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

In the Matter of the Accusation Against: Rajninder K. Jutla, M.D. Physician's & Surgeon's Certificate No C 151510 Petitioner.	Case No.: 800-2019-056261

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Albert J. Garcia, Esq., attorney for Rajninder K. Jutla, for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on July 2, 2021.

IT IS SO ORDERED: July 6, 2021

Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation Against: **Rajninder K. Jutla, M.D.** Physician's & Surgeon's Certificate No. C 151510 Respondent.	Case No. 800-2019-056261 **ORDER GRANTING STAY** (Government Code Section 11521)

Albert J. Garcia, Esq., on behalf of respondent, Rajninder K. Jutla, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of June 25, 2021, at 5:00 p.m.

Execution is stayed until July 2, 2021, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: June 11, 2021

William Prasifka
Executive Director
Medical Board of California

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

In the Matter of the Accusation **Against** **Rajinder K. Jutla, M.D.** **Physician's and Surgeon's** **Certificate No. C 151510** **Respondent.**	**Case No. 800-2019-056261**

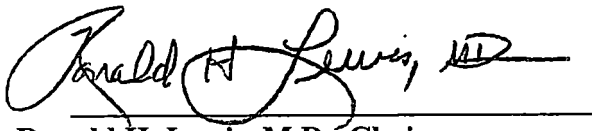
DECISION

The attached Proposed Decision 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 June 25, 2021.

IT IS SO ORDERED May 27, 2021.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Accusation Against:

RAJNINDER K. JUTLA, M.D.,

Physician's and Surgeon's Certificate No. C 151510

Respondent.

Agency Case No. 800-2019-056261

OAH No. 2020110470

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter by videoconference on February 4, 2021.

Deputy Attorney General Thomas Ostly represented complainant William J. Prasifka, Executive Director of the Medical Board of California.

Attorney Albert Garcia represented respondent Rajninder K. Jutla, M.D., who was present for the hearing.

The matter was submitted for decision on February 4, 2021.

FACTUAL FINDINGS

1. The Medical Board of California (CA Board) issued Physician's and Surgeon's Certificate No. C 151510 to respondent Rajninder K. Jutla, M.D., on August 31, 2017. This certificate is scheduled to expire May 31, 2021.

2. Effective April 22, 2020, the CA Board suspended respondent from practicing medicine in California, because of the Oregon disciplinary order described below in Finding 15. The suspension remained in effect at the time of the hearing.

3. Acting in his official capacity as the Executive Director of the CA Board, complainant William J. Prasifka filed an accusation against respondent on July 15, 2020. Complainant seeks revocation of respondent's California Physician's and Surgeon's Certificate on the ground that the Oregon Medical Board (OR Board) has revoked respondent's Oregon medical license for conduct that qualifies under California law as unprofessional conduct.

4. Respondent requested a hearing on the suspension (described in Finding 2) and on the accusation (described in Finding 3).

Education and Professional History

5. Respondent received her medical degree in 2001.

6. Between 2001 and 2004, respondent was an intern and then a resident in general surgery, in Washington. She obtained a Washington medical license in 2001.

7. Respondent followed her general surgery residency with a residency in anesthesia between 2004 and 2007, also in Washington.

8. From 2007 to 2008, respondent completed a fellowship in pain management, in Oregon. She obtained her Oregon medical license in July 2007.

9. Between 2008 and 2020, respondent operated a solo pain management clinic in Washington. A nurse practitioner, Melissa Barclay, currently treats patients at this Washington clinic. Between 2010 and 2019, respondent operated a similar solo pain management clinic in Oregon.

10. Respondent received an MBA in 2020. She obtained the California medical license described above in Finding 1 at the beginning of her MBA program. The evidence did not establish that respondent has practiced medicine in California, however.

11. Respondent has been certified by the American Board of Anesthesiology in Anesthesia and in Pain Management, and by the American Board of Addiction Medicine. The evidence did not establish either when respondent received these certifications or whether they remained in effect at the time of the hearing.

12. At the time of the hearing, respondent worked with a consulting firm, serving biotechnology clients seeking approval from the federal Food and Drug Administration for new clinical and diagnostic devices. She hoped, however, to take a new position as an anesthesiologist at a hospital in Brawley. For the reasons described below in Finding 21, respondent does not intend to resume practicing outpatient pain management.

Disciplinary Actions

13. On May 21, 2019, with respondent's consent, the OR Board entered an order prohibiting respondent from prescribing controlled substances in Oregon. The

order stated that it would remain in effect while the OR Board completed an investigation into respondent's Oregon medical practice, and that at the investigation's conclusion the OR Board would "decide whether to close the case or proceed to some form of disciplinary action."

14. On September 13, 2019, the Executive Director of the OR Board issued a Complaint and Notice of Proposed Disciplinary Action against respondent. Respondent's request for a hearing on this complaint was untimely by less than two weeks.

15. Effective March 5, 2020, the OR Board found that respondent did not have good cause for her failure to make a timely response to the complaint described in Finding 14. On her default, the OR Board revoked respondent's Oregon medical license. Respondent has sought judicial review of this decision, which was not complete at the time of the hearing.

