BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of LYNN KARI FRIEDMAN, MD LICENSE NO. MD13860	)))))	SECOND AMENDED COMPLAINT AND NOTICE OF PROPOSED DISCIPLINARY ACTION

1.

Parties

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. Lynn Kari Friedman, MD (Licensee) is a physician licensed in the State of Oregon.

2.

Proposed Sanctions

Based on the facts and violations below, the Board proposes to take disciplinary action against Licensee pursuant to ORS 677.205(2), including: revocation of license; assessment of a civil penalty of $10,000; and assessing costs of any contested case hearing on the matter not to exceed $80,000. The Board proposes to take this disciplinary action for violations of the Medical Practice Act, specifically: ORS 677.190(1)(a) unprofessional 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; ORS 677.190(13) repeated acts of negligence in the practice of medicine; ORS 677.190(13) gross negligence in the practice of medicine; 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 without following accepted procedures for record keeping.

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Jurisdiction

3.1 Under ORS chapter 677, the Board has the duty to protect the public and the authority to exercise general supervision over the practice of medicine.

3.2 At all relevant times, Licensee was licensed to practice medicine in the State of Oregon, board certified in psychiatry, and practicing in Portland, Oregon.

3.3 As a licensee of the Oregon Medical Board, Licensee is subject to the laws, rules, and standards established by the Oregon Medical Board, including but not limited to Oregon Revised Statutes chapters 676 and 677 and Oregon Administrative Rules chapter 847.

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Facts

4.1 Patient A. Patient A is a female who was 56 years old when she began treatment with Licensee in 1992, and who remained under Licensee's care into 2019. Her primary diagnosis was Major Depressive Disorder, recurrent, in remission. Patient A's medication list initially included the antipsychotic aripiprazole (Abilify) 10 mg; the antipsychotic quetiapine (Seroquel) 200 mg; the antidepressant vortioxetine (Trintellix) 10 mg; the antidepressant bupropion XL (Wellbutrin) 150 mg; the antidepressant levomilnacipran 80 mg; the benzodiazepine sedative temazepam (Restoril, Schedule IV controlled substance[1]) 15 mg; the benzodiazepine sedative clorazepate (Tranxene, Schedule IV controlled substance) 7.5 mg; and the hypnotic sedative zolpidem CR (Ambien, Schedule IV controlled substance) 12.5 mg. These last three are all central nervous system (CNS) depressants, but were to be used on an alternating schedule – one medication each night – for sleep.

4.1.1 There is no recorded indication for prescribing two antipsychotic medications, as Patient A had no history of bipolar disorder or psychosis, including from schizophrenia. Antipsychotic medications can cause tardive dyskinesia and

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[1] *See* Title 21 United States Code (USC) Controlled Substances Act.

parkinsonism. At no point did Licensee monitor Patient A for tardive dyskinesia or parkinsonism.

4.1.2 An ordinarily skillful, careful, and diligent psychiatrist does not simultaneously prescribe multiple antipsychotic medications to a patient with no history of bi-polar disorder or of psychosis, including from schizophrenia. By doing so, Licensee breached the standard of care in her treatment of Patient A.

4.1.3 An ordinarily skillful, careful, and diligent psychiatrist monitors a patient who is on multiple antipsychotics for tardive dyskinesia and parkinsonism. By failing to monitor Patient A for tardive dyskinesia and parkinsonism, Licensee breached the standard of care. Additionally, prescribing multiple antipsychotics to a patient without monitoring that patient for tardive dyskinesia and parkinsonism is conduct that might constitute danger to patient health.

4.1.4 Licensee prescribed the Ambien CR and temazepam at doses in excess of FDA recommendations with no recorded justification for those doses. Concurrent prescribing of multiple CNS depressants is associated with significant risks, including death, from severe respiratory depression, even in patients who are not abusing them.

4.1.5 Because of the significant risks, a reasonably prudent, careful, and skillful physician avoids concurrently prescribing multiple CNS depressants at doses above FDA recommendations when possible, documents any well-reasoned justification for concomitant prescribing of multiple CNS depressants at levels above FDA recommendations, and documents efforts to minimize doses of the same. By prescribing multiple CNS depressants to Patient A, including in dosages above FDA recommendations, and doing so without well-reasoned justification, Licensee breached the standard of care in her treatment of Patient A. Additionally, by prescribing multiple CNS depressants to Patient A at dosages above FDA recommendations, Licensee engaged in a practice or conduct that does or might constitute a danger to patient health.

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4.1.6 Additionally, Licensee failed to monitor the Oregon PDMP[2] with respect to Patient A, in spite of the fact that Licensee was prescribing three different controlled substances to Patient A. The accepted procedure for recordkeeping when prescribing controlled substances, with respect to the Oregon PDMP, is to check the Oregon PDMP records on the patient at least annually.

4.1.7 Renal excretion is the primary mechanism for the body to eliminate levomilnacipran, and elderly patients in particular can suffer from decreased renal function. Licensee did not assess renal function in Patient A when determining the proper dose of levomilnacipran for her.

4.1.8 An ordinarily skillful, careful, and diligent physician prescribing levomilnacipran assesses renal function in the patient to determine proper dosage. By failing to assess Patient A's renal function when determining the dose of levomilnacipran to prescribe for Patient A, Licensee breached the standard of care. Additionally, prescribing levomilnacipran without assessing renal function is conduct that does or might constitute a danger to patient health.

4.1.9 On July 14, 2016, Licensee noted that Patient A had not recovered from heat exhaustion; she appeared very discouraged. She was offering very brief responses to questions and lacked spontaneity. Psychotropic medications such as Seroquel, Abilify and Wellbutrin are associated with a risk of heat exhaustion during periods of high temperatures, but Licensee failed to assess and document the risk of – or warn the patient of the risk of recurrence of – heat exhaustion associated with psychotropic medication.

4.1.10 An ordinarily skillful, careful, and diligent psychiatrist with a patient who takes psychotropic medications and suffers heat exhaustion assesses, documents, and warns the patient of the risks of heat exhaustion and recurrent heat exhaustion associated with those medications. By failing to do so, Licensee breached the standard of care in her treatment of Patient A. Additionally, continuing to prescribe psychotropics to a patient

[2] Prescription Medication Monitoring Program

suffering ongoing heat exhaustion is conduct that does or might constitute a danger to the patient's health and safety.

4.1.11 On or about July 14, 2016, when Patient A was 80, Licensee was prescribing her quetiapine 500 mg – an excessive dose; no more than 300 mg is recommended for adults without a schizophrenia or bipolar disorder diagnosis – with no clear indication for prescribing it, much less at this dosage. On or about December 2, 2016, Licensee increased Patient A's quetiapine to 600 mg at night for insomnia. This is an extraordinarily high dose for a patient without schizophrenia as well as a high dose for an older adult. Quetiapine can cause dizziness or lightheadedness, and a feeling of sedation. It is also associated with a greater decline in cognitive function in patients with dementia.

4.1.12 An ordinarily skillful, careful, and diligent psychiatrist does not prescribe excessive doses of quetiapine to a patient without clear indications and justification, especially when the patient is geriatric. By prescribing excessive doses of quetiapine to Patient A, Licensee breached the standard of care. Additionally, prescribing excessive doses of quetiapine to a patient without clear indications and justifications, particularly to an older patient, is conduct that does or might create a danger to patient health and safety.

4.1.13 On or about July 26, 2016, licensee increased Patient A's antidepressant paroxetine to 60 mg, which was above the usual dose of 40 to 50 mg used in geriatric patients. Paroxetine has strong anticholinergic and sedative properties, both of which can lead to negative effects on cognition. Anticholinergic medications are often considered potentially inappropriate for the elderly patients with dementia or cognitive impairment. Adverse effects associated with anticholinergic use in older adults include memory impairment, confusion, hallucinations, dry mouth, blurred vision, constipation, nausea, urinary retention, impaired sweating, and tachycardia.

4.1.14 An ordinarily skillful, careful, and diligent psychiatrist does not prescribe paroxetine to an elderly patient if other antidepressant options are available, and does not

prescribe paroxetine to an elderly patient in doses higher than recommended by the FDA. Additionally, prescribing paroxetine to an elderly patient in doses higher than those recommended by the FDA is a practice or conduct that does or might constitute a danger to patient health and safety.

