

Oregon Medical Board
BOARD ACTION REPORT
January 15, 2019

The information contained in this report summarizes new, interim, and final actions taken by the Oregon Medical Board between December 16, 2018, and January 15, 2019.

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 the License Verification and Malpractice Report Request (<http://www.oregon.gov/OMB/ombforms1/request-licensee-info-verification.pdf>) found under the Forms link on the Board's web site. Submit it with the \$10.00 fee *per licensee* and mail to:

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

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

***Chen, Poly, MD; MD29276; Corvallis, OR**

On January 10, 2019, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's 2016 Stipulated Order.

***Conrad, Arthur Kelly, Jr., MD; MD14553; Bend, OR**

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order Licensee retires his medical license while under investigation.

***Craig, Gerald Bartholomew Roger, MD; MD22708; Walla Walla, WA**

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; disciplinary action by another state of a license to practice; and willful violation any Board rule or order. This Order reprimands Licensee; assesses a \$5,000 civil penalty; prohibits Licensee from treating Oregon chronic pain patients with DEA scheduled medications; prohibits Licensee from concomitantly prescribing benzodiazepines or muscle relaxants with Schedule II or III medications for acute pain; requires Licensee to comply with the Oregon Opioid Prescribing Guidelines; requires Licensee to register with and utilize the Oregon Prescription Drug Monitoring Program when initiating treatment with controlled substances; and requires Licensee to comply with his Washington Modified Stipulated Findings of Fact, Conclusions of Law and Agreed Order as well as report any modifications of this Agreed Order to the Oregon Medical Board.

***Davis, William Edward, DO; DO07432; Klamath Falls, OR**

On January 10, 2019, the Board issued a Default Order for unprofessional or dishonorable conduct; willful violation of any rule adopted by the board, or failing to comply with a board request; and prescribing a controlled substance without a legitimate medical purpose, or without following accepted procedures for examination of patients or without following accepted procedures for record keeping. This Order revokes Licensee's Oregon medical license.

***Desai, Rahul Naren, MD; MD28444; Beaverton, OR**

On January 10, 2019, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on professional boundaries.

***Fairchild, Suzanne Catherine, LAc; AC150669; Eugene, OR**

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order, Licensee surrenders her acupuncture license while under investigation.

***Farney, Thomas Leo, MD; MD15383; Hermiston, OR**

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. With this Order, Licensee retires his medical license while under investigation.

***Frye, Lindsay Elizabeth, DO; DO187215; Hermiston, OR**

On January 10, 2019, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2018 Corrective Action Agreement.

***Gallagher, Timothy Adrian, MD; MD21152; Lakeview, OR**

On January 10, 2019, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2017 Corrective Action Agreement.

George, Robert Andrew, MD; MD10785; Portland, OR

On January 11, 2019, Licensee entered into a Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to practice under the supervision of a pre-approved mentor for three months, to include chart review and reports to the Board by the mentor.

***Graham, Charles Scott, DO; DO21658; Lakeview, OR**

On January 10, 2019, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2017 Corrective Action Agreement.

***Hall, Terrence Joseph, MD; MD175340; Benton, IL**

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and fraud or misrepresentation in applying for or procuring a license to practice in Oregon. With this Order, Licensee retires his medical license while under investigation.

***Harp, Kristina Elizabeth, MD; MD18780; Lake Oswego, OR**

On January 10, 2019, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2017 Corrective Action Agreement.

***Harrison, Patrick Trent, DO; DO184926; Hermiston, OR**

On January 2, 2019, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

***Hussey, Stephen Arthur, MD; MD22430; Lakeview, OR**

On January 10, 2019, the Board issued an Order Terminating Corrective Action Agreement. This Order terminates Licensee's 2017 Corrective Action Agreement.

***Kahn, Heather Elaine, MD; MD22858; Grants Pass, OR**

On January 10, 2019, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's January 29, 2016, Interim Stipulated Order.

***Kimura, Hidenao, MD; MD19944; Tualatin, OR**

On January 10, 2019, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved CPEP education plan.

***Soldevilla, Francisco Xavier, MD; MD14348; Portland, OR**

On January 10, 2019, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's 2018 Interim Stipulated Order.

***Trotta, Adam Levi, MD; MD184793; Medford, OR**

On December 28, 2018, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

***Yoon, Justin Kyungho, MD; MD162038; Pendleton, OR**

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; conviction of any offense punishable by incarceration in a Department of Corrections institution or in a federal prison; and disciplinary action by another state of a license to practice. This Order reprimands Licensee; assesses a \$10,000 civil penalty, \$5,000 held in abeyance; requires Licensee to complete a pre-approved course on medical ethics; places Licensee on 5-year probation held in abeyance while Licensee's license is inactive; and requires Licensee to complete 192 hours of community service.

If you have any questions regarding this service, please call the Board at (971) 673-2700 or toll-free within Oregon at (877) 254-6263.

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
POLY CHEN, MD) ORDER TERMINATING
LICENSE NO. MD29276) STIPULATED ORDER
)

1.

On July 7, 2016, Poly Chen, MD (Licensee) entered into a Stipulated Order with the Oregon Medical Board (Board). This Order placed Licensee on probation with certain conditions. On November 2, 2018, Licensee submitted a written request to terminate this Order.

2.

Having fully considered Licensee's request and his compliance with the terms of this Order, the Board terminates the July 7, 2016, Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
 ARTHUR KELLY CONRAD, JR., MD)
 LICENSE NO. MD14553) STIPULATED ORDER

1.

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

2.

On November 27, 2017, the Board opened an investigation after receiving credible information regarding Licensee's possible violation of the Medical Practice Act.

3.

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

4.

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

1 4.1 Licensee retires his Oregon medical license while under investigation.

2 4.2 Licensee must obey all Federal and Oregon State laws and regulations pertaining
3 to the practice of medicine.

4 4.3 Licensee stipulates and agrees that any violation of the terms of this Order shall
5 be grounds for further disciplinary action under ORS 677.190(17).

6 5.

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

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9 IT IS SO STIPULATED this 27 day of Sept. 2018.

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11 ARTHUR KELLY CONRAD, JR., MD

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13 IT IS SO ORDERED this 10th day of January 2019.

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15 OREGON MEDICAL BOARD
16 State of Oregon

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18 K. DEAN GUBLER, DO
19 Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
GERALD BARTHOLOMEW ROGER) STIPULATED ORDER
CRAIGG, MD)
LICENSE NO. MD22708)

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. Gerald Bartholomew Roger Craigg, MD (Licensee) is a licensed physician in the State of Oregon.

2.

2.1 Licensee is a board-certified internal medicine physician practicing in Walla Walla, Washington. On November 5, 2015, the State of Washington Medical Quality Assurance Commission (WMQAC) issued a Stipulated Findings of Fact, Conclusions of Law, and Agreed Order. This Order concluded that Licensee committed unprofessional conduct in that he violated Washington Administrative Codes addressing the treatment of chronic non-cancer pain. Licensee reported to the Board in 2015 that WMQAC had taken action restricting his prescribing.

2.2 On April 7, 2016, Licensee and this Board entered into a Stipulated Order that imposed certain terms and conditions, to include paragraph 4.2, which states: "Any modification to the WMQAC Agreed Order must be reported to the Board, with a copy of the modification sent to the Board's Compliance Officer within ten business days of the effective date of the modification."

2.3 On November 31, 2016, Licensee and WMQAC entered into a Modified Stipulated Findings of Fact, Conclusions of Law, and Agreed Order that placed restrictions on

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1 Licensee's Washington license. The modified Washington Order is hereby incorporated into this
2 Order by reference (Attachment A).

3 2.4 Licensee failed to comply with paragraph 4.2 of his Oregon Stipulated Order by
4 failing to report within 10 business days to this Board that he had entered into a Modified
5 Stipulated Findings of Fact, Conclusions of Law, and Agreed Order with WMQAC. Licensee's
6 failure to report violates ORS 677.190(17) and OAR 847-001-0024(2) requiring Licensee to
7 comply with the terms of all Board Orders. It is noted that on or about March 1, 2018, the
8 WMQAC changed the name of the agency to the Washington Medical Commission and shall be
9 referred to as the WMC throughout the rest of this Order.

