BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Jana Marie Van Amburg, M.D. Physician's & Surgeon's Certificate No A 77111 Respondent	Case No. 800-2019-060497

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 23, 2021.

IT IS SO ORDERED June 24, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
THOMAS OSTLY
Deputy Attorney General
State Bar No. 209234
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JANA MARIE VAN AMBURG, M.D.** **1900 NE 3rd Street, Suite 106 #317** **Bend, OR 97701** **Physician's and Surgeon's Certificate No. A 77111** Respondent.	Case No. 800-2019-060497 OAH No. 2021010050 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Thomas Ostly, Deputy Attorney General.

2. Respondent Jana Marie Van Amburg, M.D. (Respondent) is represented in this proceeding by attorney Adam Brown from the Law Offices of Brown and Brown.

3. On or about November 16, 2001, the Board issued Physician's and Surgeon's Certificate No. A 77111 to Jana Marie Van Amburg, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-060497, and will expire on October 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-060497 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 21, 2020. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-060497 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-060497. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2019-060497.

10. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED THAT respondent Jana Van Amburg, M.D., as holder of Physician's and Surgeon's Certificate No. A 77111, shall be and hereby is **publicly reprimanded** pursuant to Business and Professions Code section 2227. This Public Reprimand is issued as a result of the following:

On September 26, 2019, the Oregon Medical Board entered into a Stipulated Order with Respondent, against Respondent's Oregon license. The Stipulated Order was based on the

Board finding that Respondent engaged in conduct that was unprofessional or dishonorable as defined in ORS 677.190(1)(a) and that might constitute a danger to the health and safety of a patient or the public. ORS 677.188(4)(a).

B. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later. If Respondent fails to enroll, participate in, or successfully complete the professionalism program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until he has completed the professionalism program.

Failure to enroll, participate in, or successfully complete the professionalism program within the designated time period shall constitute unprofessional conduct and grounds for further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/5/21

JANA MARIE VAN AMBURG, M.D.
Respondent

I have read and fully discussed with Respondent Jana Marie Van Amburg, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 5/5/21

Attorney for Respondent
ADAM B. BROWN

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 5/5/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

THOMAS OSTLY
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-060497

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
THOMAS OSTLY
Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Jana Marie Van Amburg, M.D.** **1900 NE 3rd Street, Suite 106 #317** **Bend, OR 97701** **Physician's and Surgeon's Certificate No. A 77111,** Respondent.	Case No. 800-2019-060497 **A C C U S A T I O N**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 16, 2001, the Medical Board issued Physician's and Surgeon's Certificate Number A 77111 to Jana Marie Van Amburg, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2021, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California under the authority of the following sections of the California Business and Professions Code (Code) and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

> "(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.
>
> "(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

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FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

4. On September 26, 2019, the Oregon Medical Board (Oregon Board) issued a Stipulated Order against Respondent's license to practice medicine in Oregon.

5. The Stipulated Order resolved a pending Complaint and Notice of Proposed Disciplinary Action alleging that Respondent demonstrated multiple serious complications associated with laparoscopic cholecystectomies, due to poor surgical technique, and resulting in serious post-operative complications. In addition, it was alleged that Respondent was slow to recognize serious post-operative complications, and failed to provide timely treatment or make a timely referral. Under the terms of the Stipulated Order, Respondent was required to undergo a complete evaluation at the University of California, San Diego Physician Assessment and Clinical Education (PACE) Program, and complete a documentation course. Respondent may not perform hepatobiliary surgery until Respondent has completed training, and when she returns to performing surgery, she must obtain a surgical mentor. Respondent is also subject to chart audits and office visits by the Oregon Board, and must inform the Oregon Board of all practice sites. Copies of the Stipulated Order and the Complaint and Notice of Proposed Disciplinary Action issued by the Oregon Medical Board are attached as Exhibit A.

6. Respondent's conduct and the action of the Oregon Medical Board, as set forth in paragraph 5, above, constitute cause for discipline pursuant to sections 2305 and/or 141 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 77111, issued to Jana Marie Van Amburg, M.D.;

2. Revoking, suspending or denying approval of Jana Marie Van Amburg, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jana Marie Van Amburg, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: OCT 21 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT A

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
JANA MARIE VAN AMBURG, MD LICENSE NO. MD23515	)	COMPLAINT & NOTICE OF PROPOSED DISCIPLINARY ACTION
	)	
	)	

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. Jana Marie Van Amburg, MD (Licensee) is a licensed physician in the State of Oregon.

2.

