BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF OREGON
for the
OREGON BOARD OF CHIROPRACTIC EXAMINERS

IN THE MATTER OF:	)	**FINAL ORDER**
	)	
RICK WHITE, D.C.	)	OAH Case No. 2017-ABC-00868
	)	Agency Case Nos. 2013-1002, 2013-3014,
	)	2016-1021, 2016-1023, 2016-3012
	)	

HISTORY OF THE CASE

On July 10, 2017, the Oregon Board of Chiropractic Examiners (Board) issued Rick White, D.C., a Notice of Proposed Disciplinary Action (Suspension), proposing to suspend his chiropractic physician's license and assess him a $5,000 civil penalty and the costs of the disciplinary proceeding. On August 7, 2017, Dr. White filed a Response to Notice of Disciplinary Action (Suspension) and requested a hearing.

On August 29, 2017, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned Administrative Law Judge (ALJ) Bernadette Bignon to preside at hearing. On October 5, 2017, ALJ Bignon convened a telephone prehearing conference. Dr. White appeared and was represented by his attorney Kathleen Dyer. The Board appeared and was represented by Senior Assistant Attorney General (AAG) Lori Lindley. ALJ Bignon scheduled the hearing for January 29 and 30, 2018, and set deadlines for submission of motions, witness lists and exhibits.

On November 1, 2017, the OAH reassigned the matter to ALJ Samantha Fair.

On December 26, 2017, the Board filed a Motion for Qualified Protective Order. On January 2, 2018, ALJ Fair granted the motion, and the OAH issued the Qualified Protective Order Limiting Use and Disclosure.

On January 4, 2018, the Board and Dr. White jointly requested a postponement of the scheduled hearing. On January 5, 2018, ALJ Fair granted the postponement and scheduled a telephone prehearing conference for January 29, 2018. On January 29, 2018, ALJ Fair convened a telephone prehearing conference. Dr. White and Ms. Dyer appeared. The Board appeared and was represented by AAG Lindley. ALJ Fair scheduled the hearing for May 30 and 31, 2018, and set new deadlines for the submission of witness lists and exhibits.

On April 16, 2018, the Board issued Dr. White an Amended Notice of Proposed Disciplinary Action (Suspension) (Amended Notice), in which it amended its allegations against Dr. White.

On May 17, 2018, Dr. White requested a postponement of the scheduled hearing. On May 22, 2018, the Board filed its objection to the request. On May 22, 2018, ALJ Fair denied the request but allowed Dr. White the opportunity to renew the request if he provided additional documentation to support the request. On May 24, 2018, Dr. White renewed his request, and the Board renewed its objection. On May 24, 2018, ALJ Fair denied the request, finding that Dr. White failed to establish good cause to support the request.

On May 30, 2018, ALJ Fair convened an in-person hearing in Salem, Oregon.[1] Dr. White appeared, testified, and was represented by Ms. Dyer. The Board appeared and was represented by AAG Lindley. Testifying on behalf of Dr. White was Krisann Owens, Dr. White's office manager. Testifying on behalf of the Board were Bill Moriarty, M.D.; Tien Wee, M.D.; Shawna Samargis, a licensed massage therapist (LMT); Manora Fawn, LMT; Patient 1;[2] George Finch, the Board's investigator; Frank Prideaux, D.C., the Board's health care investigator; and Michelle Waggoner, D.C. The record closed on May 30, 2018, at the conclusion of the hearing.

In the Proposed Order, ALJ Fair notified Dr. White that he could file exceptions to the Proposed Order and the deadline for those exceptions. They were due within 10 days of the Proposed Order being issued. Timely exceptions were not filed by Dr. White.

On October 9, 2018, the Board filed an Amended Proposed Order including the cost assessment and provided it to Licensee. In October 2018, the Board was notified that Frank Moscato would be representing Licensee. On October 25, 2018, the Board received exceptions to the Amended Proposed Order. At their November 15, 2018 Board meeting, the Board considered those exceptions and found them to be without legal merit. The Board voted to issue the Final Order without any changes.

ISSUES

1. Whether Dr. White engaged in unprofessional or dishonorable conduct. ORS 684.100(1)(f), OAR 811-015-0005, and OAR 811-035-0005(1) and (2).

2. Whether the Board may take disciplinary action against Dr. White. ORS 684.100.

EVIDENTIARY RULINGS

[1] At the beginning of the hearing, Dr. White requested additional discovery (a recording of a telephone settlement conference and the LMTs' chart notes) from the Board. The Board confirmed that it did not have copies of any chart notes taken by the LMTs and that there was no recording of the conference call. Dr. White also requested discovery regarding any initial complaints filed by the LMTs with the Board. The Board objected to the request as confidential and protected information. Pursuant to ORS 676.175 and 684.200(2), the information is confidential and not subject to disclosure, and the Board is not required to disclose it. Dr. White's requests were denied.

[2] For purposes of confidentiality and to match the identification in the Amended Notice, the patient that is the subject of the Board's Amended Notice is identified as Patient 1.

Exhibits A1 through A8 and A10, offered by the Board, were admitted into the record without objection. The Board withdrew Exhibit A9 and it was remarked as a pleading document.

ALJ Fair granted the Board's motion to exclude witnesses with the exception of expert witnesses.

The following witnesses appeared by telephone: Dr. Moriarty, Dr. Wee, Ms. Samargis, Ms. Fawn, and Patient 1. Dr. White objected to their telephonic appearances, asserting that it violated his Fifth Amendment right to confront his accusers. ALJ Fair overruled Dr. White's objection to the witnesses' telephonic appearances.

Dr. White had not provided any witness list prior to the hearing. The Board objected to his witnesses (Dr. White and Ms. Owens) based upon the lack of notice. ALJ Fair overruled the Board's objections.

FINDINGS OF FACT

1. Dr. White graduated from Western States Chiropractic College in 1998. The Board first issued Dr. White a chiropractic license on August 25, 1999. (Ex. A4 at 2.) He worked as a chiropractic physician until June 4, 2012, when he retired from practice. (Test. of White.)

2. In November 2013, Dr. White and the Board entered into an Agreement of Voluntary Compliance (Agreement) to resolve complaints the Board had received regarding inaccurate record-keeping, improper coding and billing, failure to re-examine patients, lack of clinical justification for treatment, allowing unlicensed individuals to perform therapies, and unprofessional conduct. In the Agreement, Dr. White acknowledged deficiencies in his billing and patient records. In the Agreement, the parties agreed that, if Dr. White resumed active chiropractic practice, he would complete 20 hours of continuing education regarding record-keeping and billing practices; allow the Board to pull files at random for two years; keep complete and accurate patient records; and participate in any interviews requested by the Board. (Ex. A1 at 1-3.)

3. In 2014, Dr. White decided to return to chiropractic practice. He completed the continuing education classes required by the Agreement, as well as completing a 100-hour course presented by a chiropractic consultant in the insurance industry. (Test. of White and Waggoner.) He returned to active chiropractic practice in January 2015 and joined a chiropractic clinic in March 2015. Upon resuming his active practice, Dr. White manually added more notes to the patients' charts than the canned language generated by the electronic case record system utilized by the clinic because he anticipated file pulls by the Board pursuant to the terms of the Agreement. He subsequently ceased that practice. (Test. of White.)

4. In September 2015, Dr. White opened his own chiropractic clinic in Coos Bay, Oregon, and successfully grew his practice to its current level of approximately 120 to 130 patients per week. Currently, he has seven employees for his clinic, including a second chiropractor. (Test. of White.)

5. In his clinic, Dr. White utilizes an electronic health records system called ChiroSpring to generate patients' charts and billing records. Dr. White relied on the automatic fields (including complaints, subjective comments, vitals, adjustments, objective comments, diagnosis, assessment comments, treatment plan, and plan comments) and canned language generated by ChiroSpring. Once a patient chart was created after an initial visit, ChiroSpring automatically filled in the fields for subsequent visits with the existing language used for the prior visit. Dr. White or staff would have to alter the pre-filled language to accurately reflect a current visit's proceedings. (Exs. A2 at 1-3; A8 at 7, 24; test. of White.)