10 3.

11 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
12 Licensee understands that he has the right to a contested case hearing under the Administrative
13 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
14 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
15 Order in the Board's records. Licensee admits that he violated ORS 677.190(1)(a), as defined by
16 ORS 677.188(4)(a); ORS 677.190(15); and ORS 677.190(17). Licensee understands that this
17 Order is a public record and is a disciplinary action that is reportable to the National Practitioner
18 Data Bank and the Federation of State Medical Boards.

19 4.

20 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order
21 subject to the terms below:

22 4.1 Licensee is reprimanded.

23 4.2 Licensee must pay a civil penalty of \$5,000 within nine months from the effective
24 date of this Order. Licensee may make payments, as long as no payment, excepting the final
25 payment, is less than \$500.

26 4.3 Licensee must not treat Oregon patients for chronic pain with any DEA scheduled
27 medications. For the purposes of this Order, chronic pain is defined as pain that persists or
28 progresses over a period of time greater than 30 days. Licensee may prescribe DEA scheduled

1 medications for patients who are enrolled in hospice or have a life expectancy of less than six
2 months. Licensee must certify on the written prescription that the patient is a hospice patient.

3 4.4 Licensee may treat Oregon patients for acute or intermittent pain, with short
4 acting opiates, for no more than 30 days per patient in a calendar year in an amount not to exceed
5 50 morphine equivalent dose (MED) per day. In addition, Licensee must not combine
6 benzodiazepines or muscle relaxants with Schedule II or III medications for Oregon patients.

7 4.5 Licensee must comply with the Oregon Opioid Prescribing Guidelines published
8 by the Oregon Health Authority when prescribing opioids for Oregon patients.

9 4.6 Licensee must register with the Oregon Prescription Drug Monitoring Program
10 (PDMP). Licensee must query the PDMP prior to initiating treatment with controlled substances
11 for any Oregon patient and periodically thereafter (at least annually) for as long as controlled
12 substances are being prescribed to that patient. Licensee must include a printed copy of the
13 results of the PDMP queries in the patient charts.

14 4.7 As required by term 4.7 of the 2016 modified Washington Agreed Order,
15 Licensee must submit to periodic practice reviews by an entity pre-approved by the WMC.
16 Licensee must sign all necessary releases to allow full communication and exchange of
17 documents and reports between the Oregon Medical Board and the practice review entity.

18 4.8 Licensee must comply with all terms and conditions of the November 31, 2016,
19 Modified Stipulated Findings of Fact, Conclusions of Law, and Agreed Order as well as any
20 future modifications to the Order. Licensee must provide copies to this Board of all
21 correspondence with the WMC regarding his compliance with the Washington Agreed Order
22 within ten business days from his receiving or him sending the correspondence.

23 4.9 Any modifications to the WMC Agreed Order must be reported to the Board, with
24 a copy of the modification sent to the Board's Compliance Officer within ten business days of
25 the effective date of the modification.

26 4.10 Upon termination of the Washington Modified Stipulated Findings of Fact,
27 Conclusions of Law, and Agreed Order, Licensee may submit a request to terminate this Order.

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1 4.11 The Stipulated Order of April 7, 2016, terminates effective the date the Board
2 Chair signs this Order.

3 4.12 Licensee must inform the Compliance Section of the Board of any and all practice
4 sites, as well as any changes in practice address(es), employment, or practice status.
5 Additionally, Licensee must notify the Compliance Section of any changes in contact
6 information within 10 business days.

7 4.13 Licensee stipulates and agrees that this Order becomes effective the date it is
8 signed by the Board Chair.

9 4.14 Licensee must obey all federal and Oregon state laws and regulations pertaining
10 to the practice of medicine.

11 4.15 Licensee stipulates and agrees that any violation of the terms of this Order shall
12 be grounds for further disciplinary action under ORS 677.190(17).
13

14 IT IS SO STIPULATED THIS 4 day of November, 2018.

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16 
17 GERALD BARTHOLOMEW ROGER CRAIGG, MD

18 IT IS SO ORDERED THIS 10th day of January, 2019.
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20 OREGON MEDICAL BOARD
21 State of Oregon
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23 K. DEAN GUBLER, DO
24 BOARD CHAIR
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STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice
as a Physician and Surgeon of:

GERALD B. CRAIGG, MD
License No. MD00044814

Respondent.

No. M2015-1

MODIFIED STIPULATED FINDINGS
OF FACT, CONCLUSIONS OF LAW,
AND AGREED ORDER

The Medical Quality Assurance Commission (Commission), through Seana Reichold, Commission Staff Attorney, and Respondent, represented by counsel, Joel Comfort, stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On August 6, 2015, the Commission issued a Statement of Charges against Respondent. On October 30, 2015, the Commission issued an Amended Statement of Charges against Respondent to include allegations concerning additional patients, Patients E through J.

1.2 In the Amended Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180 (4) and (7) and WAC 246-919-853 through -855, -857, -858, and -862.

1.3 On November 5, 2015, the Commission entered a Stipulated Findings of Fact, Conclusions of Law and Agreed Order (November 2015 Agreed Order) to resolve the matter.

1.4 Under the terms of the November 2015 Agreed Order, Respondent underwent a Competency Assessment at the Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego School of Medicine. The PACE Program issued a report on May 17, 2016. The terms of the November 2015 Agreed Order provided that the Commission at its discretion could issue a Modified Agreed Order based on the assessment and recommendations of the PACE Program.

1.5 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Modified Agreed Order (Modified Agreed Order).

MODIFIED STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW, AND AGREED ORDER
NO.M2015-1

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1.6 This Modified Agreed Order adds the recommendations from the PACE Program's report as required terms, and deletes those terms in the November 2015 Agreed Order which Respondent has already satisfied.

1.7 Respondent waives the opportunity for a hearing on the modification if the Commission accepts this Modified Agreed Order.

1.8 This Modified Agreed Order is not binding unless it is accepted and signed by the Commission.

1.9 If the Commission accepts this Modified Agreed Order, it will be reported to the National Practitioner Data Bank (45 CFR Part 60), the Federation of State Medical Boards' Physician Data Center and elsewhere as required by law.

1.10 This Modified Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Modified Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Modified Agreed Order presentation.

2. FINDINGS OF FACT

Respondent acknowledges that the evidence is sufficient to justify the following findings, and the Commission makes the following findings of facts:

2.1 On March 31, 2005, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is board certified in Internal Medicine. Respondent's license is currently active

2.2 The Findings of Fact in the November 2015 Agreed Order between the Commission and Respondent were:

Patient A

2.2.1 Patient A died on February 23, 2014 from methadone intoxication. At the time of his death, Patient A was a 39-year-old man living in an assisted living facility and receiving physical rehabilitation services. Patient A suffered from the following

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medical conditions: Diabetes mellitus, obesity, sleep apnea (for which he had nightly C-pap treatments), hypertension, depression and bipolar I disorder, obsessive compulsive disorder, schizoaffective disorder, alcohol abuse, GERD, and pain both from diabetic Charcot joint of foot and from two surgeries on his left shoulder after recurrent dislocations. The staff at the assisted living facility administered all of Patient A's medications.

2.2.2 Respondent saw Patient A five times over approximately a six-week period prior to his death, with the first visit occurring on December 12, 2013. Patient A's mother or sister accompanied him to most of his visits to Respondent's office. Respondent last saw Patient A during an office visit on February 20, 2014, three days before Patient A's death due to methadone toxicity.

2.2.3 Prior to seeing Respondent for the first time, Patient A had periodically been prescribed pain medications for his shoulder and foot pain. Patient A's Prescription Monitoring Program records document that he was prescribed intermittent, low-dose oxycodone or hydrocodone over the previous two years.

2.2.4 During the time that the Respondent prescribed for Patient A, he issued similarly low-dose oxycodone until Patient A's last office visit: in mid-December 2013, Respondent prescribed oxycodone-acetaminophen 5-325mg, one tablet every three hours as needed (up to three tablets per day, MED of 22.5 mg). In late December 2013, January 15 and 21, and February 3, 2014, he prescribed oxycodone 5mg, one to two tablets every four hours as needed for pain (up to 12 tablets per day, MED of 90mg). On February 6, 2014, Respondent discontinued the routine doses of oxycodone every four hours.