The Board proposes 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 per violation, 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) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee is a board-certified general surgeon practicing in Bend, Oregon. Licensee's acts and conduct alleged to violate the Medical Practice Act follow:

3.1 The Board conducted a review of laparoscopic cholecystectomies that Licensee performed where patients encountered serious post-operative complications. The Board's review revealed that Licensee has had multiple serious complications associated with the laparoscopic cholecystectomies she has performed, indicating poor surgical technique. The review also revealed that Licensee was slow to recognize when her patients had serious post-operative complications and failed to provide timely treatment or to make a timely referral. Licensee's

conduct breached the standard of care and violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence. Specific patient care concerns are identified in the paragraphs below.

3.2 Patient A, a 63-year-old female, initially presented to Licensee in June of 2011 complaining of bloating and nausea after meals. Licensee made the pre-operative diagnosis of "gallbladder dyskinesia" and performed a laparoscopic cholecystectomy with intraoperative cholangiogram on December 3, 2012. Licensee noted no gallstones and pathology showed only "mild chronic cholecystitis." Post-operatively, Patient A complained of persistent right flank pain. Patient A called Licensee's office on multiple occasions complaining of having a temperature and pain. Patient A's primary care physician (PCP) obtained a CAT scan that confirmed a 14 x 7 x 12 cm biloma below the liver. Licensee admitted Patient A on January 10, 2013, and percutaneously drained the bile collection on January 11, 2013. An endoscopic retrograde cholangiopancreatography (ERCP) on January 13, 2013, reported a "cystic duct stump leak with dislodgment of the surgical clips." A stent was successfully placed in the common bile duct during this procedure. On January 16, 2013, Licensee performed a laparoscopic incision and drained a right flank abscess with placement of a JP drain, which drained 1,000 ccs of bile a day. Abscess cultures were positive for 4+ Candida Glabrata. On January 18, 2013, a magnetic resonance cholangiopancreatography (MRCP) identified an accessary bile duct leak from a right hepatic duct emptying directly into the peritoneal cavity. Patient A was transferred to OHSU on January 21, 2013. At OHSU an ERCP confirmed a proximal common hepatic duct injury and an injury to the right hepatic accessory duct. Licensee breached the standard of care by causing injury during surgery and failing to adequately evaluate Patient A after she reported post-operative pain and fever. Licensee failed to timely recognize that Patient A had sustained injury to the common hepatic duct (and right accessory duct) during surgery, and failed to provide timely care to address the complication. Licensee's conduct violated ORS 677.190(1)(a), as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence.

3.3 Patient B, a 20-year-old female who was 22 weeks pregnant (BMI 36.67), presented at the Prineville Emergency Department on August 13, 2016, complaining of abdominal pain radiating to the right upper quadrant and back with emesis. An ultrasound demonstrated cholelithiasis with wall thickening to 4.8 mm (normal < 3mm). Patient B was afebrile, and her laboratory studies were normal. Licensee was consulted and performed a laparoscopic cholecystectomy later that day. Licensee noted that the "...cystic duct was rather large, but there was a stone that was trying to make its way through the cystic duct to the common duct, this was pushed back up into the gallbladder and then the cystic duct was cleared of tissue." No cholangiogram was done. Patient B was discharged on August 15, 2016, with postoperative pain which Licensee addressed by prescribing oxycodone and acetaminophen (Percocet, Schedule II). Patient B was readmitted on August 17, 2016, with fever and persistent abdominal pain. Ultrasound demonstrated a large amount of perihepatic fluid. A paracentesis yielded 500 ccs of bile from a biloma. An ERCP revealed a transection of the common hepatic duct at its bifurcation. Patient B was transferred to OHSU on August 18, 2016. Patient B underwent reparative surgery. Shortly thereafter, Patient B delivered an infant with a birth weight of 0.5 kg who expired several days later. Licensee breached the standard of care by unnecessarily exposing this pregnant patient to the risk of surgery rather than provide supportive, non-surgical care, and by transecting the hepatic duct during surgery and not promptly recognizing the complication. Licensee's conduct violated ORS 677.190(1)(a), as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence.

