

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

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

Scanned copies of Interim Stipulated Orders, Orders of Emergency Suspension, Stipulated Orders, Final Orders, Termination Orders, Modification Orders and Voluntary Limitations are included at the end of this report in the order that they appear in the report. These orders are marked with an \* asterisk. **Scanned copies of Consent 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 (<http://egov.oregon.gov/BME/PDFforms/VerDispMalFillin.pdf>) found under the Licensee Information Request Form link on the Board's web site, submit it with the \$10.00 fee *per licensee* and mail to:

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

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

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**\*Adams, Justin Robert, MD; MD156479; Ashland, OR**

On April 14, 2015, Licensee entered into an Interim Stipulated Order to voluntarily cease performing injections other than immunizations and cease retrieving or processing blood and tissue from patients pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**\*Bernardo, Peter Augusto, MD; MD17631; Woodburn, OR**

On April 2, 2015, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's April 3, 2014, Stipulated Order.

**\*Colorito, Anthony Ivar, MD; MD22621; Portland, OR**

On April 2, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order retires Licensee's medical license while under investigation.

**\*Gallant, James David, MD; MD12529; Corvallis, OR**

On April 2, 2015, the Board issued an Order Modifying Stipulated Order. This Order modifies Licensee's October 2, 2014, Stipulated Order.

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

On April 2, 2015, the Board issued a Final Order on Remand. This Order revokes Licensee's medical license and assesses the costs of the contested case hearing. On April 2, 2015, the Board issued an Addendum to Final Order on Remand - Bill of Costs, outlining the costs of the contested case hearing.

**\*Goldberg, Uri Zoe, DO; DO159256; Toledo, OR**

On April 2, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to provide a copy of this Agreement to any employer in the healthcare field, and complete a Board-approved educational plan prior to her return to the practice of obstetrics.

**\*Harbison, Andrew Ross, MD; MD166694; Portland, OR**

On April 2, 2015, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's April 16 2014, Consent Agreement.

**\*Helman, Edward Allan, MD; MD09729; Medford, OR**

On April 2, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 10, 2014, Corrective Action Agreement.

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

On April 2, 2015, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's February 4, 2010, Stipulated Order.

**\*Jensen, Robert Mark, MD; MD17220; Medford, OR**

On April 2, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on medical record keeping, and report any complaints regarding Licensee's professionalism.

**\*Kemple, Kip Louis, MD; MD10387; Portland, OR**

On April 2, 2015, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's February 4, 2015, Interim Stipulated Order effective April 30, 2015.

**\*Kemple, Kip Louis, MD; MD10387; Portland, OR**

On April 2, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. This Order retires Licensee's medical license while under investigation.

**\*Kort, Daniel Duane, MD; MD18043; Salem, OR**

On April 2, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; willfully violating any provision of a board rule; and violation of the federal Controlled Substances Act. This Order reprimands Licensee; assesses a civil penalty of \$5,000; places Licensee on probation; prohibits Licensee from practicing aesthetic medicine; requires Board pre-approval of any practice setting; and requires that Licensee comply with Oregon Administrative Rules when offering weight loss treatment.

**\*Laird, Sheri Lee, MD; MD21936; West Linn, OR**

On April 2, 2015, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's July 12, 2012, Corrective Action Agreement.

**\*Laird, Sheri Lee, MD; MD21936; West Linn, OR**

On April 2, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated acts of negligence. This Order reprimands Licensee; requires Board pre-approval of any practice setting; and prohibits Licensee from prescribing for chronic pain.

**\*Levanger, Nathan Blacker, DO; DO22827; Driggs, ID**

On April 2, 2015, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's June 2, 2011, Stipulated Order.

**\*Lindberg, John Francis, MD; MD12005; Portland, OR**

On April 2, 2015, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's January 10, 2013, Stipulated Order.

**\*Loehden, Otto Louis, MD; MD05975; Hillsboro, OR**

On April 3, 2015, Licensee entered into a Voluntary Limitation in which he agreed to refrain from performing surgery or seeing patients in a clinical setting.

**\*Logan, Jacqueline Susan, MD; MD20914; Salem, OR**

On April 2, 2015, the Board issued an Order Terminating Corrective Action Order. This Order terminates Licensee's April 12, 2007, Corrective Action Order.

**\*Luty, Jeffrey Alexander, MD; MD155853; Beaverton, OR**

On April 2, 2015, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's April 5, 2013, Consent Agreement, and January 8, 2015, Order Modifying Consent Agreement.

**\*Matz, Paul David, MD; MD12660; Medford, OR**

On March 18, 2015, Licensee entered into an Interim Stipulated Order to voluntarily reduce the morphine equivalent doses and eliminate benzodiazepines and muscle relaxants for chronic pain patients pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**\*Mentzer, Richard Lynn, Jr., MD; MD08548; Greenleaf, OR**

On April 2, 2015, the Board issued an Order Terminating Corrective Action Order. This Order terminates Licensee's July 12, 2007, Corrective Action Order.

**Miller, Blythe Megan, LAc; Applicant; Portland, OR**

On March 19, 2015, Applicant entered into a Consent Agreement with the Board. In this Agreement, Applicant agreed to complete a 20-hour mentorship with a Board-approved clinical supervisor.

**Pursley, Lance Christopher, LAc; AC01170; Portland, OR**

On March 19, 2015, Licensee entered into a Consent Agreement with the Board. In this Agreement, Licensee agreed to complete a 20-hour mentorship with a Board-approved clinical supervisor.

**\*Reyes, Vincent Pedro, MD; MD16883; Hillsboro, OR**

On April 2, 2015, Licensee entered into a Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to perform ten interventional cardiac cases under the mentorship of a Board-approved cardiologist.

**\*Rivadeneira Almenara, Adriana, LAc; AC166926; Portland, OR**

On April 2, 2015, the Board issued an Order Terminating Consent Agreement. This Order terminates Licensee's October 7, 2014, Consent Agreement.

**\*Sasich, Randy Louis, MD; MD28977; Portland, OR**

On April 2, 2015, the Board issued an Order Modifying Consent Agreement. This Order modifies Licensee's October 3, 2013, Consent Agreement.

**\*Thomashefsky, Allen Jan, MD; MD08126; Ashland, OR**

On April 14, 2015, Licensee entered into an Interim Stipulated Order to voluntarily cease performing injections other than immunizations and cease retrieving or processing blood and tissue from patients pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

**\*Tyler, Jeffrey Richard, MD; MD13966; Portland, OR**

On April 2, 2015, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and gross or repeated acts of negligence. This Order reprimands Licensee; assesses a \$7,500; places Licensee on probation; requires Licensee to complete a pre-approved medical ethics course; requires Licensee to practice only in a group setting; prohibits Licensee from supervising physician assistants; and prohibits Licensee from treating substance use disorder or chronic pain.

