BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of KENNETH JAY WELKER, MD LICENSE NO. MD 22731	)	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. Kenneth Jay Welker, MD (Licensee) is a licensed physician in the state of Oregon.

2.

Licensee is a board certified surgeon, but has ceased practicing as a surgeon, and now practices medicine at a clinic called Optimal Health, in Eugene, Oregon. Licensee states that he is a Diplomate of the American Academy of Anti-Aging Regeneration and Functional Medicine. This organization is not recognized by the American Board of Medical Specialties or the American Osteopathic Association. The acts and conduct that support this Order for Emergency Suspension follow:

2.1 Patient A, a 56-year-old female, presented to Licensee on November 19, 2010, with complaints of a non-healing ulcer on her left calf. Patient A was morbidly obese with underlying insulin dependent adult onset diabetes with renal insufficiency and a history of congestive heart failure, and chronic obstructive pulmonary disease. Licensee estimated her weight to be between 350 and 400 pounds. Licensee noted that Patient A was interested in hydrogen peroxide intravenous (IV) therapy and that she did not want her conventional medicine providers to know that she was receiving other forms of therapy. Licensee initiated a course of IV hydrogen peroxide therapy that was to be done twice a week while she continued with ongoing conventional medical treatment from her primary care provider (PCP). Licensee failed to explain (or document that he explained) the risks, alternatives and

side effects associated with this type of treatment, and whether the patient had any questions regarding the treatment. Patient A experienced dizziness and nausea during the initial IV hydrogen peroxide therapy. Patient A returned to the clinic on November 22, 2010 for a repeat treatment, and received hydrogen peroxide IV therapy from another provider.

2.2 Patient B, a 77-year-old male, presented to Licensee on November 30, 2011, with complaints of fatigue, joint pain, sleep deprivation, and benign prostate hypertrophy. Licensee examined Patient B, noted an elevated blood pressure of 163/91 and ordered both conventional and unorthodox laboratory studies, but did not conduct a digital rectal examination or check Patient B's prostate-specific antigen (PSA), which was last checked in 2005, when Patient B's PSA level was 10, which is elevated. Licensee diagnosed Patient B with hypercholesterolemia, hypertension, and fatigue due to "heavy metal burden chronic toxicity." Licensee's chart note for this initial visit lists thirty eight (38) distinct diagnoses. Licensee started Patient B on a course of medications and supplements, to include clonazepam (Schedule IV), Pregnenolone, hydrochlorothiazide, and ultimately 29 dietary supplements. Patient B underwent a test infusion of disodium ethylene diamine tetra-acetic acid (EDTA) on December 2, 2011 as well as heavy metal testing and other studies. Patient B's testosterone level was 396 (within the normal range) and his thyroid stimulating hormone (TSH) level was 2.99 (also within the normal range). On December 19, 2011, Licensee reviewed the recent lab studies with Patient B and decided to treat Patient B with 10 sessions of IV chelation, and prescribed an additional one half grain of thyroid and began treating Patient B with injections of 0.5 mL of testosterone per week along with anastrozole (Armidex) (a medication normally used for breast cancer prophylaxis for women) 1 mg per week. Licensee told Patient B that his testosterone level should be in an optimal range of 850 to 950. Licensee did not check Patient B's PSA level or conduct a digital rectal examination (DRE). Licensee did not advise Patient B of the risks and possible side effects associated with the regimen of medications and supplements that he was taking. On January 13, 2012, Patient B came in for chelation treatment, and complained that his arthritic right knee had