3.4 Patient C, a 48-year-old female, presented to Licensee with a history of three episodes of right upper quadrant pain with emesis requiring emergency department visits. Licensee's diagnosis was cholecystitis with biliary colic. On July 20, 2015, Licensee performed a laparoscopic cholecystectomy without a cholangiogram. Patient C subsequently developed post-operative diffuse abdominal discomfort and nausea. Examination revealed free fluid in the

abdomen, with bile coming out of the cystic duct and extending to the left upper quadrant. Patient C was readmitted for peritonitis due to a cystic duct leak. On July 28, 2015, Patient C underwent an ERCP with cholanglogram. Another surgeon conducted a sphincterotomy and removed a 7 mm stone in the distal common bile duct. Another surgeon conducted another ERCP on September 27, 2015, in which an additional 8 mm stone was removed from the common duct. Licensee breached the standard of care and caused harm to Patient C by exhibiting poor surgical technique that resulted in injury to the patient and failed to provide timely follow-up to identify and treat Patient C's post-operative complications. Licensee's conduct violated ORS 677.190(1)(a), as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence.

3.5 Patient D, a 56-year-old female, was admitted on October 21, 2014, for right upper quadrant pain. Ultrasound revealed "some tiny stones" with no gallbladder thickening. Patient D's history included multiple pelvic laparoscopies with subsequent total abdominal hysterectomy for chronic pelvic pain. When Licensee performed a laparoscopic cholecystectomy on October 21, 2014, she divided the small cystic duct with electrocautery and placed two large hemoclips on the cystic duct stump to address the bleeding. Licensee irrigated and reexamined the surgical site and was not satisfied that the bleeding was controlled, so she placed two #1 PDS Endoloops on the cystic duct stump. Patient D was discharged the next day. Patient D was readmitted on October 23, 2014, for pain and a 101.7° F fever. A hepatobiliary iminodiacetic acid scan confirmed a cystic duct leak. Another surgeon addressed these complications in subsequent procedures. Licensee breached the standard of care and caused harm to Patient D by using poor surgical technique that resulted in injury to the patient. Licensee's conduct violated ORS 677.190(1)(a), as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence.

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3.6 Patient E, an 84-year-old male with a history of atrial fibrillation, presented to Licensee with obstructive jaundice and a positive MRCP for hepatic bile duct stones. Licensee diagnosed acute cholecystitis, with possible hepatic duct stones. Licensee performed a laparoscopic cholecystectomy with cholangiogram on September 15, 2017. Patient E presented to the Emergency Department on September 22, 2017, complaining of acute right upper quadrant abdominal pain, nausea and emesis after eating breakfast. A trans-hepatic cholangiogram (THC) showed a dilated biliary ductal system with occlusion of ampulla due to a biliary calculus and bile leak from the cystic duct. Patient E developed sepsis due to cholangitis and bile peritonitis from the cystic duct leak. Patient E was eventually stabilized and made a slow recovery. Licensee breached the standard of care and caused harm to Patient E by exhibiting poor surgical judgment and technique in taking this high-risk patient to surgery that resulted in injury to the patient. Licensee's conduct violated ORS 677.190(1)(a), as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence.

3.7 The Board also investigated a case in regard to Patient F, a 39-year-old female who presented to Licensee on September 4, 2014, with a diagnosis of invasive ductal carcinoma in the left breast with a palpable mass; no abnormality was noted in the right breast. Licensee presented the case to a multidisciplinary tumor board. Licensee placed a Port-A-Cath and conducted a left sentinel node biopsy on September 19, 2014. The biopsy of the lymph node was negative for cancer. Patient F agreed to proceed with neoadjuvant chemotherapy to treat the invasive ductal carcinoma of the breast. Patient F received two cycles of chemotherapy, but could not tolerate additional treatment. Patient F presented to Licensee on November 20, 2014, desiring a left mastectomy and breast reconstruction. Licensee obtained Patient F's written informed consent to perform a left simple mastectomy. Patient F later met with a plastic surgeon, who recommended immediate breast reconstruction at the time of the mastectomy. On December 5, 2014, Patient F signed an informed consent form presented by the plastic surgeon for "Tissue Expander Placement for Breast Reconstruction." On December 9, 2014, Patient F signed another consent form for left mastectomy and Port-A-Cath removal. Surgery was

