**BEFORE THE**
**BOARD OF CHIROPRACTIC EXAMINERS**
**STATE OF OREGON**

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| In the Matter of | ) | |
| | ) | Stipulated Final Order |
| Mark Gabriel, D.C. | ) | |
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| | ) | Cases # 2020-3010 |
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| Licensee. | ) | |

The Board of Chiropractic Examiners (Board) is the state agency responsible for licensing, regulating, and disciplining chiropractic physicians in the State of Oregon. Mark Gabriel, DC (Licensee), is licensed by the Board to practice as a chiropractic physician in the State of Oregon.

Findings of Fact

1.

Patient 1, a 60-year-old female patient, sought treatment for various physical conditions. Her medical history was complicated as she had a prior stroke as well as atrophy of the upper extremity muscles due to the stroke.

She initially sought treatment on October 16, 2019 from Licensee. When receiving treatment from an associate doctor, on November 6, 2019, during a manipulation, her left shoulder was injured due to dislocation by the doctor. On November 8, 2019, Patient 1 saw an associate doctor for treatment and complained of shoulder pain following the November 6, 2019 adjustment. Patient 1 was referred by Licensee to Meridian Park for a shoulder evaluation, received an assessment, and x rays were taken. The shoulder was reduced at Meridian Park. Patient 1 returned for treatment on November 13, 2019, and continued to complain of shoulder pain.

On December 11, 2019, Licensee made an MRI referral to EPIC Imaging for her left shoulder. Patient 1 continued to be treated conservatively with massage and trigger point injections by an associate naturopath in the clinic where Licensee provided treatment.

On February 2, 2020, Patient 1 had an MRI for the left shoulder that showed a large slap tear extending well into the biceps anchor with a large displaced fragment in the glenohumeral joint. She also had diffused atrophy of the rotator cuff muscles involving the deltoid and teres major related to another condition.

On March 2, 2020, an associate doctor in the clinic saw Patient 1 specifically for a dislocated left shoulder. Between November 27, 2019, and March 11, 2020, with dates of service of 11/27/19, 11/27/19, 12/18/19, 12/4/19, 12/11/19, 12/13/19, 12/23/19, 12/26/19, 1/2/20, 1/8/20, 1/9/20, 1/16/20, 2/5/20, 2/14/20, 2/20/20, 2/27/20, and 3/11/20, Patient 1 received treatment by Licensee which consisted of chiropractic manipulative therapy to several areas and physical therapy exercises. On the dates of service noted, Licensee did not document discussion with Patient 1 regarding any results of the MRI of her shoulder.

After the February 2, 2020, MRI result, Licensee continued to treat Patient 1, but did not inform her of the results of the MRI, did not adequately provide the patient with information enough for her to give informed consent as to the results of the MRI, did not adequately provide medical recommendations for follow up care based on the outcome of the MRI, and failed to timely and adequately refer the patient for an orthopedic consult.

The Board determined that Licensee did not perform the appropriate evaluation of Patient 1's conditions after she received the adjustment on November 6, 2019, and complained of shoulder pain. Licensee failed to recognize the seriousness of her symptoms. When a patient is suffering these types of symptoms within a short period of an adjustment, the standard of care for a chiropractic physician is to refer them to the emergency room or to their primary care physician for follow up to those symptoms and to rule out more serious injury. There was no indication that Licensee had contact with any follow up care providers or even conferred with her other care providers. Licensee also failed to document any treatment plan or course of treatment for this patient beyond the palliative care he was already providing.

The Board is concerned by Licensee's failure to take responsibility for deficiencies in his evaluation and treatment process. The treatment of this patient violates ORS 684.100(1)(f)(A), (B) and (C); OAR 811-035-0005(1), (2) (a) and (b).

2.

