDER  
)

1.

On December 7, 2006, Jon Eric Petterson, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On May 6, 2011, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his successful compliance with the terms of this Order, the Board terminates the December 7, 2006 Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 7<sup>th</sup> day of July, 2011.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURES REDACTED

RAUPHA. YATES DO  
Board Chair



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
DANIEL MARK SKOTTE, DO ) ORDER MODIFYING  
LICENSE NO. DO13485 ) STIPULATED ORDER  
)

1.

On July 10, 2008, Daniel Mark Skotte, DO (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation under certain conditions. On September 24, 2010, Licensee submitted a written request to terminate this Order. The Board declines to terminate this Order, but agrees to replace section 5 of the Stipulated Order with the following:

5.1 Licensee is reprimanded.

5.2 Licensee remains on probation for the ten-year term and must report in person to the Board at each of its quarterly meetings at the scheduled times for a probation interview, unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.

5.3 Licensee will be subject to random chart audits by a Board consultant on an annual basis.

5.4 Licensee shall obey all federal and Oregon laws and regulations pertaining to the practice of medicine.

5.5 Licensee will provide his Commanding Officer in the National Guard with a copy of this Order, as well as any Commander where he is assigned or attached.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
KATHRYN M.D. THOMSON, DO ) INTERIM STIPULATED ORDER  
LICENSE No. DO13836 )  
 )

1.  
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. Kathryn Mary Donoghue Thomson, DO (Licensee) is a licensed osteopathic physician in the state of Oregon.

2.

Licensee is a board-certified family practitioner, who works in Salem, Oregon. The Board has 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 all of the following terms, effective the date this Order is signed by Licensee:

- 3.1 Licensee voluntarily withdraws from the practice of medicine, to include conducting any chart reviews and reviewing medication treatment plans.
- 3.2 The medical license of Licensee is placed in inactive status pending the completion of the Board's investigation.

1 3.3 Licensee understands that violating any term of this Order will be grounds for  
2 disciplinary action under ORS 677.190(17).

3 4.

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

8 5.

9 This order is issued by the Board pursuant to ORS 677.265(2) for the purpose  
10 of protecting the public, and making a complete investigation in order to fully inform itself with  
11 respect to the performance or conduct of the Licensee and Licensee's ability to safely and  
12 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are  
13 confidential and shall not be subject to public disclosure, nor shall they be admissible as  
14 evidence in any judicial proceeding. However, as a stipulation, this order is a public document  
15 and reportable to the National Practitioner Data Bank, the Health Integrity Practitioner Data  
16 Bank, and the Federation of State Medical Boards. This Order becomes effective the date she  
17 signs it.

18 IT IS SO STIPULATED THIS 17<sup>th</sup> day of June, 2011.

19 (SIGNATURE REDACTED)

20 KATHRYN M.D. THOMSON, DO

21  
22 IT IS SO ORDERED THIS 17<sup>th</sup> day of June, 2011.

23 State of Oregon  
24 OREGON MEDICAL BOARD

25 (SIGNATURE REDACTED)

26 KATHLEEN HALEY, JD  
27 EXECUTIVE DIRECTOR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
MARCUS IRA WEINER, DO ) ORDER OF EMERGENCY  
LICENSE NO. DO22960 ) 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. Marcus Ira Weiner, DO (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 On April 22, 2011 the Board opened an investigation after receiving notification that Licensee was terminated from employment at a health clinic in Washington State for a second violation of a workplace agreement.

2.2 Licensee was arrested at his residence by Portland Police on May 28, 2011, at about 11:40 pm, and charged with Assault in the Fourth Degree and Strangulation. The police report stated that Licensee appeared to be intoxicated at the time of his arrest, with impaired motor skills, bloodshot eyes, and speech that was slightly slurred. Licensee admitted to police that he had consumed a bottle of wine that night.

2.3 On May 13, 2011, Board staff mailed a letter to Licensee notifying him of the initial complaint and requesting a summary report on the matter by no later than June 8, 2011. A response was not forthcoming. On June 10, 2011, Board staff called Licensee at his home phone number and left a voice mail message notifying him that the Board had not received his response and asking him to contact Board staff as soon as possible. Licensee did not respond. On June 16,

1 2011, a second letter was mailed to Licensee requesting a response by no later than June 25,  
2 2011. To date, Licensee has failed to provide the requested summary report.

3 2.4 During the course of this investigation, the Board's staff has received information  
4 from a credible source that Licensee is impaired due to his ongoing consumption of intoxicants.

5 2.5 On June 20, 2011, Board staff spoke with Licensee by phone. Licensee agreed to  
6 review and possibly sign an Interim Stipulated Order removing himself from practice until the  
7 Board could further investigate this matter. Board staff advised Licensee that an Interim  
8 Stipulated Order would be mailed to him immediately. Board staff requested that Licensee  
9 return the signed Order to the Board by no later than 5:00 p.m., June 21, 2011. Licensee did not  
10 provide a response.

11 2.6 Board staff attempted three times by telephone to contact Licensee on June 21,  
12 2011, and left detailed voicemail messages asking Licensee to contact Board staff as soon as  
13 possible regarding the Interim Stipulated Order. Licensee did not respond.

14 3.

15 Based on the above information, the Board has determined that Licensee is impaired to  
16 the extent that his continued practice of medicine constitutes an immediate danger to the health  
17 and safety of the public. The Board orders that pursuant to ORS 677.205(3), the license of  
18 Marcus Ira Weiner, DO, be suspended on an emergency basis and that Licensee immediately  
19 cease the practice of medicine until otherwise ordered by the Board.

20 4.

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

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1 request for a hearing, the Board will notify Licensee of the time and place of the hearing and will  
2 hold a hearing as soon as practicable.

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IT IS SO ORDERED THIS 22<sup>nd</sup> day of June, 2011.

OREGON MEDICAL BOARD  
State of Oregon

(SIGNATURE REDACTED)

~~RALPH A. YATES, DO~~  
Board Chair