July 12, 2016 Visit

6. Patient 1 did not have a primary care physician. (Ex. A3 at 11.) She was distrustful of conventional medical physicians and preferred to seek treatment from naturopathic or homeopathic doctors. (Test. of Patient 1.) Dr. White was aware of Patient 1's lack of a primary care physician, her distrust of conventional medicine, and her reliance on homeopathic remedies. (Test. of White.)

7. On July 12, 2016, Patient 1 had an initial appointment with Dr. White, regarding a compliant of temporomandibular joint (TMJ) pain and cervical pain. (Ex. A2 at 1.) After she described her complaints, Dr. White performed transcutaneous electrical nerve stimulation (TENS) therapy on Patient 1 and then performed some adjustments. Patient 1 experienced relief from her TMJ pain following the appointment. (Ex. A6 at 6-7; test. of Patient 1.) Based upon her experience, she posted a five-star review of Dr. White on Google that stated:

> Despite being in the healthcare industry myself, it is infrequent that I come across a provider with genuine concern and care for the clients he serves. "Doc White" does. * * *. Doc takes the time to listen to your concerns and adjusts his approach to create the best in person centered care. He will often take extra time when his attempts to intervene are less than effective and continues to make sure to always reassess your comfort level along the way. His education and support are priceless in a world that has created a disconnect with most "professionals" who show a lack of patience and interest with healthcare recipients!

(Ex. A5 at 2.)

8. Prior to the initial appointment, Patient 1 completed a lengthy intake form for Dr. White, listing her medications and supplements, areas of concern, and symptoms. (Ex. A2 at 17-23.) In Patient 1's chart in the complaint field, Dr. White noted Patient 1's pain levels as 4 for both the cervical and TMJ pain. (*Id.* at 1.) In Patient 1's chart in the subjective comments field, Dr. White noted the following:

- Patient 1 presented with a chief complaint of left temporomandibular joint (TMJ) pain;
- She reported that the pain began about a month prior to the appointment and the

condition was improving;

- She reported that the pain occurred primarily when she first awoke, lasted about two to three hours, and she suspected the pain was caused by a combination of her bed, stress and her neck being out of alignment;
- She also reported cervical pain; and
- She reported both pain levels as 4 out of 10.

(*Id.* at 1-2.) Dr. White included Patient 1's responses to a host of questions regarding her current physical condition, sleep habits, stress levels, and her past medical history in this same field. The charted subjective findings also included a list of the supplements Patient 1 consumed, including turmeric,[3] homeopathic Rhus tox for TMJ, and magnesium progesterin for menopause. (*Id.*)

9. During the initial appointment, Dr. White did not take Patient 1's blood pressure or pulse, and he did not listen to her heart. (Ex. A6 at 6.) In the vitals field of Patient 1's chart, Dr. White noted her height, weight and body mass index in the like-named boxes. In the remaining boxes of the vitals field, which included boxes for "blood pressure, pulse and extremity used," he made no entries. (Ex. A2 at 2.)

10. In Patient 1's chart in the objective comments field, Dr. White noted Patient 1 had aberrant motion and loss of function on her cervical discs and the first three thoracic discs with some accompanying muscle spasms. Dr. White failed to note what tests had been performed on which he based these observations. Dr. White noted that "there were no abnormal sensory findings * * *. All muscle groups tested were within normal limits." (Ex. A2 at 2.) Dr. White failed to note what tests had been performed on which he based these negative and normal observations. Dr. White noted the performance of a foraminal compression test on Patient 1, which supported his noted finding of foraminal encroachment rather than nerve root compression. (*Id.*)

11. As noted in the diagnosis section of Patient 1's chart, Dr. White diagnosed Patient 1 with TMJ arthralgia, segmental and somatic dysfunction of the head and cervical region, and back muscle spasms. (Ex. A2 at 3.) He performed multiple spinal adjustments along her cervical and first four thoracic discs and noted these adjustments in the chart notes. Patient 1 also received laser therapy for five minutes, as noted in her chart, without any notation as to who performed the therapy or on what body part the therapy was performed. Dr. White concluded by suggesting that Patient 1 engage in at-home stretches and further treatment of two visits per week for two weeks and one visit per week for two weeks, as noted in her chart. (*Id.* at 2-3.) The chart's assessment comments section noted that Patient 1 "felt better after her treatment today." (*Id.* at 3.)

July 15, 2016 Visit

12. On July 15, 2016, Patient 1 met with Dr. White for further treatment of her TMJ and cervical complaints. (Ex. A2 at 4-5.)

[3] Patient 1utilized turmeric for its anticoagulant properties but her purpose for using this supplement was not listed in Dr. White's chart. (Exs. A2 at 1-2; A3 at 103.)

13. In Patient 1's chart in the complaint field, Dr. White noted Patient 1's pain levels as 1 for both the cervical and TMJ pain and 1 for a newly-noted lumbosacral pain. The subjective comments field of her chart only included the same first three sentences of the subjective comments from the July 12, 2016 visit, referencing her TMJ complaint, its location and its causes. The objective comments field included the same comments from the equivalent July 12, 2016 field, regarding the aberrant motion, muscle spasms, and loss of function, although Dr. White now listed a lumbar and a sacral disc that were not referenced in the July 12, 2016 chart notes. No other objective comments were made, and there was no mention of any physical examination or the performance of any tests on Patient 1 in the chart notes. (Ex. A2 at 1-6.) In the chart, Dr. White reiterated the same diagnoses from the July 12, 2016 visit and added a new diagnosis of segmental and somatic dysfunction of the sacral and lumbar region. (*Id.* at 5.) As noted in the chart, Dr. White performed multiple spinal adjustments from Patient 1's C3 vertebrae to the pelvis and had laser therapy performed on her for eight minutes, again without noting who performed the laser therapy or on what part of Patient 1 the therapy was performed. (*Id.* at 5-6.) As noted in the chart, Dr. White modified Patient 1's treatment plan to provide for her to schedule appointments as needed. The chart's assessment comments section noted that Patient 1 "felt better after her treatment today." (*Id.* at 5.)

July 20, 2016 Visit

14. On July 20, 2016, as noted in her chart in the subjective comments field, Patient 1 met with Dr. White for a "chief complaint of lumbosacral pain. [Patient 1] is also experiencing cervical and upper thoracic pain and right leg pain worse in posterior knee." (Ex. A2 at 8.)

15. In Patient 1's chart in the complaint field, Dr. White noted Patient 1's pain levels as 1 for her cervical pain, 0 for her TMJ pain, and 3 for her lumbosacral pain. There was no notation regarding the pain level for her knee. (Ex. A2 at 7-8.) In the chart, Dr. White included the same diagnoses as the prior visit and included the same objective comments from the July 15, 2016 visit. (*Id.* at 4-8.) The chart notes did not include any information regarding any tests or examinations performed on Patient 1. (*Id.* at 7-9.) According to the chart notes, Dr. White performed the exact same treatment on Patient 1 that he had performed at the prior visit: multiple spinal adjustments from Patient 1's C3 vertebrae to her pelvis and eight minutes of laser therapy. (*Id.* at 5-9.) The chart's notes failed to document who performed the laser therapy or on what portion of Patient 1's body the therapy was applied. (*Id.* at 8-9.) Her treatment plan remained unchanged. The chart's assessment comments section noted that Patient 1 "felt better after her treatment today." (*Id.* at 8.)

July 21, 2016 Visit

16. On July 21, 2016, as noted in her chart in the subjective comments field, Patient 1 met with Dr. White with a "chief complaint of lumbosacral pain. [Patient 1] is also experiencing cervical and upper thoracic pain and right leg pain worse in posterior knee. [Patient 1] has been feeling worse in the posterior knee since her last visit." (Ex. A2 at 11.)