2.2.5 On February 20, 2014, approximately two weeks after discontinuing Patient A's routine doses of oxycodone, Respondent initiated a prescription of 30mg of methadone daily (10mg of methadone, three times per day). The instructions did not direct the facility to provide the doses at eight-hour intervals. Respondent's records contain no explanation for the switch from low-dose oxycodone (90 mg MED daily) to methadone. Respondent instructed Patient A to return in a month for a follow-up visit.

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2.2.6 Patient A died of methadone intoxication three days later, on February 23, 2014.

2.2.7 Prior to prescribing 30mg of methadone three times per day to Patient A, Respondent failed to:

- 1) provide adequate education about methadone risks, including symptoms associated with methadone toxicity;
- 2) obtain informed consent concerning the risks of methadone;
- 3) obtain an EKG; or
- 4) titrate the dosage of methadone.

2.2.8 During the time Respondent treated Patient A, he failed to document a treatment plan, in violation of WAC 246-919-854.

2.2.9 Respondent failed to adequately and appropriately monitor Patient A while initiating treatment with methadone.

2.2.10 Respondent failed to consider the contraindications for prescribing methadone to Patient A, including taking into account his other medications such as amitriptyline. He further failed to prescribe methadone to Patient A in appropriate amounts and at appropriate dosing schedules. In his treatment of Patient A, the Respondent created an unreasonable risk of harm and/or death.

Patient B

2.2.11 At the time she initiated treatment, Patient B was a 31-year-old woman residing in Clarkston, Washington, approximately 194 miles roundtrip from Respondent's office. She had a history of treatment for chronic non-cancer pain, including pain associated with knee surgeries and multiple four-wheeler crashes.

2.2.12 Patient B first saw Respondent on April 14, 2014. She identified her previous physician and claimed she was being prescribed 80-120mg of methadone daily, 50mg of hydrocodone-acetaminophen 10/325mg daily (five tablets of hydrocodone-acetaminophen 10/325mg), and 3mg of Xanax, a benzodiazepine, daily (three tablets of Xanax 1mg). Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient B 50mg of hydrocodone-acetaminophen 10/325mg daily (five tablets of hydrocodone-acetaminophen 10/325mg), 80-120mg of methadone daily (four tablets, two to

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three times daily of methadone 10mg), and 3mg of Xanax (three tablets of Xanax 1mg), all the amounts she self-reported. Respondent's records do not contain adequate justification to support his methadone, hydrocodone, or Xanax prescriptions. Respondent's records also do not document that he provided adequate education about medication treatment risks, including symptoms associated with methadone toxicity.

2.2.13 Throughout the time Respondent prescribed for Patient B, he failed to document an adequate treatment plan or to taper the controlled substances prescribed.

2.2.14 Also during the time Respondent treated Patient B, she failed to comply with her pain contracts but he continued to prescribe pain medications. Patient B reported that her methadone, Xanax, and hydrocodone were stolen from her car, but without any sign of a break in. Respondent wrote her another 30-day supply for each medication. He also continued to write opioid prescriptions after Patient B failed to consult with a pain specialist or attend physical therapy.

Patient C

2.2.15 At the time she initiated treatment, Patient C was a 51-year-old woman residing in Clarkston, Washington, approximately 194 miles roundtrip from Respondent's office.

2.2.16 Patient C first saw Respondent on June 20, 2014. She had a history of treatment for chronic non-cancer pain and had diagnoses that included degenerative disc disease, arthritis, fracture of lower spine, neuropathy in leg, obesity, spinal stenosis, fibromyalgia, depression, lupus, compression fracture, irritable bowel syndrome, ulcer, pancreatitis, Hiatal hernia, and carpal tunnel syndrome. Patient C listed no former health care provider on her intake form, but listed with specificity the thirteen prescription drugs she reported taking, including methadone, hydrocodone, clonazepam, trazodone, Fioricet, tizanadine, and zolpidem. Patient C also reported two recent falls, one caused for no stated reason and one of which caused her to be taken to the hospital by ambulance.

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2.2.17 Respondent did not obtain Patient C's prior medical records until approximately five months after he began treatment, and only obtained records from 2009 through 2010.

2.2.18 Patient C reported to Respondent that she had been prescribed 160mg of methadone per day (four times per day of 40mg methadone) by her former health care provider. The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had prescribed 40mg *total* of methadone per day. Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 160mg of methadone per day, the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his methadone prescriptions. Respondent's records also do not document that he provided adequate education about methadone risks, including symptoms associated with methadone toxicity.

2.2.19 Patient C also reported to Respondent that she had been prescribed 80mg of hydrocodone per day (eight tablets of hydrocodone 10mg, 80 MED). The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had prescribed two tablets of hydrocodone-acetaminophen 10/325mg per day (20 MED). Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 80mg of hydrocodone per day (eight tablets of hydrocodone 10mg, 80 MED), the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his hydrocodone prescriptions.

2.2.20 Patient C also reported to Respondent that she had been prescribed 16mg of clonazepam, a benzodiazepine, per day (eight tablets of clonazepam 2mg). The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had prescribed *four* tabs of clonazepam 2mg per day, or 8mg per day. Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 16mg of clonazepam per day (eight tablets of clonazepam 2mg), the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his clonazepam prescriptions.

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2.2.21 Patient C also reported to Respondent that she had been prescribed 2,800mg of Soma, a muscle relaxant, per day (eight tablets of carisoprodol 350mg). The Prescription Monitoring Program profile for Patient C indicates that Patient C's previous physician had infrequently prescribed two tabs of carisoprodol 350mg per day. Without obtaining her prior medical records or otherwise confirming her prior prescriptions, Respondent prescribed Patient C 2,800mg of carisoprodol per day (eight tablets of carisoprodol 350mg), the amount Patient C self-reported. Respondent's records do not contain adequate justification to support his carisoprodol prescriptions.

2.2.22 While prescribing methadone, hydrocodone, clonazepam, and carisoprodol to Patient C, Respondent also prescribed zolpidem, a sleep aid, to be taken nightly.

2.2.23 Respondent saw Patient C from June 2014 until at least November 11, 2014, at which time she reported spilling her methadone and hydrocodone medications and needed an early refill, which Respondent provided.

2.2.24 Throughout the time Respondent prescribed for Patient C, he failed to document an adequate treatment plan or to taper the controlled substances prescribed.

2.2.25 Respondent failed to enforce the pain contracts signed by Patient C. He did not obtain urine drug screens to confirm Patient C was taking the medications as prescribed. Respondent referred Patient C to a pain specialist and a physical therapist when he first saw her on June 20, 2014, but failed to enforce her compliance with the pain specialist consultation requirement.

Patient D

2.2.26 At the time he initiated treatment, Patient D was a 33-year-old man residing in Clarkston, Washington, approximately 194 miles roundtrip from Respondent's office. Patient D first saw Respondent on July 11, 2013, to establish care and treatment of chronic, non-cancer pain. Patient D's diagnoses included a history of skull fracture and chronic bilateral heel and ankle pain resulting from injury and surgeries after jumping off a three-and-a-half story building in a suicide attempt. Respondent obtained some of Patient D's recent prior medical records and reviewed them on July 14, 2013. These prior medical records document Patient

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D's recurrent pattern of drug-seeking behavior, doctor shopping, dishonesty, and non-compliance with pain contracts.