16. As bases for its decision to revoke respondent's Oregon medical license, the OR Board found with respect to four patients that:

> 3.1.1 Licensee maintained the identified patients on a long-term course of controlled substances in a manner that does or might constitute a danger to the health or safety of her patients and that breached the standard of care;
>
> 3.1.2 Licensee maintained patients on excessive dosages of opiates with morphine equivalent doses (MED) in excess of 50, even though patient function and pain failed to improve over time;

3.1.3 Licensee did not prescribe the lowest effective dosage of opioids, with initial dosages of opioids for patients in excess of MED 50 per day, and for one patient, in excess of 90 MED;

3.1.4 Licensee failed to conduct an adequate risk assessment during the course of treatment;

3.1.5 Licensee failed to consistently check the Oregon Prescription Drug Monitoring Program (PDMP) at the inception and during the course of treatment with opioids;

3.1.6 Licensee failed to identify and address evidence of aberrant departures from the treatment plan, to include the use of Schedule I drugs detected in urine drug screens.

17. In addition, the OR Board found that a criminal indictment was pending against respondent in the United States District Court for the Western District of Washington, charging respondent with health care fraud and related crimes arising from her role as a paid speaker for a pharmaceutical company. According to the OR Board's order, "the conduct described in the indictment" violates several statutes governing ethical medical practice in Oregon.

18. The suspension order described in Finding 2 resulted from the OR Board order described in Findings 15 through 17. In addition, the Washington Medical Commission suspended respondent's Washington medical license effective June 23, 2020, also as a result of the OR Board order.

Additional Evidence

19. At the time of the hearing, the indictment described in Finding 17 remained unresolved. Respondent declined to discuss the criminal allegations against her in detail at the hearing, but acknowledged that they include allegations that she prescribed a medication called Subsys for "off-label" use and that she accepted kickbacks from a pharmaceutical company for prescribing this drug or others. Respondent denies having engaged in this or any unlawful conduct.

20. Respondent describes herself as a "thoughtful, judicious" prescriber, and denies having committed any of the professional misconduct summarized in Finding 16. She emphasized that every patient for whom she prescribed narcotic pain medication also received a prescription for an overdose antidote; that she treated patients for addiction as well as for chronic pain; and that she regularly used questionnaires, drug agreements, urine drug screening, random medication audits, and the Oregon PDMP to monitor her patients' drug use. Respondent's testimony about her general practices in outpatient pain management is credible, but does not demonstrate that the OR Board's findings were incorrect with respect to the four specific patients whose care the OR Board investigated.

21. Respondent regrets having attempted to practice outpatient pain management as a sole practitioner. She realizes now that meticulous record-keeping and patient monitoring are essential to such a practice, both to protect patients against harm from drug misuse and to protect the medical provider against charges of professional misconduct.

22. When the Washington Medical Commission suspended respondent's Washington medical license, as described above in Finding 18, she did not realize

immediately that the Washington Medical Commission had taken this action. She testified that she did receive notice about the suspension by mail, but did not open the item right away. Respondent saw patients in Washington and prescribed pain medications to them between July 9 and 24, 2020. She then hired Barclay to assume responsibility for patient care, as described above in Finding 9.

23. Respondent understands that if the CA Board permits her to retain her California physician's and surgeon's certificate, but imposes a period of probation, the Brawley hospital described above in Finding 12 would permit her to practice there. She understands as well that one or more other anesthesiologists at that hospital would be available to serve as practice monitors. Respondent stated her willingness to follow any probation conditions the CA Board might impose on her.

References

24. David Naibert, M.D., testified on respondent's behalf, and provided a letter summarizing his opinions about respondent. Dr. Naibert is also a pain management physician, with more than 30 years' experience; he has known respondent since 2008, when she started her Washington pain management practice. Dr. Naibert notes that people who suffer from chronic pain are, in his view, "the most difficult patient population in modern medicine," and is proud to have mentored respondent in the early years of her outpatient pain management practice. He has referred "dozens and dozens" of chronic pain patients to respondent, and considers her competent, ethical, and honest.

25. Dr. Naibert is familiar with the circumstances that led the OR Board to revoke respondent's Oregon medical license. He considers the OR Board's action "shameful," both because the OR Board proceeded on respondent's default rather

than accepting her late request for hearing and because the OR Board disregarded the "massive intricacies of safely caring for chronic pain patients."

26. Dr. Naibert also is familiar with the criminal indictment that is pending against respondent. He testified credibly that he has personal knowledge of some facts alleged in the indictment, although he refused to discuss those facts at the hearing. He is confident, however, that respondent is not guilty.

27. Barclay, the nurse practitioner described above in Findings 9 and 22, also provided a reference letter for respondent. Barclay's letter states that Barclay is "temporarily caring for [respondent's] patients while she resolves her license issues." Barclay describes respondent as a "dedicated physician" who is "unfailingly helpful and generous in sharing her knowledge and experience." Barclay also states, however, that she is "not sure quite what grievous offense [respondent] has committed."

28. Respondent offered a reference letter from Tanner Jones, a registered nurse whose wife has been respondent's patient. Jones's letter states that respondent's care enabled Jones's unidentified wife to return to active work as an emergency department nurse after a "catastrophic knee injury" that led to a chronic pain disorder. Jones describes respondent as a "highly qualified physician" with valuable "pain management expertise."