**\*Yeakey, Patrick Carl, MD; MD23238; Phoenix, OR**

On March 27, 2015, Licensee entered into an Interim Stipulated Order to voluntarily reduce the morphine equivalent doses and eliminate benzodiazepines and muscle relaxants for chronic pain patients pending the completion of the Board's investigation into his 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.







1 This modification becomes effective the date this Order Modifying Stipulated Order is  
2 signed by the Board Chair. All other terms of the April 3, 2014, Stipulated Order are unchanged.

3  
4 IT IS SO ORDERED this 2<sup>nd</sup> day of April 2015.

5 OREGON MEDICAL BOARD  
6 State of Oregon

7 **SIGNATURE REDACTED**

8 SHIRIN SUKUMAR, MD  
9 Board Vice Chair

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
ANTHONY IVAR COLORITO, MD ) STIPULATED ORDER  
LICENSE NO. MD22621 )

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. Anthony Ivar Colorito, MD (Licensee) is a licensed physician in the State of Oregon.

2.

Licensee is an orthopedic surgeon. On August 13, 2014, the Board opened an investigation after receiving credible information regarding Licensee.

3.

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

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4.

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

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

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

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

IT IS SO STIPULATED this 19 day of February, 2015.

SIGNATURE REDACTED

ANTHONY IVAR COLORITO, MD

IT IS SO ORDERED this 2nd day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURE REDACTED

MICHAEL MASTRANGELO, MD  
BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
JAMES DAVID GALLANT, MD ) ORDER MODIFYING  
LICENSE NO. MD12529 ) STIPULATED ORDER  
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1.

On October 2, 2014, James David Gallant, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On March 20, 2015, Licensee submitted a written request asking the Board to modify Term 5.5 of this Order, which reads:

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*5.5 Within 180 days from the signing of this Order by the Board Chair, Licensee must at his own expense enroll in and complete a physician assessment at the Center for Personalized Education for Physicians (CPEP). Licensee must sign all necessary releases to allow full communication and exchange of documents and reports between the Board and CPEP. Licensee must timely and successfully complete the recommended CPEP Education or Remediation Plan, if any, at Licensee's expense. This plan must be reviewed and approved by the Board's Medical Director prior to implementation.*

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2.

Having fully considered Licensee's request, the Board modifies Term 5.5 of the October 2, 2014, Stipulated Order as follows:

5.5 Within 180 days from the signing of this Modifying Order by the Board Chair, Licensee must at his own expense, enroll in and complete a physician competency and health assessment at the Florida Comprehensive Assessment and Remedial Education Services Program (CARES). Licensee must fully cooperate with the CARES program and complete all recommended assessments. Licensee must sign all necessary releases to allow full communication and exchange of

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

5 This modification becomes effective the date this Order is signed by the Board Chair.  
6 All other terms of the October 2, 2014, Stipulated Order are unchanged and remain in full force  
7 and effect.

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9 IT IS SO STIPULATED THIS 1st day of April, 2015.

10  
11 SIGNATURE REDACTED

12 JAMES DAVID GALLANT, MD

13  
14 IT IS SO ORDERED this 2nd day of April, 2015.

15 OREGON MEDICAL BOARD  
16 State of Oregon

17 SIGNATURE REDACTED

18 MICHAEL MASTRANGELO, MD  
19 Board Chair



1 this conclusion was supported by substantial evidence. The Board also determined that  
2 Licensee's treatment of Patients I and L (in regard to thyroid) violated the ISO. The Court  
3 determined that the Board properly found that Paragraph 3.1 of the ISO applied to Licensee and  
4 that he violated it by treating Patient L. The Court, however, found that the Board erred in  
5 concluding that Licensee's treatment of Patient I violated the ISO.  
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7 The Court affirmed the Board's determination that Licensee's hormone treatment of  
8 patients did not constitute practicing alternative medicine because Licensee's hormone treatment  
9 posed a greater risk of harm to his patients than the standard or recognized treatment. The Court  
10 concluded that substantial evidence supported the Board's finding that by treating patients (A –  
11 E) with thyroid without establishing a medical deficiency, Licensee exposed his patients to  
12 specific risks of harm, to include possible "accelerated bone density loss, or osteopenia, cardiac  
13 complications include cardiac arrhythmia, and developing hyperthyroidism, which may increase  
14 the risk for hypertension." The Court also concluded that substantial evidence supported the  
15 Board's finding that Licensee's testosterone treatment posed a greater risk of harm to his patients  
16 (F and G) than the generally recognized treatment.  
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18 The Board's Final Order of July 7, 2011 (as modified by the Court of Appeals' decision  
19 and the Opinion of the Court of Appeals, filed on February 20, 2014) is incorporated by  
20 reference in this Order.  
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#### 22 REASSESSING THE SANCTION UPON REMAND 23

24 The Board's statutory statement of purpose is to protect the public "from the practice of  
25 medicine by unauthorized or unqualified persons and from unprofessional conduct by persons  
26 licensed to practice under this chapter." Licensee's conduct in diagnosing hypothyroidism and  
27 hypogonadism without sufficient medical basis constituted a pattern of conduct that both  
28 breached the standard of care and posed a risk of harm to the public in ways that were  
29 specifically described in the Final Order. In addition, Licensee violated the terms of the Board's  
30 Order Modifying the Stipulated Order of January 15, 2004 on multiple occasions and the ISO on  
31 one occasion. Licensee's conduct demonstrates that he has failed to practice medicine in  
32 conformity with established medical standards and that his manner of practice subjects his  
33 patients to the unnecessary risk of harm. Licensee's conduct is so deficient that his conduct in  
34 regard to Patients A – E together with F and G, would warrant revocation of his license and the  
35 imposition of costs, even without consideration of the allegations that he failed to obey the terms  
36 of the ISO of March 15, 2010, and the Order Modifying the Stipulated Order of January 15,  
37 2004, as described in the opinion of the Court of Appeals.  
38

39 Therefore, upon remand, the Board having considered Licensee's conduct as described in  
40 the findings of fact of the Final Order as modified upon remand in accordance with the court's  
41 rulings, and the multiple violations of the Medical Practice Act, concludes that it will not modify  
42 the sanction set forth in the Final Order of July 7, 2011.  
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**ORDER**

Based on the foregoing, IT IS HEREBY ORDERED that the medical license of John Edwin Gambee is revoked and that he is assessed the costs of the hearing, as set forth in the Addendum to the Final Order On Remand – Bill of Costs. Costs are due within 90 days from the date this Order becomes final by operation of law or on appeal.