4.1.15 Licensee displayed a persistent pattern in her treatment of Patient A, in which Patient A would present with serious cognitive and balance difficulties, including a motor vehicle accident, all of which could have been attributable to the medications Licensee was prescribing, but during which Licensee failed to conduct adequate cognitive assessments, and failed to account for pharmacodynamic reactions of more than one benzodiazepine co-prescribed with other sedatives, excessive doses of quetiapine, and paroxetine. A non-exhaustive set of examples of this pattern include:

4.1.15.1 On September 19, 2016, Patient A reported dizzy spells and taking 18 supplements per day. Licensee did not inquire about the supplements; she did not assess orthostatic vital signs or cognitive function.

4.1.15.2 On or about October 17, 2016, Patient A's medications included bupropion (Wellbutrin), vortioxetine (Trintellix), aripiprazole (Abilify), quetiapine (Seroquel), and the three alternating medications prescribed for sleep, specifically temazepam, clorazepate, and Ambien CR. In November 2016, Patient A reported feeling "absolutely dreadful," described her face as "frozen," and gave only brief responses to questions. Each of these is a potential side effect of the antipsychotic medications aripiprazole and quetiapine, yet Licensee only lowered her bupropion dose. She performed no neurologic exam.

4.1.15.3 In early 2017, the patient missed two office visits. On March 27, 2017, Patient A reported a low mood and insomnia. Licensee started vilazodone, lowered Patient A's fluoxetine to 60 mg daily, and advised her to stop her clorazepate. On April 11, 2017, the patient phoned to say that clorazepate

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was no longer working. Licensee reminded her she was not to be taking it any longer, yet made no assessment of cognitive function.

4.1.15.4 On April 28, 2017, Patient A reported having crashed her car when her foot slipped off the brake and onto the accelerator. She was noted to have trouble word finding. Licensee's subsequent mental status exam of Patient A was incomplete; there was no assessment of cognitive function.

4.1.15.5 On May 14, 2017, Patient A was unsteady when standing to walk, her face was "masked," and her responses were brief. Licensee conducted no physical exam at all.

4.1.15.6 On December 4, 2018, Licensee noted that Patient A had fallen. Medications were adjusted, but there was no assessment of cognition, vital signs, or neurologic function.

4.1.15.7 On January 23, 2019, Licensee's medication regimen for Patient A included anti-anxiety medication buspirone (Buspar) 10 mg; antidepressant Wellbutrin XL 300 mg; antidepressant fluoxetine (Prozac) 20 mg; Seroquel 200 mg; Restoril 15 mg; clorazepate (Tranxene) 7.5 mg; Ambien CR 12.5 mg; and antidepressant (and nerve-pain medication) Cymbalta 30 mg.

4.1.15.8 Benzodiazepines, especially in combination, and even more so when also combined with hypnotic sedative CNSs, can cause drowsiness, confusion, dizziness, and impaired coordination – all affecting cognition and increasing the risk of falls and accidents. These effects are exacerbated by excessive doses of quetiapine and by paroxetine in elderly patients.

4.1.15.9 In none of the instances illustrating Licensee's practice pattern above did Licensee assess or discuss pharmacodynamic interactions in a patient taking multiple benzodiazepines and other sedatives, as well as excessive doses of quetiapine and paroxetine (in elderly Patient A).

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4.1.16 An ordinarily skillful, careful, and diligent psychiatrist conducts cognitive assessments and physical examinations on patients for whom they prescribe combinations of antipsychotics, benzodiazepines, other sedatives, paroxetine (in an elderly patient), and excessive doses of quetiapine, especially when the patient is reporting cognitive difficulties, falls, and motor vehicle accidents. By failing to do so in September 2016, October 2016, early 2017, April 2017 and May 2017, Licensee repeatedly breached the standard of care in her treatment of Patient A. Additionally, failing to conduct appropriate cognitive and physical assessments in a patient for whom one is prescribing combinations of antipsychotics, benzodiazepines, other sedatives, paroxetine (in an elderly patient), and excessive doses of quetiapine, is a practice or conduct that does or might create a danger to patient health and safety.

4.1.17 An ordinarily skillful, careful, and diligent psychiatrist accounts for the pharmacodynamic changes of aging and tailors the patient's prescriptions accordingly, including by avoiding or limiting prescriptions of medications that impair cognition and balance, especially in combination, and especially in a patient who has repeatedly demonstrated cognitive and balance dysfunction, including falls and a motor vehicle accident. By failing to do so in September 2016, October 2016, early 2017, April 2017 and May 2017, Licensee repeatedly breached the standard of care in her treatment of Patient A. Additionally, co-prescribing and prescribing excessive doses of medications that impair cognition and balance, especially in combination, and especially in an elderly patient who has repeatedly demonstrated cognitive and balance dysfunction, including falls and a motor vehicle accident, is a practice or conduct that constitutes a danger to patient health and safety, and to public safety.

4.2 Patient B. Patient B, female, was 59 when she began care with Licensee in 2001. Patient B had a history of depression previously treated by her primary care physician and a psychiatrist. Medications at the time included citalopram (Celexa) 40 mg daily and zolpidem (Ambien) 10 mg at night. Licensee diagnosed recurrent major depressive disorder and

dysthymic disorder. Comorbidities included high blood pressure, osteoporosis, irritable bowel syndrome, osteoarthritis, and scoliosis. Licensee increased the citalopram to 60 mg daily, continued the zolpidem, and added alprazolam (Xanax) 0.25 mg to be used for anxiety; 30 pills dispensed.

4.2.1 In 2017, when the patient was 75 years old, licensee maintained Patient B on duloxetine (Cymbalta) 60 mg and alprazolam 0.25 mg; four times a day. She was also prescribing zolpidem 15 mg to Patient B nightly, three times the recommended dose for women and for the elderly (5 mg nightly).

4.2.2 On May 1, 2017, Patient B canceled an appointment because she "soiled herself and can't get up stairs." On August 15, 2017, Licensee noted Patient B reported she was "having a lot of trouble walking." On March 13, 2018, Licensee noted that Patient B fell and broke her left arm, requiring surgery. At the time, Licensee prescribed Cymbalta 60 mg; Ambien 10 mg; and Xanax 0.25 mg; four times a day. On September 10, 2018, Licensee reported that Patient B fell on her concrete driveway and noticed that she had difficulty with word finding. Nevertheless, Licensee maintained Patient B on the same medication regimen, which continued into early 2019. Licensee asserts Patient B's gait issues and difficulty with word finding were caused by gabapentin, ignoring Xanax as the much more likely cause of Patient B's gait issues and ignoring residual sedation from excessive amounts of zolpidem as the much more likely cause of Patient B's word finding difficulties and her other signs of over-sedation. Furthermore, throughout this course of events, Licensee did not assess Patient B's vital signs, gait, cognition, or neurologic function.

4.2.3 An ordinarily skillful, careful, and diligent psychiatrist does not prescribe impairing medication to an elderly patient at three times the recommended dose. By doing so, Licensee breached the standard of care in her treatment of Patient B.

4.2.4 An ordinarily skillful, careful, and diligent psychiatrist who is prescribing an elderly patient both zolpidem at three times the recommended dosage and Xanax when

the patient falls repeatedly, including a fall that severely breaks her arm, misses appointments with the psychiatrist because the patient has soiled herself and cannot go up stairs, and is having difficulty finding words, considers the Xanax and zolpidem, rather than gabapentin as the likely causes of those impairments and signs of over-sedation, and decreases the zolpidem – at a minimum – accordingly. By failing to consider the Xanax and excessive doses of zolpidem as likely causes of Patient B's impairments and symptoms of over-sedation, and by also failing to decrease at least Patient B's zolpidem to recommended dosage in the face of those impairments and symptoms of over-sedation, Licensee breached the standard of care. Additionally, continuing to prescribe zolpidem at three times the recommended dosage, concurrently with Xanax, to a patient showing signs of impairment and over-sedation, including injuring herself in falls, is a practice or conduct that constitutes a danger of harm to patient health and safety.

4.2.5 An ordinarily skillful, careful, and diligent physician with an elderly patient who is falling repeatedly, including a fall that severely breaks the patient's arm, who misses appointments because she has soiled herself and cannot go up stairs, and who begins having difficulty finding words, assesses the patient's vital signs, gait, cognition, and neurologic function. By failing to do so, Licensee breached the standard of care in her treatment of Patient B.