caused him to stop playing basketball. Licensee injected his right knee with "1 mm" (sic) aqueous testosterone and 6 mL of prolotherapy. Patient B returned for repeated treatments of aqueous testosterone and prolotherapy. Although Patient B had a history of hypertension, Licensee did not record a blood pressure reading at the January 13th visit. On February 24, 2012, Patient B's blood pressure was noted to be 178/101, and on February 29th, Patient B collapsed at his chiropractor's office. Later that day, his blood pressure readings at Licensee's office were 196/109 and 178/126. Licensee failed to address the issue of hypertension in his progress notes. On March 4, 2012, Patient B was seen at the Sacred Heart Emergency Department (ED), with a blood pressure of 168/108. Patient B was discharged from the ED with a diagnosis of Transient Ischemic Attack (TIA). On March 12, 2012, Patient B informed Licensee that he had an MRI that documented multiple small strokes in the left basal area and right frontal lobe, and that he had been placed on a statin drug and clopidogrel (Plavix), which reduces the risk of strokes by reducing platelet aggregation in the blood. On March 13, 2012, Patient B was again seen at Sacred Heart Emergency Department and diagnosed with a TIA. Licensee spoke by phone with Patient B while he was being seen at Sacred Heart and prescribed losartan 25 mg BID without coordination with the emergency department physicians. Patient B returned on March 19 for EDTA chelation, and informed Licensee that he had been hospitalized for two days the previous week due to a small stroke, and was having trouble with his peripheral vision and understanding the radio. On April 6, 2012, Patient B's testosterone level was 717, blood sugar of 124, A1C of 5.8, and cholesterol/HDL ratio of 6.2. Patient B presented to Licensee on April 9, 2012, for EDTA chelation (#12) treatment. He complained of being irritable and had a large ecchymosis on his left buttocks. Licensee informed Patient B that his ecchymosis may be a hemorrhage at his testosterone injection site caused by his Plavix. Licensee told Patient B to stop taking Plavix. Licensee did not consult with Patient B's PCP, and did not advise Patient B of the risks associated with discontinuing this medication, particularly in the context of his recent history of cerebrovascular disease. Licensee charted that he thought Patient B was "well

covered to reduce his risk of stroke particularly on EDTA chelation." During this time, Patient B experienced difficulty urinating and asked Licensee if his symptoms could be attributed to the medications and supplements that Licensee had prescribed or recommended. Licensee rejected the idea, but on April 20, 2012, did prescribe tamsulosin (Flomax) 0.4 mg 30 tablets. On April 23, 2012, Patient B's PCP noted that Patient B did not understand the importance of taking Plavix as well as his statin medication and recommended that Patient B and the Licensee not alter any of his allopathic medications. Patient B continued to experience urination problems, and on May 23, 2012, presented to his PCP with complaints of incomplete voiding. Patient B received a consultation with Oregon Urology Institute, where he presented on May 30, 2012, with complaints associated with urine retention. Patient B was found to have a PSA of 17.6 (elevated) and an enlarged prostate. Patient B declined a transurethral resection of the prostate and elected to discontinue testosterone and to continue taking Flomax. Patient B's symptoms gradually resolved. Licensee failed to inform Patient B of the health risks associated with his treatment plan, recommended unnecessary treatments to address his health condition, to include treatment with thyroid and testosterone, jeopardized Patient B's health by recommending that he discontinue Plavix without medical justification, did not inform the PCP of his intervention into the treatment plan, which included the prescribing of Plavix, and failed to effectively address Patient B's cerebrovascular disease while providing misleading information that chelation therapy is an effective treatment for cerebrovascular disease.

2.3 A review of the charts for Patients C – F revealed an ongoing pattern of conduct in which Licensee breached the standard of care by prescribing testosterone for men over the age of 60 that was not medically indicated and without checking their PSA or conducting a digital rectal exam (DRE). Patients C - F ranged in ages from 61 to 65, and presented to Licensee with various complaints of fatigue. Licensee tested the patients' testosterone level, informed these patients that their testosterone was low (although their test results were in the normal range), recommended that they take various supplements and began

treating them with testosterone. Licensee put Patients C – F on a course of Arimidex (1 mg, 1 tablet twice a week) and intra muscular injections of testosterone (200mg/mL at 0.5 mL) that was not medically indicated. In addition, during the course of treatment, Licensee did not monitor PSA levels and did not conduct a DRE prior to initiating testosterone therapy and three to six months after initiating therapy.

