BEFORE THE

BOARD OF MEDICAL EXAMINERS

STATE OF OREGON

In the Matter of	)	
RICHARD KELLY STAGGENBORG, MD,	)	VOLUNTARY LIMITATION
Applicant.	)	

1.

The Board of Medical Examiners (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers in the State of Oregon. Richard Kelly Staggenborg, MD (Applicant), is an applicant for a medical license in the State of Oregon.

2.

Applicant was granted a limited license, post-graduate, from April 1, 1996 to June 30, 1996 to do a rotation through Oregon Health Sciences University (OHSU), in Coos Bay, Oregon, as part of his residency program in New Mexico. Applicant has a history of psychiatric illness for which he previously was hospitalized on multiple occasions and which affected his prior internship and residency programs. Applicant successfully completed his residency rotation in Coos Bay through OHSU.

3.

Applicant understands that the Board's statutory mandate is to protect the public and, consequently, agrees to the entry of this Voluntary Limitation permitting him to practice medicine in the State of Oregon with the following conditions:

3.1 Applicant shall enter into a therapeutic relationship with a psychiatrist approved in advance by the Board. The psychiatrist shall monitor his mental health and medications, if any, and report immediately to the Board if Applicant's health status changes so that he might constitute a danger to the public or patients. The psychiatrist shall be directed to report in writing to the Board no later than the first day of the month of each quarterly Board meeting, until otherwise ordered by the Board. The written report shall comment on Applicant's ability to safely practice medicine.

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3.2 Within three (3) business days of receipt of this order in a fully executed state, Applicant shall give written notice of the existence of this order, with a copy of the order attached, to the chief administrator of each business, hospital, care facility, or other institution in which Applicant has privileges or is employed or practices. Applicant shall also send a copy of this order to any other entity with whom Applicant proposes to associate for practicing under the auspices of that entity. The chief administrator shall report in writing to the Board by the first day of the month of each quarterly Board meeting. The report shall describe Applicant's compliance with the term of this order and on Applicant's ability to safely practice medicine. Applicant shall also send a copy of this order to Applicant's psychiatrist.

3.3 Applicant shall not self-prescribe any controlled substance.

3.4 Applicant shall appear for an interview as a conditional licensee at the Board's quarterly meeting each January, beginning in January, 1997.

4.

Applicant and the Board understand that by issuing a license pursuant to the terms of this Voluntary Limitation, Applicant waives his right to any contested case hearing under the Oregon Administrative Procedures Act and waives his right to any appeal from an adverse decision thereunder. Licensee and the Board also understand that this order is a final action within the meaning of the Oregon Public Meetings Law and, therefore, this voluntary Limitation is a public record. This Voluntary Limitation, however, is not a disciplinary action and is not reportable as an adverse action to the National Practitioner Data Bank nor the Federation of State Medical Boards. This Voluntary Limitation will remain in effect until otherwise ordered by the Board.

IT IS SO STIPULATED this 25th day of July, 1996.

RICHARD KELLY STAGGENBORG, M.D.

IT IS SO ORDERED this 15th day of July, 1996

JAMES H. SAMPSON, M.D., CHAIRMAN
BOARD OF MEDICAL EXAMINERS
STATE OF OREGON

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BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of RICHARD KELLY STAGGENBORG, MD LICENSE NO. MD20053	)))))	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. Richard Kelly Staggenborg, MD (Licensee) is a licensed physician in the state of Oregon.

2.

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

3.

In order to address the concerns of the Board, Licensee and the Board agree to enter into this Interim Stipulated Order, which provides that Licensee shall comply with the following conditions effective the date this Order is signed by Licensee:

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

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

4.

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

5.

This order is issued by the Board pursuant to ORS 677.265(2) for the purpose of protecting the public, and making a complete investigation in order to fully inform itself with respect to the performance or conduct of the Licensee and Licensee's ability to safely and competently practice medicine. Pursuant to ORS 677.425, Board investigative materials are confidential and shall not be subject to public disclosure, nor shall they be admissible as evidence in any judicial proceeding. However, as a stipulation this order is a public document.

6.

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

IT IS SO STIPULATED THIS 21 day of October, 2010.

Signature Redacted

RICHARD KELLY STAGGENBORG, MD

IT IS SO ORDERED THIS 22nd day of October, 2010.