17. In Patient 1's chart in the complaint field, Dr. White noted Patient 1's pain levels as

0 for her cervical and TMJ pain and 4 for her lumbosacral pain. There was no notation regarding the pain level for her knee. (Ex. A2 at 10-11.) In the chart, Dr. White reduced the number of diagnoses and left only the diagnoses of segmental and somatic dysfunction of the sacral and lumbar regions and accompanying back muscle spasms. In the objective comments field, he continued to note the aberrant motion and loss of function, but reduced the number of affected discs to four, and continued to note the muscle spasms, but reduced the number of affected areas to the gluteus and lumbar extensions. (*Id.* at 8, 11.) The chart notes did not reference any tests or examinations performed on Patient 1. (*Id.* at 10-12.)

18. During the July 21, 2016 visit, Dr. White observed little change in Patient 1's condition from the prior visit. He visually observed Patient 1's right leg because she was "wearing shorts" but did not perform any further examination of her leg pain complaint. (Test. of White.) During this visit, Dr. White concluded that Patient 1's leg pains, low back pain and likely sciatica were caused by her job, which required extensive sitting in cars and at a desk, and he opined that Patient 1 may be developing pre-compartment syndrome. (Ex. A8 at 5; test. of White.) Dr. White knew that there could be many causes for knee pain and that his assessment of her pain and sedentary job affects could also support concerns for a deep venous thrombosis (DVT). (Ex. A8 at 19; test. of White.) Other than Patient 1's report of pain, he did not observe any abnormalities such as redness, swelling, edema, tightness, or heat, which would all be indicative of a DVT. Based upon the lack of other signs of abnormality, Dr. White assumed the knee pain was generated from Patient 1's lumbar region. (Test. of White.) Because he "didn't think [DVT] was enough of an issue," Dr. White took no action to examine Patient 1 for a possible DVT. (Ex. A8 at 12, 19.) Dr. White did not inform Patient 1 of his concerns regarding pre-compartment syndrome or the possibility of a DVT, and he did not include these concerns in her chart. (Test. of Patient 1 and White.)

19. Patient 1 also reported foot pain to Dr. White during this visit. Her foot pain was initially subtle and intermittent but had increased with time. Dr. White examined Patient 1's right foot and adjusted it with the Impulse IQ.[4] After her treatment with Dr. White, the foot pain increased and subsequently interfered with the mobility of her leg.[5] (Test. of Patient 1.)

20. As noted in Patient 1's chart, Dr. White performed multiple spinal adjustments from her L1 vertebrae to the pelvis and had laser therapy performed on Patient 1 for 8 minutes and interferential current (IFC) therapy performed on Patient 1 for 15 minutes. The chart's notes

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[4] The Impulse IQ is a hand-held electronic percussion device with a feedback unit that delivers a focused precisely-controlled adjustment to a patient. It includes a gauge that shows the amount of movement that occurred from the application of the Impulse IQ. (Ex. A8 at 8; test. of White, Prideaux and Waggoner.)

[5] The parties' positions regarding the interactions with Patient 1's foot during the July 20th and 21st visits were in considerable dispute. I found much of the evidence to be contradictory, vague, adversely affected by passage in time, internally inconsistent, and improbable. Although I did not find it credible that Dr. White knowingly slammed a neuroma on Patient 1's foot with an adjustment device as claimed by Patient 1, I found the evidence did establish the specific facts noted in this finding (a complaint, a physical examination, an adjustment with the Impulse IQ, and subsequent changes in her symptoms). I do not find that Dr. White determined that Patient 1 had a neuroma (I actually find that Patient 1 self-diagnosed that condition), and I do not find that Dr. White utilized the Impulse IQ on a neuroma in Patient 1's foot (I find that the evidence failed to demonstrate that Patient 1 even had a neuroma).

failed to document who performed the laser therapy or on what portion of Patient 1's body the therapy was applied. (Ex. A2 at 11-12.) Dr. White had his assistant perform the laser therapy on Patient 1's knee and leg. (Test. of White.) Per her chart, Patient 1's treatment plan remained unchanged. The chart's assessment comments section noted that Patient 1 "felt better after her treatment today." (Ex. A2 at 11.)

21. During Patient 1's multiple visits with Dr. White, Dr. White made spinal adjustments to Patient 1 with the Impulse IQ device as well as with manual manipulations. Dr. White never noted in Patient 1's chart the modality he used during any particular visit. Dr. White never noted who performed the laser and IFC therapies on Patient 1 in her chart. (Test. of White.) Dr. White never checked Patient 1's blood pressure, pulse or respiration during any of the visits. (Ex. A8 at 12; test. of Patient 1 and White.)

Patient 1's Subsequent Contacts with Health Treatment Providers

22. In mid-August, 2016, Patient 1 sought massage therapy from a LMT for sciatica and foot pain on two occasions. On Patient 1's first visit, the LMT observed that Patient 1 used a cane to assist in her mobility. The LMT noted edema in both of Patient 1's legs with greater severity on the right leg. Because of the condition of Patient 1's legs, the LMT would not treat her legs and urged Patient 1 to seek treatment with a doctor or at the emergency room. Patient 1 refused and indicated her preference for herbal and homeopathic remedies and her lack of trust in medical practitioners based on a traumatic incident in her youth. On the second visit to the LMT, Patient 1 used a wheel walker to assist in her mobility. The LMT observed Patient 1's legs were still swollen but less so than in the first visit and remained tender. The LMT referred Patient 1 to another LMT for further treatment. (Test. of Samargis.)

23. On August 24, 2016, Patient 1 sought massage therapy from the second LMT. Patient 1 reported considerable pain primarily in her right leg, and the LMT observed minimal swelling in the leg. The LMT exerted no pressure on Patient 1's leg during this visit because of the amount of pain exhibited by Patient 1. Patient 1 returned to the LMT on September 7, 2016. The LMT observed significant swelling on the right leg. The LMT only performed light massage work because of the nature of the swelling and urged Patient 1 to see a doctor for testing because of the possibility of a DVT. On September 14, 2016, Patient 1 met with the LMT, who observed that the right calf was better but the right ankle remained distinctly swollen. The LMT again urged Patient 1 to see a doctor to confirm the presence of a DVT. On September 21, 2016, Patient 1 met with the LMT for a final visit. The LMT observed continued swelling with pain in the right leg and again urged Patient 1 to see a doctor. (Test. of Fawn.)

24. Patient 1 wanted to meet with Dr. White to let him know how much pain she was experiencing since her July 21, 2016 appointment. (Ex. A6 at 8; test. of Patient 1.) On August 17, 2016, she arrived at Dr. White's office on crutches without making an appointment. After waiting a few minutes in the hopes of speaking with Dr. White, Patient 1 left his office after the office manager advised her that Dr. White would give Patient 1 a call when he had a moment. (Test. of Owens.) On August 17, 2016, Dr. White entered a chart note on Patient 1's chart to document a telephone conversation he had with her that day after her attempt to meet with him. (Ex. A2 at 14.) As noted in the chart, Patient 1 reported that she felt the last treatment caused her

a marked increase in her right leg pain. She reported that homeopathic remedies had helped with the pain and that her internet research and consultations with another health care practitioner and a massage therapist had confirmed that the last treatment had caused the pain. In the chart, Dr. White wrote:

> She stated that the adjustment with the impulse IQ to her foot had irritated a neuroma attached to the sciatic nerve causing this cascade of symptoms. I asked why she had not contacted me sooner and she stated that she was very angry about this and had not wanted a confrontation. She further went on to claim that "male doctors" don't listen to females and this has been a long standing issue in her life. I did not think at the time it was appropriate to point out that I had spent nearly 30 minutes on our last encounter discussing this and other issues with her. I mentioned that she should be properly evaluated. She stated that she was doing slightly better and was going for a massage. I asked that she keep me apprised of her progress and she stated she would. I am at this time very concerned about this patient's status. She seemed very confused and spent a good deal of time rambling about homeopathy, being healer, graduating from Rutgers with a BSN and having saved many patients over the years with her healing gifts that doctors would have lost. On our last visit she had stated that she needed to travel to Brookings for work and her job also seems to entail a great deal of traveling and desk work. I am concerned that her home made homeopathic remedies may be affecting her abilities to reason properly and that perhaps her constant sitting puts her at risk for compartment syndrome or DVT.