2.4 Licensee treated Patients G – H with hydrogen peroxide therapy without documenting in the patients' charts that he explained the potential side effects, alternatives, risks, or answered his patients' questions.

2.5 Patient I, a 44-year-old adult male, presented to Licensee on October 13, 2009 with a history of chronic fatigue, fibromyalgia, insomnia, and complained about numbness and tingling in the hands, with progressive clumsiness and weakness. Licensee examined Patient I and noted for the cardiovascular examination: "RRR [regular rate rhythm], No murmur." Licensee tested for heavy metals and initiated therapy with tramadol (Ultram). On October 26th, Patient I called Licensee to report that he was experiencing "a worsening in his irregular heartbeat and chest discomfort" as well as nausea, headaches and feeling of weakness. Patient I presented to Licensee on October 29, 2009, and reported an increase in his irregular heartbeats with an addition of racing heart and chest discomfort. Patient I attributed his symptoms of diarrhea, nausea, headaches and faintness to his rapid titrated increase of ProtoClear (a nutritional supplement). Licensee's assessment and plan follows: "Due to slight loss in lean body mass, will increase calorie intake to 1600 calories. Begin use of Chasteberry Plus to assist with symptoms of racing heart and thermo regulation." Licensee did not document that he conducted a cardiovascular examination, did not record Patient I's heart rate or blood pressure, did not order an EKG, check enzyme levels, obtain a consult with a cardiologist or contact Patient I's PCP. Licensee failed to document whether he recognized the significance of Patient I's potentially life threatening symptoms, and failed to follow up by examination, laboratory work or referral. By so doing, Licensee unnecessarily exposed Patient I to risk of harm.

2.6 Patient J, a 62-year-old female, initially presented to Licensee on January 28, 2013 with complaints of dizziness, ataxia, and a body mass index of 20. She had previously been diagnosed with multiple sclerosis, and a chiropractor had documented a finding of "lead heavy metal toxicity issues" after an April 2012 post provocative urine test. A November 2011 blood test reported normal lead and copper levels. Licensee discussed with Patient J the possibility of "fat transfer with respect to getting cells fat for the purposes of her first rating (sic) her neurological growth." Licensee noted a plan to "pursue a detox case of lead via EDTA chelation". Patient J subsequently underwent a series of 20 IV calcium EDTA chelation treatments at Licensee's clinic. On May 14, 2013, Patient J signed an informed consent form to undergo a "Fat Transfer." This form states that this procedure is not FDA approved, is usually not covered by health insurance, and that there are "inherent risks." On that same day, Licensee performed a "stem cell transfer" procedure on Patient J, by removing 80 mL of fluid and fat from the patient's abdomen through liposuction as well as 120 mL of blood, and processing it. Licensee subsequently injected 8 mLs of the processed solution into the patient's spinal fluid by lumbar puncture, while the remainder was injected intravenously into Patient J. Within 5 minutes, Patient J complained of tingling in her body and both legs. Licensee noted that she had a high respiratory rate and elevated blood pressure with a lot of perspiration that lasted about 45 minutes. Licensee was surprised by this reaction and could not offer an explanation for the adverse reaction. He did not report this reaction to the drug company that made the stem cell transfer material or the FDA. Patient J was not seen again at the clinic until two days later. Licensee's clinic records for this patient included two (2) different versions of her Vital Signs log for the period of 1/28/2013 through 6/11/2013. The first version has three (3) log entries for vital signs taken during the May 14, 2013, stem cell therapy, the second version of this log does not include any vital signs recorded for that date. Licensee subjected Patient J to a series of EDTA chelation treatments that were not medically indicated and "stem cell transfer" that were not medically indicated and subjected her to an

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unnecessary risk of harm. When the patient experienced an adverse reaction, Licensee did not report the incident or provide proper follow-up.