4.3 Patient C. Patient C was 61 when he came under Licensee's care in 2003. He had a history of depression in the context of chronic pain. At that time, his relevant medications included the opioid morphine (Schedule II controlled substance), the benzodiazepine diazepam (Valium, Schedule IV controlled substance), the anticonvulsant and nerve pain medication gabapentin (a Covered Substance for the Oregon PDMP, which increases the risk of respiratory depression when used in conjunction with CNS depressants), and the antidepressant mirtazapine. Licensee diagnosed recurrent major depressive disorder and dysthymic disorder. Licensee also provided samples of the antipsychotic quetiapine, 25-50 mg at night for sleep. Each of these four drugs is a Central Nervous System Depressant. Combinations of CNS depressants, particularly

opioids and benzodiazepines, are synergistic in effect, i.e., have an effect beyond the mere additive. Concurrent prescribing of four CNS depressants, especially of opioids in combination with benzodiazepines, put Patient C at risk of the complications of over-sedation including but not limited to cognitive dysfunction, accidental self-injury, respiratory depression, and death.

4.3.1 Because of the significant and life-threatening risks, a reasonably prudent, careful, and skillful physician avoids concurrently prescribing opioids and other CNS depressants—especially benzodiazepines, plus gabapentin and quetiapine, whenever possible; documents any well-reasoned justification for concomitant prescribing of multiple CNS depressants; and documents efforts to minimize doses of the same. By concurrently prescribing opioids and benzodiazepines, exacerbated by gabapentin, without documenting well-reasoned justification and without attempting to reduce doses of the same enough to impact Patient C's impairment or danger, Licensee breached the standard of care in her treatment of Patient C. Additionally, concurrently prescribing opioids and benzodiazepines without attempting to meaningfully reduce the doses is a practice or conduct that does or might constitute a risk to patient health and safety.

4.3.2 On March 29, 2017, when Patient C was 75, Licensee was prescribed the antipsychotic aripiprazole but did not monitor Patient C for tardive dyskinesia. Antipsychotic medications can cause tardive dyskinesia.

4.3.3 An ordinarily skillful, careful, and diligent psychiatrist monitors a patient who is on antipsychotics for tardive dyskinesia. By failing to monitor Patient C for tardive dyskinesia, Licensee breached the standard of care. Additionally, prescribing antipsychotics to a patient without monitoring that patient for tardive dyskinesia is a practice or conduct that might constitute danger to patient health.

4.3.4 In March 2017, Licensee noted that Patient C had been in a motor vehicle accident. On May 25, 2017, she noted Patient C was slow, rambling in his speech, and losing track of his thoughts in his responses to a mental status exam. In August 2017, he missed an appointment, had previously presented for an appointment on the wrong day,

and Licensee noted he needed others to remind him of appointments. Also in August 2017, Licensee continued to note Patient C's difficulties in responding to a mental status examination. In October 2017, Patient C reported losing his balance and having several falls. Licensee did not assess Patient C's vital signs, gait, or neurologic function. Licensee documented a belief that the Valium she was prescribing for Patient C was helping him with his pain, but also documented a concern that the Valium could be contributing to memory loss and that the Valium and sleep deprivation, along with depression, was a likely contributor to both daytime sleepiness and memory loss. Licensee did not assess Patient C's cognitive function nor decrease or eliminate his Valium prescription throughout these time periods.

4.3.5 An ordinarily skillful, careful, and diligent physician with a patient for whom she is prescribing benzodiazepines, when the patient is reporting falls and a motor vehicle accident and is displaying cognitive dysfunction, assesses the vital signs, gait, and cognition of the patient. By failing to do so with Patient C, Licensee breached the standard of care. Additionally, failing to assess the vital signs, gait, and cognition of a patient to whom a physician is prescribing benzodiazepines when the patient is reporting falls and a motor vehicle accident and is displaying cognitive dysfunction is a practice or conduct that constitutes a danger to patient and public health and safety.

4.3.6 An ordinarily skillful, careful, and diligent psychiatrist who is concerned that the Valium she is prescribing for a patient is contributing to memory loss and daytime sleepiness attempts to eliminate, replace, or reduce that Valium prescription. By failing to do so, Licensee breached the standard of care in her treatment of Patient C.

4.3.7 In April 2017, licensee prescribed the stimulant armodafinil (Nuvigil, Schedule IV controlled substance) 500 mg to Patient C with no contemporaneous indication. Licensee later indicated this was to counteract sleepiness from the pain medications, yet she made no effort to reduce the pain medications. A 500 mg dose is twice the FDA recommended maximum for any adult, and is more excessive in the

elderly because, in elderly patients, elimination of armodafinil and its metabolites may be reduced as a consequence of aging. Excessive amounts of armodafinil can produce confusion as well as a fast or slow heart rate.

4.3.8 An ordinarily skillful, careful, and diligent physician documents why they are prescribing a medication to a patient. An ordinarily skillful, careful, and diligent psychiatrist who prescribes Nuvigil to counteract sleepiness from pain medications, especially in an elderly patient, first attempts to reduce the pain medication and then, if prescribing Nuvigil, prescribes it within the recommended FDA dosage for the elderly. By failing to document her reasoning for prescribing Nuvigil, by then failing to attempt to reduce Patient C's pain medication before prescribing Nuvigil, and then by prescribing Nuvigil to an elderly patient with cognitive dysfunction, in doses more than double FDA recommendations, Licensee repeatedly breached the standard of care in her treatment of Patient C. Additionally, prescribing Nuvigil to an elderly patient with cognitive dysfunction, in doses more than double FDA recommendations, is a practice or conduct that does or might constitute a danger to patient health and safety.

4.3.9 In September 2017, additional medications Licensee prescribed Patient C included the antidepressant, anti-anxiety, and nerve medication amitriptyline 50 mg, three times a day; the benzodiazepine sedative diazepam (Schedule IV controlled substance) 5 mg, three times a day; and the antidepressant and anti-anxiety medication escitalopram (Lexapro) 40 mg, every morning. This last prescription is four times the recommended dose for the elderly. Licensee did not check Patient C's amitriptyline levels, nor did she order an EKG for him.

4.3.10 Amitriptyline is metabolized to nortriptyline. The relative blood levels of amitriptyline and nortriptyline are highly variable among patients. Nortriptyline is unique among the antidepressants in that its blood level exhibits the classical therapeutic window effect; blood concentrations above or below the therapeutic window correlate with poor clinical response. Therefore, therapeutic monitoring to ensure that the blood level is

within the therapeutic window is critical to accomplish successful treatment with this drug[3]. Additionally, amitriptyline displays major cardiac toxicity when the combined serum level of amitriptyline and nortriptyline is above 500 ng/mL, characterized by QRS widening, which leads to ventricular tachycardia and asystole.[4] In some patients, toxicity may manifest at lower concentrations.

4.3.11 An ordinarily skillful, careful, and diligent psychiatrist prescribing amitriptyline monitors amitriptyline levels and orders an EKG for the patient. By failing to monitor Patient C's amitriptyline levels or order an EKG for him, Licensee breached the standard of care in her treatment of Patient C. Additionally, failing to monitor amitriptyline levels in, or order an EKG for, a patient taking amitriptyline is a practice or conduct that constitutes a danger to patient health and safety.

4.3.12 Escitalopram may affect the hormones that regulate the body's elimination of water and salt, causing sodium levels in the blood to fall, a condition called hyponatremia. Elderly patients are particularly vulnerable to low sodium. Symptoms of hyponatremia include changes in mental functioning, such as confusion, memory problems, difficulty thinking, and also include balance problems or unsteadiness. An ordinarily skillful, careful, and diligent physician prescribing escitalopram to an elderly patient, especially an elderly patient who is reporting falls and displaying cognitive dysfunction does not prescribe doses above those recommended by the FDA. By prescribing escitalopram to Patient C in doses four times those recommended by the FDA, Licensee breached the standard of care. Additionally, prescribing escitalopram to an elderly patient who is reporting falls and displaying cognitive dysfunction is a practice or conduct that does or might constitute a danger to patient and public health and safety.

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[3] https://www.mayocliniclabs.com/test-catalog/overview/63506#Clinical-and-Interpretive

[4] Colloquially, asystole is flatline.