Licensee's patient records for that time period were lacking in any clinical justification for Licensee to perform treatment after the shoulder injury which was an acute medical condition. Once Patient 1 had her x-ray of the shoulder after November 6, 2019, Licensee should have reestablished an updated treatment plan for the patient to address the new condition. Licensee's chart notes did not address or document this. Licensee continued to provide treatment for chronic active care consisting of chiropractic manipulative therapy and physical therapy exercises. Licensee's chart notes did not address the shoulder condition, an updated treatment plan as to the shoulder condition, nor did the notes address the shoulder rehabilitation for the Patient diagnosed with a slap tear lesion. Licensee did not document any orthopedic consult referral, nor treatment plan for patient care, and contained no PARQ or that informed consent was provided to Patient 1 for the MRI result or treatment provided by Licensee.

Licensee was notified of this investigation on July 7, 2020. On July 24, 2020, Licensee added an electronic addendum in Patient 1's chart notes for the treatment date of November 6,

2019, stating the provider of care was an associate doctor and not Licensee. Prior to this addendum, the chart notes indicted that Licensee was the provider of care to Patient 1.

Electronic records are required to be signed within 30 days after the treatment is provided and must be signed by the doctor who provided care. The addendum was 7 months post care of Patient 1. The original chart note is not signed by the provider and the addendum was added to a generated chart Licensee signed 7 months later, and only after being noticed by the Board about this investigation.

Licensee failed to maintain his patient files at the minimum standard required by the Board for a chiropractic physician practicing in Oregon. These patient charts are in violation of ORS 684.100(1)(f)(A), (B) and (C); and OAR 811-015-0005(1)(a)(b)(c), (A), (B), (C) (i) through (vii); (D), (E) and (F), Oregon Board of Chiropractic Examiners Guide to Policy and Practice Questions on Record Keeping chart note completion.

3.

On the March 2, 2020, visit, the associate doctor provided Patient 1 with the findings from her MRI and notified her he would be referring her for consultation with an orthopedic surgeon as the condition may need surgical repair. Patient 1 was shocked that she needed further care as it was her belief Licensee had told her the shoulder was normal.

The same associate doctor then saw Patient 1 again on April 27, 2020, and at that time, Patient 1 reported she had a lot of shoulder pain and mobility was very limited. She expressed concern for her symptoms and stated to the associate doctor that Licensee had told her that her MRI result was normal.

Additional associate doctors in the practice also confirmed that Patient 1 was not provided the results of her MRI by Licensee during the time periods mentioned above.

Subsequently, Patient 1 was referred to OHSU for orthopedic consult and is currently seeking surgical repair in February 2021.

Management of this patient with an MRI result of a slap tear in February 2020 was below the standard of care for an Oregon chiropractic physician. The Board determined that Licensee did not perform the appropriate evaluation of Patient 1's conditions. The Board determined that Licensee was not performing appropriate follow up and referral care to this patient when her symptoms developed after treatment. The Board is concerned by Licensee's failure to take responsibility for deficiencies in his evaluation and treatment process. This violates ORS 684.100(1)(f)(A), (B) and (C); OAR 811-035-0005(1), (2) (a) and (b).

Licensee's failure to render a differential diagnosis or clinical impression on Patient 1's reported symptoms constitutes, or might constitute, a danger to the health or safety of the patient. A chiropractic physician licensed in the State of Oregon is required to perform an examination of

a patient before rendering a diagnosis or clinical impression, providing a PARQ, and obtaining an informed consent, prior to rendering care or providing treatment. Failing to do so violates ORS 684.100(1)(f)(A) and (B) and OAR 811-035-0001(3), which defines diagnosis under the Oregon Chiropractic Practices and Utilization Guidelines (OCPUG). These practice and utilization guidelines are summarized in the chiropractic management algorithm, which demonstrates that a chiropractic physician should first consult with the patient, obtain their history of present illness, and then move on to the appropriate physical examination.

4.