State of Oregon
OREGON MEDICAL BOARD

Signature Redacted

KATHLEEN HALEY, JD
EXECUTIVE DIRECTOR

within 30 days, begin participation in the program of re-education and training within 90 days and successfully complete it within the time parameters set by the program constitutes grounds for lifting the stay of the suspension and imposing an immediate suspension of license.

Failure of Licensee to abide by the terms of this order constitutes a violation of ORS 677.190(18), and could result in further disciplinary action by this Board.

IT IS SO ORDERED this 19th day of OCTOBER, 1995.

BOARD OF MEDICAL EXAMINERS
State of Oregon

EDWARD A. HEUSCH, D.O., CHAIRMAN

NOTICE: You are entitled to judicial review of this order pursuant to the provisions of ORS 183.480. Judicial Review may be obtained by filing a petition in the Oregon Court of Appeals. The petition must be filed within 60 days from the date of service of this order.

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VA) that reportedly suffer from chronic pain. Specific concerns include the following: (1) Licensee lacks adequate training and medical knowledge to manage the care and treatment of chronic pain patients; (2) Licensee failed to document an adequate history or physical examination and his chart notes lack objective findings; (2) Licensee failed to document his medical decision-making and failed to address the efficacy of the treatment provided and in follow up clinical visits; (3) Licensee failed to require patients receiving chronic pain medications to undergo periodic urine monitoring tests and failed to conduct periodic pill counts to monitor appropriate medication use; (4) Licensee failed to provide written notice (as required by OAR 847-015-0030) to his patients disclosing material risks associated with controlled substances for the treatment of intractable pain or to obtain their informed consent; (5) Licensee failed to maintain an up to date medication list, as a result, it is difficult to discern how much medication a patient was taking at any given point in time; (6) Licensee wrote overlapping prescriptions of scheduled medications without addressing the risk of over-medication and the possibility of diversion; and (7) Licensee failed to address possible co-morbidities between the Oxycodone he was prescribing and patient concomitant use of medical marijuana as well as prescribed opioids or benzodiazepines.

3.2 Specific examples of substandard care include the following:

a. Licensee wrote prescriptions for Oxycodone 30 mgs (Schedule II) for Patient A, a 58 year old female, on July 19, 2010 for 240 tablets; on July 28th 180 tablets, and on July 30, 2010 for 120 tablets, as well as a prescription for 60 tablets of Hydromorphone 4 mgs (Dilaudid, Schedule II) on July 30, 2010. On August 3, 2010, Patient A filled another prescription written by Licensee for 120 tablets of Oxycodone 30 mgs and 60 tablets of Dilaudid 8 mgs after Patient A claimed that her medications had been stolen from her vehicle. In a letter to Licensee dated August 10, 2010, Patient A referred to the recent theft of medications from her vehicle and enclosed a corresponding police report. The police report reflects that Patient A informed the Roseburg police on August 3, 2010, that her car had been broken into while parked at the Roseburg Hospital on August 1, and that four prescription bottles of medications had been stolen. There was no damage to her vehicle and there was no evidence of a break in. A review

of the patient record reveals that between August 2, 2010 and September 29, 2010, Licensee prescribed 1,170 tablets of Oxycodone 30 mgs for Patient A. Between November 5, 2010 and November 16, 2010, Licensee prescribed 180 tablets of Oxycodone 30 mgs and 120 tablets of Dilaudid 8 mgs for Patient A. These prescriptions were excessive and exposed Patient A to the risk of harm.

b. Patient B, a 25 year old male, presented to Licensee on June 29, 2010 with complaints that included severe lower back pain. Licensee prescribed 180 tablets of Oxycodone 30 mgs, two tablets, tid (three times a day). Licensee's chart for this patient includes a pain management flow sheet that has one entry: "oxycodone 30 mg three x's daily". Nevertheless, on July 14, 2010, Licensee increased the prescription to 300 tablets of Oxycodone 30 mg, two tablets, qid (four times a day), and one to two tablets per day for breakthrough pain. Moreover, on August 17, 2010, Licensee increased the prescription to 360 tablets of Oxycodone 30 mgs, two tablets, five times a day, and one or two tablets per day for breakthrough pain. Licensee increased the dosage without documented medical justification. The excessive dosage exposed Patient B to the risk of harm.