LEGAL CONCLUSIONS

1. Discipline against a medical license respondent holds in another state, on grounds that would have been cause for discipline in California, is cause for discipline against respondent's California physician's and surgeon's certificate. (Bus. & Prof. Code, § 2305.) The out-of-state disciplinary order itself is "conclusive evidence" of the

facts the order states. (*Id.*, § 141, subd. (a).) Clear and convincing evidence must prove any additional facts supporting California discipline.

2. The CA Board may suspend a California physician's and surgeon's certificate if another state's medical licensing agency suspends or revokes that physician's medical license. (Bus. & Prof. Code, § 2310, subd. (a).) An administrative law judge may rescind the suspension if the suspended physician shows that the other state's suspension was on grounds that would not have been cause for discipline in California, or if the other state lifts the order. (*Id.*, subd. (c).)

3. Excessive prescribing of dangerous drugs, and prescribing drugs without medical indication, are causes for professional discipline in California. (Bus. & Prof. Code, §§ 725, subd. (a), 2242, subd. (a).)

4. The matters stated in Finding 15 constitute discipline against respondent's Oregon medical license. The matters stated in Finding 16 and Legal Conclusion 3 confirm that the OR Board's chief reasons for revoking respondent's Oregon medical license (excessive and unwarranted prescribing) constitute cause as well for disciplinary action in California. These matters constitute cause under Business and Professions Code section 2305 for the CA Board to take disciplinary action against respondent, and cause under Business and Professions Code section 2310 for the CA Board to have suspended respondent's physician's and surgeon's certificate.

5. The matters stated in Finding 17 show that the OR Board also based its decision on criminal allegations against respondent. These matters, and the matters stated in Finding 19, show the allegations to be serious but do not constitute clear and convincing evidence proving those allegations to be true. By themselves, the criminal charges pending against respondent do not constitute cause under Business and

Professions Code section 2305 for the CA Board to take disciplinary action against respondent, or cause under Business and Professions Code section 2310 for the CA Board to have suspended respondent's physician's and surgeon's certificate.

6. The matters stated in Finding 15 show that the OR Board could lift its order revoking respondent's Oregon medical license, but they do not show that the OR Board has lifted that order. These matters do not constitute cause to rescind the California suspension order described in Finding 2.

7. The CA Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition 2016" (Cal. Code Regs., tit. 16, § 1361, subd. (a)), call for a minimum of five years' probation for a physician who has prescribed narcotic medications irresponsibly, but also allow for license revocation. Taken together, the matters stated in Findings 6 through 12 do not show that respondent ever has practiced medicine in California, and they do show that she has not practiced surgical anesthesia (as she proposes to do in California) in many years. Moreover, the matters stated in Findings 9, 18, 22, and 27 cast doubt on respondent's ability to follow California probation conditions. Revocation of respondent's California physician's and surgeon's certificate is appropriate.

ORDER

Physician's and Surgeon's Certificate No. C 151510, issued to respondent Rajninder K. Jutla, M.D., is revoked.

DATE: 03/02/2021

Juliet E. Cox

JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the Accusation Against: **Rajninder K. Jutla, M.D.** 6900 E Green Lake Way N Ste. J Seattle WA 98115-5480 Physician's and Surgeon's Certificate No. C 151510, Respondent.	Case No. 800-2019-056261 **ACCUSATION**

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 August 31, 2017, the Medical Board issued Physician's and Surgeon's Certificate Number C 151510 to Rajninder K. Jutla, M.D. (Respondent). The Physician's and Surgeon's Certificate will expire on May 31, 2021, and is SUSPENDED by virtue of an Order issued on April 22, 2020 pursuant to Business and Professions Code section 2310(a).

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated:

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."

FIRST CAUSE FOR DISCIPLINE

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

4. On March 5, 2020, the Oregon Medical Board issued a Default Final Order, revoking Respondent's license to practice medicine in Oregon. The Default Final Order arose out of a review of Respondent's pain medicine practice which revealed a pattern of practice that constituted a danger to the health and safety of patients and breached the standard of care. Respondent inappropriately maintained patients on long-term courses of controlled substances, in excessive dosages, without conducting adequate risk assessments and without checking the Oregon Prescription Drug Monitoring Program, and failed to identify and address evidence of

aberrant departures from the treatment plan. In addition, the Oregon Medical Board noted that on July 24, 2019, Respondent was indicted in the United States District Court on charges of Conspiracy to Pay and Receive Kickbacks, Receipt of Kickbacks and Health Care Fraud. The indictment alleges that Respondent accepted more than $100,000 from a pharmaceutical company in the form of sham speaking fees, in exchange for prescribing an oral fentanyl spray. A copy of the Default Final Order issued by the Oregon Medical Board is attached as Exhibit A.

5. Respondent's conduct and the action of the Oregon Medical Board, as set forth in paragraph 4, 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 C 151510, issued to Rajninder K. Jutla, M.D.;

2. Revoking, suspending or denying approval of Rajninder K. Jutla, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Rajninder K. Jutla, 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: JUL 15 2020

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

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BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of RAJNINDER KAUR JUTLA, MD LICENSE NO. MD27622	)	DEFAULT FINAL ORDER

1.

