BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of PETER SAMUEL MOREY, MD LICENSE NO. MD24236	)))))	 ORDER OF EMERGENCY SUSPENSION

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. Peter Samuel Morey, MD (Licensee) is a licensed physician in the state of Oregon.

2.

The acts and conduct that support this Order for Emergency Suspension are as follows:

2.1 Licensee is a psychiatrist, with a practice in downtown Portland, Oregon. Patient A, an adult female patient, called various health care providers during Memorial Day weekend of 2007, pleading for an appointment. Licensee returned her call and agreed to meet with her on Sunday, May 27, which was the Memorial Day holiday. Patient A sought treatment for an adjustment disorder related to the death of her mother. Patient A had a history of abuse and faced emotional and family turmoil. Patient A's history includes mental health treatments and psychotropic medications. At the end of the first clinical visit, Licensee prescribed various medications for Patient A, to include trazodone (an anti-depressant), clonazepam (Schedule IV controlled substance), bupropion (Wellbutrin, an anti-depressant), and fluoxetine (Prozac, an anti-depressant). Patient A returned frequently for clinical visits at Licensee's requests, and Licensee continued to write prescriptions for her. Licensee later added Adderall (Schedule II controlled substance of dextroamphetamine + amphetamine) to her medication regimen. Licensee continued to see Patient A in his clinic for many hours and almost daily during some weeks in 2007. Patient A eventually relocated to Bend and stopped seeing Licensee on a regular

basis. However, Licensee continued to refill medications for her in 2008. Licensee completed and signed prescription forms and mailed them to Patient A in Bend. Some of these prescriptions included controlled substances. Licensee signed these prescription forms without seeing Patient A for therapy sessions. Licensee also corresponded with her by e-mail for some period of time until she began to receive care from other health care providers. The last time that Licensee prescribed medication (clonazepam) for Patient A occurred in November of 2008. During the time that Licensee was prescribing medications to Patient A, he engaged in unprofessional boundary violations with Patient A by entering into a personal friendship with her and inappropriately touching Patient A. Licensee's conduct contributed to the emotional and mental health destabilization of Patient A. Licensee's boundary violations with Patient A were multiple and varied, to include the following:

a. Licensee provided Patient A with a key to access his clinic and a vacant office space by his practice on the top floor of a downtown building. Licensee offered to furnish this space and to pay for the new furniture so that Patient A could live there. Licensee did not seek any rent from Patient A, who elected not to accept this living arrangement from Licensee.

b. Licensee waived all of the co-pays for Patient A for all her office visits, and he did not charge her for prescription refills. During the summer of 2007, Licensee also provided her with on-the-job training with the plan that she could work at his office as his assistant. Licensee paid her $100 for one day of training, and Licensee admitted that the $100 was an intentional overpayment.

c. During clinical visits, as well as during their informal personal interactions, Licensee made personal disclosures to Patient A about his own personal issues, to include his marital problems with his wife, his sexual frustrations, and his social life. Licensee disclosed to Patient A that he was diagnosed with attention deficit disorder (ADD), was prescribed Adderall for ADD, and suffered health problems with this medication. Licensee revealed

personal details regarding his sexual health to Patient A. Such disclosures serve no medical or therapeutic purpose for Patient A.

d. Licensee would meet with Patient A in this vacant space by his clinic and at his office, where he engaged in inappropriate touching, to include embracing her, kissing her, and stroking her hair while her head was resting in his lap. On multiple occasions, Licensee initiated sexualized conversations with Patient A about his own sexual activities and frustrations, as well as Patient A's sexual relationship with her then-boyfriend.

e. Licensee sent Patient A numerous e-mails during the course of his treatment relationship with her. These e-mails were sent during various times of the day and night with discussions about his feelings, their friendship, and his need to see her soon. Licensee also requested Patient A to meet him immediately at his clinic during the early morning and in the evenings, such as 7 p.m., to discuss his feelings and their interactions.

f. Licensee called Patient A on her cell phone multiple times after some sessions. Licensee also contacted Patient A to inquire if he had stepped over his professional boundaries by doing things such as hugging her.

g. Licensee divulged confidential information regarding other patients to Patient A. For example, Licensee pointed out a female patient in his waiting room to Patient A and then told Patient A about some details of this patient. Such conduct violates patient confidentiality and served no medical or therapeutic purpose for Patient A.

h. At the conclusion of one clinic visit, and while still at Licensee's office, Licensee displayed a semi-automatic handgun to Patient A. There was no medical or therapeutic purpose for this action.