c. Patient C, a 41 year old male, presented to Licensee with complaints of chronic bilateral knee pain and mild to moderate lower back pain. Licensee's chart note for July 30, 2010 reflects that he prescribed Oxycodone 30 mg, two tablets, tid and Methadone (Schedule II) 10 mgs bid (twice a day) for breakthrough pain. On August 4, 2010, Licensee prescribed 240 tablets of Oxycodone 30 mgs, two tablets qid (four times a day). On August 10, 2010, Licensee prescribed 240 tablets of Oxycodone 30 mgs, two tablets, qid, and Methadone 10 mgs bid. This was followed by successive prescriptions on August 23, September 21, and October 19, 2010 for 240 tablets of Oxycodone 30 mgs two tablets, qid and 90 tablets of Methadone 10 mgs tid. These prescriptions were excessive, lacked monitoring and patient follow up, were not supported by Licensee's chart notes, and exposed Patient C to the risk of harm.

d. On August 31, 2010, Patient D, an adult male, came to a pharmacy in Eugene, Oregon, with a prescription for 180 tablets of Oxycodone, 30 mg, two tablets, tid that had been signed by Licensee. After verifying the prescription, the pharmacist filled the prescription.

Patient D was subsequently observed to leave the pharmacy, enter the passenger side of a parked car in the parking lot, and transfer some tablets of Oxycodone to a person sitting on the driver's side. This person was observed to crush the tablets and snort the powder into his nostrils via a straw. Licensee subsequently received a phone call from the pharmacist, who reported his observations and expressed concern that this patient was diverting controlled substances. Licensee responded by directing repeated invective insults to the pharmacist. During the phone phone call, Licensee's behavior displayed a cavalier disregard to the information provided by the pharmacist and the potential hazard this patient's behavior posed to both the patient and the public. The Board's review has not found a chart note that addresses this call.

e. Patient E, a 25 year old female with complaints of migraine headaches, lower back pain and anxiety, presented to Licensee on May 4, 2010. Licensee conducted an examination and prescribed 270 tablets of Oxycodone 15 mgs three tablets, tid and 60 tablets of Diazepam 5 mgs (Valium, Schedule IV). On July 18, 2010, Licensee began prescribing methylphenidate (Ritalin, Schedule II) 10 mgs, two tablets, tid to Patient E. A review of the chart reveals that Patient E requested a new prescription due to incarceration, an alleged theft of a prescription, and requested early refills. Despite these "red flags," Licensee continued to prescribe increasing dosages of controlled substances without medical justification, monitoring, or adequate follow-up. From June – October 2010, Licensee prescribed more than 3,000 tablets of Oxycodone (15 – 30 mgs). On October 12, 2010, Licensee drove from Roseburg, Oregon to the Costco pharmacy in Salem, Oregon, and wrote a "counter prescription" for 360 tablets of Oxycodone, 30 mgs, two tablets, six times a day. Licensee stated that the patient would come by later that day to pick up the medication. Patient E came by later that day (about 6:20 p.m.), but the pharmacist did not fill the prescription. Licensee was observed to be with Patient E in the Costco parking lot after Patient E left the pharmacy. Licensee's conduct displayed poor judgment and exposed this patient to the risk of harm.

f. Licensee displayed poor judgment by meeting with Patient F (an adult female residing in Roseburg) in Eugene, where he wrote a "counter prescription" for Oxycodone on or about October 15, 2010. Licensee could not provide verification of his medical license, so the

pharmacist refused to fill the prescription. Licensee was subsequently observed to meet with Patient F outside of the pharmacy and walk with her next door to Safeway.

4.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (chapter 183), Oregon Revised Statutes, and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that he engaged in the conduct described in paragraph 3, and that this conduct violated ORS 677.188(4)(a); ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willfully violate any provision of the Medical Practice Act or any rule adopted by the Board. Licensee understands that this Order is a public record and is a disciplinary action that is reportable to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and the Federation of State Medical Boards.

5.

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

5.1 Licensee surrenders his license to practice medicine while under investigation.

5.2 Licensee may not apply for a license to practice medicine with this Board until two years have elapsed from the date this Order is signed by the Board Chair.

5.3 This Order terminates Licensee's Voluntary Limitation of July 25, 1996, and Licensee's Interim Stipulated Order of October 21, 2010, effective the date this Order is signed by the Board Chair.

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

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

IT IS SO STIPULATED THIS 27th day of October, 2011.

SIGNATURES REDACTED

RICHARD KELLY STAGGENBORG, MD

IT IS SO ORDERED THIS 3rd day of November, 2011.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURES REDACTED

RALPH A. YATES, DO
BOARD CHAIR