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

2.

2.1 On September 13, 2019, 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 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 contrary to recognized standards of ethics of the medical profession or 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(4) obtaining any fee by fraud or misrepresentation; ORS 677.190(13) gross or repeated acts of negligence; ORS 677.190(20) making a fraudulent claim; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose. The Board's Notice informed Licensee of her right to request a hearing, and that the "...Board must receive Licensee's written request for hearing within twenty-one (21) days of the mailing of this Notice to Licensee." The Notice also informed Licensee that if she 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 failed to submit a timely request for hearing. Instead, Licensee submitted a request for hearing through her attorney (who holds a license to practice law in the State of Washington) on October 15, 2019, which was 32 days after the Notice was issued. The Board informed Licensee's counsel by letter dated October 21, 2019, that the request was untimely. The Board received a letter, dated December 9, 2019, from an Oregon licensed attorney retained by Licensee, which explained that Licensee did not ignore the Board's Notice, and "...made efforts to retain an attorney to assist her in preparing and submitting her request for hearing." Counsel requested that the Board accept Licensee's late request for hearing.

2.2 The Board has reviewed the letter submitted by Licensee's legal counsel explaining the circumstances of her failure to submit a timely request for hearing and accepts the representations made by counsel in that letter. As a result, there is no factual dispute for the Board to address in its analysis. The legal standard that the Board applies to its review of this late request for hearing is found in OAR 137-003-0528(1)(b) and (d), which state:

> (1)(b) The agency may accept any other late hearing request only if:
>
> (A) There was good cause for the failure to timely request the hearing, unless other applicable statutes or agency rules provide a different standard; and
>
> (B) The agency receives the request before the entry of a final order by default or before 60 calendar days after the entry of the final order by default, unless other applicable statutes or agency rules provide a different timeframe.
>
> (d) In determining whether to accept a late hearing request, the agency may require the request to be supported by an affidavit or other writing that explains why the request for hearing is late and may conduct such further inquiry as it deems appropriate.

It is apparent from the record of correspondence in this case, to include the explanation provided by Licensee's legal counsel, that the Board's Notice was promptly sent to Licensee, that she was aware of her right to be represented by legal counsel and of her right to request a hearing, and that she consulted with or called three different legal counsel prior to the passage of the 21 days provided to request a hearing, which was due on October 3, 2019. Licensee did not submit a

request for hearing until October 15, 2019. After the Board's letter of response, Licensee submitted an explanation for the late request on December 9, 2019. The question for the Board is whether there was good cause for Licensee's failure to timely request a hearing. OAR 137-003-0501(7) states that:

> ..."good cause" exists when an action, delay or failure to act arises from an excusable mistake, surprise, excusable neglect, reasonable reliance on the statement of a party or agency relating to procedural requirements, or from fraud, misrepresentation, or other misconduct of a party or agency participating in the proceeding.

The Board concludes that Licensee has not demonstrated good cause for her failure to timely request a hearing. Licensee has not set forth a basis to conclude that her failure to request a hearing within the time specified is attributable to an excusable mistake or neglect, surprise nor any other reason or circumstance that would constitute good cause for Licensee not to submit a timely request for hearing. As a result, the Board concludes that Licensee has waived her right to a hearing and now stands in default. The Board elects in this case to designate the record of proceedings to date, which consists of Licensee's file with the Board as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

3.

FINDINGS OF FACT

Licensee is a board-certified anesthesiologist and pain medicine specialist who practices medicine in multiple locations in the State of Washington and in Lake Oswego, Oregon. The Board conducted a review of Licensee's management and treatment of chronic pain patients (Patients A – D), which revealed a pattern of practice that constituted a danger to the health and safety of patients and breached the standard of care[1]. The Center for Disease Control and Prevention (CDC) and Oregon's task force adopted guidelines for the safe prescribing of opioids, which set the standard of care and are designed to ensure the health and safety of patients. The American Medical Association's Code of Medical Ethics Opinion 9.6.6 states that it is the

[1] *See* the Oregon Chronic Opioid Prescribing Guidelines and the CDC 2016 Guidelines for Prescribing Opioids for Chronic Pain.

physician's ethical responsibility to "prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectation of effectiveness for the particular patient." The Opinion further states at 9.6.6(c)(i) that physicians should "avoid direct or indirect influence of financial interest on prescribing decision by declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products."

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

3.1.1 Licensee maintained the identified patients on a long-term course of controlled substances in a manner that does or might constitute a danger to the health or safety of her patients and that breached the standard of care;

3.1.2 Licensee maintained patients on excessive dosages of opiates with morphine equivalent doses (MED) in excess of 50, even though patient function and pain failed to improve over time;

3.1.3 Licensee did not prescribe the lowest effective dosage of opioids, with initial dosages of opioids for patients in excess of MED 50 per day, and for one patient, in excess of 90 MED;

3.1.4 Licensee failed to conduct an adequate risk assessment during the course of treatment;

3.1.5 Licensee failed to consistently check the Oregon Prescription Drug Monitoring Program (PDMP) at the inception and during the course of treatment with opioids;

3.1.6 Licensee failed to identify and address evidence of aberrant departures from the treatment plan, to include the use of Schedule I drugs detected in urine drug screens (UDS).