2.2 Licensee, accompanied by his legal counsel, met with two Board investigators on December 30, 2009, at the Board's office. During the course of that interview, Licensee stated

that he has not attempted to contact Patient A by any manner after she had moved to Bend. Licensee insisted that his last e-mail to Patient A occurred in March 2008, involving a medication refill. Licensee repeated this assertion in a letter to the Board, dated January 6, 2010. This statement is inconsistent with other information available to the Board. In a letter dated December 16, 2009, Licensee admitted to having a "lapse in judgment in November of 2008, where I received a refill request from Chicago from [Patient A] looking for clonazepam." Licensee admitted to refilling this controlled substance. In addition, the Board has a copy of an e-mail communication between Licensee and Patient A that is dated October 21, 2009. This e-mail from Licensee consisted of Licensee re-sending the e-mail to Patient A that he had previously sent to her on August 20, 2007, at 12:21 p.m. about his need to see Patient A that evening, and that he will not try to talk her "into coming back to work or anything. I just feel like I really need to understand what happened. I am totally confused."

2.3 Licensee began to date Patient B, a massage therapist, in the fall of 2007, while he was still married. Following Licensee's divorce, Licensee and Patient B subsequently entered into a short-lived marriage. Licensee prescribed Adderall for Patient B on at least one or two occasions, but he did not maintain a patient chart for her. Licensee also requested that Patient B provide massage therapy to his psychiatric patients, and there was a period of time in which Patient B did not hold an active massage therapist's license in Oregon when she was providing massage therapy at his clinic.

2.4 Licensee engaged in multiple boundary violations by providing personal loans of up to $500 to multiple psychiatric patients. Licensee also formed friendships with two other adult female patients, Patients C and D. Licensee made inappropriate personal disclosures to Patient D, by telling her about problems with his marriage and his subsequent dating activity, to include disclosing details of a sexually explicit nature about himself. This type of self-disclosure of a psychiatrist's personal life to a patient constitutes a boundary violation. Patient D had formed a strong attachment to Licensee and had given him personal presents before Licensee discharged her as a patient in December 2008.

2.5 Licensee is in a solo practice with an office that has several private rooms, which he has sub-leased to a nurse practitioner and a massage therapist. He has no support staff, and does all of his own office administrative work, to include answering messages, sending faxes and making appointments. Licensee does not routinely request charts from other providers or hospitals concerning his patients, stating that he "errs on the side of trusting what they say" about their prescription medications and diagnoses. Licensee frequently accepts complex patients who are already under the care of other providers. Nevertheless, Licensee frequently writes prescriptions, refills, and/or changes the medication regimen for these new patients without confirming with other providers or hospitals information regarding their diagnoses, medication history, hospitalizations, and/or possible history of abuse or suicidal ideations. Licensee's reliance upon the ability or willingness of his new and often complex patients to accurately recall their diagnoses, prescription medications and dosages, while Licensee continues to prescribe and refill medications, places some of his patients at risk for harm.

3.

Based on the above information, the Board has determined that from the evidence available to the Board at this time, Licensee's continued practice of medicine would pose an immediate danger to the public and to his patients, and that his medical judgment may be impaired. Licensee has engaged in a pattern of behavior that displays disregard for concepts of professional boundaries and professional ethics. The Board is also concerned that Licensee practices alone, without frequent professional interaction with colleagues. Licensee has also made misrepresentations to the Board, which casts his credibility into doubt. This behavior causes the Board to conclude that it would be subjecting patients to the risk of harm if he were allowed to continue to practice while this case remains under investigation. Pursuant to ORS 677.205(3), the Board orders that the license of Peter Samuel Morey, MD, to practice medicine, including refilling medications, is suspended on an emergency basis. Licensee is directed to immediately cease the practice of medicine until otherwise ordered by the Board. This Order becomes effective at 6:00 p.m. on the date this Order is signed by the Board Chair.