DATED this 2nd day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

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MICHAEL MASTRANGELO, MD  
Board Chair

**APPEAL**

If you wish to appeal the Final Order on Remand, you must file a petition for review with the Oregon Court of Appeals within 60 days after the Final Order on Remand is served upon you. See ORS 183.482.

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**CERTIFICATE OF MAILING**

On, April 3, 2015, I mailed the foregoing Final Order on Remand regarding John Edwin Gambee, MD, to the following parties:

**By: First Class Certified/Return Receipt U.S. Mail**  
**Certified Mail Receipt # 7014 1200 0000 8349 8715**

John Edwin Gambee, MD  
93244 Highway 99 S  
Junction City, OR 97448

**By: Regular U. S. Mail**

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

Beverly Loder  
Beverly Loder  
Investigations Secretary  
Oregon Medical Board

BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of: )  
 )  
JOHN EDWIN GAMBEE, MD ) ADDENDUM TO FINAL ORDER  
License No. MD09526 ) ON REMAND - BILL OF COSTS  
 )

1.

On June 21, 2011, the Oregon Medical Board (Board) issued a Proposed Final Order in the matter of John Edwin Gambée, MD (Licensee). In this Order, Licensee was assessed the costs related to his Contested Case Hearing held on December 13 - 17, 2010. Subsequent to a review of the Contested Case Hearing by the Oregon Court of Appeals, the Board issued a Final Order on Remand on April 2, 2015, assessing Licensee the costs of his Contested Case Hearing. This payment is due within 90 days from the date the Final Order on Remand is issued by the Board.

2.

The State of Oregon, by and through its Oregon Medical Board, claims costs related to the December 13 - 17, 2010, Contested Case Hearing in the above-captioned case as follows:

Total Dept. of Justice costs	\$	22,248.80
Rate: \$137.00/hr - AAG hours: 143.8		19,700.60
\$ 77.00/hr - Paralegal: 26.70		2,055.90
\$ 93.00/hr - Program coordinator: 1.10		102.30
Other DOJ Charges (Westlaw, motor pool, witness fee)		390.00
Board Consultant/Witness –David Cook, MD	\$	2,125.00
Board Consultant/Witness – Anne Nedrow, MD	\$	4,500.00
Rate: \$125/hr - 53 hours		
Office of Administrative Hearings costs	\$	23,667.40
Rate: \$82.00/hr – ALJ: 232.25		12,048.92
OAH Admin. Charges:		9,664.31
OAH 9% working capital charge:		1,954.17

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2 Court Reporter Appearance - Naegeli Corp. \$ 6,527.25  
3 **TOTAL COSTS DUE:** \$ **59,068.45**

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5 The above costs are certified as a correct accounting of actual costs incurred preparing for  
6 and participating in the Contested Case Hearing in this matter.

7  
8 Dated this 2nd of April, 2015.

9 OREGON MEDICAL BOARD  
10 State of Oregon

11 SIGNATURE REDACTED  
12 KATHLEEN HALEY, JD U  
13 EXECUTIVE DIRECTOR

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**CERTIFICATE OF MAILING**

On April 3, 2015, I mailed the foregoing Addendum to Final Order on Remand – Bill of Costs regarding John Edwin Gambee, MD to the following parties:

**By: First Class Certified/Return Receipt U.S. Mail**  
**Certified Mail Receipt # 7014 1200 0000 8349 8715**

John Edwin Gambee, MD  
93244 Highway 99 S  
Junction City, OR 97448

**By: Regular U. S. Mail**

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

Beverly Loder  
Beverly Loder  
Investigations Secretary  
Oregon Medical Board

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
URI ZOE GOLDBERG, DO )  
LICENSE NO. DO159256 ) CORRECTIVE ACTION AGREEMENT

1.

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

2.

The Board opened an investigation after receiving a report that Licensee's obstetrical privileges had been suspended by Samaritan Pacific Communities Hospital on January 27, 2014, for failure to complete an education plan.

3.

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

4.

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





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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
EDWARD ALLAN HELMAN, MD ) ORDER TERMINATING  
LICENSE NO. MD09729 ) CORRECTIVE ACTION AGREEMENT  
)

1.

On July 10, 2014, Edward Allan Helman, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On November 24, 2014, Licensee submitted documentation that he has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

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

IT IS SO ORDERED this 2nd day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon  
**SIGNATURE REDACTED**  
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MICHAEL MASTRANGELO, MD  
Board Chair

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

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

1.

On February 4, 2010, Larry Arthur Jackson, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On January 28, 2015, Licensee submitted a written request to terminate this Order.

2.

In view of Licensee's entry into a Stipulated Order with the Board on January 8, 2015, the Board terminates the February 4, 2010, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2<sup>nd</sup> day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

MICHAEL MASTRANGELO, MD  
Board Chair



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4.

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

4.1 Within six months from the signing of this Agreement by the Board Chair, Licensee, at his own expense, must complete a course on medical record keeping that is pre-approved by the Board's Medical Director.

4.2 Licensee must immediately report to the Board any complaint that he becomes aware of in regard to his professional conduct at any health care setting.

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

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

IT IS SO AGREED this 3 day of March, 2015.

**SIGNATURE REDACTED**

ROBERT MARK JENSEN, MD

IT IS SO AGREED this 23 day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

†  
MICHAEL J. MASTRANGELO, MD  
Board Chair



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
KIP LOUIS KEMPLE, MD ) STIPULATED ORDER  
LICENSE NO. MD10387 )

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. Kip Louis Kemple, MD (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is a board-certified rheumatologist. The Board has previously investigated Licensee's manner of prescribing controlled substances for chronic pain that culminated in Licensee entering into a Stipulated Order with this Board that became effective on March 8, 2007. Licensee was placed on probation for 5 years. The Board terminated this Order on May 5, 2011. On May 20, 2014, the Board opened an investigation related to possible violations of the Medical Practice Act, after receiving credible information regarding Licensee's medical practice. On February 4, 2015, Licensee entered into an Interim Stipulated Order with the Board which limits Licensee's treatment of and prescribing for chronic pain.

3.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to retire his license while under investigation, consistent with the terms of this Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board

1 finds, that Licensee engaged in conduct that violated the Medical Practice Act, to wit ORS  
2 677.190(1)(a) unprofessional conduct, as defined in ORS 677.188(4)(a). Licensee  
3 understands that this document is a public record and is reportable to the National Databank  
4 and the Federation of State Medical Boards.

5 4.

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

8 4.1 Licensee permanently retires his license to practice medicine while under  
9 investigation. This retirement of license becomes effective at 5:00 p.m. on April 30, 2015.