2.2.27 The records Respondent obtained revealed that Patient D had been treated for his chronic non-cancer pain by another physician who had tapered Patient D's methadone down from "an astronomical amount." After he was discharged from that physician's practice for dishonesty and non-compliance with his pain contract, Patient D saw a podiatric physician to obtain pain medications on May 3, 2013. At his second visit, on May 30, 2013, the podiatrist noted that Patient D had missed two appointments with his new primary care provider and confirmed he would not refill the methadone prescription for the eight days prior to his appointment with the new primary care provider. Patient D did not return to the podiatrist nor did he follow through with his new primary care provider. About one week later, on June 5, 2013, Patient D sought treatment from yet another physician. After this new physician obtained information regarding Patient D's behavior with prior physicians, he refused to accept Patient D as a patient because Patient D had "been less than honest with" him. This physician questioned "whether any of the neuropathic pain medications ... have ever been trialed on [Patient D] in the past as these are avenues that could be considered." He further noted: "I think, however, until [Patient D] is honest with his providers and shows a willingness to stick to the plan that is prescribed he is not a good candidate for long-term opioid therapy. If this is ever pursued in the future [Patient D] would need to be watched closely with frequent urine drug screens, goals would need to be obtained based upon his utilization of medication, and any deviation would be reason for dismissal."

2.2.28 Patient D first saw Respondent on July 11, 2013. Patient D reported that he had been prescribed 6mg of clonazepam per day (three times per day of 2mg clonazepam) and 120mg of methadone per day (three times per day of 40mg methadone) by his former health care providers.

The Prescription Monitoring Program profile for Patient D indicated that Patient D had been prescribed 4mg of clonazepam, not 6mg as he reported, with the last filled prescription occurring in October of 2012. The profile also indicated that Patient D's previous physicians had generally prescribed him 30mg of

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methadone per day, not 120mg as he reported. Without confirming his prior prescriptions, Respondent prescribed Patient D 6mg of clonazepam per day (three times per day of 2mg clonazepam) and 120mg of methadone per day (three times per day of 40mg methadone), the amounts Patient D self-reported. Respondent's records do not contain adequate justification to support his methadone or clonazepam prescriptions. Respondent's records also do not document that he provided adequate education about methadone risks, including symptoms associated with methadone toxicity. Respondent referred Patient D to a pain specialist and physical therapist.

2.2.29 On July 22, 2013, less than two weeks after his first visit, Patient D returned to Respondent and reported that all his medications got wet and were ruined. Despite having obtained Patient D's prior medical records that detailed numerous accounts of his drug-seeking behavior, doctor shopping, dishonesty, and non-compliance with pain contracts, Respondent refilled his prescriptions, including for methadone.

2.2.30 On August 13, 2013, Respondent added a prescription for Hydrocodone 5/325 mg every six hours as needed, in addition to continuing to prescribe methadone 120 mg per day, without adequate justification. Also at this visit, Patient D called the Respondent requesting an early refill of his methadone prescription because he had used up the prior month's methadone prescription early and had then used his mother's methadone. Despite being warned not to borrow from others or take it upon himself to find other means of obtaining methadone, later that same day, he attempted to fill his methadone prescription early at an unapproved pharmacy, in clear violation of his pain contract.

2.2.31 The next appointment, September 30, 2013, Respondent increased the strength of the hydrocodone prescription to 10/325mg and increased the frequency to every four hours. Over the following year, Respondent increased Patient D's methadone dose to 160mg per day and added hydromorphone with doses up to 12mg per day, all without documenting adequate justification for the prescriptions.

2.2.32 Respondent routinely failed to provide accurate documentation of each visit due to importing outdated and incorrect information from prior visits into the

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electronic health record. Respondent's records do, however, document Patient D's pattern of pain contract violations and generally dishonest, drug-seeking behaviors:

- On October 9, 2013, Patient D reported being pushed down the stairs and requested an increase in his pain medications.
- On December 10, 2013, Patient D reported being in a car crash and stated that was going to increase his methadone dose to four times a day. Respondent noted this violated Patient D's pain contract.
- When Respondent saw Patient D the next day, he learned that the car crash incident also involved Patient D's children who were in the vehicle with him when it "rolled 5 times fifty feet down mountain." The children were taken by ambulance to the hospital.
- On December 31, 2013, Respondent reviewed a police report in which an acquaintance stated that Patient D invited him to his home on December 25, 2013, to buy some of Patient D's methadone pills. Patient D reported to the police that that the acquaintance had stolen the 480 tabs of methadone. Respondent later issued Patient D a refill for the methadone.
- On March 4, 2014, Patient B (Patient D's wife) called and requested more pain medication for Patient D due to his having had teeth pulled.
- On April 14, 2014, Patient D reported that he had been involved in another four-wheeler crash in which he "flew off [and] rolled on road" with loss of consciousness, and that he wanted to be back on monthly methadone.
- On May 7, 2014, Patient D reported he had used up his Dilaudid (hydromorphone) prescription early and needed a refill.
- Patient D again requested early refills of his oploid prescriptions on June 9, 2014.

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- The next month, on July 7, 2014, a pharmacist informed Respondent that Patient D had tried to obtain an early refill of hydromorphone.

2.2.33 During the time Respondent treated and prescribed for Patient D, he consistently failed to follow through with appointments for physical therapy and pain management.

When Patient D finally obtained an evaluation by a physical therapist on May 28, 2014, ten months after the initial referral, he was discharged from the practice within a month for failing to return; cancelling or failing to show each time.

Respondent noted for nine months that Patient D failed to see the referred pain specialist. Once Patient D finally saw the pain specialist in April 2014, the physician noted that "Patient has pain everywhere. Per notes wants to be on methadone. ... I don't manage methadone. Recommend a true pain clinic." On June 30, 2014, Respondent referred Patient D to another specialist, starting the cycle again and noting at each visit that Patient D had not gone to see the pain specialist.

2.2.34 Instead of discharging Patient D due to his repeated non-compliance, Respondent explained to the Commission that Patient D's "inconsistency with keeping appointments ... complicated his treatment."

2.2.35 During the time Respondent treated Patient D, he failed to document an adequate treatment plan.

2.2.36 Patients B, C and D listed themselves in Respondent's records as family members. Patient B is listed as Patient D's wife. Patient C is Patient D's mother. All three patients traveled from the Clarkston-Lewiston area to see Respondent, a trip of approximately 194 miles roundtrip. The Respondent did not document any suspicion or other inquiry into the reason these three family members would travel 194 miles to obtain prescriptions for high levels of opioid pain medications for chronic, non-cancer pain.

2.2.37 While treating Patients A through D with high levels of methadone, Respondent had inadequate training in pain management with long-acting opioids,

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and did not discharge Patients B, C, or D for their failures to comply with the pain contracts.

Patients E Through J

2.2.38 For the following patients Respondent violated the applicable standard of care by initiating high-dose methadone without titration or observation, or by greatly increasing methadone doses without titration or observation: Patients E, F, G, I, and J.

2.2.39 For the following patients Respondent violated the applicable standard of care by failing to provide adequate education about methadone risks, and failing to obtain informed consent concerning the risks of methadone: Patients E through J.

2.2.40 Respondent violated the applicable standard of care for Patients G and J by abruptly discontinuing their high-dose methadone, without taper schedules.

2.2.41 Respondent violated the applicable standard of care for Patient H by maintaining him on an extremely high-dose of methadone, without a taper schedule or justification for the high dose.

2.2.42 For the following patients Respondent violated the applicable standard of care by failing to provide documentation of his reasoning and/or justification for his prescribing practices and by failing to develop a meaningful treatment plan: Patients E through J.

2.2.43 For the following patients Respondent violated the applicable standard of care by increasing without justification the patients' lifetime risks of opioid tolerance and hyperalgesia as a result of his prescribing practices: Patients E through J.

2.2.44 For the following patients Respondent violated the applicable standard of care by failing to require that they consult with a pain specialist: Patients E through J.

2.2.45 For the following patients Respondent violated the applicable standard of care by failing to perform urine drug screens: Patients E, G, and I.

3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law.

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3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (4) and (7) and WAC 246-919-853 through -855, -857, -858, -860, and -862.

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

4. MODIFIED AGREED ORDER

This Modified Agreed Order supersedes the Agreed Order entered in November 2015. Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Modified Agreed Order:

4.1 Opioid Prescribing Limitation. Respondent shall not prescribe opioids (this term includes schedule II and III narcotics and schedule IV controlled substances) to any patient with chronic pain, without first having the patient evaluated by a pain specialist who has formal pain management training and expertise. Respondent shall not prescribe schedule II and III narcotics and schedule IV controlled substances for chronic pain patients, unless they are recommended by the pain specialist, as described above. The pain specialist shall provide Respondent with appropriate dosing guidelines as to how the medications should be used and titrated. Respondent will obtain copies of the pain specialist consult and include the records in the patient's chart. Respondent may prescribe Schedule III and Schedule IV controlled substances to treat patients with severe acute pain without oversight from a pain specialist; however, such prescriptions shall be limited to no more than 7 days worth of pain medication with no refills.

