BEFORE THE

BOARD OF MEDICAL EXAMINERS

STATE OF OREGON

In the matter of,	)	
	)	
STUART GORDON WEISBERG, MD	)	STIPULATED ORDER
LICENSE NO. MD 23402	)	

1.

The Board of Medical Examiners (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including psychiatrists, in the state of Oregon. Stuart Gordon Weisberg MD (Licensee) is a licensed physician in the state of Oregon.

2.

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) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(14), gross negligence or repeated acts of negligence in the practice of medicine; and ORS 677.190(25) prescribing controlled substances without a legitimate medical purpose, without following accepted procedures for record keeping and without giving the notice required under ORS 677.485.

3.

Licensee is a psychiatrist who has a solo practice in a clinic in Portland, Oregon. Licensee resigned in lieu of being terminated from his four year residency program at Oregon Health Sciences University in Portland, several months prior to completion. Licensee is certified by the federal Food and Drug Administration to prescribe the sublingual tablet forms of buprenorphine (Suboxone and Subutrex, Schedule III), which have been approved to treat opioid dependence. Suboxone is a combination of buprenorphine and naloxone. Naloxone is an opioid antagonist.

3.1 Review of Licensee's management of adult patients presenting at his clinic revealed a pattern of practice in which Licensee attempted to convert opioid-dependent patients

who were being treated with methadone to buprenorphine without documenting withdrawal symptoms and without stating an induction protocol in the chart. In some cases, Licensee prescribed buprenorphine for chronic pain, which is an off-label use of the drug. On frequent occasions, Licensee concomitantly prescribed benzodiazepines for patients who were taking buprenorphine, which placed his patients at risk of potentially life threatening drug interaction. Licensee also failed to follow the best practice standards of placing medication lists and keeping duplicate prescriptions in the chart to assist in the management of complex medication regimens for his patients.

The Board's review has identified the following specific concerns in regard to Patients A - G:

a. Patient A, a 28-year-old female, presented at Licensee's clinic in May 14, 2004, with a six year history of methadone use after two years of abusing both heroin and methamphetamine and a conviction for the possession of illegal drugs. Licensee prescribed buprenorphine (Suboxone, 4 mg twice day) with authorized refills. Suboxone in most circumstances should be ordered once daily rather than twice daily, and no refills should be authorized. Licensee failed to determine whether Patient A was pregnant, failed to chart an induction protocol, and failed to document informed consent. Licensee prescribed methylphenidate (Ritalin, Schedule II) to Patient A without establishing the requisite diagnosis of attention deficit hyperactivity disorder (ADHD). Licensee also concomitantly prescribed alprazolam (Xanax, Schedule IV) and methylphenidate to this patient who was a known methamphetamine abuser. Benzodiazepines, such as alprazolam, present the risk of adverse interaction, to include reported deaths, when a patient is taking buprenorphine.

b. Patient B, a 25-year-old female, self-referred to Licensee's clinic sometime in May of 2004, reporting chronic pain associated with an automobile collision that occurred seven years earlier. Patient B was taking methadone administered by a methadone clinic. Licensee evaluated Patient B and prescribed clonazepam (Klonopin,

Schedule IV), a benzodiazepine that had been previously prescribed by a former physician, which is inadvisable when a patient is taking methadone. Licensee did not document communication with the methadone clinic to coordinate his prescribing. After a number of months, Licensee caused Patient B to discontinue treatment at the methadone clinic and began prescribing sustained release morphine for chronic pain. Licensee did not identify the source of the pain or obtain the patient's medical records from her previous health care providers. Licensee failed to obtain Patient B's informed consent for his treatments and failed to have her sign a material risk notice for the treatment of her chronic pain. After several months, Licensee also prescribed methylphenidate (Ritalin, Schedule II) for Patient B without establishing the requisite diagnosis of ADHD.

c. Patient C, a 46-year-old male, was self-referred to Licensee with a history of abusing hydrocodone and acetaminophen (Vicodin, Schedule III). Licensee determined that Patient C was a good candidate for buprenorphine without verifying opioid dependence, and failed to document opioid withdrawal or an induction protocol in the chart. Licensee prescribed buprenorphine, using an abrupt detoxification schedule, as well as lorazepam (Ativan, Schedule IV), which is a benzodiazepine and which could have provoked a dangerous drug interaction.

d. Patient D, a 31- year- old female, was referred to Licensee for treatment with buprenorphine in 2004. Her history included five years of methadone maintenance for opioid dependence. Again, it should be noted that buprenorphine should generally be given once per day due to its long half-life of thirty-nine hours. Licensee prescribed buprenorphine (8 mg twice a day) while Patient D's primary care physician continued to prescribe clonazepam (Klonopin, Schedule IV) a benzodiazepine, and while Patient D continued to receive methadone. Licensee failed to document opioid withdrawal or an induction protocol for this patient. Licensee's chart does not document necessary coordination of care between Licensee and Patient D's primary care physician or the methadone clinic. Licensee subsequently prescribed methylphenidate (Ritalin, Schedule