(*Id.*) In her chart, Dr. White changed Patient 1's diagnosis to biomechanical lesions. (*Id.*) Dr. White was "very much into pushing [Patient 1] to the hospital." (Ex. A6 at 9; test. of Patient 1.) Dr. White did not convey any diagnostic impressions to Patient 1 and did not offer to perform any diagnostic testing on Patient 1. (Ex. A6 at 9.) When Patient 1 told Dr. White that his use of a mechanical adjuster on a neuroma in her foot caused her subsequent symptoms, he did not correct her statement because he did not want to increase her level of agitation. (Ex. A8 at 9.) Based upon the "massive escalation of her symptoms" since the July 2016 visits when she reported pain as her only symptom, Dr. White concluded from the phone call that Patient 1's condition may be more serious than he previously believed. (Test. of White.)

25. Dr. White and Patient 1 had no further contact following the August 17, 2016 phone call. (Test. of Patient 1.)

26. On September 27, 2016, Patient 1 arrived at the emergency room of the Bay Area Hospital (Hospital). (Ex. A3 at 1.) She reported persistent vaginal bleeding since 2012, which worsened over the past five days. She had not seen a primary care physician for this problem and had not had a gynecologic examination in approximately 20 years. As noted by Dr. Sarah Feldman, the emergency room physician, in the chart notes, Patient 1 also reported "pain in her right lower extremity secondary to a chiropractor breaking up a neuroma. She states that within 12 hours of the chiropractor working on her right foot and trying to break up the neuroma she

had foot drop and weakness in the right lower extremity." (*Id.* at 30.) During the initial physical examination, Dr. Feldman noted right lower extremity edema from mid-calf to the foot, and another physician, Dr. Bridgette Fink, noted that Patient 1 had moderate edema of the right ankle into the calf with significant pain at the lower edge of the calf. Based upon the condition of Patient 1's leg, Dr. Fink had "significant suspicion for deep venous thrombosis." (*Id.* at 26, 31.) Dr. Fink admitted Patient 1 to the Hospital for immediate rehydration, transfusion of several units of blood, and additional testing, including venous Doppler studies. (*Id.* at 24-26.)

27. Medical doctors know that when a patient exhibits symptoms of a DVT, the patient needs to be immediately directed to an appropriate physician or to an emergency room if a physician is not available. (Test. of Wee.) A patient with a DVT is in constant pain and discomfort and runs the risk of a fatal pulmonary embolism, which occurs when a blood clot dislodges and passes to the lung. (Test. of Moriarty).

28. Dr. Tien Wee performed a right leg vascular ultrasound with duplex Doppler on Patient 1, which showed a DVT throughout the right leg from the thigh to the calf. The age of the DVT cannot be determined by an ultrasound, but its existence could have begun as early as July 2016. Dr. Wee immediately called Dr. Feldman with the results of the test. (Ex. A3 at 28; test. of Wee and Moriarty.) Dr. Feldman contacted Dr. Prabhaker Patel to evaluate the DVT. The normal treatment for the DVT would be anticoagulants, but, because of Patient 1's severe anemia, anticoagulants were contraindicated. On September 28, 2016, Dr. Ricky Latham and Dr. Patel inserted an inferior vena cava (IVC) filter into Patient 1's leg. (Ex. A3 at 31-32, 41, 107; test. of Moriarty.) The insertion of the IVC filter was a necessary procedure to prevent a pulmonary embolism. (Ex. A3 at 32, 41; test. of Moriarty.)

29. On September 29, 2016, Dr. Fink completed a dilation and curettage on Patient 1 based upon her abnormal post-menopausal bleeding and anemia. (Ex. A3 at 13-19.) Further testing confirmed the presence of a uterine carcinoma of a serious variety, and, on September 30, 2016, Patient 1 was transferred to another facility for gynecologic oncology care and an anticipated complete hysterectomy. (*Id.* at 33.) After the hysterectomy, Patient 1 transferred to an out-of-state hospital and received treatment for endometrial and cervical cancer. (Ex. A6 at 4-5.) Cancer patients have a high risk factor for developing blood clots. (Test. of Moriarty.)

The Board's Investigation

30. In September 2016, the Board received complaints regarding Dr. White's treatment of Patient 1. (Ex. A4 at 3.) In response to a letter of inquiry from the Board, Dr. White sent a letter to the Board in which he stated:

> I have no recollections or notes of performing any adjustments to this patient's foot. Nor could I find any mention of a neuroma in any of the patients' intake records or elsewhere.
>
> I never use the activator buried deep in my tool drawer. I utilize my Impulse IQ mechanical adjustor daily. It is an amazing tool, highly effective, and considered to be a low force instrument. I have never

heard of a patient being injured by this tool but there are certain areas of the anatomy that I believe any doctor with a modicum of training and experience, would certainly consider to be off limits; eyes, genitalia, and certainly a neuroma would fall on this list. * * * I believe that if anyone ever made this error the consequences of their poor judgment would be immediate, the patient would protest loudly and the session would cease at that point. I would likely remember such an event. I do not. I do remember the patient walking out under her own power with no apparent discomfort, that's all. I have deep doubts that even if her claim were true, that tapping a neuroma with a low force adjuster would lead to severe "sciatica," her "entire leg swelling up" and debilitating leg pain. I think it far more likely that this patients sedentary work activities, sitting in a car driving long distances then at a desk typing reports, could be the cause of her issues.

* * * * *

I believe all of the notes submitted to be a reasonably complete and accurate representation of the event that transpired to the best of my recollections.

(Ex. A5 at 1-2.)

31. The Special Purposes Examination for Chiropractic (SPEC) is a comprehensive examination that covers all areas of chiropractic practice. A chiropractic physician's successful completion of the SPEC demonstrates to the Board that the chiropractor has the current knowledge needed to practice in this field, and the Ethics and Boundaries Assessment Services (EBAS) exam includes the chiropractor's knowledge of appropriate and comprehensive interactions between chiropractors and their patients. (Test. of Finch.)

Dr. White's Practices and Expert Opinion

32. At each visit with a patient, Dr. White discusses the patient's condition; reviews the skeletal, nerves and muscle models and diagrams, located in the exam room; reviews the proposed treatment; answers the patient's questions; obtains the patient's consent to proceed with the treatment; and then performs the treatment. Dr. White does not note the performance of PARQ[6] in a patient's chart. He understood that charting PARQ was only "suggested" by the statutes. (Test. of White.)

33. Shortly before the February 21, 2017 Board interview, Dr. White heard that he was required by law to obtain a patient's height, weight and blood pressure. Previously, Dr. White

[6] PARQ is a common acronym used in the chiropractic field that stands for the review of the proposed treatment with the patient that a chiropractor must conclude before obtaining informed consent from a patient. The "P" stands for procedures intended for treatment; the "A" stands for alternatives to the proposed treatment; the "R" stands for the risks of the proposed treatment; the "Q" stands for answering any questions from the patient.

only took a patient's blood pressure when he determined it to be clinically relevant, which was his understanding of the chiropractic standard from when he attended chiropractic college. He was unaware of when the requirement had changed. (Ex. A8 at 5-6; test. of White.)

34. A chiropractic physician could find signs of a DVT upon palpitating a patient's leg. Such signs could include pain, heat, edema, and redness. Dr. White opined that a patient with a DVT would have to have more symptoms than just pain. (Test. of White.) Laser therapy, which promotes circulation, would be contraindicated for a patient with a DVT. A chiropractic physician would need to immediately refer a patient with a suspected DVT to a specialist or a hospital. (Ex. A8 at 18; test. of White.)

35. Dr. White is aware that progesterone has a potential side effect of blood clots. He is aware that turmeric is an anticlotting agent. (Ex. A8 at 12.)

36. Dr. White opined that a chiropractic physician would need to take extra care when treating a patient, such as Patient 1, who is so distrustful of conventional medical treatment. (Test. of White.)