4.3.13 A possible complication of combining amitriptyline and escitalopram is QT interval prolongation.[5] An ordinarily skillful, careful, and diligent physician prescribing both amitriptyline and escitalopram to a patient orders an EKG for that patient. By failing to order an EKG for Patient C, Licensee breached the standard of care in her treatment of him. Additionally, failing to order an EKG for a patient to whom a physician is simultaneously prescribing amitriptyline and escitalopram is a practice or conduct that does or might constitute a danger to patient health and safety.

4.3.14 On January 30, 2018, Licensee was prescribing Patient C escitalopram 40 mg every morning, bupropion XL (Wellbutrin XL) 450 mg per day; diazepam 15 mg per day; amitriptyline 150 mg per day; armodafinil, which can cause dizziness and difficulty concentrating or paying attention, 500 mg per day; and the nerve pain and seizure medication pregabalin (Lyrica), which can cause clumsiness, dizziness, unsteadiness, and trouble with thinking, 450 mg per day. Aripiprazole (Abilify) was tried and stopped. Amitriptyline is a known anticholinergic, and anticholinergic medications are often considered potentially inappropriate for elderly patients with dementia or cognitive impairment because they can cause cognitive impairment. In March 2018, Licensee again noted slow and rambling speech in Patient C. On April 16, 2018, Patient C reported memory loss. Again, Licensee failed to assess possible side effects of the medications she prescribed throughout this period, including but not limited to ordering an EKG, checking vital signs, checking amitriptyline levels, monitoring anticholinergic effects, and monitoring for tardive dyskinesia. As with other patients, Licensee again repeatedly failed to respond to evidence that the medications she prescribed Patient C – such as the amitriptyline, armodafinil, diazepam, and Lyrica – might have been causing or contributing to his impairments.

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[5] QT interval prolongation is an extended interval between the heart contracting and relaxing, which can increase a person's risk of experiencing abnormal heart rhythms and sudden cardiac arrest

4.3.15 An ordinarily skillful, careful, and diligent psychiatrist with an elderly patient who has slow and rambling speech as well as memory loss, and a history of falls, avoids co-prescribing medications that can cause or contribute to cognitive dysfunction and falls, or at the very least considers the relationship between those impairments and the medications prescribed, and monitors the patient for those side effects. By co-prescribing amitriptyline, armodafinil, diazepam, and Lyrica to an elderly patient with cognitive and balance impairments, without considering the possible relationship between those medications and the patient's impairment, and by failing to appropriately monitor for side effects of those medications, Licensee repeatedly breached the standard of care in her treatment of Patient C. Additionally, co-prescribing amitriptyline, armodafinil, diazepam, and Lyrica to an elderly patient with cognitive and balance impairments, without considering the possible relationship between those medications and the patient's impairment, and while also failing to appropriately monitor for side effects of those medications, is conduct or a practice that does or might constitute a danger to patient health and safety.

4.4 Patient D. Patient D, a female, was 67 when first seen by licensee in 2013. Her primary care physician had been prescribing antidepressant and nerve-pain medication amitriptyline and muscle relaxant carisoprodol (Soma, Schedule IV controlled substance and CNS depressant) for chronic pain, but stopped them because of EKG changes (prolonged QTc interval),[6] and this change had led to what Licensee described as a "tailspin," notably including insomnia. Subsequent medication trials had not helped, and Patient D became depressed. Comorbidities included fibromyalgia, migraine, hypertension, a left bundle branch block, irritable bowel syndrome, gastroesophageal reflux disease, hypercholesterolemia, and hypothyroidism. Licensee diagnosed major depressive disorder, single episode. Licensee

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[6] *See* fn 5. QTc is a QT interval that has undergone a rate correction calculation to compare measurements at different time points and at different heart rates.

prescribed Soma for Patient D without rechecking an EKG. She did not coordinate care with Patient D's primary care physician.

4.4.1 An ordinarily careful, skillful, and diligent psychiatrist coordinates care with a patient's primary care physician. By failing to coordinate Patient D's care with Patient D's primary care physician, Licensee breached the standard of care. An ordinarily careful, skillful, and diligent physician does not prescribe Soma to a patient who was previously taken off of Soma and other medications because of EKG changes, without first rechecking that patient's EKG. By prescribing Soma to Patient D without first rechecking the patient's EKG, Licensee breached the standard of care. Additionally, prescribing Soma to a patient who was previously taken off of Soma and other medications because of EKG changes, without first rechecking that patient's EKG, is a practice or conduct that does or might constitute a danger to patient health.

4.4.2 April 2017, when patient D was 71 years old, Licensee was maintaining her on the benzodiazepine sedative clonazepam (Klonopin, Schedule IV controlled substance and CNS depressant) 0.5 mg, one-half tab at bedtime as needed for sleep; and the muscle relaxant carisoprodol (Soma, Schedule IV controlled substance and CNS depressant) 350 mg, one-half tab at night for pain, although it is not analgesic. Licensee did not monitor Patient D's Oregon PDMP records. On April 14, 2017, Patient D requested more Soma because she sometimes took more than prescribed. Licensee increased the dose without checking an EKG or further discussion of pain or the importance of not taking more medications than prescribed.

4.4.3 An ordinarily careful, skillful, and diligent physician does not increase a Soma prescription for a patient without first checking an EKG on the patient, especially when the patient was previously taken off of Soma and other medications because of EKG changes, and the physician had not rechecked the patient's EKG before re-initiating the prescription in the first place. By increasing Patient D's Soma prescription without first checking her EKG, Licensee breached the standard of care. Additionally, increasing

a Soma prescription for a patient without first checking an EKG on the patient, who was previously taken off of Soma and other medications because of EKG changes, and whose Soma prescription had been re-initiated without first rechecking the patient's EKG, is a practice or conduct that does or might constitute a danger to patient health.

4.4.4 An ordinarily careful, skillful, and diligent physician with a patient who discloses taking more of a controlled substance than prescribed does not continue or increase the prescription of that controlled substance without first discussing the importance of not taking more medications than prescribed and assessing the patient for evidence of substance abuse. By increasing Patient D's Soma prescription without first discussing the importance of not taking more medication than prescribed, Licensee breached the standard of care.

4.4.5 Licensee did not keep an active medication list for Patient D. An ordinarily careful, skillful, and diligent physician maintains an active list of all patient medications to remain cognizant of potential interactions and potentially additive side effects. Failing to keep an active medication list for a patient is also a practice or conduct that does or might constitute a danger to the health of the patient.

4.4.6 By prescribing Soma for pain when it is not analgesic, Licensee prescribed it without a legitimate medical purpose.

4.5 Patient E. Patient E, a 69-year-old male, began treatment with Licensee in April of 2015. He had a history of coronary bypass surgery. He had a remote history of polysubstance use. Licensee's initial assessment included Major Depression, recurrent, Attention Deficit Hyperactive Disorder, and Panic Disorder without Agoraphobia. However, the intake history did not detail criteria to support these diagnoses, and Licensee did not describe his symptoms. Patient E was transferring care from another psychiatrist who at the time was prescribing five psychoactive medications, yet Licensee did not review those outside records. Licensee recorded having considered Bipolar Type II, but without having questioned the patient about mania or hypomania.

4.5.1 An ordinarily skillful, careful, and diligent psychiatrist describes patient symptoms and details criteria to support psychiatric diagnoses in new patients. An ordinarily skillful, careful, and diligent psychiatrist does not consider a Bipolar Type II diagnosis without questioning the patient about mania or hypomania and without reviewing outside records for a history of mania or hypomania. By initially diagnosing Patient E with Major Depression, recurrent, Attention Deficit Hyperactive Disorder, and Panic Disorder without Agoraphobia, without detailing criteria or describing patient symptoms in support of those diagnoses, Licensee breached the standard of care. By considering a Bipolar type II diagnosis without questioning the patient about mania or hypomania and without reviewing the patient's outside psychiatric records, Licensee breached the standard of care in her treatment of Patient E.

4.5.2 On or about June 1, 2017, Licensee maintained Patient E on antidepressant and nerve-pain medication duloxetine (Cymbalta) 90 mg per day; the benzodiazepine sedative clonazepam (Klonopin, Schedule IV controlled substance) 0.5 mg at bedtime; the benzodiazepine sedative trazodone (Schedule IV controlled substance) 75-150 mg at bedtime; and the anticonvulsant lamotrigine (a CNS depressant, which can also be used to treat bi-polar disorder, and is sometimes used to treat depression) 75 mg every morning. The risk of overdose is magnified when simultaneously taking more than one benzodiazepine, and further magnified when taking more than one benzodiazepine simultaneously with other CNS depressants. Excessive consumption of CNS depressants can lead to respiratory depression, seizures, and potentially even death.