II) for Patient D without establishing the requisite diagnosis and without evaluating the medical efficacy of prescribing multiple controlled substances for a drug dependent patient with a history of drug abuse.

e. Patient E, a 28-year-old female, was referred to Licensee in August of 2004 for treatment of her chronic pain. Patient E had suffered injuries from an automobile accident five years prior, and was receiving prescriptions from other providers for hydrocodone & acetaminophen (Vicodin, Schedule III), oxycodone & acetaminophen (Percocet, Schedule II) and carisoprodol (Soma, Schedule IV). Licensee prescribed 8 mg of buprenorphine (Subutrex) to treat her pain, but without an induction protocol or diagnosis of opioid dependence stated in the chart. Patient E initially reported a good response to the buprenorphine, but in September of 2004, reported an allergic reaction. Licensee subsequently prescribed sustained release oxycodone (OxyContin, Schedule II) and sertraline (Zoloft). Licensee failed to coordinate care with Patient E's primary care physician, who wrote a prescription of morphine sustained release (MS Contin, Schedule II) for Patient E also in September of 2004. In December of 2004, Licensee displayed poor judgment in directing that a month's prescription (with two refills, which violates federal standards) of OxyContin be mailed to Patient E's home.

f. Patient F, a 19-year-old male with a history of heroin abuse, presented to Licensee in November of 2004. Licensee diagnosed opioid dependence and attention deficit disorder without sufficient basis to establish either diagnosis. Licensee prescribed buprenorphine to detoxify Patient F, but failed to note an induction protocol or withdrawal symptoms. Licensee concomitantly prescribed the benzodiazepine, lorazepam (Ativan, Schedule IV), as well as dextroamphetamine & racemic amphetamine (Adderall, Schedule II) without medical justification.

g. Patient G, a 71-year-old female, presented to Licensee with a history that reportedly included fibromyalgia, opiate escalation and odd behavior. Patient G was taking a complex regimen of medications that included sustained release oxycodone

(OxyContin, Schedule II), oxycodone & acetaminophen (Percodan, Schedule II), clonazepam (Klonopin, Schedule IV), pramipexole (Mirapex, an anti-Parkinsonian agent) and valsartan/hydrochlorthiazide (Diovan, for hypertension). Licensee attempted to detoxify Patient G by substituting MS Contin for Oxycontin and by adjusting the dosage of her other medications, but he did so without communicating with Patient G's rheumatologist or her primary care physician. Licensee noted that he was treating Patient G's "opioid dependence on a slow, steady taper." Licensee's efforts to detoxify Patient G in an office based setting were inappropriate.

4.

Licensee 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, and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee admits that he engaged in the conduct described in paragraph 3 and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(14), gross negligence or repeated acts of negligence in the practice of medicine; and ORS 677.190(25) prescribing controlled substances without a legitimate medical purpose, without following accepted procedures for record keeping and without giving the notice required under ORS 677.485. Licensee understands that this Order is a public record and is reportable to the National Practitioner Databank.

5.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order, subject to the following terms and conditions of probation:

5.1 Licensee is reprimanded.

5.2 Licensee will arrange call coverage for his patients. The coverage will be provided by a psychiatrist who does not have a physician/patient relationship with the Licensee.

5.3 Licensee is placed on probation for five years. At the conclusion of Licensee's first year of probation, Licensee may request and the Board will consider a reduction in the term of Licensee's probationary period. The Board shall have the sole discretion to either shorten the probationary period or deny Licensee's request. Licensee will report in person to the Board at each of its regularly scheduled quarterly meetings for a probationer interview unless ordered to do otherwise by the Board's Compliance Officer.

5.4 Within 30 days from the approval of this Order, Licensee shall enroll in the Oregon Medical Association's Physicians Evaluation Education Renewal program (PEER). Licensee must successfully complete this program within 24 months from the approval of this Order. Licensee must also sign all necessary releases to ensure that the Board may freely communicate with PEER, and that quarterly progress reports and the final evaluation report from the education program are provided promptly to the Board.

5.5 Licensee shall obey all federal, state and local laws, and all rules governing the practice of medicine in the state of Oregon.

5.6 Licensee stipulates and agrees that any deviation or violation from terms of this Order shall be grounds for discipline pursuant to ORS 677.190(18).

5.

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

IT IS SO STIPULATED THIS 31st day of May, 2006.

STUART GORDON WEISBERG, MD

IT IS SO STIPULATED THIS 13th day of July, 2006.

BOARD OF MEDICAL EXAMINERS
State of Oregon

DAVID R. GRUBE, MD
BOARD CHAIR