37. After the Board initiated its current investigation, Dr. White implemented changes to increase the accuracy and completeness of his patient records by including more detailed notes, and the company that published ChiroSpring provided him with updates that improved the product. ChiroSpring now produces pop-up warnings as reminders when a chiropractor is entering SOAP[7] notes, including a warning about recording the patient's blood pressure. (Ex. A8 at 24, 28; test. of White.) Dr. White also hired a human resource individual, whose job includes reviewing staff's compliance with record-keeping practices, training staff in record-keeping practices, and implementing any necessary changes to record-keeping practices. (Test. of White.)

Dr. Prideaux's Expert Opinion

38. Dr. Prideaux graduated from chiropractic college in 1978. He first became licensed as an Oregon chiropractor in 1979 and spent 34 years in active chiropractic practice until retiring from private practice in 2013. (Ex. A10 at 1.) He is employed as the Board's health care investigator and his responsibilities include reviewing the chiropractic care aspect of the Board's investigations. (Test. of Finch.) At various times throughout his career, he has held clinic director positions, taught as an adjunct professor, and worked on medical advisory committees, all in the chiropractic field. (Ex. A10 at 1-2.)

39. The Board publishes an Oregon Chiropractic Practices and Utilization Guidelines (OCPUG), which includes the minimum acceptable standards for record-keeping. OCPUG requires chiropractors to maintain clear and legible records that include the following: a patient's case history; a patient's chief complaint and reason for seeking treatment; the significant events that effect the chief complaint; a patient's health history; verification of the patient's informed consent; the examinations performed; and the diagnosis rendered. (Test. of Prideaux.)

[7] SOAP is an acronym that stands for subjective, objective, assessment, and procedure.

40. The minimum standard of chiropractic care requires a chiropractor to take the subjective complaint of the patient; make objective findings; determine a diagnosis; perform PARQ; obtain the patient's informed consent to the treatment plan; and perform the treatment. (Test. of Prideaux.)

41. When Patient 1 presented with the leg complaint at the July 20, 2016 visit, the standard of care required a chiropractic physician to assess the leg pain as a new condition. The chiropractor must perform tests and note the results of the tests in the patient's chart notes. The tests could include deep tendon reflexes, range of motion, pulses above and below the knee, leg squeezes, vascular assessment, and straight leg raise. The chiropractor would also need to differentiate between the type of pain, which would aid in the determination of whether the pain is neurological or vascular. Dr. White's chart notes did not reflect the performance of any tests or examination of the leg complaint. (Test. of Prideaux.)

42. When Patient 1 returned on July 21, 2016 with increased leg pain, Dr. White's chart notes indicated the ongoing treatment plan was just "as needed," despite Patient 1's reported worsened symptoms. (Test. of Prideaux.) Because of the worsening of her symptoms, an "as needed" treatment plan was not justified and failed to meet the minimum standards for chiropractic care. (*Id.*)

43. Dr. White's chart notes for Patient 1 failed to include any notations for blood pressure for Patient 1; failed to include the performance of PARQ or the obtaining of informed consent; and failed to include examination or diagnosis for Patient 1's leg complaint. Notes for all of these items must be included in patient records to meet the acceptable standard of chiropractic care. (Test. of Prideaux.)

44. Dr. White's chart notes for Patient 1 failed to indicate who performed the therapies and where the therapies were applied, which are needed to meet the acceptable standard of chiropractic care. (Test. of Prideaux.)

45. Chiropractors must note every test performed and the results of each test in a patient's chart. If the chiropractor finds nothing abnormal upon an examination or a test is negative, then the chiropractor must note those findings in the patient's chart. A chiropractor should not perform any treatment unless an examination and assessment of the patient's condition supports such treatment. (Test. of Prideaux.)

46. Dr. White's chart notes listed homeopathic remedies taken by Patient 1, including turmeric, which acts as a blood thinner, and progesterone, which is a hormone replacement that can cause DVTs. Laser therapy increases circulation to aid in healing. Laser therapy is contraindicated for a patient with a potential DVT because it may alter the vascular condition of the patient and loosen any blood clots. If a patient presents with symptoms of DVT, a chiropractor must refer the patient to a vascular specialist or the emergency room. (Test. of Prideaux.)

Dr. Waggoner's Expert Opinion

47. Dr. Waggoner graduated from chiropractic college in 2006. She first became licensed as an Oregon chiropractor in 2007 and has continuously been employed in clinical chiropractic practice since that time. She has been an adjunct professor at a chiropractic university since 2011 and has been a member of the Board's peer review and rules advisory committees. (Ex. A10 at 3-4.)

48. Dr. Waggoner concurred with Dr. Prideaux on the minimum standards required for chart notes in the chiropractic field, including the requirement that chiropractors chart any negative test results. (Test. of Waggoner.)

49. Dr. Waggoner opined that chiropractors must take a patient's blood pressure, height and weight, as required by the Board.[8] Height, weight and blood pressure are measuring sticks for a patient's health. Although the Board's requirement regarding taking a patient's vitals does not reference when to take such vitals, a chiropractor's due diligence would require recording these vitals at a patient's initial visit, so that a comparison can be made later if a patient's condition changes. (Test. of Waggoner.)

50. Dr. Waggoner found Dr. White's chart notes to be incomplete in that they lacked references to the performance of any examinations on Patient 1 and failed to include any complaint history when Patient 1 presented with the new condition of leg pain. When Patient 1 returned on July 21, 2016 and noted worsening leg pain, Dr. White failed to chart any examination of the leg condition. Based upon Patient 1's complaints, Dr. White was required to observe the leg, palpate it for edema, determine the extent of any tenderness and elevated temperature, and perform some orthopedic tests. Dr. White's notes failed to meet the minimum standard for chiropractic care because they failed to include PARQ; failed to include any examination of the lower extremities; and failed to include the results, or lack of results, of any examinations. (Test. of Waggoner.)

CONCLUSIONS OF LAW

1. Dr. White engaged in unprofessional or dishonorable conduct.

2. The Board may take disciplinary action against Dr. White.

OPINION

The Board proposes to take disciplinary action against Dr. White's chiropractic license based on multiple allegations of unprofessional and dishonorable conduct. As the proponent of the allegations, the Board has the burden to establish, by a preponderance of the evidence, that the allegations are correct and that the proposed disciplinary actions are appropriate. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Dixon v. Board of Nursing*, 291 Or App 207 (2018) (in administrative actions, burden

[8] *See* OAR 811-015-0005(1)(c)(D).

of proof is by a preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely true than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

Applicable Law

ORS 684.100 provides, in part:

> (1) The State Board of Chiropractic Examiners may refuse to grant a license to any applicant or may discipline a person upon any of the following grounds:
>
> * * * * *
>
> (f) Unprofessional or dishonorable conduct, including but not limited to:
>
> (A) Any conduct or practice contrary to recognized standard of ethics of the chiropractic profession or any conduct or practice that does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition that does or might adversely affect a physician's ability safely and skillfully to practice chiropractic.
>
> (B) Willful ordering or performance of unnecessary laboratory tests or studies; administration of unnecessary treatment; failure to obtain consultations or perform referrals when failing to do so is not consistent with the standard of care; or otherwise ordering or performing any chiropractic service, X-ray or treatment that is contrary to recognized standards of practice of the chiropractic profession[.]

OAR 811-035-0005 lists the duties and obligations of chiropractic physicians to their patients. It provides, in part:

> (1) The health and welfare of the patient shall always be the first priority of Chiropractic physicians and expectation of remuneration shall not affect the quality of service to the patient.
>
> (2) The patient has the right to informed consent regarding examination, therapy and treatment procedures, risks and alternatives, and answers to questions with respect to the examination, therapy and treatment procedures, in terms that they can be reasonably expected to understand.
>
> (a) Chiropractic physicians shall inform the patient of the diagnosis, plan of management, and prognosis in order to obtain a fully informed consent of the patient during the early course of treatment.
>
> (b) In order to obtain the informed consent of a patient, the chiropractic

physician shall explain the following:

(A) In general terms, the examination procedure or treatment to be undertaken;

(B) That there may be alternative examination procedures or methods of treatment, if any; and

(C) That there are risks, if any, to the examination procedure or treatment[.]