3.2 Specific patient care concerns are set forth in the paragraphs below:

3.2.1 Patient A, a 25-year-old male, presented to Licensee on October 8, 2017, via a physician referral with a three-year history of chronic back pain after major spinal

reconstructive surgery. Patient A's treatment history included prescriptions from different providers, to include oxycodone HCL, 5 mg, #30 on June 17, 2016, and tramadol (Ultram, Schedule IV) HCL, 300 mg, #30 on September 20, 2017. Licensee conducted an evaluation, with normal findings on the physical examination. Patient A did not report a history of psychiatric issues or substance abuse. Without querying the PDMP, Licensee prescribed tapentadol (Nucynta IR, Schedule II) 50 mg, daily; tramadol (Ultram, Schedule IV) 100 mg; diclofenac, 75 mg; and tizanidine (Zanaflex) 4 mg; as well as Naloxone nasal spray, 4 mg to use if necessary in case of overdose, at the first visit. The patient chart contains an unsigned Material Risk Notification (MRN). During a second office visit on November 15, 2017, Patient A reported that the pharmacy would not fill the prescription for Nucynta. A UDS was consistent with the prescription for tramadol. Licensee noted Schizophrenia in Patient A's history and discussed various treatment options with Patient A. Licensee discontinued Nucynta and tramadol, and initiated treatment with oxycodone HCL (Schedule II), 10 mg, 4 times a day #112; Oxycontin (Schedule II) 10 mg, 1 daily, #28; and baclofen (Lioresal) 10 mg, 1 daily #28 (total MED 75). Licensee initiated treatment with an excessive dose of opioids[2] instead of seeking to prescribe the lowest effective dose of short acting opioids for a limited duration. Licensee also failed to check the Oregon PDMP during the course of treatment to ensure that Patient A was receiving medications from a single source.

3.2.2 Patient B, a 45-year-old morbidly obese male, presented to Licensee by way of referral on December 21, 2016, with a history of osteoarthritis of the knees, sciatica, and obstructive sleep apnea. Licensee obtained an extensive history and physical exam. Licensee assessed Patient B as low risk for opioid dependence, discussed treatment options, and had Patient B sign an opioid agreement. Licensee recommended physical therapy and prescribed oxycodone 15 mg, 1 tablet every 4 – 6 hours, #140 (MED 112); diclofenac, 75 mg, 1 tablet every 12 hours #56; and ranitidine, 150 mg, 1

[2] An MED of 75 is an excessive dosage to initiate treatment with an opiate. *See* the Oregon Acute and Chronic Opioid Prescribing Guidelines.

tablet daily, # 28. Patient B returned to Licensee's clinic monthly, and was authorized medication refills at the same or similar dosage. Chart review reveals that on December 13, 2017, Licensee's medication regimen for Patient B included oxycodone, 15 mg, 1 tablet every 4 – 6 hours, #140; diclofenac, 75 mg, 1 tablet every 12 hours, #56; ranitidine, 150 mg, 1 tablet daily, # 28; and Oxycontin, 30 mg, 2 daily, #56.[3] Patient B underwent surgical repair of a bladder fistula and colon resection in February 2018. On May 30, 2018, Licensee discontinued Oxycontin, and maintained Patient B on oxycodone, 15 mg, 1 tablet every 4 hours, #168;[4] diclofenac, 75 mg, 1 tablet every 12 hours, #56; ranitidine, 150 mg, 1 tablet daily, # 28. Licensee maintained Patient B on a long-term course of an excessive amount of opiates, well over 50 MED a day. Licensee also failed to check the Oregon Prescription Drug Monitoring Program (PDMP) during the course of treatment to aid in the monitoring of Patient B's narcotic intake.

3.2.3 Patient C, a 52-year-old male, was referred to Licensee in 2013 with a history of chronic pain in his back and shoulders from motor vehicle accidents. Licensee performed a history and physical examination and discussed various treatment options with Patient C. Licensee maintained Patient C on oxycodone, 15 mg, 4 tablets daily, #112 (MED 90). On August 5, 2015, Licensee's medication regimen for Patient C included morphine ER (Schedule II) 15 mg, 1 tablet every 12 hours, #56; oxycodone, 15 mg, 1 tablet every 8 hours, #84; and oxycontin, 30 mg, 1 tablet every 12 hours, # 56 (MED 187.5). On March 15, 2017, Licensee's medication regimen for Patient C included oxycodone, 15 mg, 1 tablet every 6 hours, #112; and Oxycontin, 40 mg, 1 tablet every 12 hours, # 56 (MED 210). Patient C underwent periodic urine drug screens (UDS) that reflected aberrant use of Schedule I and II substances during the course of treatment. A UDS in August of 2014 detected the presence of clonazepam (Schedule IV), which was not prescribed by a treating physician for Patient C. A UDS in August 2016 detected methamphetamine and THC. Additionally, a UDS in September

[3] MED of 202.
[4] MED 135.