4.5.3 An ordinarily skillful, careful, and diligent psychiatrist avoids prescribing more than one benzodiazepine simultaneously, and especially avoids prescribing more than one benzodiazepine and other CNS depressants simultaneously. By routinely prescribing more than one benzodiazepine concurrently with other CNS depressants to Patient E, Licensee breached the standard of care. Additionally, prescribing more than

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one benzodiazepine concurrently with other CNS depressants is a practice or conduct that does or might constitute a danger to patient health and safety.

4.5.4 At this time, License also prescribed the stimulant methylphenidate (Ritalin, Schedule II controlled substance) 80 mg per day to Patient E. Ritalin has a high risk of abuse; its use potentially leads to severe psychological or physical dependence, and it can aggravate sleep disorders, which are common in older adults. Eighty mg per day is between 1½ times and more than twice the recommended dosage range, but Licensee did not assess the ongoing need for and benefit from a dose of a potentially dangerous Schedule II medication above the recommended range. Additionally, patients taking stimulants with benzodiazepines are likelier to abuse their medications – including to the point of overdose – than patients taking only one or the other because concurrent use of stimulants and depressants can lead to patients increasing the amounts they take, in order to continue to achieve the desired effects of both types of medications.

4.5.5 An ordinarily skillful, careful, and diligent psychiatrist does not prescribe a higher than recommended dosage of Ritalin, especially to an older adult, without first assessing the ongoing need for and benefit from such a dose. By prescribing and maintaining 80 mg of Ritalin per day for Patient E without first assessing the ongoing need for and benefit from this dose of the medication, Licensee breached the standard of care. An ordinarily skillful, careful, and diligent psychiatrist avoids prescribing multiple CNS depressants simultaneously with a stimulant. By prescribing multiple CNS depressants to Patient E while concurrently prescribing a stimulant, Licensee breached the standard of care. Additionally, prescribing multiple CNS depressants while concurrently prescribing a stimulant is a practice or conduct that does or might constitute a danger to patient health and safety.

4.5.6 At some point between 2015 and 2017, Licensee started Patient E on clonazepam for sleep-related movements, however there was no monitoring for parkinsonism or consideration of referral for a sleep study. An ordinarily careful, skillful,

and diligent physician with an elderly patient experiencing sleep-related movements, monitors for parkinsonism, refers the patient for a sleep study, or both, before prescribing a benzodiazepine sedative controlled substance for that patient. By prescribing clonazepam to Patient E without monitoring for parkinsonism or referring Patient E for a sleep study, Licensee breached the standard of care.

4.5.7 In December 2017 and January 2018, Patient E reported gastrointestinal concerns and nosebleeds requiring cautery. This was coincident with licensee prescribing the antidepressant vortioxetine (Trintellix). Licensee documented but dismissed the possibility these symptoms were a side effect of the Trintellix. However, GI upset can be a symptom of serotonin syndrome and nosebleeds can be a sign of platelet dysfunction, either of which could be a serious side effect of the medication. Additionally, Licensee maintained Patient E's prescription of duloxetine after she added the prescription of vortioxetine, but duloxetine inhibits the metabolism of vortioxetine.

4.5.8 An ordinarily careful, skillful, and diligent psychiatrist newly prescribing Trintellix does not dismiss the possibility that gastrointestinal concerns and nosebleeds requiring cautery, which coincided with the new prescription of Trintellix, are side effects of the medication. By doing so, Licensee breached the standard of care in her treatment of Patient E. Additionally, dismissing the possibility that a patient's gastrointestinal concerns and nosebleeds requiring cautery are side effects of the Trintellix the physician is prescribing is a practice or conduct that does or might constitute a danger to patient health.

4.5.9 An ordinarily careful, skillful, and diligent psychiatrist does not prescribe Trintellix while maintaining a prescription of duloxetine, which will inhibit the metabolism of the Trintellix. By doing so, Licensee breached the standard of care in her treatment of Patient E.

4.5.10 Patient E's medications on May 9, 2018, included Abilify 2.5 mg every morning; Trintellix 5 mg; lamotrigine 75 mg every morning; Cymbalta 90 mg; trazodone

75 mg at bedtime; Klonopin 0.5 mg; and Ritalin 80 mg per day. On July 9, 2018, Licensee's medication regimen for Patient E included the antipsychotic aripiprazole (Abilify) 2.5 mg, Trintellix 5 mg, lamotrigine 75 mg, and Cymbalta 90 mg every morning; and trazodone 75 mg and Klonopin 0.5 mg every night. Licensee prescribed Ritalin 80 mg through the day, but did not assess the ongoing need or efficacy for it. Licensee subsequently titrated Patient E off of Abilify in October of 2017, but increased the dosage of Trintellix for a total of 15 mg daily. On November 5, 2018, Patient E's medications included Trintellix 15 mg; lamotrigine 75 mg every morning; Cymbalta 90 mg; trazodone 75 mg at bedtime; Klonopin 0.5 mg; and Ritalin 80 mg per day. During these multiple changes of multiple medications, the Licensee never recorded her medical decision making despite complex polypharmacy.

4.5.11 An ordinarily careful, skillful, and diligent psychiatrist does not make multiple medication changes in a complex polypharmacy construct without recording the medical decisions behind such changes. By doing so, Licensee breached the standard of care in her treatment of Patient E.

4.6 By breaching the standard of care in her treatment of Patients A through E on over 35 occasions, as detailed above, Licensee committed errors of such recurrence that her willful indifference to the consequences of her acts may be inferred.

5.

Applicable Law and Standards

5.1 ORS 677.190(1)(a) authorizes the Board to discipline a licensee for unprofessional or dishonorable conduct.

5.2 Under ORS 677.188(4)(a), unprofessional or dishonorable conduct means any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public.

5.3 ORS 677.190(13) authorizes the Board to discipline a licensee for gross negligence or repeated acts of negligence in the practice of medicine.

5.3.1 Professional negligence in Oregon occurs when a professional breaches the standard of care. ORS 677.095(1) and ORS 677.265(1)(c) define the standard of care as "that degree of care, skill and diligence that is used by ordinarily careful physicians in the same or similar circumstances in the community of the physician or a similar community."

5.3.2 Professional gross negligence in Oregon is an error "of such magnitude or recurrence" that a willful indifference to the consequences of the act may be inferred. *Hambleton v. Bd. of Engineering Examiners*, 40 Or App 9, 12, 594 P2d 416 (1979).

5.4 ORS 677.190(24) authorizes the Board to discipline a licensee for prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients or without following accepted procedures for record keeping.

5.5 ORS 677.205(1)(a) to (b) and (2)(b) to (f) authorize the Board to take disciplinary action for each of the violations listed in the foregoing paragraphs. In issuing discipline, the Board may refuse to grant, place conditions on, suspend, revoke, or limit a license to practice, order probation, and issue other such disciplinary action as the Board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty or assessment of a civil penalty not to exceed $10,000 per violation, or both.

6.

Violations – Unprofessional or Dishonorable Conduct

By engaging in conduct or practices that do or might constitute a danger to the health or safety of Patients A through E and the public, Licensee committed unprofessional conduct as defined by ORS 677.188(4)(a) on multiple occasions, which is grounds for discipline under ORS 677.190(1)(a).

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7.

Violations – Negligence

By failing to meet the standard of care as described in her care of Patients A through E above, Licensee committed negligence in the practice of medicine on at least 35 occasions. Repeated negligence in the practice of medicine is grounds for discipline under ORS 677.190(13).

8.

Violations – Gross Negligence

By committing errors of such recurrence in her treatment of Patients A through E that Licensee's willful indifference to the consequences of her actions can be inferred, Licensee committed gross negligence in the practice of medicine. Gross negligence in the practice of medicine is grounds for discipline under ORS 677.190(13).

9.

Controlled Substances

9.1 By failing to check the Oregon PDMP on patients to whom Licensee was prescribing controlled substances, Licensee prescribed controlled substances without following accepted procedures for examination and record keeping, which is grounds for discipline under ORS 677.190(24).