OAR 811-015-0005 lists the record-keeping requirements for chiropractic physicians. It provides, in part:

(1) Failure to keep complete and accurate records on all patients shall be considered unprofessional conduct

(a) Each patient shall have exclusive records which shall be clear, legible, complete and accurate; as to allow any other Chiropractic physician to understand the nature of that patient's case and to be able to follow up with the care of that patient if necessary.

(b) Every page of chart notes will identify the patient by name and one other unique identifier (date of birth, medical record number, etc.), and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record.

(c) Clear, legible, complete and accurate records contain the following:

(A) A description of the chief complaint or primary reason the patient sought treatment from the licensee.

(B) Documentation of any significant event that affects the chief complaint of the patient or the general history of the health of the patient.

(C) An accurate record of the diagnostic and therapeutic procedures that the licensee has employed in providing chiropractic services to the patient, including, but not limited to:

(i) Examinations and the results of those examinations;

(ii) Diagnoses;

(iii) Treatment plan, and any subsequent changes to the treatment plan and the clinical reasoning for those changes;

(iv) Dates on which the licensee provided clinical services to the patient, as well as the services performed and clinical indications for those services;

(v) Areas of the patient's body where the licensee has provided care;

(vi) Patient's response to treatment;

(vii) Therapeutic procedures must be clearly described including information such as providers involved, timing, setting and tools used as appropriate.

(D) Relevant information concerning the patient such as height, weight, and blood pressure.

(E) Documentation of informed consent for examination and treatment.

(F) Other clinically relevant correspondence including but not limited to telephonic or other patient communications, referrals to other practitioners, and expert reports[.]

ORS 684.010 provides, in part:

(2) "Chiropractic" is defined as:

(a) That system of adjusting with the hands the articulations of the bony framework of the human body, and the employment and practice of physiotherapy, electrotherapy, hydrotherapy and minor surgery.

(b) The chiropractic diagnosis, treatment and prevention of body dysfunction; correction, maintenance of the structural and functional integrity of the neuro-musculoskeletal system and the effects thereof or interferences therewith by the utilization of all recognized and accepted chiropractic diagnostic procedures and the employment of all rational therapeutic measures as taught in approved chiropractic colleges.

(3) "Chiropractic physician" means a person licensed by ORS 677.060, 684.025, 684.100, 684.155 or 688.010 to 688.201 and this section as an attending physician[.]

OAR 811-035-0001(3) (1995), *amended* effective April 21, 2017,[9] provides:

"Diagnosis": as defined in the Practice and Utilization Guidelines means

[9] The administrative rule was amended, effective April 21, 2017. The amendments made no changes to the cited portions of the administrative rule.

the art of distinguishing one disease from another.

OAR 811-010-0005(4) (1992), *amended* effective January 6, 2017,[10] provides, in part:

> "Patient" means any person who is examined, treated, or otherwise provided chiropractic services whether or not the person has entered into a physician/patient relationship or has agreed to pay a fee for services.

Unprofessional or Dishonorable Conduct

Patient 1 met with Dr. White on four occasions for treatment of complaints for TMJ, back pain and leg pain. Pursuant to ORS 684.010(3), as a licensed chiropractic physician, Dr. White performed treatment as Patient 1's attending physician with the resultant responsibility for her care and treatment. Dr. White was also aware that Patient 1 did not have a primary care physician, avoided conventional medical treatment, and resorted to homeopathic treatments for her ailments. As Dr. White acknowledged during the hearing, as a chiropractic physician, he would need to take greater care in his treatment of Patient 1 because of her refusal to engage in regular treatment and her distrust of conventional medicine. However, as explained below, his treatment of Patient 1 did not meet the minimum standards of chiropractic care and potentially placed her health and safety in jeopardy.

Dr. White's most thorough examination of Patient 1 occurred during the initial July 12, 2016 visit. Patient 1 completed a lengthy intake form in which she listed her areas of concern, her symptoms, and her medications and supplements. Dr. White also obtained considerable information from Patient 1 regarding her current physical condition, medical history, sleep habits and stress levels. Dr. White recorded this information in Patient 1's chart including her height and weight. He performed a physical examination of Patient 1 and additional tests on her and recorded the test results, including negative test results such as "no abnormal sensory findings," in her chart. *See* Exhibit A2 at 2. Based upon this information, Dr. White made diagnoses for her presenting conditions and recorded that information in her chart. He then performed specific spinal adjustments and noted the adjustments in her chart. He also noted in her chart that she received laser therapy during the initial visit. Despite these extensive notes in her chart, Dr. White failed to include all the information required by law and the standards of his profession.

OAR 811-015-0005(1)(a) states the generally accepted standard that a chiropractor's records must be complete and accurate so that any other chiropractor would be able to understand the treatment provided and be able to provide follow-up care. OAR 811-015-0005(1)(c) provides a specific list of items that must be included in a chiropractor's chart for a patient. For the July 12, 2016 visit, although he included the test results in her chart, Dr. White failed to chart the actual tests performed (thus, there is nothing in the chart to indicate what test(s) were performed from which Dr. White concluded that there were no abnormal sensory findings), with the one exception of the foraminal compression test; failed to note which areas of Patient 1's body received laser therapy; failed to note his use of the Impulse IQ and its settings; failed to include Patient 1's blood pressure, which Dr. White acknowledged he never obtained in

[10] The administrative rule was amended, effective January 6, 2017. The amendments only changed the numbering of the cited portions of the administrative rule.

any of her visits;[11] and failed to include any documentation of Patient 1's informed consent, which would include PARQ, a necessary precursor to obtaining informed consent.[12] Dr. White's failure to include in Patient 1's chart all the required information, in particular the tests performed on Patient 1, would make it difficult for a subsequent chiropractor to understand exactly what Dr. White had observed that led him to make the specific diagnoses and to determine the appropriate treatment.[13] For these reasons, the Board has established that Dr. White violated OAR 811-015-0005(1)(a), (c)(C)(i), (c)(C)(v), (c)(C)(vii), (c)(D) and (c)(E), which is unprofessional conduct as provided in OAR 811-015-0005(1).

As indicated above, Dr. White's examination and charting for Patient 1 was more thorough in the July 12th visit than his subsequent visits with Patient 1. The same deficiencies that occurred in the July 12th visit also occurred in the three subsequent visits on July 15, 20 and 21, 2016. Thus, Dr. White also violated OAR 811-015-0005(1)(a), (c)(C)(i), (c)(C)(v), (c)(C)(vii), (c)(D) and (c)(E) during the three subsequent visits.

Additional deficiencies in charting also occurred during these three subsequent visits. Dr. White unfortunately demonstrated a high degree of reliance on the electronic health record system he utilized to the detriment of the accuracy of Patient 1's chart. ChiroSpring automatically populated fields for subsequent visits with the information previously contained in the prior visit's fields. The evidence established that Dr. White modified some of the information during the subsequent visits, but only in certain fields, such as the severity of the pain, the diagnoses, and the spinal adjustments. In some fields, he would modify the automatically-populated information at the next visit but not during the subsequent visits. For example, during the July 15th visit, Dr. White modified the earlier recommended treatment plan of two visits per week for two weeks to treatment as needed. But, he never modified the treatment plan after the July 15th visit, despite the appearance of a new condition that worsened

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[11] The blood pressure requirement was another area of much discussion during the hearing. First, Dr. White questioned when and where such a requirement was contained. The requirement is contained in OAR 811-015-0005(1)(c)(D). Earlier versions of OAR 811-015-0005 did not include the requirement to record a patient's height, weight, and blood pressure. By 2014, shortly before Dr. White resumed his practice, the Board had amended the administrative rule to include this requirement. Secondly, the rule does not delineate when the chiropractor should record such information. Dr. White implied that he would have taken her blood pressure at some point except that Patient 1 discontinued treatment. The ALJ found this representation disingenuous. By her second visit, Dr. White had altered her treatment plan from regular follow-ups to treatment as needed, demonstrating that he was then unaware of when, if at all, she would return for further treatment. Additionally, Dr. White testified that he was unaware of the requirement, did not understand the reason for the requirement, and asserted that he only took blood pressure readings when it was clinically appropriate as he was taught in college 20 years ago. Dr. White did not intend to check Patient 1's blood pressure.