In Board interviews, Licensee stated he provided Patient 1 with the MRI results orally, but admits that he failed to note in the records that he discussed the results with her, that he failed to obtain informed consent about the MRI results, that he failed to document in the patient files any treatment plan for Patient 1 after the MRI results and that his notes failed to show clinical justification for the care provided to Patient 1.

5.

Conclusions of Law

Licensee's failure to take responsibility for deficiencies in his evaluation and treatment process of the shoulder patient violates ORS 684.100(1)(f)(A), (B) and (C); OAR 811-035-0005(1), (2) (a) and (b).

Licensee failed to maintain his patient files at the minimum standard required by the Board for a chiropractic physician practicing in Oregon. These patient charts are in violation of ORS 684.100(1)(f)(A), (B) and (C); and OAR 811-015-0005(1)(a)(b); Oregon Board of Chiropractic Examiners Guide to Policy and Practice Questions on Record Keeping chart note completion.

Licensee's failure to render a differential diagnosis or clinical impression on Patient 1's reported symptoms constitutes, or might constitute, a danger to the health or safety of the patient. A chiropractic physician licensed in the State of Oregon is required to perform an examination of a patient before rendering a diagnosis or clinical impression, providing a PARQ, and obtaining an informed consent, prior to rendering care or providing treatment. Failing to do so violates ORS 684.100(1)(f)(A) and (B) and OAR 811-035-0001(1), which defines diagnosis under the Oregon Chiropractic Practices and Utilization Guidelines (OCPUG).

6.

Stipulations

Therefore, pursuant to ORS 183.417(3) and ORS 684.100(9)(f) the OBCE orders:

1. The parties have agreed to enter this Stipulated Final Order. Licensee agrees that he is aware of his right to a hearing with his attorney present to contest the charges and hereby waives that right and agrees to entry of this order. Licensee agrees to waive any right to appeal. Licensee denies the allegations but wishes to settle and resolve the above matter without further proceedings. Licensee denies the findings of fact as recited by the Board.
2. Licensee agrees to pay a civil penalty of $4,000 to be paid to the Board within 1 year this order becomes final. Pursuant to ORS 293.231, the Board will refer the amounts owed to collection if it has received no payment on the account for more than 90 days. Thereafter, the Board will consider assignment to the Oregon Department of Revenue or a private collection agency for collection. Final fees may include additional percentages of any increase in the amount you owe due to the accrual of interest on the unpaid principal amount.

3. Licensee will take and successfully pass all sections of the EBAS test within 6 months this order is final. This is at Licensee's expense and Licensee is responsible to report to the Board successful completion.

4. Licensee will take 4 hours of continuing education on shoulder case management and 2 hours of record keeping within 90 days this order is final. This will be in addition to continuing education required for licensure. Licensee is responsible to report completion of the continuing education to the Board.

5. Licensee will submit to Board file reviews, with two file pulls of two files each within a six-month period once this order is final and after completion of the required continuing education. Licensee is required to cooperate with providing the files to the Board or their staff.
6. Failure to abide by this stipulation may result in further discipline up to and including revocation.
7. This order is public and is reportable to NPDB.
8. This order is effective on the date signed by the Board.

Dated this 31st of August, 2021

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

Original signatures are available in OBCE administrative office

Cassandra C. McLeod-Skinner, J.D.
Executive Director
Oregon Board of Chiropractic Examiners

Dated: _____

Original signatures are available in OBCE administra

Mark Gabriel D.C.

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**Certificate of Service**

I, Cassandra C. McLeod-Skinner, certify that on August ____, 2021, I served the foregoing Stipulated Final Order upon the party hereto a true, exact, and full copy thereof via email at the request of counsel, to:

Adina Matasaru, AAL
1500 SW 1st Ave Suite 800
Portland OR 97201
adina@matasarulaw.com

Original signatures are available in OBCE administrative office

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Cassandra C. McLeod-Skinner, J.D.
Executive Director
Oregon Board of Chiropractic Examiners