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant to ORS 183.430(2).

Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practical.

IT IS SO ORDERED this 6th day of January 2010.

OREGON MEDICAL BOARD

Signature Redacted on Copies

DOUGLAS B. KIRKPATRICK, MD
Board Chair

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of PETER SAMUEL MOREY, MD LICENSE NO. MD24236	)	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. Peter Samuel Morey, MD (Licensee) is licensed to practice medicine in the state of Oregon.

2.

The Board issued an Order of Emergency Suspension to Licensee on January 6, 2010. Licensee requested a hearing. The Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a), (b) and (c) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(5) willfully or negligently divulging a professional secret to another without written consent; and ORS 677.190(13) gross or repeated negligence.

3.

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

3.1 Licensee is a psychiatrist, who had a full time solo practice in downtown Portland, Oregon, starting in April of 2007, Patient A, an adult female patient, called various health care providers during Memorial Day weekend of 2007, pleading for an appointment. Licensee returned her call and agreed to meet with her on Monday, May 28, which was the Memorial Day holiday, but a regular work day for Licensee. Patient A was seen and diagnosed by Licensee for an adjustment disorder related to the death of her mother. Patient A had a

history of abuse and faced emotional and family turmoil. Patient A's history includes mental health treatments and psychotropic medications. At the end of the first clinical visit, Licensee prescribed various medications for Patient A, to include trazodone (an anti-depressant), clonazepam (Schedule IV controlled substance), bupropion (Wellbutrin, an anti-depressant), and fluoxetine (Prozac, an anti-depressant). Patient A returned frequently for clinical visits at Licensee's requests, and Licensee continued to write prescriptions for her. Approximately a month later, Licensee added Adderall (Schedule II controlled substance of dextroamphetamine + amphetamine) to her medication regimen, which Patient A said that she found to be helpful. Licensee continued to see Patient A in his clinic for many sessions and sometimes daily during some weeks in 2007. Patient A eventually relocated to Bend, Oregon, and stopped seeing Licensee on a regular basis for therapy. However, Licensee continued to refill medications for her in 2008. Licensee completed and signed prescription forms and mailed them to Patient A in Bend as she was searching for a new provider in that area. Some of these prescriptions included controlled substances as indicated above. Licensee signed these prescription forms without seeing Patient A for therapy sessions. Licensee also corresponded with her by e-mail for some period of time until she began to receive care from other health care providers. The last time that Licensee prescribed medication (clonazepam) for Patient A occurred in November of 2008. During the time that Licensee was prescribing medications to Patient A, he engaged in unprofessional boundary violations with Patient A by entering into a personal friendship with her and inappropriately touching Patient A. Licensee's conduct contributed to the emotional and mental health destabilization of Patient A. Licensee's boundary violations with Patient A include the following:

a. Licensee provided Patient A with a key to his office suite and access codes to the building to allow her to enter his clinic. Licensee offered to purchase new office furniture for the vacant office space located near his office suite so that Patient A could provide receptionist and other office administrative assistance to help Licensee in his practice. When Patient A and her boyfriend were facing homelessness, Licensee offered

for them to stay in the vacant office space temporarily instead of living in their car. Patient A elected not to accept this offer of a living arrangement from Licensee. This arrangement with Patient A could have compromised the confidentiality of chart information pertaining to other patients.

b. Licensee waived all of the co-pays for Patient A for all her office visits, and he did not charge her for prescription refills. Licensee asserts that he has waived the co-pays for other patients facing financial difficulties. During the summer of 2007, Licensee also provided her with one day of on-the-job training with the plan that she could work at his office as his assistant. Licensee paid her $100 for one day of training, and Licensee admitted that the $100 was an intentional overpayment.

c. During clinical visits, as well as during their informal personal interactions, Licensee made personal disclosures to Patient A about his own personal issues, to include his marital problems with his wife, sexual frustrations, social life, and challenges with other patients. Licensee disclosed to Patient A that he was diagnosed with attention deficit disorder (ADD), was prescribed Adderall for ADD, and suffered health problems with this medication. Licensee revealed personal details regarding his sexual health related to Adderall to Patient A. Such disclosures serve no medical or therapeutic purpose for Patient A.