10 4.2 Licensee must obey all federal and Oregon state laws and regulations  
11 pertaining to the practice of medicine.

12 4.3 Licensee stipulates and agrees that any violation of the terms of this Order  
13 would be grounds for further disciplinary action under ORS 677.190(17).

14  
15 IT IS SO STIPULATED this 12<sup>th</sup> day of March, 2015.

16 SIGNATURE REDACTED

17 KIP LOUIS KEMPLE, MD

18  
19 IT IS SO ORDERED this 2<sup>nd</sup> day of April, 2015.

20 OREGON MEDICAL BOARD  
21 State of Oregon

22 SIGNATURE REDACTED

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24 MICHAEL MASTRANGELO, MD  
25 BOARD CHAIR  
26



1 ORS 677.190(17); “Willfully violating any provision of a board rule” and ORS 677.190(23);  
2 “Violation of the federal Controlled Substances Act.” Licensee understands that this Order is a  
3 public record and is a disciplinary action that is reportable to the National DataBank and the  
4 Federation of State Medical Boards.

5 4.

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

8 4.1 Licensee is reprimanded.

9 4.2 Licensee must pay a civil penalty of \$5,000. Licensee must pay this civil penalty  
10 in full within 24 months from the signing of this Order by the Board Chair. Payments must be  
11 no less than \$100 per payment.

12 4.3 Licensee is placed on probation for five years. Licensee will report in person to  
13 the Board at each of its regularly scheduled quarterly meetings at the scheduled times for a  
14 probationer interview unless ordered to do otherwise by the Board.

15 4.4 Licensee must not practice aesthetic medicine (to include laser and Botox  
16 treatments).

17 4.5 If Licensee offers treatment for weight loss, Licensee must comply with the  
18 requirements of OAR 847-015-0010 and OAR 847-015-0015.

19 4.6 Any practice setting in Oregon must be pre-approved in writing by the Board’s  
20 Medical Director.

21 4.7 After two years of demonstrated compliance with the terms of this Order,  
22 Licensee may submit a written request to the Board to modify the terms of this Order.

23 4.8 Licensee stipulates and agrees that this Order becomes effective the date it is  
24 signed by the Board Chair.

25 4.9 Licensee must obey all federal and Oregon state laws and regulations pertaining  
26 to the practice of medicine.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of

SHERI LEE LAIRD, MD  
LICENSE NO. MD21936

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STIPULATED ORDER

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1.

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

2.

On July 29, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violating the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that she engaged in conduct as set forth in the July 29, 2014, Complaint and Notice of Proposed Disciplinary Action, and that this conduct violated ORS 677.190(1)(a), as defined in ORS 677.188(4)(a), and ORS 677.190(13). Licensee understands that this Order is a public record and

1 is a disciplinary action that is reportable to the National Data Bank and the Federation of State  
2 Medical Boards.

3  
4 4.

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

7 4.1 Licensee is reprimanded.

8 4.2 Licensee may only practice medicine in settings that are pre-approved by the  
9 Board's Medical Director.

10 4.3 Licensee must not prescribe for chronic pain, to include prescribing any Schedule  
11 II or III medication in excess of 30 days in one calendar year to any patient, and never in  
12 conjunction with any benzodiazepine (Schedule IV).

13 4.4 Licensee stipulates and agrees that this Order becomes effective the date it is  
14 signed by the Board Chair.

15 4.5 Licensee must obey all federal and Oregon state laws and regulations pertaining  
16 to the practice of medicine.

17 4.6 Licensee stipulates and agrees that any violation of the terms of this Order shall  
18 be grounds for further disciplinary action under ORS 677.190(17).

19 IT IS SO STIPULATED THIS 24<sup>th</sup> day of February, 2015.

20  
21 SIGNATURE REDACTED

22 SHERI LEE LAIRD, MD

23 IT IS SO ORDERED THIS 20<sup>th</sup> day of April, 2015.

24 OREGON MEDICAL BOARD

25  
26 SIGNATURE REDACTED

27 MICHAEL MASTRANGELO, MD  
28 BOARD CHAIR







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4.

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

IT IS SO STIPULATED this 10 day of MARCH, 2015.

**SIGNATURE REDACTED**

OTTO LOUIS LOEHDEN, MD

IT IS SO ORDERED this 3rd day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

MICHAEL MASTRANGELO, MD  
BOARD CHAIR

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
 )  
JACQUELINE SUSAN LOGAN, MD ) ORDER TERMINATING  
LICENSE NO. MD20914 ) CORRECTIVE ACTION ORDER  
 )

1.

On April 12, 2007, Jacqueline Susan Logan, MD (Licensee) entered into a Corrective Action Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon license. On February 15, 2015, Licensee submitted documentation that she has successfully completed all terms of this Order and requested that this Order be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Order. The Board terminates the April 12, 2007, Corrective Action Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 2<sup>nd</sup> day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

MICHAEL MASTRANGELO, MD  
Board Chair







1 as evidence in any judicial proceeding. However, as a stipulation this Order is a public document  
2 and is reportable to the National Databank and the Federation of State Medical Boards.  
3

4 IT IS SO STIPULATED THIS 18<sup>th</sup> day of MARCH, 2015.

5 **SIGNATURE REDACTED**

6 PAUL DAVID MATZ, MD  
7

8 IT IS SO ORDERED THIS 23<sup>rd</sup> day of March, 2015.

9 OREGON MEDICAL BOARD  
10 State of Oregon

11 **SIGNATURE REDACTED**

12 KATHLEEN HALEY, JD U  
13 EXECUTIVE DIRECTOR  
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1 Practice Act. This agreement is a public document; however, it is not a disciplinary action. This  
2 document is reportable to the National Data Bank and the Federation of State Medical Boards.

3 4.

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

6 4.1 Licensee must, at his own expense, perform ten elective or emergent  
7 interventional cardiac cases under the mentorship of a cardiologist that is pre-approved by the  
8 Board's Medical Director. The ten mentored cases must be completed within 60 days of the  
9 approval of the mentor. At the conclusion of the ten cases, the Board approved mentor will  
10 submit a written report to the Board that includes an assessment of Licensee's interventional  
11 cardiology skills, clinical judgment, and ability to safely practice medicine.

12 4.2 Licensee must obey all federal and Oregon State laws and regulations pertaining  
13 to the practice of medicine.

14 4.3 Licensee agrees that any violation of the terms of this Agreement constitutes  
15 grounds to take disciplinary action under ORS 677.190(17).

16  
17 IT IS SO AGREED this 9 day of March, 2015.

18 SIGNATURE REDACTED

19 VINCENT PEDRO REYES, MD

20  
21 IT IS SO AGREED this 20 day of April, 2015.