2.7 Patient K, a 60-year-old female, presented to Licensee on March 27, 2013 with complaints of rheumatoid arthritis and postherpetic neuralgia. Licensee started her on DHEA (dehydroepiandrosterone) 25 mg a day, with a plan to increase this to 50 mg a day, in order to "help modulate her immune system." On July 30, 2013, Patient K signed a "Fat Transfer" informed consent form and underwent localized stem cell infusion into both knees, breasts, and shoulders, as well as IV infusion. On August 27, 2013, Licensee attempted to draw blood from Patent K in order to provide her with Platelet Rich Plasma (PRP) therapy. Licensee's chart note reflects he made "Multiple attempts to obtain blood from L wrist R wrist R femoral a/v L femoral L & R carotid and ext jugular were unsuccessful." Patient K finally told Licensee to discontinue and that she wanted to go home. After being informed of the Board's concern about the multiple documented attempts to access this patient's arteries to obtain blood for his proposed therapy, Licensee now asserts that his chart note is not accurate. Licensee now claims that "at no time was any effort made to gain access in an arterial vessel (neither carotid nor femoral)." Licensee's "stem cell transfer" procedure was not medically indicated, and subjected Patient K to significant and unwarranted risk of harm. Furthermore, either Licensee is responsible for an erroneous detailed dictation, or he attempted to draw blood from the femoral and carotid artery, thereby subjecting Patient K to an unnecessary risk of harm.

2.8 The Board also reviewed other cases where Licensee provided stem cell IV infusion treatments in 2013, pertaining to Patient L – N. Patient L was a 39-year-old female with a history of rheumatoid arthritis who first saw Licensee in July of 2010. Patient L returned to Licensee's clinic on July 15, 2013, after an absence of over one year. On July 22, 2013, Licensee administered injections of autologous processed fat and blood into the right knee, left and right wrist, right hip and right shoulder of Patient L. Excess fat was processed and injected into each breast for this patient. On January 10, 2013, Patient M, a 71-year-old

male and former marathon runner, presented with complaints of knee pain and left medial knee arthropathy. This patient was seeking an alternative to knee replacement surgery. On January 22, 2013, Licensee performed a "mini liposculpture and venipuncture for his platelet rich plasma." Licensee processed the extracted fat and blood and injected it into Patient M's left knee. Licensee wrapped Patient M's abdomen, prescribed him 20 tablets of Oxycodone (Schedule II) and discharged him. Licensee also started Patient M on DHEA, 50 mg. Patient N, a 39-year-old male, initially presented to Licensee complaining of a tear in his left patellar ligament that he sustained from playing basketball. Licensee referred him to an orthopedic surgeon. After receiving surgery, Patient N returned to Licensee, and on January 29, 2013, Licensee performed a mini liposculpture, processed the extracted fat and blood, and injected it into Patient N's left knee in the patellar tendon and into the right knee. On February 28, 2013, Licensee injected platelet rich plasma into Patient N's left knee. These procedures were not medically indicated and subjected these patients to an unnecessary risk of harm.

3.

The Board has determined from the evidence available at this time that Licensee's continued practice of medicine would pose an immediate danger to the public and to his patients. Based upon the information available to the Board at this time, Licensee's pattern of treating patients with forms of treatment that are not medically indicated and unnecessarily exposed his patients to the risk of harm leads the Board to conclude that it is necessary to immediately suspend his license to practice medicine. To do otherwise would subject Licensee's patients to the risk of harm while this case remains under investigation.

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

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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.

5.

The Board orders that pursuant to ORS 677.205(3), the license of Kenneth Jay Welker, MD, be suspended on an emergency basis and that Licensee immediately cease the practice of medicine until otherwise ordered by the Board.

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 800-452-7500 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil.

IT IS SO ORDERED THIS 9th day of January, 2014.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

DONALD E. GIRARD, MD
BOARD VICE CHAIR

CERTIFICATE OF MAILING

On, January 9, 2014, I mailed the foregoing Order of Emergency Suspension regarding Kenneth Jay Welker, MD to the following parties:

By: First Class Certified/Return Receipt U.S. Mail
Certified Mail Receipt # 7013 1090 0001 2845 4382

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