2017 detected methamphetamine and amphetamine, unexpected positive test results indicating that Patient C was self-administering Schedule I substances. Licensee's chart notes reflect that she failed to address these occasions of aberrant behavior by Patient C, to include conducting a new risk assessment or to increase the frequency of a UDS. Licensee's conduct unnecessarily exposed Patient C to the risk of harm, by maintaining this patient on excessive dosages of opiates for approximately four years and by failing to address Patient C's repeated violations of the treatment plan by his self-administering Schedule I and II substances.

3.2.4 Patient D, a 33-year-old male with a history of chronic back pain, first presented to Licensee in September 2015. Licensee performed a history and physical examination and initiated treatment with oxycodone, 45 mg daily (MED 67.5), and gabapentin (Neurontin), 300 mg. On March 16, 2016, Licensee maintained Patient D on oxycodone, 15 mg, 4 tablets daily, #112; Oxycontin, 40 mg, 2 tablets daily, #56; and gabapentin, 900 mg, 4 tablets daily (MED 210). Licensee switched Patient D to hydromorphone (Schedule II) later that year. On November 23, 2016, Licensee prescribed Oxycontin, 15 mg, 1 tablet per day, #28; hydromorphone IR, 8mg, 4 daily, #112; and hydromorphone ER, 8 mg, 2 daily (MED 214.5). On May 31, 2017, the medication regimen included hydromorphone IR, 8 mg, 4 – 6 daily, #140; hydromorphone ER, 8 mg, 1 daily, #28 (MED 160 - 224); and diazepam (Schedule IV) for pre-flight anxiety. Licensee subsequently tried to taper Patient D off of opioids, but on February 7, 2018, Licensee remained on hydromorphone IR, 8 mg, 3 daily, #84 (MED 96), and ropinirole 1 mg, 1 daily.

3.3 On July 24, 2019, the United States District Court for the Western District of Washington at Seattle issued Licensee an indictment, to include charges of Conspiracy to Pay and Receive Kickbacks, Receipt of Kickbacks, and Health Care Fraud due to Licensee's relationship and dealings with the company Insys Therapeutics. The indictment outlines an incident that occurred on or about August 30, 2013, in Portland, Oregon, at which Licensee

forged the signature of another healthcare provider on a sign-in sheet for an event which Licensee was the paid speaker. According to the indictment, the event was actually a birthday dinner with friends, and no presentation was made by Licensee; however, Licensee was compensated $800 as if she had delivered a presentation.

3.4 On May 21, 2019, Licensee voluntarily entered into an Interim Stipulated Order with the Board in which she agreed to cease the prescribing of all controlled substances pending the completion of the Board's investigation.

3.5 Licensee is not a person in the military service of the United States.

4.

CONCLUSIONS OF LAW

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

4.1 Licensee's conduct unnecessarily exposed Patient A to the risk of harm and violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.2 Licensee's conduct unnecessarily exposed Patient B to the risk of harm, particularly in view of his comorbidities (obesity and sleep apnea) and violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.3 Licensee's conduct unnecessarily exposed Patient C to the risk of harm and breached the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) gross negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.4 Licensee's conduct unnecessarily exposed Patient D to the risk of harm by maintaining this patient on a prolonged course of treatment with opioids in excess of 90 mg daily, which also violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

4.5 Licensee's conduct described in the indictment of July 24, 2019, violates recognized standards of ethics for the medical profession and violates ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession; ORS 677.190(4) obtaining any fee by fraud or misrepresentation; and ORS 677.190(20) making a fraudulent claim.

5.

ORDER

In order to protect the public and appropriately address Licensee's conduct, the Board enters the following order:

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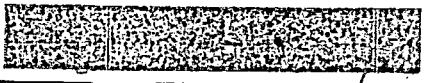
IT IS HEREBY ORDERED THAT the license of Rajninder Kaur Jutla, MD to practice medicine in the State of Oregon is revoked and that Licensee must pay a civil penalty of $5,000, payable in full within 90 days from the date this Order is signed by the Board Vice Chair. Violation of the terms of this Order constitutes a violation of the Medical Practice Act.

DATED this 5 day of MARCH, 2020.

OREGON MEDICAL BOARD
State of Oregon



SAURABH GUPTA, MD
BOARD VICE CHAIR

Right to Judicial Review

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

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of RAJNINDER KAUR JUTLA, MD LICENSE NO. MD27622	)	INTERIM STIPULATED ORDER

1.

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

2.

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

3.

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

3.1 Licensee must cease prescribing any controlled substance to any patient.

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

3.3 Licensee understands this Order becomes effective the date she signs it.

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4.

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

5.

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

IT IS SO STIPULATED THIS 21st day of May, 2019.

[redacted]

RAJNINDER KAUR JUTLA, MD

IT IS SO ORDERED THIS 21st day of May, 2019.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of RAJNINDER KAUR JUTLA, MD LICENSE NO. MD27622	)))))	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. Rajninder Kaur Jutla, MD (Licensee) is a licensed physician in the State of Oregon and holds an active medical license.

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 contrary to recognized standards of ethics of the medical profession or 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(4) obtaining any fee by fraud or misrepresentation; ORS 677.190(13) gross or repeated acts of negligence; ORS 677.190(20) making a fraudulent claim; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose.