22 OREGON MEDICAL BOARD  
23 State of Oregon

24 SIGNATURE REDACTED

25 MICHAEL J. MASTRANGELO, MD  
26 Board Chair

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
ADRIANA RIVADENEIRA ) ORDER TERMINATING  
ALMENARA, LAC ) CONSENT AGREEMENT  
LICENSE NO. AC166926 )

1.

On October 7, 2014, Adriana Rivadeneira Almenara, LAc, (Licensee) entered into a Consent Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On March 23, 2015, Licensee submitted documentation that she has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board's Medical Director has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board does hereby order that the October 7, 2014, Consent Agreement be terminated effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 21<sup>st</sup> day of April, 2015.

OREGON MEDICAL BOARD  
State of Oregon

**SIGNATURE REDACTED**

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MICHAEL MASTRANGELO, MD  
Board Chair





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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
ALLEN JAN THOMASHEFSKY, MD ) INTERIM STIPULATED ORDER  
LICENSE NO. MD08126 )  
)

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. Allen Jan Thomashefsky, MD (Licensee) is a licensed physician in the state of Oregon and holds an active medical license.

2.

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

3.

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

3.1 Licensee must not order or perform any injections except immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

3.2 Licensee must not retrieve or process any blood or tissue from a patient unless it is sent to a laboratory that is certified in Oregon.



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
)  
JEFFREY RICHARD TYLER, MD ) STIPULATED ORDER  
LICENSE NO. MD13966 )  
)

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 Richard Tyler, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On April 3, 2014, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed taking disciplinary action by imposing up to the maximum range of sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), (b) and (c); and ORS 677.190(13) gross or repeated acts of negligence.

3.

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

3.1 Patient A, a 59-year-old male, first presented to Licensee in March of 2007 with complaints related to anxiety and insomnia. During the first clinical visit, Patient A had an alcohol withdrawal seizure. Patient A's wife, who had accompanied him, reported that Patient A customarily drank about 20 beers a day. Shortly thereafter, Patient A entered an alcohol treatment program. Following his discharge from that program, Patient A asked Licensee for a prescription of hydrocodone/acetaminophen (Vicodin, Schedule III). Licensee acquiesced and wrote a prescription for both Vicodin and Zolpidem (Ambien, Schedule IV) without medical

1 justification. By November of 2007, Patient A admitted to drinking about 4 – 8 beers a day. A  
2 neurology consultation in 2008 opined that Patient A had chronic alcoholism and alcohol  
3 withdrawal seizures. An MRI of the brain showed early atrophy (suggestive of dementia). In  
4 June and September of 2009, Licensee provided Chlordiazepoxide (Librium) to help Patient A  
5 withdraw from alcohol on his own, but Licensee did not provide any monitoring, thereby  
6 unnecessarily exposing Patient A to the risk of harm. During the course of a clinical visit,  
7 Licensee engaged in a boundary violation by disclosing to Patient A that Licensee's sister was  
8 expected to die within the next couple of weeks, but that he could not afford to go see her.  
9 Shortly thereafter, in January of 2010, Patient A called Licensee to offer him some frequent flyer  
10 miles. Licensee accepted a gift of frequent flyer miles from Patient A and used those miles to  
11 pay for a personal roundtrip to Chicago from Portland. In May of 2010, Patient A left Hazelden  
12 Springbrook treatment center early against medical advice, where he was receiving inpatient care  
13 for alcohol as well as dependence on Clonazepam (Klonopin, Schedule IV) and Zolpidem  
14 (Ambien, Schedule IV). Patient A presented to Licensee in July of 2010, complaining that he had  
15 difficulty sleeping. Patient A asked Licensee to restart Zolpidem. Licensee agreed and  
16 prescribed Zolpidem 10 mg nightly, and Zolpidem CR (Zolpidem Tartrate) 12.5 mg nightly.  
17 Licensee engaged in gross or repeated acts of negligence by prescribing Zolpidem to Patient A  
18 after he had recently undergone inpatient treatment for Zolpidem dependence, and by continuing  
19 to prescribe Zolpidem in excess of the recommended dose of 10 mg. Licensee's manner of  
20 prescribing also subjected Patient A to the risk of harm.

21           3.2     In August of 2010, Patient A's wife reported that Patient A was still drinking  
22 alcohol and "passing out," and that he had "hundreds" of Zolpidem tablets that he was hiding in  
23 the trunk of his car. Licensee charted that he told Patient A that he would no longer prescribe  
24 Zolpidem for him. Nevertheless, about 8 days later, Licensee wrote a prescription for  
25 chlordiazepoxide for outpatient alcohol withdrawal and restarted Patient A on Zolpidem and did  
26 not order a urinary drug screen (UDS), despite the evidence of diversion. This treatment was not  
27 medically indicated and exposed Patient A to the risk of harm. In September of 2010, Licensee  
28 noted in the chart that he told Patient A that if he continued to drink he would terminate him as a

1 patient. In December of 2010, Licensee continued to prescribe Zolpidem 10 mg every night at  
2 bedtime and Zolpidem CR, 12.5 mg nightly. Licensee asserts that he verbally instructed Patient  
3 A to either take one, or the other, but not both, but that is not reflected in the chart. Licensee  
4 authorized an early refill of medication in February of 2011, ostensibly because Patient A  
5 claimed that it was stolen from his car. In the subsequent months, Patient A continued to drink  
6 alcohol, promised to stop drinking, and then resumed drinking. Licensee continued to prescribe  
7 Zolpidem 10 mg and Zolpidem CR 12.5 mg nightly, as well as lorazepam (Schedule IV), 1 mg  
8 twice daily. On January 10, 2012, Licensee noted that Patient A had missed two scheduled  
9 appointments, had resumed drinking, and had another alcohol withdrawal seizure. Licensee  
10 noted that he would no longer prescribe Zolpidem, lorazepam, Librium "or any potentially  
11 sedating medications" and referred to this patient as a "drunk" and a "liar." Licensee's decision  
12 to continue to prescribe a high dosage of Zolpidem along with lorazepam despite the evidence of  
13 Patient A's ongoing abuse of alcohol and treatment noncompliance constituted gross or repeated  
14 acts of negligence and subjected Patient A to the risk of harm.