scheduled for December 15, 2014. On the day of surgery, Licensee noted that Patient F had markings on her chest consistent with bilateral tissue expander placement. Licensee asserts that the original surgery consent form was not available at the time of surgery. Licensee did not document but reports that she asked Patient F on the day of surgery if she wanted Licensee to perform a bilateral mastectomy. Licensee states that Patient F provided her verbal consent. Licensee did not have Patient F sign an informed consent form to that effect. While the surgery was in progress, a call was made from the operating room by the plastic surgeon to Patient F's husband to clarify what procedure was to be performed. Licensee performed a bilateral mastectomy and the plastic surgeon performed the tissue expander reconstructive surgery. Patient F later filed a lawsuit. The Board's investigation reflects that there is a great deal of confusion regarding Patient F's consent for a bilateral mastectomy; however, it remains clear that even after the procedure had begun, a question remained about which procedure Patient F had provided consent for. This question should have been resolved prior to the beginning of surgery. Licensee failed to follow accepted procedures for obtaining informed consent. This failure breached the standard of care and resulted in Patient F receiving a bilateral mastectomy when she had previously provided consent for a left breast mastectomy only. Licensee's conduct was negligent and violated ORS 677.190(1)(a), as defined in 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.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by counsel at the hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within twenty-one (21) days of the mailing of this Notice to Licensee. Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing.

5.

5.1 If Licensee requests a hearing, Licensee will be given information on the procedures, right of representation, and other rights of parties relating to the conduct of the hearing as required under ORS 183.413(2) before commencement of the hearing.

5.2 In the event of a hearing, the Board proposes to assess against Licensee the Board's costs of this disciplinary process and action, including but not limited to all legal costs from the Oregon Department of Justice, all hearing costs from the Office of Administrative Hearings, all costs associated with any expert or witness, all costs related to security and transcriptionist services for the hearing and administrative costs specific to this proceeding in an amount not to exceed $75,000, pursuant to ORS 677.205(2)(f).

6.

NOTICE TO ACTIVE DUTY SERVICEMEMBERS: Active Duty Servicemembers have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil. The Oregon Military Department does not have a toll-free telephone number.

7.

Failure by Licensee to request a timely hearing or failure to appear at any hearing scheduled by the Board will constitute waiver of the right to a contested case hearing and will result in a default order by the Board, including the revocation of his medical license and assessment of such penalty and costs as the Board deems appropriate under ORS 677.205. If a default order is issued, the record of proceeding to date, including Licensee's file with the Board and any information on the subject of the contested case automatically becomes a part of the contested case record for the purpose of proving a prima facie case per ORS 183.417(4).

DATED this 9th day of September, 2019.

OREGON MEDICAL BOARD
State of Oregon

[redacted]
JOSEPH J. THALER, MD
MEDICAL DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of JANA MARIE VAN AMBURG, MD LICENSE NO. MD23515	)	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. Jana Marie Van Amburg, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On September 9, 2019, 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 per violation, 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) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; and ORS 677.190(13) gross or repeated acts of negligence.

3.

Licensee and the Board desire to settle this matter by entry of this Stipulated Order. Licensee understands that she has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that she engaged in the conduct described in the September 9, 2019, Complaint and Notice of Proposed Disciplinary Action and that this conduct violated ORS 677.190(1)(a) unprofessional or

dishonorable conduct, as defined in 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; and ORS 677.190(13) gross or repeated acts of negligence. 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 to resolve this matter by the entry of this Stipulated Order subject to the following terms and conditions:

4.1 Licensee must complete the existing PACE education plan in its entirety, with the exception of the follow-up PULSE survey, to include any recommendations made by PACE for follow-up or post-plan education within twelve months from the effective date of this Order.

4.2 Within six months of the effective date of this Order, Licensee must complete a documentation course that has been pre-approved by the Board's Medical Director.

4.3 Licensee must not perform hepatobiliary surgery prior to completing additional training that has been pre-approved by the Board's Medical Director.

4.4 Upon Licensee's return to performing surgery in a hospital or ambulatory surgery center, Licensee must, at her own expense, enter into an agreement with a board-certified general surgeon who has been pre-approved by the Board's Medical Director to serve as her surgical mentor. Licensee must meet with the approved mentor at least twice a month, and the mentor must review, on an ongoing basis, at least 20% of charts for patients who underwent any operative procedure performed by Licensee. The mentor is to provide quarterly written reports to the Board on Licensee's ability to safely and competently practice medicine. The reports shall include the types of surgery reviewed and any complications which occurred. Any request for modification of this term must be accompanied by a written recommendation for modification from the mentor. Mentoring and reporting shall continue until Licensee is notified in writing by the Board that this term has been fulfilled.

4.5 At the discretion of the Board or its designees, random, not notice chart audits and office visits may be conducted by Board designees.

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

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

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

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

IT IS SO STIPULATED THIS 26 day of September, 2019.

[redacted]

JANA MARIE VAN AMBURG, MD

IT IS SO ORDERED THIS 3rd day of October, 2019.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

R. DEAN GUBLER, DO
BOARD CHAIR