9.2 By prescribing Soma to Patient D without a legitimate medical purpose, Licensee prescribed a controlled substance without a legitimate medical purpose, which is grounds for discipline under OR 677.190(24).

10.

Committing dishonorable or unprofessional conduct, repeated negligence in the practice of medicine, gross negligence in the practice of medicine, prescribing controlled substances without a legitimate medical purpose, and prescribing controlled substances without following accepted procedures for examination and recordkeeping, are grounds for license discipline up to and including revocation, civil penalties up to $10,000 per violation, and the costs of the

proceeding under ORS 677.205(1) and (2). Pursuant to OAR 137-003-0505(1)(i), the Board may impose the maximum penalties against Licensee without amending its notice, up to and including revocation of license, a $10,000 civil penalty per violation, and the costs of the proceeding.

11.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (ORS 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. The address to which the request for hearing may be sent is:

Oregon Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201

12.

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.

13.

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 $80,000, pursuant to ORS 677.205(2)(f).

14.

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.

15.

Failure by Licensee to timely request a hearing, failure to appear at any hearing scheduled by the Board, withdrawal of the request for hearing, or failure to appear at any hearing scheduled by the Board on time will constitute waiver of the right to a contested case hearing. Waiver of the right to a contested case hearing may result in a default order by the Board, including the potential revocation of Licensee's medical license and assessment of such penalty and costs as the Board deems appropriate under ORS 677.205. If the Board issues a final order by default, the Board designates the discoverable material which comprises the file, including all submissions by Licensee, as the record for the purpose of proving a prima facie case.

16.

Licensee may appeal any final order issued in this case by filing a petition for review with the Oregon Court of Appeals within 60 days after it is served upon Licensee. See ORS 183.480 et seq.

Dated this 5TH day of MAY 2022.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

R. DAVID FARRIS, MD
Medical Director

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of LYNN KARI FRIEDMAN, MD LICENSE NO. MD13860	)))))	AMENDED 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. Lynn Kari Friedman, 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), which may 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.

Licensee is a board-certified psychiatrist who practices medicine in Portland, Oregon. The acts and conduct alleged to violate the Medical Practice Act follow:

3.1 The Board conducted a review of Licensee's management and treatment of patients (Patients A – E) that revealed a pattern of practice in which Licensee was prescribing medications in combinations that were not medically indicated and carry serious risks of drug

interactions and which were not adjusted for patient age. Licensee's conduct constituted a danger to the health and safety of patients and breached the standard of care. The Board's review of Licensee's charts for Patients A – E reveals a pattern of practice in which Licensee breached the standard of care and exposed these patients to the risk of harm to include the following:

3.1.1 Licensee failed to document that she requested and reviewed the medical records for her new patients.

3.1.2 Licensee failed to document why she changed medications or changed the dosages, and failed to address the drug interactions and specific risks posed to each patient with the complex regimen of medications that each patient was taking.

3.1.3 Licensee failed to document vital signs, laboratory results, AIMS (Abnormal Involuntary Movement Scale), and screening tools.

3.1.4 Licensee failed to document patient weight and body mass index (BMI) prior to starting atypical antipsychotic medications, such as quetiapine (Seroquel) and aripiprazole (Abilify).

3.1.5 Licensee exceeded the recommended dosages for elderly patients for the following medications: temazepam (Restoril) 15 mg, quetiapine (Seroquel) 200 mg, citalopram (Celexa), zolpidem (Ambien) 12.5 mg, armodafinil (Nuvigil), escitalopram (Lexapro), and methylphenidate ER (Ritalin ER).

3.1.6 Licensee treated patients with benzodiazepines for long durations without meeting with patients for follow-up for periods in excess of 3 to 4 months, and as a result, failed to provide adequate monitoring for potential side effects of adverse reactions.

3.1.7 Licensee failed to document in the charts that she informed patients of the potential side effects of the use and prolonged use of psychotropic medications and the alternative treatment options and did not document informed consent for medication or dosage changes.

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3.1.8 Licensee failed to inform her patients of the risk associated with antipsychotic medications during hot and humid weather, to include the risk of developing excessive body temperature, or hyperthermia.

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

3.2 Patient A, an 82-year-old female began treatment with Licensee in October of 1992 with a diagnosis of Major Depressive Disorder, recurrent, in remission. On July 14, 2016, Licensee noted that Patient A had not recovered from heat exhaustion and appeared very discouraged. Licensee's medication list on August 22, 2016, included vortioxetine (Trintellix) 10 mg; aripiprazole (Abilify) 10 mg; quetiapine (Seroquel) 200 mg; bupropion XL (Wellbutrin) 150 mg; and alternating doses of temazepam (Restoril, Schedule IV) 15 mg; clorazepate (Transxene) 7.5 mg; and zolpidem CR (Ambien, Schedule IV) 12.5 mg. On September 19, 2016, Licensee documented that Patient A reported having dizzy episodes, taking 18 supplements a day, and a family history of heart disease and stroke. On December 4, 2018, Licensee noted that Patient A had fallen on her left knee (Patient A had also experienced motor vehicle accidents in 2018). Licensee discontinued aripiprazole (Abilify) but started duloxetine (Cymbalta) 30 mg. On January 23, 2019, Licensee's medication regimen for Patient A included buspirone (Buspar) 10 mg; Wellbutrin XL 300 mg; fluoxetine (Prozac) 20 mg; Seroquel 200 mg; Restoril 15 mg; clorazepate (Transxene) 7.5 mg; Ambien CR 12.5 mg; and Cymbalta 30 mg. Licensee failed to assess and document if Patient A's heat exhaustion in 2016 was related to risks associated with psychotropic medication such as Seroquel, Abilify and Wellbutrin during periods of high temperatures. Licensee's conduct exposed this elderly patient to the risk of harm and breached the standard of care by treating this patient with complex combinations of medications with unexplained interactions and risks to the patient, and inadequate monitoring of patient response to long-term prescriptions of Ambien and Restoril. Licensee's 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24)

prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.3. Patient B, a 76-year-old female, presented to Licensee with a history of high blood pressure, osteoporosis, irritable bowel syndrome (IBS), osteoarthritis, and scoliosis. Licensee's initial diagnoses included Major Depression, recurrent, and Dysthymic Disorder. In May of 2017, Licensee maintained Patient B on citalopram (Celexa) 60 mg; Cymbalta 60 mg; Ambien 10 mg; and alprazolam (Xanax, Schedule IV) .25 mg; 4 times a day. On March 13, 2018, Licensee noted that Patient B fell and broke her left arm, requiring surgery. Licensee's medications for Patient B at this time included Cymbalta 60 mg; Ambien 10 mg; and Xanax .25 mg; 4 times a day. On September 10, 2018, Licensee reported that Patient B fell on her concrete driveway and noticed that she had difficulty with word finding. Nevertheless, Licensee maintained Patient B on the same medication regimen, which continued into early 2019. On March 11, 2019, Licensee noted that Patient B reported having eye problems, dryness, cataracts, start of macular degeneration and possible glaucoma. Licensee maintained Patient B on a high dosage of Celexa, despite the black box warning for dosing in excess of 40 mg, particularly in view of this patient's advanced age and other medications. Licensee did not order EKGs to check for possible adverse effects on this patient's heart rhythm. Licensee breached the standard of care and exposed this patient to the risk of harm by maintaining Patient B on an excessive and long-term course of medications that exposed this elderly patient to the risk of excess sedation. Licensee's 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.4 Patient C, a 77-year-old male, came under Licensee's care in 2003, with a history of chronic low back pain, chronic diarrhea, and peptic ulcer disease. The Board's chart review