15 3.3 Patient B, a 60-year-old male, presented to Licensee in April of 2012 with a  
16 history that included atherosclerotic heart disease, chronic pain "due to trauma," alcohol  
17 dependence, depressive disorder, suicide ideations, and an intracranial hemorrhage from a car  
18 accident in 1977. Licensee conducted a limited physical examination and ordered a urine drug  
19 screening (UDS) test, which was positive for marijuana metabolite and phenobarbital. Licensee  
20 had Patient B sign a pain management agreement and prescribed hydrocodone-acetaminophen  
21 (Vicodin, Schedule III) at 5 mg/500mg, 2 tablets, 3 times daily, and lorazepam (Ativan, Schedule  
22 IV), 1 mg tablet daily. These medications were not medically indicated. Patient B presented  
23 again on May 24, 2012, following his discharge from a hospitalization for suicidal ideations.  
24 Patient B's UDS was again positive for marijuana metabolite. Licensee continued to prescribe  
25 Vicodin and Ativan. On June 21, 2012, Patient B presented to Licensee complaining of left  
26 shoulder pain due to a dislocation he suffered in a car accident years ago. Despite the risk of  
27 increased sedation posed by combining an opiate with a benzodiazepine, Licensee continued to  
28 prescribe Vicodin, 5/500 mg 2 tablets, 3 times a day, and Ativan, 1 mg, 3 times daily. Licensee

1 renewed these prescriptions in July. Patient B was admitted to an emergency room in April,  
2 May, July and August of 2012, with recurring complaints of depression, anxiety and suicidal  
3 ideations. Licensee reviewed these ER visits and noted that Patient B had alcohol in his system  
4 when he went to the ER in July and August of 2012. On August 21, 2012, Licensee informed  
5 Patient B that he would no longer prescribe him Vicodin, although Licensee did give Patient B a  
6 prescription for 2 tablets per the patient's request. Licensee's decision to prescribe both Vicodin  
7 and Ativan, (an opioid with a benzodiazepine) to a depressed, active alcoholic without  
8 documented medical indication and positive UDS tests constituted gross or repeated acts of  
9 negligence and subjected Patient B to the risk of harm.

10 3.4 Patient C, an 81-year-old female from Long Beach, Washington, began to receive  
11 ultraviolet (UV) light therapy from Licensee in 1995. In 1996, Patient C was diagnosed with  
12 breast cancer. Licensee subsequently drove into the state of Washington where Licensee does  
13 not have a license to practice medicine to treat Patient C on a recurring basis over the course of  
14 12 to 18 months. Practicing medicine in another state without the appropriate state medical  
15 license constitutes unprofessional or dishonorable conduct. Licensee's pattern of treatment for  
16 Patient C consisted of the following: he would withdraw a pint of blood from Patient C, pass the  
17 blood through a glass tube housed inside an UV light chamber and reinfuse that blood into  
18 Patient C, for the asserted benefit of stimulating the immune system to help fight infection. This  
19 form of UV therapy is not supported by peer-reviewed medical science, poses a risk of harm to  
20 the patient, and provides no proven medical benefit. In 2010, Patient C developed bone  
21 metastasis to her spine. Licensee reports that he recommended radiation and chemotherapy, but  
22 she declined this form of treatment, which could have been of great value during the early stages  
23 of breast cancer. Licensee continued to treat Patient C with UV light therapy. Subsequently,  
24 Patient C developed difficulties with intravenous (IV) access, so Licensee arranged for a surgeon  
25 to place a Hickman catheter into her right subclavian vein, so that he could access her vein on  
26 repeated occasions to withdraw and reinfuse blood for UV light treatments. In January 2011, the  
27 Hickman catheter was replaced with a new one. In June 2011, Patient C developed increasing  
28 back pain and Licensee referred the patient for radiation therapy. In 2011, Patient C finally came

1 under the care of an oncologist in the state of Washington who treated her extensive metastatic  
2 disease with chemotherapy. In March of 2013, when Patient C complained of new lower neck  
3 pain, and when x-rays showed evidence of increasing tumor activity in her bones, the oncologist  
4 began additional chemotherapy. Chest and abdominal CT scans showed evidence of pulmonary  
5 emboli and she was hospitalized. On May 22, 2013, she presented to the oncologist complaining  
6 of fever and chills. A blood culture was taken, which returned positive for gram-negative rod  
7 *Alcaligenes* (which is resistant to Ceftriaxone). Patient C presented to Licensee on May 24,  
8 2013. Licensee gave Patient C a dose of IV Ceftriaxone as well as oral tablets. Licensee asserts  
9 that he did not have the results from the blood culture at the time he administered Ceftriaxone to  
10 the patient. The treating oncologist informed Licensee that the Hickman catheter was infected  
11 and should be replaced with a Port-A-Cath, which allows for the continued administration of  
12 chemotherapy. Licensee reports that Patient C insisted that the catheter be replaced with another  
13 Hickman catheter, so that blood could still be withdrawn for UV light treatment, which was not  
14 medically indicated to treat Patient C's cancer. Licensee did not document Patient C's insistence  
15 of the replacement in the patient record. Licensee persisted in treating Patient C with UV light  
16 treatment using the Hickman catheter. This type of catheter unnecessarily exposed Patient C to  
17 the risk of infection, and was the likely cause of Patient C's sepsis. For many years, Licensee's  
18 medical records on Patient C reveal infrequent and incomplete documentation of patient visits,  
19 with almost no documentation of vital signs, physical examinations, and informed consent. The  
20 treatment that Licensee provided Patient C was not medically indicated and unnecessarily  
21 exposed her to the risk of infection.

22 3.5 Patient D, a 60-year-old male, presented to Licensee on May 18, 2010, with a  
23 complaint of suprapubic pain. On November 1, 2010, Patient D presented to Licensee and  
24 complained that the one-half pill of 10 mg Diazepam (Valium, Schedule IV), that Licensee had  
25 prescribed for him was not helping "much with his anxiety." Patient D reported that he was  
26 drinking on average, two bottles of wine every day and perhaps more on weekends and holidays.  
27 He expressed a desire to stop drinking and requested Antabuse. Licensee increased his Valium  
28 intake to one 10 mg pill, twice daily, and a prescription for Antabuse, 500 mg, 30 tablets, with 2

1 refills, to take once daily. Licensee also gave two refills of Valium and administered a  
2 Testosterone (Schedule III) intramuscular (IM) injection. Licensee's chart notes do not reflect  
3 any discussion or recommendation for alcohol detoxification, or referral to either an inpatient or  
4 outpatient substance abuse treatment center. Neither did Licensee order a liver function test.  
5 Licensee continued to prescribe Valium and testosterone. On July 28, 2011, Licensee was  
6 prescribing Valium, 10 mg, 1 tablet, twice daily, testosterone 200 mg IM, every 2 weeks, and  
7 hydrocodone 7.5 mg/acetaminophen 300 mg (Vicodin ES), 1 tablet, 4 times daily. Licensee's  
8 decision to prescribe Antabuse for Patient D before having him undergo treatment for alcohol  
9 detoxification, and to continue to prescribe Valium and Vicodin ES while the patient reported  
10 consuming a large volume of alcohol on an ongoing basis (and without performing a liver  
11 function study) constituted gross or repeated acts of negligence and subjected Patient D to the  
12 risk of harm.