d. Licensee during a therapy session met with Patient A in his office engaged in inappropriate touching, to include embracing her, kissing her on top of her head and cheek, and stroking her hair while her head was resting on a pillow in his lap. On multiple occasions, Licensee had sexualized conversations with Patient A about his own sexual activities and frustrations, as well as Patient A's sexual relationship with her then-boyfriend. On at least one occasion, Licensee placed a blanket on the floor, requested that Patient A lie down next to him, and caressed her after she complied.

e. Licensee sent Patient A numerous e-mails during the course of his treatment and medication management relationship with her. These e-mails were sent during various

times of the day and night with discussions about his feelings of the blurring of the therapeutic relationship and their friendship, and his need to see her soon regarding the proper procedure for termination of the therapeutic relationship as she was moving to Bend. Licensee also requested Patient A to meet him immediately at his clinic during the early morning and in the evenings, such as 7 p.m., to discuss their interactions and termination of the therapeutic relationship due to her immediate relocation.

f. Licensee called Patient A on her cell phone after some sessions. Licensee also contacted Patient A to inquire if he had stepped over his professional boundaries in his interactions with her, to include hugging her.

g. Licensee divulged confidential information regarding other patients to Patient A. Such conduct violates patient confidentiality and served no medical or therapeutic purpose for Patient A.

h. At the conclusion of one session, and while still at Licensee's office, Licensee displayed a semi-automatic handgun to Patient A and placed it in her hands. There was no medical or therapeutic purpose for this action.

3.2 Licensee, accompanied by his legal counsel, met with two Board investigators on December 30, 2009, at the Board's office. During the course of that interview, Licensee stated that he has not attempted to contact Patient A by any manner after she had moved to Bend. Licensee insisted that his last e-mail to Patient A occurred in March 2008, involving a medication refill. Licensee repeated this assertion in a letter to the Board, dated January 6, 2010. This statement is inconsistent with other information available to the Board. In a letter dated December 16, 2009, Licensee admitted to having a "lapse in judgment in November of 2008, where I received a refill request from [a pharmacy in] Chicago from [Patient A] looking for clonazepam." Licensee admitted to refilling this controlled substance, which Patient A never picked up. In addition, the Board has a copy of an e-mail communication between Licensee and Patient A that is dated October 21, 2009. This e-mail from Licensee consisted of Licensee re-sending the e-mail to Patient A that he had previously sent to her on August 20, 2007, at 12:21

p.m. about his need to see Patient A that evening, and that he will not try to talk her "into coming back to work or anything. I just feel like I really need to understand what happened. I am totally confused." Licensee asserts that he does not remember sending the e-mail that was dated October 21, 2009.

3.3 Licensee began to date Patient B, a massage therapist, in the fall of 2007, while he was still married. Patient B is the adult daughter of Patient E, a male. Patient B met Licensee through her father, Patient E, who was a psychiatric patient of Licensee. Following Licensee's divorce, Licensee and Patient B entered into a short-lived marriage. A patient of Licensee attended their wedding. Patient E helped Licensee move out of his previous wife's residence. Patient B approached Licensee with a previous diagnosis of ADD and requested Licensee take over refilling her prescriptions. Without an appropriate or documented workup, Licensee accepted this diagnosis and prescribed dextroamphetamine + amphetamine (Adderall, Schedule II) for Patient B without the benefit of a patient chart. Licensee prescribed multiple medications for Patient B, to include quetiapine (Seroquel), alprazolam (Xanax, Schedule IV), clonazepam (Klonopin, Schedule IV), zolpidem (Ambien, Schedule IV) and temazepam (Restoril, Schedule IV). Licensee and Patient B regularly consumed red wine together, even though Licensee knew that Patient B was taking benzodiazepines and Xanax. This combination exposed Patient B to the risk of over-sedation. Licensee also requested that Patient B provide massage therapy to some of his psychiatric patients at his clinic.

3.4 Licensee treated Patient E and saw him only a few times before refilling medications. Licensee called in refills and gave Patient E scripts without therapy sessions, examinations and/or lab tests. Licensee prescribed multiple medications to Patient E, to include: venlafaxine (Effexor), desipramine (anti-depressant), clonidine (Catapress), betaxodol (Kerlone), alprazolam (Xanax, Schedule IV), zolpidem (Ambien, Schedule IV), aripiprazole (Abilify), diazepam (Valium, Schedule IV), and extended release dextroamphetamine + amphetamine (Adderall XR, Schedule II).

3.5 Licensee engaged in a boundary violation by providing a personal loan of $500 to

a psychiatric patient for medication. Licensee also formed friendships with two other adult female patients, Patients C and D. Licensee made inappropriate personal disclosures to Patients C and D. Licensee repeatedly told Patient D, who was emotionally fragile, about problems with his marriage and his subsequent dating activity, to include disclosing details of a sexually explicit nature about himself. This type of self-disclosure of a psychiatrist's personal life to a patient constitutes a boundary violation. Over time, Patient D became increasingly reliant upon Licensee, to the point of having multiple sessions with him during the week. Patient D repeatedly told Licensee that she felt suicidal, but Licensee never conducted or documented that he performed a mental status examination and suicide assessment. Licensee failed to obtain a consult, developed a treatment plan or entered into a contract with Patient D that she would not harm herself. Licensee suggested that Patient D see a massage therapist in his office for "treatment." She ignored his remark. Patient D formed a strong attachment to Licensee and gave him personal presents. Licensee abandoned Patient D by abruptly discharging her as a patient in December 2008 by sending her a termination letter that contained the names of several other psychiatrists and that Licensee cut off all other communication with her, failed to order medication refills, and failed to help her immediately transfer care to another provider.

3.6 Licensee's solo practice had an office that has several private rooms, which he has sub-leased to several nurse practitioners and a massage therapist. Licensee has no support staff, and does all of his own office administrative work, to include answering messages, sending faxes and making appointments. Licensee does not routinely request charts from other providers or hospitals concerning his patients, stating that he "errs on the side of trusting what they say" about their prescription medications and diagnoses. Licensee frequently accepts complex patients who have been seen by previous providers. After he performs an internal office intake, Licensee frequently writes prescriptions, refills, and/or changes the medication regimen for these new patients without confirming with other providers or hospitals information regarding their diagnoses, medication history, hospitalizations, and/or possible history of abuse or suicidal ideations. Licensee's reliance upon the ability or willingness of his new and often complex

patients to accurately recall their diagnoses, prescription medications and dosages, while Licensee continues to prescribe and refill medications, places some of his patients at risk for harm.

3.7 Licensee refilled medications for Patient F without examining her, conferring with her treating physician, or maintaining a patient chart.

3.8 Licensee met with two Board investigators for an interview on December 30, 2009. Licensee denied having any social interactions with any patients outside the clinical setting. His denials were not truthful.

4.

License and the Board desire to settle this matter by 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. Licensee fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee stipulates that he engaged in the conduct described in paragraph 3 and that this conduct violated ORS 677.190(1)(a), (b) and (c) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(5) willfully or negligently divulging a professional secret to another without written consent; and ORS 677.190(13) gross or repeated negligence. Licensee understands that this Order is a disciplinary action and is reportable to the National Practitioner Data Bank, 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, in which Licensee surrenders his license while under investigation, subject to the following sanctions, terms and conditions:

5.1 Licensee surrenders his license to practice as a physician in Oregon while under investigation.

5.2 Licensee is reprimanded.

5.3 Licensee may not apply for licensure with this Board for a minimum of two years from the signing of this Order by the Board Chair.

5.4 Licensee will pay a fine of $5,000. Of this fine, $2,500 is payable within 30 days from the date this Order is signed by the Board Chair. The remaining $2,500 is payable within 180 days from the date this Order is signed by the Board Chair.

5.5 Licensee shall obey all federal and Oregon laws and regulations pertaining to the practice of medicine.

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

IT IS SO STIPULATED this 17 day of June, 2010.

SIGNATURE REDACTED

PETER SAMUEL MOREY, MD

IT IS SO ORDERED this 8th day of July, 2010.

OREGON MEDICAL BOARD

SIGNATURE REDACTED

LISA A. CORNELIUS, DPM
Board Chair