from March 2017 through February 2019 reveals that Licensee maintained Patient C on Seroquel 25 mg; Abilify 5 mg; buproprion XL (Wellbutrin XL) 450 mg; armodafinil (Nuvigil) 500 mg; diazepam (Valium, Schedule IV) 15 mg; amitriptyline (Elavil) 150 mg; and escitalopram (Lexapro) 20 mg. On March 29, 2017, Licensee noted that Patient C had a motor vehicle accident, and on May 25, 2017, that Patient C was slow, rambling, and losing track of his thoughts in his responses to a mental status exam. Licensee continued to note Patient C's difficulties in responding during a mental status examination in August 2017 and March 2018. In October 2017, Patient C reported losing his balance and having several falls and thought that the Valium and sleep deprivation, along with depression was a likely contributor to daytime sleepiness and memory loss. No medication changes were documented. On April 16, 2018, Patient C reported memory loss. Licensee failed to respond to evidence that the medications may be causing impairment, and prescribed Nuvigil without a documented medical indication, and failed to document his rationale for maintaining this patient on high dosages and complex combination of medications. Licensee's conduct breached the standard of care and exposed this patient to the risk of harm in violation of 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.5 Patient D, a 72-year-old female presented to Licensee with a history of fibromyalgia, hypertension and left bundle branch block since her early 40s, migraine, IBS, GERD, hypercholesterolemia, and QT interval prolongation in January 2012. The Board reviewed Licensee's records for this patient from March 2017 through January 2019. The record for April 12, 2017, reveals that Licensee maintained Patient D on clonazepam (Klonopin, Schedule IV) 0.5 mg at bedtime; carisoprodol (Soma, Schedule IV) 350 mg; and vortioxetine (Trintellix) 10 mg. On December 10, 2018, Licensee maintained Patient D on Klonopin 0.25 mg

at bedtime; Soma 350 mg and eszopiclone (Lunesta, Schedule IV) 2 mg, ½ tablet at bedtime. The record for March 21, 2019, reveals a change to the medication: Trintellix 10 mg; Klonopin 0.25 mg; and Soma 350 mg. During the course of her treatment for Patient D, Licensee breached the standard of care by maintaining this elderly patient on a long-term course of Soma with a benzodiazepine and Trintellix, which could induce confusion, dizziness, drowsiness, and difficulty concentrating. Licensee's conduct is in violation of 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.6 Patient E, a 69-year-old male, began treatment with Licensee in April of 2015, with a history of hypokalemic periodic paralysis, coronary artery disease, hypercholesterolemia, borderline diabetes mellitus, and status post double coronary bypass surgery. Licensee's initial assessment included Major Depression, recurrent, Attention Deficit Hyperactive Disorder, and Panic Disorder without Agoraphobia. A review of records reveals that on June 1, 2017, Licensee maintained Patient E on methylphenidate (Ritalin, Schedule II) 20 mg, 4 per day; Cymbalta 90 mg; Klonopin 0.5 mg; trazodone 150 mg ½ qhs; and lamotrigine 150 mg ½ qam. On July 9, 2018, Licensee's medication regimen for Patient E included Abilify 5 mg ½ qam; Trintellix 5 mg; lamotrigine 150 mg ½ qam; Cymbalta 90 mg; trazodone 150 mg ½ qhs; Klonopin 0.5 mg; and Ritalin 20 mg, 4 per day. Licensee subsequently titrated Patient E off of Abilify in October of 2018, but increased the dosage of Trintellix for a total of 15 mg daily. Patient E's medications on May 9, 2018, included Abilify 5 mg ½ qam; Trintellix 5 mg; lamotrigine 150 mg ½ qam; Cymbalta 90 mg; trazodone 150 mg ½ qhs; Klonopin 0.5 mg; and Ritalin 20 mg, 4 per day. On November 5, 2018, Patient E's medications included Trintellix 15 mg; lamotrigine 150 mg ½ qam; Cymbalta 90 mg; trazodone 150 mg ½ qhs; Klonopin 0.5 mg; and Ritalin 20 mg, 4 per day. Licensee continued to prescribe Ritalin to Patient E despite his age and history of cardiovascular

disease without consulting with a cardiologist. Licensee's conduct 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 which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

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 $75,000.00, 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.

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 her 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 August, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]
NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
LYNN KARI FRIEDMAN, MD	)	COMPLAINT & NOTICE OF
LICENSE NO. MD13860	)	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. Lynn Kari Friedman, 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), which may include the revocation of license, a $10,000 civil penalty, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) 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 or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.

Licensee is a board-certified psychiatrist who practices medicine in Portland, Oregon. The acts and conduct alleged to violate the Medical Practice Act follow:

3.1 The Board conducted a review of Licensee's management and treatment of patients (Patients A – E) that revealed a pattern of practice in which Licensee was prescribing medications in combinations that were not medically indicated and carry serious risks of drug interactions and which were not adjusted for patient age. Licensee's conduct constituted a

danger to the health and safety of patients and breached the standard of care. The Board's review of Licensee's charts for Patients A – E reveals pattern of practice in which Licensee breached the standard of care and exposed these patients to the risk of harm to include the following:

3.1.1 Licensee failed to document that she requested and reviewed the medical records for her new patients.

3.1.2 Licensee failed to document why she changed medications or changed the dosages, and failed to address the drug interactions and specific risks posed to each patient with the complex regimen of medications that each patient was taking.

3.1.3 Licensee failed to document vital signs, laboratory results, AIMS (Abnormal Involuntary Movement Scale), and screening tools.

3.1.4 Licensee failed to document patient weight and body mass index (BMI) prior to starting atypical antipsychotic medications, such as quetiapine (Seroquel) and aripiprazole (Abilify).

3.1.5 Licensee exceeded the recommended dosages for elderly patients for the following medications: temazepam (Restoril) 15 mg, quetiapine (Seroquel) 200 mg, citalopram, (Celexa), zolpidem (Ambien) 12.5 mg, armodafinil (Nuvigil), escitalopram (Lexapro), and methylphenidate ER (Ritalin ER).

3.1.6 Licensee treated patients with benzodiazepines for long durations without meeting with patients for follow-up for periods in excess of 3 to 4 months, and as a result, failed to provide adequate monitoring for potential side effects of adverse reactions.

3.1.7 Licensee failed to document in the charts that she informed patients of the potential side effects of the use and prolonged use of psychotropic medications and the alternative treatment options and did not document informed consent for medication or dosage changes.

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3.1.8 Licensee failed to inform her patients of the risk associated with antipsychotic medications during hot and humid weather, to include the risk of developing excessive body temperature, or hyperthermia.

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

3.2 Patient A, an 82-year-old female began treatment with Licensee in October of 1992 with a diagnosis of Major Depressive Disorder, recurrent, in remission. On July 14, 2016, Licensee noted that Patient A had not recovered from heat exhaustion and appeared very disorganized. Licensee's medication list on August 22, 2016, included vortioxetine (Trintellix) 10 mg; aripiprazole (Abilify) 10 mg; levomilnacipran (Fetzima) 80 mg; quetiapine (Seroquel) 200 mg; bupropion XL (Wellbutrin) 150 mg; temazepam (Restoril, Schedule IV) 15 mg; clorazepate (Transxene) 7.5 mg; and zolpidem CR (Ambien, Schedule IV) 12.5 mg. On September 19, 2016, Licensee documented that Patient A reported having dizzy episodes, taking 18 supplements a day, and a family history of heart disease and stroke. On December 4, 2018, Licensee noted that Patient A had fallen on her left knee (Patient A had also experienced motor vehicle accidents in 2018). Licensee discontinued aripiprazole (Abilify) but started duloxetine (Cymbalta) 30 mg. On January 23, 2019, Licensee's medication regimen for Patient A included buspirone (Buspar) 10 mg; Wellbutrin XL 300 mg; fluoxetine (Prozac) 20 mg; Seroquel 200 mg; Restoril 15 mg; clorazepate (Transxene) 7.5 mg; Ambien CR 12.5 mg; and Cymbalta 30 mg. Licensee failed to assess and document if Patient A's heat exhaustion in 2016 was related to risks associated with psychotropic medication such as Seroquel, Abilify and Wellbutrin during periods of high temperatures. Licensee's conduct exposed this elderly patient to the risk of harm and breached the standard of care by treating this patient with complex combinations of medications with unexplained interactions and risks to the patient, and inadequate monitoring of patient response to long-term prescriptions of Ambien and Restoril. Licensee's 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24)

prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.3. Patient B, a 76-year-old female, presented to Licensee with a history of high blood pressure, osteoporosis, irritable bowel syndrome (IBS), osteoarthritis, and scoliosis. Licensee's initial diagnoses included Major Depression, recurrent, and Dysthymic Disorder. In May of 2017, Licensee maintained Patient B on citalopram (Celexa) 60 mg; Cymbalta 60 mg; Ambien 10 mg; and alprazolam (Xanax, Schedule IV) .25 mg; 4 times a day. On March 13, 2018, Licensee noted that Patient B fell and broke her left arm, requiring surgery. Licensee's medications for Patient B at this time included Cymbalta 60 mg; Ambien 10 mg; and Xanax .25 mg; 4 times a day. On September 10, 2018, Licensee reported that Patient B fell on her concrete driveway and noticed that she had difficulty with word finding. Nevertheless, Licensee maintained Patient B on the same medication regimen, which continued into early 2019. On March 11, 2019, Licensee noted that Patient B reported having eye problems, dryness, cataracts, start of macular degeneration and possible glaucoma. Licensee maintained Patient B on a high dosage of Celexa, despite the black box warning for dosing in excess of 40 mg, particularly in view of this patient's advanced age and other medications. Licensee did not order EKGs to check for possible adverse effects on this patient's heart rhythm. Licensee breached the standard of care and exposed this patient to the risk of harm by maintaining Patient B on an excessive and long-term course of medications that exposed this elderly patient to the risk of excess sedation. Licensee's 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.4 Patient C, a 77-year-old male, came under Licensee's care in 2003, with a history of chronic low back pain, chronic diarrhea, and peptic ulcer disease. The Board's chart review

from March 2017 through February 2019 reveals that Licensee maintained Patient C on Seroquel 25 mg; Abilify 5 mg; buproprion XL (Wellbutrin XL) 450 mg; armodafinil (Nuvigil) 500 mg; diazepam (Valium, Schedule IV) 15 mg; amitriptyline (Elavil) 150 mg; and escitalopram (Lexapro) 20 mg. On March 29, 2017, Licensee noted that Patient C had a motor vehicle accident, and on May 25, 2017, that Patient C was slow, rambling, and losing track of his thoughts in his responses to a mental status exam. Licensee continued to note Patient C's difficulties in responding during a mental status examination in August 2017 and March 2018. In October 2017, Patient C reported losing his balance and having several falls and thought that the Valium and sleep deprivation, along with depression was a likely contributor to daytime sleepiness and memory loss. No medication changes were documented. On April 16, 2018, Patient C reported memory loss. Licensee failed to respond to evidence that the medications may be causing impairment, and prescribed Nuvigil without a documented medical indication, and failed to document his rationale for maintaining this patient on high dosages and complex combination of medications. Licensee's conduct breached the standard of care and exposed this patient to the risk of harm in violation of 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.5 Patient D, a 72-year-old female presented to Licensee with a history of fibromyalgia, hypertension and left bundle branch block since her early 40s, migraine, IBS, GERD, hypercholesterolemia, and QT interval prolongation in January 2012. The Board reviewed Licensee's records for this patient from March 2017 through January 2019. The record for April 12, 2017, reveals that Licensee maintained Patient D on clonazepam (Klonopin, Schedule IV) 0.5 mg at bedtime; carisoprodol (Soma, Schedule IV) 350 mg; and vortioxetine (Trintellix) 10 mg. On December 10, 2018, Licensee maintained Patient D on Klonopin 0.25 mg

at bedtime; Soma 350 mg and eszopiclone (Lunesta, Schedule IV) 2 mg, ½ tablet at bedtime. The record for March 21, 2019, reveals a change to the medication: Trintellix 10 mg; Klonopin 0.25 mg; and Soma 350 mg. During the course of her treatment for Patient D, Licensee breached the standard of care by maintaining this elderly patient on a long-term course of Soma with a benzodiazepine and Trintellix, which could induce confusion, dizziness, drowsiness, and difficulty concentrating. Licensee's conduct is in violation of 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; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

3.6 Patient E, a 69-year-old male, began treatment with Licensee in April of 2015, with a history of hypokalemic periodic paralysis, coronary artery disease, hypercholesterolemia, borderline diabetes mellitus, and status post double coronary bypass surgery. Licensee's initial assessment included Major Depression, recurrent, Attention Deficit Hyperactive Disorder, and Panic Disorder without Agoraphobia. A review of records reveals that on May 1, 2017, Licensee maintained Patient E on methylphenidate ER (Ritalin, Schedule II) 20 mg, 4 per day; Cymbalta 120 mg; Klonopin 0.5 mg; trazodone 150 mg; and lamotrigine 150 mg. On July 9, 2018, Licensee's medication regimen for Patient E included Abilify 5 mg; Trintellix 5 mg; lamotrigine 150 mg; Cymbalta 90 mg; trazodone 150 mg; Klonopin 0.5 mg; and Ritalin 20 mg, 4 per day. Licensee subsequently titrated Patient E off of Abilify in October of 2018, but increased the dosage of Trintellix for a total of 15 mg daily. Patient E's medications on May 9, 2018, included Abilify 5 mg; Trintellix 5 mg; lamotrigine 150 mg; Cymbalta 90 mg; trazodone 150 mg; Klonopin 0.5 mg; and Ritalin 20 mg, 4 per day. On November 5, 2018, Patient E's medications included Trintellix 15 mg; lamotrigine 150 mg; Cymbalta 90 mg; trazodone 150 mg; Klonopin 0.5 mg; and Ritalin 20 mg, 4 per day. Licensee continued to prescribe Ritalin to Patient E despite his age and history of cardiovascular disease without consulting with a cardiologist.

Licensee's conduct 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 which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.

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 $75,000.00, 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.

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 28 day of May, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]
NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

License Verification Details

Subject to **Terms and Conditions**. This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Oregon Medical Board
1500 SW 1st Ave
Suite 620
Portland, OR 97201
Phone: (971) 673-2700

Information current as of 06/07/2022 04:03:22 PM

Friedman, Lynn Kari, MD

MD License: MD13860

Originally Issued: 04/13/1984 **Basis:** NBME

Current Status: Active **Expedited Endorsement:** No

Status Effective: 1/1/2022

Expires: 12/31/2023

Other Licenses

License Number	Effective Date	Expiration Date	License Type
LL03331	07/11/1983	07/11/1983	MD Postgraduate License
LL03305	01/25/1983	01/25/1983	MD Postgraduate License

Licensee Information

Gender: Female

Specialty : Psychiatry

Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification.

Supervising Physician Status : Not Approved

Languages : English

Practice Location(s)

Street	City, State Zip	County	Phone
9900 SW Wilshire St. Ste 210	Portland, OR 97225	Washington	503-246-9337

Education

School Name	Location	Degree Date	Degree Earned
U/WI MED SCH	MADISON, WI United States	12/20/1981	MD

Post-Graduate Training	School Name	Location	From	To	Specialty
Internship	OHSU	PORTLAND, OR United States	01/1982	01/1983	
Residency	OHSU	PORTLAND, OR United States	01/1983	07/1986	

The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.

Board Actions

Board Actions are provided pursuant to ORS 676.175(5)(a) and (b).

Complaint and Notices are issued by a vote of the Board but are a preliminary action only; a final determination has not been made. Corrective Action Orders, Corrective Action Agreements, Consent Agreements, Voluntary Limitations, and rescinded Board actions are not disciplinary and are removed from this website upon completion. These are public documents available through a license verification request .

Effective Date	End Date	Order Type

Effective Date	End Date	Order Type
05/05/2022	Open	Complaint and Notice
	On May 5, 2022, the Board issued a Second Amended Complaint and Notice of Proposed Disciplinary Action alleging violations of the Medical Practice Act (state law) regarding unprofessional conduct; repeated acts of negligence in the practice of medicine; gross negligence in the practice of medicine; and prescribing controlled substances without a legitimate medical purpose, or prescribing controlled substances without following accepted procedures for examination of patients or without following accepted procedures for record keeping. This is a preliminary action by the Board. A final Board action in this matter has not been taken.	
08/13/2020	05/05/2022	Complaint and Notice
	On August 13, 2020, the Board issued an Amended Complaint and Notice of Proposed Disciplinary Action alleging violations of the Medical Practice Act (state law) regarding unprofessional or dishonorable conduct; gross or repeated acts of negligence; and prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.	
05/28/2020	08/13/2020	Complaint and Notice
	On May 28, 2020, the Board issued a Complaint and Notice of Proposed Disciplinary Action alleging violations of the Medical Practice Act (state law) regarding unprofessional or dishonorable conduct; gross or repeated acts of negligence; and prescribing controlled substances without a legitimate medical purpose or without following accepted procedures for examination of patients or for record keeping.	

Malpractice

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; a self-insured entity; or a health maintenance organization. Claim reporting and disclosure requirements are governed by ORS 742.400.

The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred. This database represents information from reporters to date. Please note: Not all reporters may have submitted claim information to the Board.

For malpractice claim information, click here.