13 3.6 Patient E, a 72-year-old female, first presented to Licensee on October 5, 2011,  
14 with a diagnosis of history of chronic lower back pain, alcohol-induced dementia, hypertension  
15 and alcohol dependence. It was reported that she occasionally "escapes" from the foster home  
16 where she was living and "goes drinking." Licensee wrote a prescription for morphine,  
17 (Schedule II), 30 mg, 1 tablet, 3 times daily and lorazepam, 1 mg tablet, 3 times daily, while  
18 discontinuing her prescriptions for clonidine and buspirone. On November 17, 2011, Licensee  
19 notes that Patient E was in the ER the previous month with "acute alcohol intoxication."  
20 Licensee continued Patient E on both morphine and lorazepam. Licensee ordered a blood test,  
21 which was negative for alcohol. On December 1, 2011, Patient E presented to Licensee with  
22 complaints of lower back pain that "shoots down her right leg." She stated that the morphine  
23 was not doing her "any good and would like to switch to Percocet." Licensee discontinued the  
24 morphine as well her acetaminophen, and prescribed Oxycodone/acetaminophen (Percocet,  
25 Schedule II), 7.5/325 mg, 2 tablets, 4 times daily. Licensee's failure to refer Patient E for  
26 treatment for her alcohol dependence, as well as his prescriptions of opioids together with a  
27 benzodiazepine, constituted gross or repeated acts of negligence and subjected this patient to the  
28 risk of harm.

1           3.7     The Board also conducted a review of patients who suffered from persistent non-  
2 malignant pain conditions, and found that in regard to Patients F - I, Licensee prescribed  
3 unacceptably high doses of multiple prescription opioids in combination with unacceptably high  
4 doses of prescription benzodiazepines. Licensee failed to provide material risk notification;  
5 failed to conduct a risk assessment before initiating high dose opioid therapy; failed to address  
6 the efficacy of the treatment provided during follow-up clinical visits (to include failing to assess  
7 patient function and pain status) after initiating high dose opioid therapy; and failed to ensure  
8 that effective surveillance measures were in place, to include UDS and pill counts. Specific  
9 patient care concerns that constituted gross or repeated acts of negligence and subjected the  
10 patients to the risk of harm follow:

11           a.       Patient F, a 62-year-old psychiatrically fragile woman, presented to  
12 Licensee with complaints of pain, anxiety, difficulty getting restful sleep, and a history of drug  
13 overdose. Licensee treated her with a morphine equivalent dose (MED) in excess of 2,650 mg a  
14 day, while prescribing a benzodiazepine, diazepam, 40 mg a day, and clonazepam, 2 mg a day.  
15 Both of these benzodiazepines, when combined with opiates, can increase the incidence of  
16 hypoxia, apnea, and increased sedation. Licensee failed to provide material risk informed  
17 consent notification to Patient F, and did not try other forms of therapy or seek a pain  
18 consultation after she suffered an injury from a motor vehicle accident. In April of 2013,  
19 Licensee was prescribing Oxycodone, 30 mg, 810 tablets a month, in addition to the  
20 benzodiazepines, and had also authorized medical marijuana for Patient F. The chart reflects that  
21 Licensee had Patient F undergo only 3 UDS since October of 2011, and did not conduct pill  
22 counts, conduct a risk assessment, or evaluate the efficacy of treatment during subsequent  
23 clinical visits. The dosage and combination of Patient F's medications were not medically  
24 indicated and posed a significant risk of harm.

25           b.       Patient G, a 62-year-old disabled woman with chronic obstructive  
26 pulmonary disease (COPD) and persistent post-operative hip pain, came under Licensee's care in  
27 2011, through September 2013. Patient G was already on a regimen of opiates and  
28 benzodiazepines from a previous provider. Licensee increased the dosage of Oxycontin

1 (Schedule II) from 405 mg a day to 540 mg a day, Oxycodone (Schedule II) from 75 mg a day to  
2 180 mg a day, and hydromorphone (Schedule II) from 8 mg to 16 mg a day. Licensee continued  
3 the dosage of benzodiazepines, to include alprazolam (Xanax, Schedule IV) 2 mg 3 times a day  
4 and Zolpidem (Ambien, Schedule IV), 10 mg at bedtime. Licensee did not conduct pill counts,  
5 conduct a risk assessment, or evaluate the efficacy of treatment during subsequent clinical visits,  
6 and conducted only two UDS' of Patient G. The dosage and combination of Patient G's  
7 medications were not medically indicated and posed an exceptionally high risk of harm in view  
8 of her COPD.

9 3.8 On June 15, 2010, Patient H, a 29-year-old male with a history of conviction for  
10 heroin possession and repeated incarcerations for probation violations, first presented to Licensee  
11 complaining of non-specific back pain from an injury sustained in a motorcycle accident. An  
12 MRI showed a broad moderate disc protrusion at L3-4. From June 15, 2010 to September 1,  
13 2010, Licensee prescribed oxycodone (Schedule II) 5 mg, 1 tablet 4 times a day; Oxycontin  
14 (Schedule II) 80 mg, 1 tablet 4 times per day; and alprazolam (Xanax, Schedule IV) .5 mg, 1  
15 tablet 3 times a day. Licensee saw Patient H on September 1, 2010 and then not again until  
16 Patient H returned to the clinic on February 27, 2013, when he informed Licensee that he  
17 suffered an injury in a recent motor vehicle accident and that his pain was localized in his lower  
18 back. Licensee prescribed oxycodone, 10 mg, 2 tablets 3 times daily and alprazolam .5 mg, 1  
19 tablet, 3 times a day. Licensee executed a new pain contract with Patient H on February 27,  
20 2013. A UDS conducted on June 19, 2013 was positive for marijuana, hydrocodone, morphine  
21 and oxycodone. Only the oxycodone had been prescribed by the Licensee. Licensee noted that  
22 Patient H was on probation due to issues involving marijuana and illegally obtained prescription  
23 drugs, however Licensee did not otherwise address Patient H's use of hydrocodone and  
24 morphine but changed the prescription of alprazolam to 1 tablet at bedtime. In July 2013, a  
25 county Probation Office called Licensee's clinic and reported that Patient H had recently  
26 appeared in Adult Drug Court in Clackamas County while impaired due to the influence of  
27 prescribed medications. On August 21, 2013, a close family member of Patient H called  
28 Licensee to report that Patient H has a history of pain medicine addiction and that he is "good at