[12] As noted previously, PARQ is the chiropractor's review with the patient of the proposed procedures, alternatives, risks and opportunity for questions. Without the completion of an adequate PARQ, a chiropractor could not obtain *informed* consent from a patient for the subsequent treatment.

[13] Even during Dr. White's testimony, he acknowledged that he could not remember certain specifics of his examination and treatment of Patient 1. For example, Dr. White was sure that he had used the Impulse IQ on Patient 1, but he did not know during which visits he used it.

from July 20 to July 21, 2016. Some fields were never modified, such as the field regarding Patient 1's response to treatment which was always noted as "felt better after treatment today," even when her condition had worsened, such as on the July 21, 2016 visit. *See* Exhibit A2 at 3, 5, 8, and 11. Thus, the evidence established that the chart notes for subsequent visits were inaccurate because they failed to reflect information based upon the current visit and instead simply reflected information provided from a prior visit. By his reliance on the auto-populating feature of ChiroSpring, Dr. White failed to keep accurate chart notes, in violation of OAR 811-015-0005(1)(a), and failed to meet the minimum standard of care for his profession.

In addition to specific record-keeping deficiencies, Dr. White also failed to perform the necessary examination and treatment for Patient 1 required by the standards of his profession. In all three of her visits following her initial visit, Patient 1 identified new conditions as her areas of concern: on July 15, the new condition of lumbosacral pain; on July 20, the new condition of upper thoracic and right leg pain; and, on July 21, the new condition of right foot pain and the worsening of the right leg pain. Both the advent of new conditions and the worsening of an existing condition require a chiropractor to examine and perform the appropriate tests to determine a diagnosis. However, Dr. White failed to perform any additional examinations or tests on Patient 1; therefore, he made unsubstantiated diagnoses for these conditions.[14] Because the additional diagnoses were unsubstantiated by findings from a physical examination and appropriate tests, his subsequent treatment was inappropriate and violated the standards of care for his profession. During the July 15th visit, Dr. White further compounded his errors (no examination or tests for the new condition of lumbosacral pain, unsubstantiated diagnosis, and inappropriate treatment based upon an unsubstantiated diagnosis) by altering Patient 1's treatment plan without providing any explanation or support for such modification from the July 12th plan of return for regular treatment to the July 15th plan of return for further treatment as needed. In the July 20th and July 21st visits, he committed the further error of relying on Chiro Spring's auto-fill of the July 15th treatment plan as the treatment plan for these two subsequent visits. In light of the worsening of Patient 1's symptoms from July 20 to July 21, 2016, the evidence demonstrated that Dr. White did not formulate a treatment plan for Patient 1's new conditions of right leg and foot pain, in violation of OAR 811-015-0005(1)(c)(C)(iii) and the standards of care for his profession.

During the hearing, there was much discussion and evidence regarding Patient 1's subsequent medical emergency, admission to the hospital, and severe and alarming medical diagnoses and treatments. The evidence clearly established that Dr. White did not perform any actions that caused Patient 1's subsequently-diagnosed conditions of DVT and cancer. Additionally, the evidence was inconclusive that Patient 1 was experiencing the DVT at the time of her July 20 and July 21, 2016 visits. However, during the July 21st visit, Dr. White thought that Patient 1 may be developing pre-compartment syndrome based upon her complaints and her sedentary job. He was also aware that her knee pain could have many causes, including DVT.

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[14] During the hearing, Dr. White asserted that he performed tests but, because the results were negative, he did not note the results in the chart. First, a failure to note negative test results violates the standard of care in his profession, which requires chiropractors to chart all tests and all results, positive or negative. Second, his notes from his July 12, 2016 examination included negative test results. There was no explanation of why he included negative test results in the initial examination but not the subsequent ones. The ALJ concluded that no such additional tests were performed.

First, Dr. White failed to document her sedentary job, a significant event that affected one of her chief complaints, in Patient 1's chart, in violation of OAR 811-015-0005(1)(c)(B). Secondly, and more importantly, Dr. White failed to perform the clinically adequate examination and testing on Patient 1 that her symptoms required. Drs. Prideaux and Waggoner agreed that Patient 1's presentation with new complaints of right leg and then right foot pain required Dr. White to assess the new complaints and perform some tests, such as tests of pulses above and below the knee or other vascular assessments, palpate for edema, and orthopedic tests. Such actions would have to be taken before the chiropractor could render a differential diagnosis as required by the standard of care in the profession. A simple visual inspection of the leg and a physical examination of Patient 1's foot were inadequate. Therefore, Dr. White violated the standards of care for his profession by failing to perform adequate examinations and tests when Patient 1 presented with new complaints and worsening of existing complaints. Even though the evidence is inconclusive that Patient 1 had developed the DVT in July 2016, given the circumstances of the July 20 and July 21, 2016 visits, his failure to adequately examine Patient 1 and perform tests, which may have uncovered the DVT, placed Patient 1's health and safety at risk. It was incumbent on Dr. White, as Patient 1's attending physician with the responsibility for her care, to provide an adequate examination that may have uncovered a significant medical issue. His dismissal of an examination of Patient 1 for possible DVT as not "enough of an issue," was inappropriate and a violation of the standards of care for his profession. He further exacerbated the risks to Patient 1's health and safety by ordering laser therapy on her leg, a therapy that is contraindicated for a patient with a DVT because it could dislodge a blood clot and cause a fatal pulmonary embolism. With this conduct, Dr. White violated the standards of care for his profession in such a manner that placed the health and safety of his patient at risk, in violation of ORS 684.100(1)(f)(A).

Dr. White argued that he regularly performed PARQ with his patients and obtained their written consent before treatments, but he simply failed to document such activities. Indeed, Dr. White persuasively testified that he performed PARQ with his patients as a regular matter, using the models and posters in the examination room, describing the conditions and his proposed treatments, discussing alternatives, and answering questions. However, the PARQs he performed during the July 15th, July 20th and July 21st visits were inadequate and did not meet the standards of his profession. When a chiropractor fails to perform an examination and any necessary tests of a patient's new complaint or the worsening of an existing complaint, the chiropractor cannot render a medically-supported diagnosis and, in the absence of such diagnosis, cannot formulate an appropriate treatment plan. Any consent to treatment is inherently not an informed consent when it is based upon a faulty and inadequate examination, diagnosis, and treatment proposal. Likewise, the PARQ discussion contains the same flaws because the chiropractor is operating on inadequate information. Therefore, during the final three visits, Dr. White violated the standard of care for his profession by failing to perform an adequate PARQ and failing to obtain informed consent from Patient 1 for the treatment he performed.

As shown above, during the July 15, July 20 and July 21, 2016 visits, Dr. White failed to describe a chief complaint of Patient 1 when Patient 1 complained on foot pain on July 21, 2016; failed to include actual treatment plans on July 20 and July 21 or the clinical reasoning for the change in plan on July 15; and failed to note Patient 1's actual responses to treatment during any

of the visits. Thus, Dr. White violated these additional administrative rules during the final three visits: OAR 811-015-0005(c)(A), (c)(C)(iii), and (c)(C)(vi). During these same visits, Dr. White failed to perform adequate examinations or testing of Patient 1 and made unsubstantiated diagnoses. By then performing treatment on Patient 1 based upon inadequate information and unsubstantiated diagnoses, Dr. White performed treatment that was contrary to recognized standards of care for his profession, in violation of ORS 684.100(1)(f)(B). Because the treatment he ordered on July 20 and 21, 2016 included laser therapy, he placed Patient 1's health and safety at risk when he violated the standards of care for his profession, in violation of ORS 684.100(1)(f)(A). Based upon these same failures in gathering information and making unsubstantiated diagnoses, Dr. White failed to perform an adequate PARQ and failed to obtain Patient 1's informed consent for the treatment he rendered during these last three visits. Dr. White violated the duties and obligations of a chiropractic physician as listed in OAR 811-035-0005(2) and violated the standards of care for his profession in such a manner that placed the health and safety of Patient 1 at risk, in violation of ORS 684.100(1)(f)(A).