3.

Licensee is a board-certified anesthesiologist and pain medicine specialist who practices medicine in multiple locations in the State of Washington and in Lake Oswego, Oregon. The Board conducted a review of Licensee's management and treatment of chronic pain patients

(Patients A – D), which revealed a pattern of practice that constituted a danger to the health and safety of patients and breached the standard of care[1]. The Center for Disease Control and Prevention (CDC) and Oregon's task force adopted guidelines for the safe prescribing of opioids, which set the standard of care and are designed to ensure the health and safety of patients. The American Medical Association's Code of Medical Ethics Opinion 9.6.6 states that it is the physician's ethical responsibility to "prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectation of effectiveness for the particular patient." The Opinion further states at 9.6.6(c)(i) that physicians should "avoid direct or indirect influence of financial interest on prescribing decision by declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products."

3.1 The acts and conduct alleged to violate the Medical Practice Act are:

3.1.1 Licensee maintained the identified patients on a long-term course of controlled substances in a manner that does or might constitute a danger to the health or safety of her patients and that breached the standard of care;

3.1.2 Licensee maintained patients on excessive dosages of opiates with morphine equivalent doses (MED) in excess of 50, even though patient function and pain failed to improve over time;

3.1.3 Licensee did not prescribe the lowest effective dosage of opioids, with initial dosages of opioids for patients in excess of MED 50 per day, and for one patient, in excess of 90 MED;

3.1.4 Licensee failed to conduct an adequate risk assessment during the course of treatment;

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[1] *See* the Oregon Chronic Opioid Prescribing Guidelines and the CDC 2016 Guidelines for Prescribing Opioids for Chronic Pain.

3.1.5 Licensee failed to consistently check the Oregon Prescription Drug Monitoring Plan (PDMP) at the inception and during the course of treatment with opioids;

3.1.6 Licensee failed to identify and address evidence of aberrant departures from the treatment plan, to include the use of Schedule I drugs detected in urine drug screens (UDS).

3.2 Specific patient care concerns are set forth in the paragraphs below.

3.2.1 Patient A, a 25-year-old male, presented to Licensee on October 8, 2017, via a physician referral with a three-year history of chronic back pain after major spinal reconstructive surgery. Patient A's treatment history included prescriptions from different providers, to include oxycodone HCL, 5 mg, #30 on June 17, 2016, and tramadol (Ultram, Schedule IV) HCL, 300 mg, #30 on September 20, 2017. Licensee conducted an evaluation, with normal findings on the physical examination. Patient A did not report a history of psychiatric issues or substance abuse. Licensee prescribed tapentadol (Nucynta IR, Schedule II) 50 mg, daily; tramadol (Ultram, Schedule IV) 100 mg; diclofenac, 75 mg; and tizanidine (Zanaflex) 4 mg; as well as Naloxone nasal spray, 4 mg to use if necessary in case of overdose. The patient chart contains an unsigned Material Risk Notification (MRN). During a second office visit on November 15, 2017, Patient A reported that the pharmacy would not fill the prescription for Nucynta. A UDS was consistent with the prescription for tramadol. Licensee noted Schizophrenia in Patient A's history and discussed various treatment options with Patient A. Licensee discontinued Nucynta and tramadol, and initiated treatment with oxycodone HCL (Schedule II), 10 mg, 4 times a day #112; Oxycontin (Schedule II) 10 mg, 1 daily, #28; and baclofen (Lioresal) 10 mg, 1 daily #28 (total MED 75). Licensee initiated treatment with an excessive dose of opioids[2] instead of seeking to prescribe the lowest effective

[2] An MED of 75 is an excessive dosage to initiate treatment with an opiate. *See* the Oregon Acute and Chronic Opioid Prescribing Guidelines.

dose of short acting opioids for a limited duration. Licensee also failed to check the Oregon PDMP during the course of treatment to ensure that Patient A was receiving medications from a single source. Licensee's conduct unnecessarily exposed this patient to the risk of harm and violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.2.3 Patient B, a 45-year-old morbidly obese male presented to Licensee by way of referral on December 21, 2016, with a history of osteoarthritis of the knees, sciatica, and obstructive sleep apnea. Licensee obtained an extensive history and physical exam. Licensee assessed Patient B as low risk for opioid dependence, discussed treatment options, and had Patient B sign an opioid agreement. Licensee recommended physical therapy and prescribed oxycodone 15 mg, 1 tablet every 4 – 6 hours, #140 (MED 112); diclofenac, 75 mg, 1 tablet every 12 hours #56; and ranitidine, 150 mg, 1 tablet daily, # 28. Patient B returned to Licensee's clinic monthly, and was authorized medication refills at the same or similar dosage. Chart review reveals that on December 13, 2017, Licensee's medication regimen for Patient B included oxycodone, 15 mg, 1 tablet every 4 – 6 hours, #140; diclofenac, 75 mg, 1 tablet every 12 hours, #56; ranitidine, 150 mg, 1 tablet daily, # 28; and Oxycontin, 30 mg, 2 daily #56.[3] Patient B underwent surgical repair of a bladder fistula and colon resection in February 2018. On May 30, 2018, Licensee discontinued Oxycontin, and maintained Patient B on oxycodone, 15 mg,

[3] MED of 202.