4.2 Prescribing Course and Medical Recordkeeping Course. Respondent has successfully completed an intensive course in medical recordkeeping and opioid prescribing.

4.3 Compliance Orientation. Respondent shall complete a compliance orientation in person or by telephone within sixty (60) days of the effective date of this Stipulation. Respondent must contact the Compliance Unit at the Commission by calling 360-236-2763, or by sending an email to: Medical.compliance@doh.wa.gov within ten

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(10) days of the effective date of this Modified Agreed Order. Respondent must provide a contact phone number where Respondent can be reached for scheduling purposes.

4.4 Term of Commission Oversight. Respondent's license to practice as a physician and surgeon in the state of Washington is subject to this Modified Agreed Order for a period of at least five years from the effective date of the November 2015 Agreed Order. During the term of the Modified Agreed Order, Respondent must comply with all of the terms and conditions of the Modified Agreed Order and Respondent's treatment of his patients must meet the standard of care.

4.5 Pain Management Rules. Respondent will fully comply with the pain management rules, found at WAC 246-819-850 through 863.

4.6 Prescription Monitoring Program. Respondent has registered with the Washington PMP. Respondent will query the PMP regularly, including for new pain patients, periodically for existing pain patients, and when a pain patient exhibits signs of possible misuse, abuse, or diversion. Respondent will print out the results of his queries and include them in the patient's chart.

4.7 Practice Reviews. In order to monitor compliance with this Modified Agreed Order, Respondent will submit to periodic practice reviews at Respondent's office performed by an entity preapproved by the Commission or its designee. The Center for Personalized Education for Physicians (CPEP) practice monitoring program is preapproved. Respondent is responsible for all costs associated with the practice monitoring program. The representative will review patient records, and may interview Respondent and Respondent's employees. The representative will contact Respondent's office to give advance notice before each practice review. The practice reviews must occur quarterly for the first year from the effective date of this Modified Agreed Order and will consist of ten (10) charts per quarterly review. The frequency of practice reviews may be increased or decreased after one (1) year at the discretion of the Commission based on the recommendations of the reviewer. The Commission intends for the practice reviews to continue at least once annually for the duration of this Agreed Order. Respondent will maintain waivers of confidentiality authorizing full exchange of information between the evaluator, the practice review entity, and the Commission. The Commission may take

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additional action, in a separate case, if the practice review reveals ongoing concerns regarding Respondent's practice.

4.8 Fine. Respondent must pay a fine to the Commission in the amount of \$5,000, which may be paid in installments, to be paid at least annually in installments of at least \$1,000 each. The first installment of \$1,000 was received on June 2, 2016. The fine must be paid by certified or cashier's check or money order, made payable to the Medical Quality Assurance Commission and mailed to the Department of Health, P.O. Box 1099, Olympia, Washington 98507-1099.

4.9 Compliance Appearances. Respondent shall appear before the Commission on an annual basis at a date, time and location designated by the Commission, at the Commission's discretion. At each compliance appearance, Respondent will present proof of continuing compliance with this Modified Agreed Order and will answer questions by the Commission related to his compliance and related to his practice in general. Respondent shall continue to appear annually unless otherwise instructed in writing by the Commission or its representative.

4.10 Repeat Neuropsychological Evaluation. Respondent shall undergo a repeat neuropsychological evaluation one (1) year from the date of the last exam, which occurred on June 27, 2016. The evaluator must be approved in advance by the Commission or its designee. Aimee Asgarian, PsyD is pre-approved. The Commission may initiate further action against Respondent's license, or require Respondent to submit to subsequent evaluations based on the recommendations of the evaluator.

4.11 Termination. Respondent may petition to terminate the terms and conditions of this Modified Agreed Order no sooner than five years from the effective date of the November 2015 Agreed Order, which was November 5, 2015. The Commission has the sole discretion to grant or deny Respondent's petition. The decision will depend on a number of factors, including Respondent's compliance with the terms and conditions of this Modified Agreed Order, Respondent's demonstration that he can practice medicine with reasonable skill and safety, and submission of any assessments and reports deemed necessary by the Commission.

4.12 Notification of Change in Practice. Respondent will notify the Commission within 30 calendar days if he stops practicing medicine.

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4.13 Obey all laws. Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.14 Compliance Costs. Respondent is responsible for all costs of complying with this Modified Agreed Order.

4.15 Violation of Order. If Respondent violates any provision of this Modified Agreed Order in any respect, the Commission may initiate further action against Respondent's license.

4.16 Change of Address. Respondent shall inform the Commission and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

4.17 Address for Communications. All reports required by this Modified Agreed Order, as well as any other communications related to it, must be sent to: Compliance Officer, Medical Quality Assurance Commission, P.O. Box 47866, Olympia, Washington 98504-7866.

4.18 Effective Date of Order. The effective date of this Modified Agreed Order is the date the Adjudicative Clerk Office places the signed Modified Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Modified Agreed Order.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies WAC 246-16-800, et seq., to determine appropriate sanctions. Tier C of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices result in severe patient harm or death. Respondent's care of Patient A caused severe harm, and Respondent created the risk of severe harm or death for Patients B through J due to Respondent's unsafe prescribing practices.

5.2 Tier C requires the imposition of sanctions ranging from three years of restrictions and/or conditions to permanent restrictions and/or conditions, or revocation.

Under WAC 246-16-800(3)(d), the starting point for the duration of the sanctions is the middle of the range, but there is no middle of the range for Tier C. The Commission uses aggravating and mitigating factors, listed below to move toward the maximum or minimum ends of the range. The mitigating and aggravating factors in this case, listed

MODIFIED STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW, AND AGREED ORDER
NO.M2015-1

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below, justify the 5 year term of oversight in this Modified Agreed Order. The terms of this Modified Agreed Order include oversight for at least five years, a limitation on opioid prescribing, a narcotic prescribing and medical documentation course, compliance appearances, practice reviews, a repeat neuropsychological exam in one year, and a \$5,000 fine.

5.3 The following are aggravating factors:

5.3.1 The injury caused by Respondent's unprofessional conduct

5.3.2 Respondent's unprofessional conduct involved multiple patients

5.4 The following are mitigating factors:

5.4.1 Respondent has not been the subject of discipline in the past;

5.4.2 Respondent cooperated with the Commission's investigation by promptly providing requested medical records;

5.4.3 After the Statement of Charges was issued, Respondent attended continuing medical education to improve his understanding of narcotic prescribing.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

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7. RESPONDENT'S ACCEPTANCE

I, GERALD B.R. CRAIGG, Respondent, have read, understand and agree to this Modified Agreed Order. This Modified Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Modified Agreed Order.


GERALD B. R. CRAIGG MD
RESPONDENT

DATE

10/31/2016


JOEL R. COMFORT, WSBA# 31477
ATTORNEY FOR RESPONDENT

DATE

10/31/2016

8. COMMISSION'S ACCEPTANCE AND ORDER

The Commission accepts and enters this Modified Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED: 10/31/16, 2016.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION


PANEL CHAIR

PRESENTED BY:


SEANA REICHOLD, WSBA#49163
COMMISSION STAFF ATTORNEY

DATE

11/3/16

MODIFIED STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW, AND AGREED ORDER
NO.M2016-1

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
WILLIAM EDWARD DAVIS, DO)
LICENSE NO. DO07432) DEFAULT ORDER
)

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. William Edward Davis, DO (Licensee) is a licensed osteopathic physician in the State of Oregon.

2.

On August 13, 2018, the Board sent to Licensee by regular and certified mail a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(17), willful violation of any rule adopted by the board (specifically OAR 847-001-0024) or failing to comply with a board request; and ORS 677.190(24), prescribing a controlled substance without a legitimate medical purpose, or without following accepted procedures for examination of patients or without following accepted procedures for record keeping. The Notice informed Licensee that if he failed to submit a request for hearing or failed to appear at a scheduled hearing, the Board may issue a final order by default. Licensee did not request a hearing. As a result, Licensee has waived his right to a hearing and now stands in default. The

1 Board elects in this case to designate the record of proceedings to date, which consists of
2 Licensee's file with the Board as the record for purposes of proving a prima facie case, pursuant
3 to ORS 183.417(4). Prior to the issuance of the Notice, on June 7, 2018, the Board issued an
4 Order of Emergency Suspension, due to Licensee's failure to respond to Board inquiries and
5 concerns regarding patient safety. Licensee did not request a hearing on the Order of Emergency
6 Suspension, and that Order remains in effect.

7 3.

8 **FINDINGS OF FACT**

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

10 3.1 Licensee prescribed alprazolam (Xanax, Schedule IV) 1 mg, #120 tablets every
11 30 days for Patient A, a 57-year-old female, over the course of several years, for depression and
12 anger. Patient A became addicted, requiring inpatient treatment. Although Licensee informed
13 Patient A that he had fears that she may be dependent on the medication, he continued to
14 prescribe Xanax for her and did not refer her for treatment or consultation. Licensee's treatment
15 of Patient A with a high dosage of Xanax exposed Patient A to the risk of harm and he failed to
16 address her symptoms of drug dependence, which adversely affected her health and the well-
17 being of her immediate family.

18 3.2 A review of Licensee's prescribing practices for the calendar year 2017 revealed
19 that Licensee was prescribing high doses of benzodiazepines to multiple patients, exposing them
20 to the risk of harm.

21 3.3 The Board has attempted to contact Licensee on multiple occasions by letter,
22 email, and phone. Licensee failed to respond to any of these attempts. Between December 13,
23 2017, and May 14, 2018, seven separate notices of investigation with requests for a response
24 were mailed to Licensee at his home and practice addresses of record. Correspondences sent on
25 February 22, 2018, and May 14, 2018, were sent by certified mail; delivery confirmations were
26 received for each of these mailings. The May 14, 2018, request stated in part, "An additional
27 copy of the referenced notice of investigation has been enclosed with this letter, which has a

1 response deadline of May 28, 2018. If you fail to respond by this date, the Oregon Medical
2 Board will suspend your license to practice medicine in the state of Oregon.” Licensee signed a
3 delivery confirmation for this letter, but failed to respond to the Board. Several phone messages
4 were left with a female who stated she was Licensee’s wife, requesting that Licensee call the
5 Board as soon as possible; Licensee never returned the calls. Several email communications
6 were also met with no response. Licensee is required to cooperate with a Board investigation by
7 Board rule, OAR 847-001-0024.

8 4.

9 **CONCLUSIONS OF LAW**

10 Based upon its examination of the record in this case, the Board finds that the acts and
11 conduct of Licensee described above is supported by reliable, probative and substantive evidence
12 and violated the Medical Practice Act, as set forth below:

13 4.1 Licensee’s manner of prescribing high doses of benzodiazepines to multiple
14 patients, to include Patient A, exposed them to the risk of harm, and violated ORS 677.190(1)(a)
15 unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a) any conduct or
16 practice which does or might constitute a danger to the health or safety of a patient or the public.

17 4.2 Licensee violated ORS 677.190(24), by prescribing a controlled substance
18 without a legitimate medical purpose, without following accepted procedures for examination of
19 patients, and without following accepted procedures for record keeping.

20 4.3 Licensee violated ORS 677.190(17), willful violation of any rule adopted by the
21 Board (OAR 847-001-0024), by failing to cooperate with the Board’s investigation, to include
22 failing to respond to Board requests for information.

23 5.

24 **ORDER**

25 The Board has the statutory duty to protect the public from the practice of medicine by
26 licensees who engage in unprofessional conduct and otherwise demonstrate that they cannot be
27 trusted with a medical license. In this case, Licensee exposed patients to the risk of harm in the

1 manner that he prescribed controlled substances and exposed his patients to the risk of harm.
2 Licensee also failed to cooperate with the Board's investigation. In order to protect the public
3 and appropriately address his conduct, license revocation is the appropriate sanction.

4 5.1 IT IS HEREBY ORDERED THAT the license of William Edward Davis, DO, to
5 practice osteopathic medicine in the State of Oregon is revoked.

6 5.2 The Order of Emergency Suspension of June 7, 2018, terminates by operation of
7 law when this Default Order becomes final.

8
9
10 DATED this 10th day of January, 2019.

11 OREGON MEDICAL BOARD
12 State of Oregon

13 
14 K. DEAN GUBLER, DO
15 BOARD CHAIR
16

17 **Right to Judicial Review**

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

In the Matter of)
)
 RAHUL NAREN DESAI, MD) CORRECTIVE ACTION AGREEMENT
 LICENSE NO. MD28444)
)

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

2.

Licensee is a board certified radiologist practicing in Beaverton, Oregon. The Board opened an investigation after receiving a complaint in regard to Licensee's interactions with members of his clinic.

3.

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

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

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4.

In order to address the concerns of the Board and for purposes of resolving this investigation, Licensee and the Board agree that the Board will close this investigation contingent upon Licensee agreeing to the following conditions:

4.1 Within six months from the signing of this Agreement by the Board Chair, Licensee agrees to successfully complete a course on professional boundaries that is pre-approved by the Board's Medical Director.

4.2 This Agreement becomes effective upon signature by the Board Chair.

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

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

IT IS SO STIPULATED THIS 21st day of Dec, 2018.


RAHUL NAREN DESAI, MD

IT IS SO ORDERED THIS 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
BOARD CHAIR

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

SUZANNE CATHERINE FAIRCHILD,
LAC
LICENSE NO. AC150669

$$\left. \begin{array}{l}) \\) \\) \\) \end{array} \right\}$$

STIPULATED ORDER

1.

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

2.

On August 16, 2018, the Board opened an investigation after receiving credible information regarding Licensee's unprofessional or dishonorable conduct and other possible violations of the Medical Practice Act.

3.

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

1 4.

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

4 4.1 Licensee surrenders her Oregon acupuncture license while under investigation.

5 4.2 Licensee must obey all Federal and Oregon State laws and regulations pertaining
6 to the practice of acupuncture.

7 4.3 Licensee stipulates and agrees that any violation of the terms of this Order shall
8 be grounds for further disciplinary action under ORS 677.190(17).

9 5.

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

11
12 IT IS SO STIPULATED this 13th day of November 2018.

13
14 
15 SUZANNE CATHERINE FAIRCHILD, LAC

16 IT IS SO ORDERED this 10th day of January 2019.

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18 OREGON MEDICAL BOARD
19 State of Oregon

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

In the Matter of

THOMAS LEO FARNEY, MD
LICENSE NO. MD15383

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

2.

On October 26, 2017, the Board opened an investigation after receiving credible information regarding Licensee's medical practice.

3.

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

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1 4.

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

4 4.1 Licensee retires his Oregon medical license while under investigation.

5 4.2 Licensee must obey all Federal and Oregon State laws and regulations pertaining
6 to the practice of medicine.

7 4.3 Licensee stipulates and agrees that any violation of the terms of this Order shall
8 be grounds for further disciplinary action under ORS 677.190(17).

9 5.

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

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12 IT IS SO STIPULATED this 13 day of December 2018.

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14 
15 THOMAS LEO FARNEY, MD

16 IT IS SO ORDERED this 10th day of January 2019.

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18 OREGON MEDICAL BOARD
19 State of Oregon

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

In the Matter of)
)
LINDSAY ELIZABETH FRYE, DO) ORDER TERMINATING
LICENSE NO. DO187215) CORRECTIVE ACTION AGREEMENT
)

1.


On April 5, 2018, Lindsay Elizabeth Frye, DO (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On October 2, 2018, Licensee submitted documentation that she has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the April 5, 2018, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
TIMOTHY ADRIAN GALLAGHER, MD) ORDER TERMINATING
LICENSE NO. MD21152) CORRECTIVE ACTION AGREEMENT

1.