1 convincing people he is in pain in order to get drugs.” On September 3, 2013, Patient H  
2 requested that Licensee increase the prescription for oxycodone to 5 tablets per day. Licensee  
3 declined but renewed the existing prescriptions. On October 1, 2013, Licensee confronted  
4 Patient H in regard to his visit to the emergency room on September 24, 2013, because “he was  
5 stuporous secondary to taking too much oxycodone and alprazolam.” Licensee told him that he  
6 was terminating his care but was willing to give him a two-week supply of oxycodone and  
7 alprazolam. Licensee never saw Patient H again. Licensee failed to provide material risk  
8 notification to Patient H; failed to conduct a risk assessment before initiating high dose opioid  
9 therapy; failed to address the efficacy of the treatment provided during follow-up clinical visits  
10 (to include failing to assess patient function and pain status) after initiating high dose opioid  
11 therapy; and failed to effectively follow up on a positive UDS. Instead of directly addressing  
12 Patient H’s underlying medical issue, opiate addiction, Licensee continued to prescribe opiates  
13 despite signs of opiate addiction and diversion, until he terminated Patient H’s care in October of  
14 2013. This exposed Patient H to the risk of harm.

15 4.

16 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.  
17 Licensee understands that he has the right to a contested case hearing under the Administrative  
18 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the  
19 right to a contested case hearing and any appeal therefrom by the signing of and entry of this  
20 Order in the Board’s records. Licensee admits that he engaged in conduct that violated ORS  
21 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), (b) and  
22 (c); and ORS 677.190(13) gross or repeated acts of negligence. Licensee understands that this  
23 Order is a public record and is a disciplinary action that is reportable to the National Data Bank  
24 and the Federation of State Medical Boards.

25  
26 5.

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

1           5.1     Licensee is reprimanded.

2           5.2     Licensee must pay a civil penalty of \$7,500, payable in full within 90 days from  
3 the signing of this Order by the Board Chair.

4           5.3     Within 180 days from the signing of this Order by the Board Chair, Licensee must  
5 successfully complete a course on medical ethics that is pre-approved by the Board's Medical  
6 Director.

7           5.4     Licensee is placed on probation. Licensee must report in person to the Board at  
8 each of its regularly scheduled quarterly meetings at the scheduled times for a probationer  
9 interview unless directed to do otherwise by the Board or its Compliance Officer.

10          5.5     Licensee may only practice in a medical group setting that is pre-approved by the  
11 Board's Medical Director. This term goes into effect 60 days after this Order is signed by the  
12 Board Chair to allow for a transition period for Licensee to close his clinical practice.

13          5.6     Notwithstanding the provision of paragraph 5.5, Licensee may continue to assist  
14 surgeons licensed in the state of Oregon with procedures, under the supervision of the lead  
15 surgeon, in accredited hospitals and accredited ambulatory surgical centers.

16          5.7     Licensee must not supervise physician assistants.

17          5.8     Licensee must not provide treatment to any patient for substance use disorder.

18          5.9     Licensee must not treat patients for chronic pain. For the purposes of this Order,  
19 chronic pain is defined as pain that persists or progresses over a period of time greater than 30  
20 days. Licensee must not prescribe any medication for pain for any patient in excess of 30 days  
21 for any one year period, and must not prescribe benzodiazepines in combination with opiates.

22          5.10    Licensee stipulates and agrees that this Order becomes effective the date it is  
23 signed by the Board Chair.

24          5.11    This order terminates the Interim Stipulated Orders of November 27, 2013, and  
25 January 7, 2014, effective the date the Board chair signs this Order.

26          5.12    Licensee must obey all federal and Oregon state laws and regulations pertaining  
27 to the practice of medicine.

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
PATRICK CARL YEAKEY, MD ) INTERIM STIPULATED ORDER  
LICENSE NO. MD23238 )  
)

1.

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

2.

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

3.

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

3.1 Licensee must not begin treatment for chronic pain for any new or existing patient, and must not increase the dosage of opioid medications or begin prescribing benzodiazepines or carisoprodol (Soma) for any existing chronic pain patient. For the purposes of this Order, chronic pain is defined as pain that persists or progresses over a period of time greater than 30 days.

1           3.2    Licensee must immediately begin to taper opioid medications for chronic pain  
2 patients with an MED over 120 as follows:

- 3           a.    For patients taking 400 or less MED, the taper to 120 MED or less must be  
4           completed within 120 days.
- 5           b.    For patients taking benzodiazepines and opioid MED of 400 or less, the taper  
6           to 120 MED or less must be completed within 120 days.
- 7           c.    For patients taking more than 400 MED, the taper to 120 MED or less must be  
8           completed within 180 days.
- 9           d.    For patients taking benzodiazepines and opioid MED more than 400, the taper  
10          to 120 MED or less must be completed within 270 days.

11          3.3    Within six months of the effective date of this Order, benzodiazepines and  
12 carisoprodol (Soma) must be eliminated from the treatment regimen for any patient on chronic  
13 opioid therapy.

14          3.4    For patients on chronic opioid therapy Licensee may prescribe benzodiazepines  
15 for a single acute event, not to exceed seven days in a calendar year.

16          3.5    Licensee must not direct any other provider to prescribe for chronic pain patients  
17 on his behalf.

18          3.6    Licensee may continue to prescribe greater than 120 MED for chronic pain for his  
19 patients who are currently enrolled in hospice or who are currently receiving treatment for a  
20 diagnosis of cancer. Licensee must certify on the written prescription that the patient is a  
21 hospice or cancer patient.

22          3.7    Licensee must not supervise any other provider's treatment of chronic pain.

23          3.8    Licensee understands that violating any term of this Order will be grounds for  
24 disciplinary action under ORS 677.190(17).

24          3.9    Licensee understands this Order becomes effective the date he signs it.

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4.

At the conclusion of the Board's investigation, the Board will decide whether to close the case or to proceed to some form of disciplinary action. If the Board determines, following that review, not to lift the requirements of this Order, Licensee may request a hearing to contest that decision.

5.

This order is issued by the Board pursuant to ORS 677.410, which grants the Board the authority to attach conditions to the license of Licensee to practice medicine. These conditions will remain in effect while the Board conducts a complete investigation in order to fully inform itself with respect to the conduct of Licensee. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this Order is a public document and is reportable to the National Databank and the Federation of State Medical Boards.

IT IS SO STIPULATED THIS 27 day of March, 2015.

SIGNATURE REDACTED  
PATRICK CARL YEAKY, MD

IT IS SO ORDERED THIS 30<sup>th</sup> day of March, 2015.

OREGON MEDICAL BOARD  
State of Oregon

SIGNATURE REDACTED  
KATHLEEN HALEY, JD  
EXECUTIVE DIRECTOR