In conclusion, Dr. White violated a number of record-keeping requirements listed in OAR 811-015-0005, which is considered unprofessional conduct pursuant to OAR 811-015-0005(1). Dr. White's interactions with Patient 1 violated numerous standards of chiropractic care. Patient 1 had cancer and developed a DVT, a condition that Dr. White at least briefly mused as a possibility for Patient 1. Because of the possibility of the presence of a DVT, Dr. White's failure to adequately examine Patient 1 and his instruction to his assistant to perform laser therapy on Patient 1's leg placed Patient 1's health and safety at risk. Therefore, the Board has established by a preponderance of the evidence that Dr. White violated the standards of chiropractic care in such a way as to constitute a danger to the health and safety of his patient in violation of ORS 684.100(1)(f)(A), which constitutes unprofessional or dishonorable conduct. When Dr. White treated Patient 1 following an inadequate examination, he performed chiropractic services on Patient 1 that were contrary to recognized standards of practice of the chiropractic profession, in violation of ORS 684.100(1)(f)(B), which also constitutes unprofessional or dishonorable conduct. Finally, the Board also established that Dr. White violated OAR 811-035-0005(2) when he failed to perform an adequate PARQ and failed to obtain informed consent from Patient 1.

Disciplinary Action

ORS 684.100(9) provides:

> In disciplining a person as authorized by subsection (1) of this section, the board may use any or all of the following methods:
>
> (a) Suspend judgment.
>
> (b) Place the person on probation.
>
> (c) Suspend the license of the person to practice chiropractic in this state.
>
> (d) Revoke the license of the person to practice chiropractic in this state.

(e) Place limitations on the license of the person to practice chiropractic in this state.

(f) Impose a civil penalty not to exceed $10,000.

(g) Take other disciplinary action as the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings.

OAR 811-035-0025 provides:

In addition to the methods enumerated in ORS 684.100(9), in disciplining, imposing probation, or limiting the license of a person as authorized under 684.100(1), the Board may do any or all of the following:

(1) Issue an order to cease and desist;

(2) Issue a censure;

(3) Issue letters or a reprimand; or

(4) Impose any reasonable conditions or limitations for the purpose of protecting the public, rehabilitating the licensee, or ensuring licensee's compliance with the statutes and rules governing the practice of chiropractic.

In its Amended Notice, the Board proposed to suspend Dr. White's chiropractic license until he successfully passes the SPEC and EBAS tests; to assess him a civil penalty of $5,000; and to assess him the costs of the disciplinary proceeding. In light of the range of sanctions available to the Board, the ALJ found the Board's proposed sanctions are not exceptionally onerous and appear to be appropriate. The Board agrees.

The Board established that Dr. White engaged in multiple instances of unprofessional conduct in regards to his conduct with this one patient. The proposed civil penalty is only one-half of the maximum available civil penalty and is appropriate in light of Dr. White's multiple violations. Additionally, because the Board proved Dr. White's unprofessional conduct, the Board's investigation of Patient 1's case was necessary and the costs the Board incurred to pursue its legitimate concerns were warranted. Therefore, it is appropriate to assess Dr. White the proposed civil penalty and the costs of the disciplinary proceeding.

As stated previously, the ALJ did not find that Dr. White's use of the Impulse IQ on Patient 1's foot caused Patient 1's DVT, cancer or the myriad of symptoms she experienced prior to her hospital admission. However, his failure to perform a minimally-acceptable examination of Patient 1's physical condition during her last two visits with Dr. White placed her health at

significant risk. A more thorough examination of Patient 1 may have resulted in Dr. White discovering actual evidence of vascular impediments rather than just having a vague suspicion that Patient 1 was susceptible to pre-compartment syndrome and DVTs. Thus, there was the possibility, a possibility that was lost by his failure to perform an adequate examination, that Dr. White could have discovered the potential presence of a DVT and urged Patient 1 to obtain more immediate treatment for that condition. Additionally, Dr. White had his assistant perform laser therapy on Patient 1's leg, a form of therapy that is contraindicated for an individual with a DVT. If the DVT was indeed already forming at the time of Patient 1's final appointments with Dr. White, the use of the laser therapy put her at risk of a pulmonary embolism. Dr. White's actions, which placed Patient 1's health at risk, not only provide further support for the assessment of the civil penalty and the costs of the proceeding, but they also support the Board's decision to suspend Dr. White's license until he successfully passes the SPEC and EBAS exams. Although he has improved his record-keeping practices and the record-keeping practices of his clinic, his conduct demonstrated deficiencies in his understanding of the minimally-acceptable standards for a chiropractic physician. His successful completion of the SPEC and EBAS exams would demonstrate his understanding of the current standards of conduct for his profession so that the Board could be assured that Dr. White can safely resume his practice. Additionally, Dr. White had prior issues with inadequate record-keeping and the continuing education classes he took to fulfill the terms of the Agreement did not rectify this problem. On this record, the suspension of his license until successful completion of the SPEC and EBAS exams is warranted.

The ALJ found that the Board should suspend Dr. White's license until he successfully completes the SPEC and EBAS examinations at his own cost; assess Dr. White a $5,000 civil penalty to be paid within 30 days of the issuance of the final order; and assess Dr. White the costs of the disciplinary proceeding. The Board agrees.

Costs:

Pursuant to this statute, the Board (having successfully proven its case) has the right to assess the costs of the disciplinary proceeding against Dr. White, and it has indicated its intention to do so.

DOJ Costs

AAG costs: 51.2 hours at $182 per hour	$9,289.10
Paralegal costs: 42.6 hours at $91 per hour	$3,876.60
Total DOJ costs:	**$13,165.70**

Experts Costs

Total Expert costs:	**$2,838.29**

OAH Costs[15]

[15] "Office of Administrative Hearings costs are based on actual charges calculated by Oregon Employment Department financial services for the administrative law judge, for the hearing, and for all associated administrative costs, pursuant to ORS 183.655. Direct costs include ALJ and OAH staff time,

A.	OAH Direct Charges: (ALJ & Operations Staff Time, Travel, & Transcripts, includes working capital)	$8,453.35
B.	OAH Admin. Charges: (OAH Overhead, includes working capital)	$ 867.51
Total OAH Costs:		**$9,320.86**
Total Costs:		**$25,324.85**

ORDER

The Oregon Board of Chiropractic Examiners issues the following order:

1. The chiropractic license of Rick White, D.C., is suspended until the Board receives confirmation of Dr. White's successful completion and passage of all sections of the SPEC and EBAS examinations. Dr. White is responsible for paying all costs associated with the SPEC and EBAS examinations, and is responsible to notify the Board when he is registered and when he passes the examinations;

2. Dr. White must pay a civil penalty in the total amount of **$5,000** to be paid within 30 days of the issuance of the Board's final order; and

3. Dr. White must pay the costs of the disciplinary proceeding in the sum of **$25,324.85.** As indicated in the Notice of Proposed Discipline, Licensee will be charged any interest charges for failure to pay the penalties including collection fees the Board incurs.

11/19/2018

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

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and any travel, transcripts and interpreters. Administrative costs include OAH overhead calculated based on hours. Working capital is assessed at 9%."

APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 *et seq*.

CERTIFICATE OF MAILING

On Nov. 19, 2018 I mailed the foregoing Final Order issued on this date in OAH Case No. 2017-ABC-00868.

By: First Class Mail

Rick White
1611 Virginia Ave, Ste 414
North Bend OR 97459

By: First Class and Certified Mail

Kathleen E. Dyer
Attorney at Law
1605 Howard St.
Coos Bay OR 97420

Frank Moscato
Matasaru Law PC
1500 SW 1st Ave Ste 800
Portland OR 97201

By: Electronic Mail

Lori H Lindley, Assistant Attorney General
Department of Justice
1162 Court St NE
Salem OR 97301

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