On October 5, 2017, Timothy Adrian Gallagher, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On October 30, 2018, 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 complied with all of the terms of this Agreement. The Board terminates the October 5, 2017, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
CHARLES SCOTT GRAHAM, DO) ORDER TERMINATING
LICENSE NO. DO21658) CORRECTIVE ACTION AGREEMENT
)

1.

On October 5, 2017, Charles Scott Graham, DO (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On October 30, 2018, 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 complied with all of the terms of this Agreement. The Board terminates the October 5, 2017, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
Board Chair

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STIPULATED ORDER

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Page 1 -STIPULATED ORDER -- Terrence Joseph Hall, MD, PhD

1 4.

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

4 4.1 Licensee retires his Oregon medical license while under investigation.

5 4.2 Licensee must obey all Federal and Oregon state laws and regulations pertaining
6 to the practice of medicine.

7 4.3 Licensee stipulates and agrees that any violation of the terms of this Order shall
8 be grounds for further disciplinary action under ORS 677.190(17).

9 5.

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

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12 IT IS SO STIPULATED this 18 day of December 2018.

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15 TERRENCE JOSEPH HALL, MD, PHD

16 IT IS SO ORDERED this 10th day of January 2019.

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18 OREGON MEDICAL BOARD
19 State of Oregon

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

In the Matter of)
)
KRISTINA ELIZABETH HARP, MD) ORDER TERMINATING
LICENSE NO. MD18780) CORRECTIVE ACTION AGREEMENT
)

1.


On April 7, 2017, Kristina Elizabeth Harp, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On August 21, 2018, Licensee submitted documentation that she has successfully completed all terms of this Agreement and requested that this Agreement be terminated.

2.

The Board has reviewed the documentation submitted by Licensee and has determined that Licensee has successfully complied with all of the terms of this Agreement. The Board terminates the April 7, 2017, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
PATRICK TRENT HARRISON, DO) INTERIM STIPULATED ORDER
LICENSE NO. DO184926)
)

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain healthcare providers, including osteopathic physicians, in the State of Oregon. Patrick Trent Harrison, DO (Licensee) is a licensed osteopathic physician in the State of Oregon.

2.

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

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

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

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

1 4.

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

6 5.

7 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
8 of protecting the public, and making a complete investigation in order to fully inform itself with
9 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
10 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are
11 confidential and shall not be subject to public disclosure. However, as a stipulation this Order is
12 a public document and is reportable to the National Practitioner Data Bank and the Federation of
13 State Medical Boards.

14 6.


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

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17 IT IS SO STIPULATED THIS 2 day of Jan, 2018⁹ PIT

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19 
20 PATRICK TRENT HARRISON, DO

21 IT IS SO ORDERED THIS 2nd day of January, 2018⁹

22 State of Oregon
23 OREGON MEDICAL BOARD

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25 NICOLE KRISHNASWAMI, JD
26 EXECUTIVE DIRECTOR
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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
STEPHEN ARTHUR HUSSEY, MD) ORDER TERMINATING
LICENSE NO. MD22430) CORRECTIVE ACTION AGREEMENT
)

1.

On October 5, 2017, Stephen Arthur Hussey, MD (Licensee) entered into a Corrective Action Agreement with the Oregon Medical Board (Board). This Agreement placed conditions on Licensee's Oregon license. On December 21, 2018, 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 complied with all of the terms of this Agreement. The Board terminates the October 5, 2017, Corrective Action Agreement, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon

K. DEAN GUBLER, DO
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
HEATHER ALAINE KAHN, MD) ORDER TERMINATING INTERIM
LICENSE NO. MD22858) STIPULATED ORDER
)

1.

On January 29, 2016, Heather Alaine Kahn, MD (Licensee) entered into an Interim Stipulated Order with the Oregon Medical Board (Board). This Order placed conditions on Licensee's Oregon medical license. On October 5, 2017, Licensee entered into a Stipulated Order with the Board. Term 5.8 of the October 5, 2017, Stipulated Order reads:

5.8 Upon notification from CPEP that in order to complete the CPEP education plan, Licensee's prescribing privileges must not be limited by the Board, the Medical Director may authorize the termination of the Interim Stipulated Order of January 29, 2016. Alternatively, upon notification from CPEP that Licensee has completed the education plan, the Medical Director may authorize the termination of the Interim Stipulated Order. Licensee will be notified in writing of such a termination when and if it occurs.

2.

On November 29, 2018, the Board received verification of Licensee's completion of the CPEP education plan. Having fully considered Licensee's completion of the CPEP education plan, the Board terminates the January 29, 2016, Interim Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
Board Chair

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)

HIDENAO KIMURA, MD)
LICENSE NO. MD19944)

CORRECTIVE ACTION AGREEMENT

1.

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

2.

Licensee is an internist who practices in Tualatin, Oregon. On January 31, 2018, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed taking disciplinary action for violations pursuant to ORS 677.205(2), against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping. Prior to the issuance of the Notice, on May 16, 2017, Licensee entered into an Interim Stipulated Order in which he agreed to certain restrictions regarding his prescribing of controlled substances.

3.

Licensee and the Board now desire to settle this matter by entry of this Agreement. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Agreement in the Board's records. The Board agrees to close the current investigation and does

1 not make a finding in regard to any violation of the Medical Practice Act. This Agreement is a
2 public document; however, it is not a disciplinary action. This document is reportable to the
3 National Practitioner Data Bank and the Federation of State Medical Boards.

4 4.

5 In order to address the concerns of the Board and for purposes of resolving this
6 investigation, Licensee and the Board agree that the Board will close this investigation
7 contingent upon Licensee agreeing to the following conditions:

8 4.1 Within 30 days of the effective date of this Agreement, Licensee agrees to
9 contract with CPEP for the development of an education plan. Licensee agrees to bear the cost
10 of the completion of any CPEP recommendations, the development of an education plan, and any
11 post-education evaluation. Licensee agrees to sign all necessary releases to allow full
12 communication and exchange of documents and reports between the Board and CPEP. Licensee
13 agrees to ensure CPEP submits the education plan and reports directly to the Board.

14 4.2 Licensee agrees to sign the appropriate paperwork indicating that he agrees to
15 enroll in the education plan, and return the signed documents to CPEP within 15 days of
16 approval of the educational plan by the Board's Medical Director. Licensee agrees to
17 successfully complete the CPEP education plan, including any post-education evaluation, within
18 18 months from the date the educational plan is approved. Licensee agrees to comply with any
19 educational recommendations, practice modifications, and timelines set forth by CPEP. Licensee
20 agrees to bear all costs associated with the approved education plan. Any educational mentor
21 must be pre-approved by CPEP and the Board's Medical Director. Licensee agrees to sign all
22 necessary releases to allow full communication and exchange of documents and reports between
23 the Board, CPEP, and any mentors. Licensee agrees to keep the Board apprised of his
24 compliance with the CPEP education plan throughout its duration.

25 4.3 Licensee agrees to provide the Board with written proof from CPEP upon
26 successful completion of the approved education plan, including successful completion of any
27 post-education evaluation, as defined above.

28 ///

1 4.4 Upon a submitted request from CPEP that Licensee's May 16, 2017, Interim
2 Stipulated Order be terminated in order to allow Licensee to complete the education plan, the
3 Board's Medical Director may approve the termination of the Interim Stipulated Order. If no
4 request is received from CPEP, the Interim Stipulated Order will be terminated upon receipt of
5 documentation of Licensee's successful completion of the education plan. Licensee will be
6 notified in writing if and when this termination occurs.

7 4.5 Licensee agrees to obey all federal and Oregon state laws and regulations
8 pertaining to the practice of medicine.

9 4.6 Licensee agrees that any violation of the terms of this Agreement constitutes
10 grounds to take disciplinary action under ORS 677.190(17).

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12 IT IS SO AGREED THIS 19th day of December 2018.

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14 
15 HIDENAO KIMURA, MD

16 IT IS SO ORDERED THIS 10th day of January 2019.

17
18 OREGON MEDICAL BOARD
19 State of Oregon

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21 K. DEAN GUBLER, DO
22 BOARD CHAIR

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
FRANCISCO XAVIER SOLDEVILLA, MD) ORDER TERMINATING
LICENSE NO. MD14348) INTERIM STIPULATED ORDER
)

1.


On March 1, 2018, Francisco Xavier Soldevilla, MD (Licensee) entered into an Interim Stipulated Order with the Oregon Medical Board (Board). This Order restricted Licensee's implantation of spinal cord stimulators.

2.

At its meeting on January 10, 2019, the Board reviewed this matter. The Board terminates the March 1, 2018, Interim Stipulated Order, effective the date this Order is signed by the Board Chair.

IT IS SO ORDERED this 10th day of January, 2019.

OREGON MEDICAL BOARD
State of Oregon


K. DEAN GUBLER, DO
Board Chair

BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
)
 ADAM LEVI TROTTA, MD) INTERIM STIPULATED ORDER
 LICENSE NO. MD184793)
)

1.

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

2.

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

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which is not an admission of any wrongdoing on the part of the Licensee, and provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

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

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

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1 4.

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

6 5.

7 This Order is issued by the Board pursuant to ORS 677.265(1) and (2) for the purpose
8 of protecting the public, and making a complete investigation in order to fully inform itself with
9 respect to the performance or conduct of the Licensee and Licensee's ability to safely and
10 competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are
11 confidential and shall not be subject to public disclosure. However, as a stipulation this Order is
12 a public document and is reportable to the National Practitioner Data Bank and the Federation of
13 State Medical Boards.

14 6.


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

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17 IT IS SO STIPULATED THIS 28 day of December, 2018.

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19 
20 ADAM LEVI TROTTA, MD

21 IT IS SO ORDERED THIS 31 day of December, 2018.

22 State of Oregon
23 OREGON MEDICAL BOARD

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26 JOSEPH J. THALER, MD
27 MEDICAL DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of:)
JUSTIN KYUNGHO YOON, MD) STIPULATED ORDER
LICENSE NO. MD162038)

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. Justin Kyungho Yoon, MD (Licensee), is a licensed physician in the State of Oregon

2.

On April 16, 2018, the Board issued a Complaint and Notice of Proposed Disciplinary Action in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(6) conviction of any offense punishable by incarceration in a Department of Corrections institution or in a federal prison; and ORS 677.190(15) disciplinary action by another state of a license to practice. Prior to the issuance of the Notice, on January 15, 2016, Licensee entered into an Interim Stipulated Order in which he voluntarily withdrew from the practice of medicine pending the completion of the Board's investigation.

3.

Licensee holds lifetime board certification in diagnostic radiology. Licensee's acts and conduct that violated the Oregon Medical Practice Act follow:

3.1 Licensee was arrested on January 5, 2016, in Seattle, Washington, and charged with one count of promoting prostitution in the second degree, a class C felony. Licensee wrote and posted reviews of his sexual experiences with some of the women that were published on the

1 websites that promoted prostitution. Licensee entered into a plea agreement and was found
2 guilty of promoting prostitution in the second degree (RCW 9A.88.080(1)(b)) in the Superior
3 Court of Washington for King County, a class C felony. His sentence of 30 days of confinement
4 was converted to 240 hours of community service. Licensee's conduct violated ORS
5 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); and
6 ORS 677.190(6) conviction of any offense punishable by incarceration in a Department of
7 Corrections institution or in a federal prison.

8 3.2 The Washington Medical Commission (WMC), formerly the Medical Quality
9 Assurance Commission of the State of Washington, issued a statement of charges against
10 Licensee on September 13, 2016, based upon his plea of guilty to one count of promoting
11 prostitution in the second degree. Licensee subsequently entered into a Stipulated Findings of
12 Fact, Conclusions of Law, and Agreed Order that became effective on January 12, 2017, in
13 which Licensee was obligated to provide community service at a local non-profit organization
14 that serves the interest of vulnerable populations for two years at a rate of at least 96 hours per
15 year; complete a course on medical ethics; complete a paper addressing how engaging in illegal
16 or immoral activities can harm a medical professional's standing in the medical profession; pay a
17 fine of \$20,000; and appear before WMC on an annual basis for the purpose of overseeing
18 Licensee's compliance with the Agreed Order. The WMC action constitutes a violation of ORS
19 677.190(15) disciplinary action by another state of a license to practice.

20 4.

21 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
22 Licensee understands that he has the right to a contested case hearing under the Administrative
23 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
24 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
25 Order in the Board's records. Licensee admits that he engaged in the conduct described in
26 paragraph 3 (above) and that this conduct violated: ORS 677.190(1)(a) unprofessional or
27 dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(6) conviction of any

1 offense punishable by incarceration in a Department of Corrections institution or in a federal
2 prison; and ORS 677.190(15) disciplinary action by another state of a license to practice.

3 Licensee understands that this Order is a public record and is a disciplinary action that is
4 reportable to the National Practitioner Data Bank and the Federation of State Medical Boards.

5 5.

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

8 5.1 Licensee is reprimanded.

9 5.2 Licensee is assessed a civil penalty of \$10,000, of which \$5,000 will be held in
10 abeyance contingent upon Licensee complying with all other terms and conditions of this Order.
11 The remaining \$5,000 is due within two years of the effective date of this Order. Licensee may
12 make payments, as long as no payment, excepting the final payment, is less than \$100.

13 5.3 Within six months of the effective date of this Order, and at his own expense,
14 Licensee must complete a course on medical ethics that is preapproved by the Board's Medical
15 Director. This course may not be used to satisfy the Board's continuing education requirement for
16 license renewal.

17 5.4 Licensee is placed on probation for five years. Licensee must report in person to
18 the Board at least once a year during a regularly scheduled quarterly meeting at the scheduled
19 time for a probationer interview unless ordered to do otherwise by the Board. Interviews may be
20 held electronically, at the Board's discretion; between Licensee and the Board's Compliance
21 Officer (or its designee) using Board established protocols for the location and electronic
22 transmission of the meeting. Licensee is responsible for supplying and maintaining the
23 equipment and technology necessary for him to participate in the electronic meetings. Licensee
24 will be notified if and when such meetings are scheduled in lieu of an in person appearance at a
25 quarterly Board meeting. This term will be held in abeyance as long as Licensee's Oregon
26 medical license is at inactive status.

27 ///

1 5.5 Licensee must volunteer his time to a non-profit organization(s) that has been pre-
2 approved by the Board. Within 60 days of the effective date of this Order, Licensee must submit
3 to the Board for approval a list of non-profit organizations as well as details regarding how each
4 organization works and how Licensee intends to volunteer his time. Within 30 days of approval
5 from the Board, Licensee must begin the volunteer work

6 5.6 Licensee must keep a log of the dates, times, and places volunteered and in what
7 capacity—i.e. mentoring, speaking, providing service, etc. Licensee must have the non-profit
8 organization manager or their designee sign the log for accuracy at the end of each time period
9 volunteered. Licensee must submit copies of his log every three months to the Board. Licensee
10 must volunteer his time for a total of 192 hours to be completed within a two-year time period.
11 These hours are in addition to the hours required by the Washington Commission.

12 5.7 After two years of successful compliance with all terms of this Order, Licensee
13 may request modification of the Order.

14 5.8 The Interim Stipulated Order of January 15, 2016, terminates effective the date
15 the Board Chair signs this Stipulated Order.

16 5.9 Licensee stipulates and agrees that this Order becomes effective the date it is
17 signed by the Board Chair.

18 5.10 Licensee must obey all federal and Oregon state laws and regulations pertaining
19 to the practice of medicine.

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1 5.11 Licensee stipulates and agrees that any violation of the terms of this Order shall
2 be grounds for further disciplinary action under ORS 677.190(17).
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4 IT IS SO STIPULATED THIS 26th day of December, 2018.

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6 
7 JUSTIN KYUNGHO YOON, MD

8 IT IS SO ORDERED THIS 10th day of January, 2019.

9
10 OREGON MEDICAL BOARD
11 State of Oregon

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13 K. DEAN GUBLER., DO
14 BOARD CHAIR
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