BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

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

1.

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

2.

2.1 On September 13, 2019, the Board sent to Licensee by regular and certified mail a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a $10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public; ORS 677.190(4) obtaining any fee by fraud or misrepresentation; ORS 677.190(13) gross or repeated acts of negligence; ORS 677.190(20) making a fraudulent claim; and ORS 677.190(24) prescribing controlled substances without a legitimate medical purpose. The Board's Notice informed Licensee of her right to request a hearing, and that the "...Board must receive Licensee's written request for hearing within twenty-one (21) days of the mailing of this Notice to Licensee." The Notice also informed Licensee that if she failed to submit a request for

hearing or failed to appear at a scheduled hearing, the Board may issue a final order by default. Licensee failed to submit a timely request for hearing. Instead, Licensee submitted a request for hearing through her attorney (who holds a license to practice law in the State of Washington) on October 15, 2019, which was 32 days after the Notice was issued. The Board informed Licensee's counsel by letter dated October 21, 2019, that the request was untimely. The Board received a letter, dated December 9, 2019, from an Oregon licensed attorney retained by Licensee, which explained that Licensee did not ignore the Board's Notice, and "...made efforts to retain an attorney to assist her in preparing and submitting her request for hearing." Counsel requested that the Board accept Licensee's late request for hearing.

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

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

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

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

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

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

3.

FINDINGS OF FACT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.

CONCLUSIONS OF LAW

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

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

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

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

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

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

5.

ORDER

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

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

DATED this 5 day of March, 2020.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

SAURABH GUPTA, MD
BOARD VICE CHAIR

Right to Judicial Review

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