1 tablet every 4 hours, #168;[4] diclofenac, 75 mg, 1 tablet every 12 hours, #56; ranitidine, 150 mg, 1 tablet daily, # 28. Licensee maintained Patient B on a long-term course of an excessive amount of opiates, well over 50 MED a day. Licensee also failed to check the Oregon Prescription Drug Monitoring Program (PDMP) during the course of treatment to aid in the monitoring of Patient B's narcotic intake. Licensee's conduct unnecessarily exposed this patient to the risk of harm, particularly in view of his comorbidities (obesity and sleep apnea) and violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.2.3 Patient C, a 52-year-old male was referred to Licensee in 2013 with a history of chronic pain in his back and shoulders from motor vehicle accidents. Licensee performed a history and physical examination and discussed various treatment options with Patient C. Licensee maintained Patient C on oxycodone, 15 mg, 4 tablets daily, #112 (MED 90). On August 5, 2015, Licensee's medication regimen for Patient C included morphine ER (Schedule II) 15 mg, 1 tablet every 12 hours, #56; oxycodone, 15 mg, 1 tablet every 8 hours, #84; and oxycontin, 30 mg, 1 tablet every 12 hours # 56 (MED 187.5). On March 15, 2017, Licensee's medication regimen for Patient C included oxycodone, 15 mg, 1 tablet every 6 hours, #112; and Oxycontin, 40 mg, 1 tablet every 12 hours, # 56 (MED 210). Patient C underwent periodic urine drug screens (UDS) that reflected aberrant use of Schedule I and II substances during the course of

[4] MED 135.

treatment. A UDS in August of 2014 detected the presence of clonazepam (Schedule IV), which was not prescribed by a treating physician for Patient C. A UDS in August 2016 detected methamphetamine and THC. Additionally, a UDS in September 2017 detected methamphetamine and amphetamine, unexpected positive test results indicating that Patient C was self-administering Schedule I substances. Licensee's chart notes reflect that she failed to address these occasions of aberrant behavior by Patient C, to include conducting a new risk assessment or to increase the frequency of a UDS. Licensee's conduct unnecessarily exposed Patient C to the risk of harm, by maintaining this patient on excessive dosages of opiates for approximately four years and by failing to address Patient C's repeated violations of the treatment plan by his self-administering Schedule I and II substances. Licensee's conduct unnecessarily exposed this patient to the risk of harm and breached the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) gross negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.2.4 Patient D, a 33-year-old male with a history of chronic back pain first presented to Licensee in September 2015. Licensee performed a history and physical examination and initiated treatment with oxycodone, 45 mg daily (MED 67.5), and gabapentin (Neurontin), 300 mg. On March 16, 2016, Licensee maintained Patient D on oxycodone, 15 mg, 4 tablets daily, #112; Oxycontin, 40 mg, 2 tablets daily, #56; and gabapentin, 900 mg, 4 tablets daily (MED 210). Licensee switched Patient D to hydromorphone (Schedule II) later that year. On November 23, 2016, Licensee

prescribed Oxycontin, 15 mg, 1 tablet per day, #28; hydromorphone IR, 8mg, 4 daily, #112; and hydromorphone ER, 8 mg, 2 daily (MED 214.5). On May 31, 2017, the medication regimen included hydromorphone IR, 8 mg, 4 – 6 daily, #140; hydromorphone ER, 8 mg, 1 daily, #28 (MED 160 - 224); and diazepam (Schedule IV) for pre-flight anxiety. Licensee subsequently tried to taper Patient D off of opioids, but on February 7, 2018, Licensee remained on hydromorphone IR, 8 mg, 3 daily, #84 (MED 96), and ropinirole 1 mg, 1 daily. Licensee's conduct unnecessarily exposed this patient to the risk of harm by maintaining this patient on a prolonged course of treatment with opioids in excess of 90 mg daily, which also violated the standard of care, in violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or 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(13) repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients, or prescribing controlled substances without following accepted procedures for record keeping.

3.3 On July 24, 2019, the United States District Court for the Western District of Washington at Seattle issued Licensee an indictment to include charges of Conspiracy to Pay and Receive Kickbacks, Receipt of Kickbacks, and Health Care Fraud due to Licensee's relationship and dealings with the company Insys Therapeutics. The indictment outlines an incident that occurred on or about August 30, 2013, in Portland, Oregon, at which Licensee forged the signature of another healthcare provider on a sign-in sheet for an event which Licensee was the paid speaker. According to the indictment, the event was actually a birthday dinner with friends, no presentation was made by Licensee; however, Licensee was compensated $800 as if she had delivered a presentation. Licensee's conduct described in the indictment is in violation of recognized standards of ethics for the medical profession and violates ORS 677.190(1)(a)

unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession; ORS 677.190(4) obtaining any fee by fraud or misrepresentation; and ORS 677.190(20) making a fraudulent claim.

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 If Licensee proceeds to 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 $100,000.00, 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.

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7.

Failure by Licensee to timely request a 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 13 day of September, 2019.

OREGON MEDICAL BOARD
State of Oregon

NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR