BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of STEVEN ARTHUR LATULIPPE, MD LICENSE NO. MD22341	)))))	FINAL ORDER UPON DEFAULT

On or about July 16, 2021, the Oregon Medical Board (Board) properly served a Complaint and Notice (Notice), proposing revocation of the medical license of Steven Arthur LaTulippe, MD (Licensee) assessment of a civil penalty of $10,000 per violation, and assessment of costs of the proceeding against Licensee. The Notice designated the Board file on this matter as the record for purposes of establishing a *prima facie* case upon default. Licensee did not request a hearing. Therefore, upon consideration of the facts and law, the Board enters the following Order:

FINDINGS OF FACT AND ULTIMATE FACTS

1. License is a physician who most recently practiced family medicine in Dallas, Oregon, and describes himself as also specializing in pain medicine and addiction medicine. Licensee was certified by the American Board of Family Medicine at all relevant times.

COVID-19 CLINICAL ISSUES

2. SARS-CoV-2 is a coronavirus that causes COVID-19, an infectious disease. The mode of transmission of respiratory viruses, including COVID-19, is via fluid droplets expelled during normal talking and especially during coughing or sneezing. It has even been shown to be transmitted by individuals with few or no symptoms. Although masks vary in effectiveness, even the simplest mask can be expected to contain the largest, most infectious droplets. The effectiveness of masks has been scientifically shown to decrease disease transmission in the current pandemic. Every member of the public is at risk – this virus is easily transmitted from

person to person. The elderly, those with chronic health conditions, those living in group care settings, and health care workers are particularly at risk for developing life threatening illness. The standard of care recognized by the State of Oregon with respect to provider care and protocols during the relevant periods of the SARS-CoV-2 (COVID-19) pandemic were the guidelines published by the Centers for Disease Control[1]; the Oregon Health Authority (OHA), under the authority of the state of emergency declared by Governor Kate Brown on March 8, 2020, and the related Executive Orders issued by the Governor under ORS 401.165; and the basic principles of respiratory physiology and infectious respiratory disease. Steps to protect oneself and others include: Covering the nose and mouth by wearing a mask when in public, washing or sanitizing hands frequently, remaining at least six feet away from people outside of one's household, avoiding crowds, staying home and away from others if sick, elderly, or have underlying medical conditions.

3. On February 28, 2020, the Oregon Health Authority (OHA) confirmed Oregon's first presumptive case of COVID-19. On March 8, 2020, Oregon Governor Kate Brown declared a state of emergency pursuant to ORS 401.165. (*See Elkhorn Baptist Church v. Brown*, 366 Or 506, 512 (2020) (discussing Governor Brown's issuance of Executive Order No. 2020-03 on March 8, 2020).) On March 11, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a global pandemic. The declared state of emergency is still in place as of the date of this Complaint and Notice.

4. Under basic principles of respiratory physiology, the body reflexively maintains carbon dioxide content within narrow parameters, by adjusting the minute ventilation (the volume of gas inhaled and exhaled in 60 seconds). The amount of carbon dioxide re-breathed within a mask is trivial and would easily be expelled by an increase in minute ventilation so small it would not be noticed. Although patients with extremely advanced lung disease may not

[1] The CDC guidelines are also the standard recognizes by the American Board of Family Medicine. *See* https://www.theabfm.org/covid-19#Info

be able to increase their minute ventilation, their pre-existing metabolic compensation would readily address the trivial potential increase in carbon dioxide content.

5. The standard of care set forth in Governor Brown's relevant Executive Orders included physical distancing and face coverings.[2]

6. The standard of care as set forth in formal guidance promulgated by the Center for Disease Control during the relevant periods of the COVID-19 pandemic included health care practitioners wearing masks and requiring patients and staff to wear masks in the clinical setting.[3]

7. The standard of care as set forth in formal guidance promulgated by the Oregon Health Authority during the relevant periods of the COVID-19 declared state of emergency

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[2] Effective June 5, 2020, Governor Brown issued Executive Order No. 20-27, which stated, in part:

> * * *
> 2. [P]ursuant to ORS 401.168(1), ORS 401.175(3), ORS 401.188(2) to (3), and ORS 433.441(3):
> * * *
> b. Individuals must comply with any public health directives set forth in my Executive Orders.
> c. Individuals should maintain physical distancing of at least six feet from any person who is not a member of their household, when possible, and should adhere to any applicable Oregon Health Authority (OHA) guidance, including but not limited to guidance on physical distancing and face coverings. OHA guidance is available at https://govstatus.egov.com/OR-OHA-COVID-19.
> * * *
> 9. Guidance. At my direction, and under the authority of this and other Executive Orders, OHA and other appropriate agencies have issued and will continue to issue and revise detailed guidance for the public, for employers, and for particular sectors of the economy[.]
> * * *
> 25. Legal Effect. This Executive Order is issued under the authority conferred to the Governor by ORS 401.165 to 401.236. Pursuant to ORS 401.192(1), the directives set forth in this Executive Order shall have the full force and effect of law, and any existing laws, ordinances, rules and orders shall be inoperative to the extent they are inconsistent with this exercise of the Governor's emergency powers.
> 26. Enforcement. The directives in this Executive Order and any guidance issued by OHA or other state agencies to implement this Executive Order are effective statewide, unless otherwise specified.

[3] On June 9, 2020, the CDC issued updated guidance for healthcare facilities, titled "Healthcare Facilities: Managing Operations During the COVID-19 Pandemic" (June 9, 2020 Guidance). (*See* Ex. A10 at 1-5.) The CDC noted in the June 9, 2020 Guidance that previous guidance "was preventative and meant to help healthcare facilities prepare for community transmission, while current guidance is for managing operations during the pandemic." (*Id.* at 1.) The June 9, 2020 Guidance recommended that healthcare systems adjust their standard delivery approaches to reduce the need for in-person care by optimizing the use of telehealth and managing mildly ill patients at home. (*Id.* at 2-3.) To prevent the transmission of COVID-19 by COVID-19 infected persons who may or may not be showing symptoms, the June 9, 2020 Guidance recommended that healthcare facilities use source control for all persons (*e.g.*, staff, patients, and visitors) who enter a healthcare facility. The June 9, 2020 Guidance specified that cloth masks are considered source control (and not personal protective equipment (PPE)), and while cloth masks may be appropriate for patients and visitors, healthcare personnel should wear PPE.

included requiring health care practitioners to wear masks and require patients and staff to wear masks in the clinical setting.[4]

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[4] OHA standards included but were not limited to:
On May 9, 2020, the OHA issued an update to its "Clinical Care, and Healthcare Prevention and Control Guidance for COVID-19" recommending universal source control (*i.e.*, masking) for both patients and providers in all healthcare settings and advising that healthcare providers wear a face covering or face mask at all times while in a healthcare facility, unless alone in a private office. Effective July 20, 2020 – All health care clinics must: have and enforce policies that require all individuals who enter the health care office to wear a face mask, face covering or face shield while inside, including when in a private examination room, except as follows: If a patient cannot tolerate any form of face mask, face covering or face shield due to a medical condition, strict physical distancing must be observed until the patient can be placed or roomed in an area that minimizes risk to others. A face mask, face covering or face shield is not required to be worn during an examination or procedure in which access to parts of the face that are covered by a face mask, face covering or face shield is necessary. A face mask, face covering or face shield is required to be worn as soon as the examination or procedure in question has completed; have and enforce policies that require health care personnel to wear appropriate personal protective equipment (PPE) for the care of patients with suspected COVID-19, confirmed COVID-19, or a known exposure to COVID-19. All health care providers must: Wear a face mask or face covering that covers the nose and mouth at all times while in the health care office, except when in a private office by themselves; face masks should be prioritized over face coverings because they offer both source control and protection for the health care provider from potentially infectious droplets, splashes, or sprays; cloth face coverings may not be worn instead of a respirator or face mask if more than source control is needed; health care providers should avoid touching the outside (contaminated) surface of a face mask or face covering. If a health care provider must adjust the face mask or face covering, hand hygiene should be performed immediately after adjustment; face shields should be worn in addition to, but not in place of, face masks for the purposes of eye protection and additional layer of splash protection; face masks or face coverings are not required while eating or drinking, but strict physical distancing should be maintained while face masks, face shields, or face covering are not worn; health care providers must wear N95 masks or higher-level respiratory protection instead of a face covering or face masks for patient care that warrants a higher level of protection (See "PPE for Healthcare Personnel" Section); respirators with exhalation valves may not be worn. Patients and visitors: All patients and visitors when visiting a health care office are required to wear a face mask, face covering, or face shield unless the individual is under five (5) years of age, except as follows: Face masks, face shields or face coverings are not required while eating or drinking, but strict physical distancing (6 feet or more) should be maintained while face masks, face shields, or face covering are not worn; a face mask, face covering or face shield is not required to be worn during an examination or procedure where access to parts of the face that are covered by a face mask, face covering or face shield is necessary; a face mask, face covering or face shield is required to be worn as soon as the examination or procedure in question has completed; face masks, face shields or face coverings can be briefly removed in situations where identity needs to be confirmed by visual comparison; if possible, limit speaking while the cover is off as speaking generates aerosols and droplets that can contain viruses; it is not recommended that individuals wear a face shield instead of a face mask or face covering - face shields provide protection for the eyes and additional layer of splash or spray protection, but the role of face shields as a method of source control has not been established; use of a face shield alone should be limited to situations when wearing a face mask or face covering is not feasible in the following situations: when a person has a medical condition that prevents them from wearing a face mask or face covering; when people need to see mouth and tongue motions in order to communicate (e.g., when communicating with people with hearing impairments).
Effective July 31, 2020: An office must implement strict infection controls in accordance with following OHA guidance: Symptoms of COVID-19 include fever, cough, shortness of breath, fatigue, myalgia, and headache. Less common symptoms include sore throat, diarrhea, and loss of smell and taste. Fever is likely during the clinical course, but some data indicate that fewer than half of hospitalized COVID-19 patients present with fever. Severity of illness may worsen in the second week of infection. Atypical presentations have been described in older adults and persons with comorbidities. CDC has provided details on the clinical presentation of COVID-19. RNA from the virus that causes COVID-19 (SARS-CoV-2) has been identified from patients who never develop symptoms (asymptomatic) and in patients before symptoms develop (presymptomatic). Transmission during both the asymptomatic and the pre-symptomatic period has been documented. The degree to which pre-symptomatic and asymptomatic transmission have contributed to the COVID-19 pandemic remains unclear. SARS-CoV-2 is believed

8. During all relevant times, Licensee treated Oregon Health Plan (OHP) patients who have limited resources and limited ability to transfer their care to another provider.

9. During all relevant times, Licensee's staff conducted an initial screening of patients for COVID-19 illness when a patient first called the clinic to make an appointment. The clinic receptionist would conduct a "telephone triage" and ask questions about the patient's symptomology and course of illness. Licensee's clinic COVID-19 screening protocol did not include calling patients proximal to their regularly scheduled appointments to screen for potential COVID-19 symptoms. Licensee instead relied upon "common sense" and expected that if a patient with a regularly scheduled appointment was "significantly sick," the patient would call prior to their appointment to report such illness.

10. Licensee's COVID-19 screening protocols did not include taking temperatures on all patients who presented at the clinic. Licensee's COVID-19 screening protocols did not include asking patients if they had been in close contact with any person who had COVID-19 symptoms or who had tested positive for COVID-19.

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to spread mainly between people in close contact or through respiratory droplets produced by coughs and sneezes. The virus can survive on surfaces for hours to days but can be rendered inactive by routine cleaning and disinfection procedures. (See "Environmental Infection Control in Healthcare Setting" Section.)
Effective 11/13/2020: Source control (i.e., universal masking) for patients and visitors. Healthcare facilities shall have policies in place requiring all individuals who enter the facility to don a face covering or face mask while in the building. If a face covering or face mask is not available or is not tolerated by a patient, face shields can also be utilized. If a patient cannot tolerate any form of face covering due to a medical condition, strict physical distancing must be observed until the patient can be placed or roomed in an area that minimizes risk to others. • Source control (i.e., universal masking) for health care personnel. Health care personnel shall wear a face covering or face mask at all times while they are in the healthcare facility. Medical-grade face masks should be prioritized for health care personnel, as they offer both source control and protection for the health care personnel from potentially infectious droplets, splashes, or sprays. Cloth face coverings should not be worn instead of a respirator or face mask if more than source control is needed. Health Care Personnel shall ensure that the mask covers their nose and mouth at all times. Health care personnel should avoid touching the outside (contaminated) surface of the mask. If Health Care Personnel must adjust the mask, hand hygiene should be performed immediately after adjustment. N95s or higher-level respiratory protection should replace face masks for patient care that warrants a higher level of protection. Respirators with exhalation valves are not recommended for source control. Universal eye protection for health care personnel. Wearing eye protection in addition to face mask or an N95 respirator ensures the eyes, nose, and mouth are all protected from exposure to respiratory secretions during encounters in healthcare settings. Due to the increased risk of spread in long-term care settings and the likelihood for close-contact exposures to residents and coworkers, long-term care facility staff should wear a face mask and eye protection (goggles or face shield) at all times within the facility (See "Extended Use of Personal Protective Equipment" Section). Health care personnel in other settings should consider the addition of eye protection to universal masking, particularly in scenarios where patients are unable to wear a face covering. Universal use of PPE does not eliminate the need for physical distancing among health care personnel in the workplace.

11. As of approximately March 2020, when a patient arrived at the clinic for a routine scheduled appointment, Licensee relied upon his receptionist to assess whether the patient had symptoms suggestive of COVID-19. Licensee had trained his receptionist "to look at [the patient] and just take a look at them and see if they look sick," and, if the patient was "smiling and happy," the receptionist was instructed to ask how the patient was feeling. If the patient indicated that they "felt fine" and they were "not ill," the receptionist would direct the patient to sit in the waiting area until Licensee's wife led them to an examination room. If Licensee's receptionist made a visual determination that a patient looked sick, or if the patient indicated that they had symptoms of COVID-19 or they were not feeling well, the patient was taken to a designated examination room.

12. Absent surgical procedures, Licensee did not wear a mask when treating patients at the clinic between March 2020 and December 2020.

13. Licensee did not require patients or clinic visitors to wear masks in the clinic between March 2020 and December 2020, unless they were "acutely ill, coughing, [or] congested," or otherwise had signs suggestive of respiratory illness. Licensee estimates that at least 95 percent of his patients chose not to wear a mask while at his clinic.

14. Licensee's wife and his receptionist did not wear masks at the clinic between March 2020 and December 2020.

15. Licensee admitted that, on one occasion during the declared state of emergency for COVID-19, Licensee treated a male patient who had developed "SARS-CoV-2 full-blown syndrome." According to Licensee, the patient was coughing violently, had nausea, severe muscle aches and fever; and he complained of feeling as though he was going to die. Licensee had the patient don a mask during parts of the exam, but did not put on a mask himself.

16. It was Licensee's wife's responsibility to bring patients with known or presumed COVID-19 from the waiting room to an examination room, where she was then in close contact with the patients while taking their temperature, blood pressure, and other vitals. Licensee

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informed his wife that she was at risk in caring for such patients and he urged her to take "all precautions." "All precautions" did not include his wife wearing a mask.

17. From March to December 2020, Licensee engaged in an informed consent process with each patient "to establish whether or not they should be wearing a mask," based on his personal opinions in general opposition to mask wearing. Licensee regularly told his patients that masks are ineffective in preventing the spread of COVID-19 and should not be worn. Licensee further asserted that, because virus particles are so small, they will pass through the recommended masks and most other face coverings people choose to wear. Licensee routinely directed patients to watch a YouTube video titled, "Tammy K. Herrera Clark on Face Mask Effectiveness," that suggested mask wearing was ineffective to prevent spread of diseases like COIVD-19.

18. Patient A. In approximately May or June 2020, Licensee informed Patient A, who was experiencing elevated blood pressure, that wearing a mask might be contributing to her condition. Licensee also told the same patient that she was at greater risk from CO2 toxicity from mask wearing than she was from getting COVID-19.

19. On at least one occasion, Licensee's wife, working under the direction of Licensee, told Patient A that COVID-19 was no different than a cold and that the flu was more hazardous.

20. Patient B. On or about June 8, 2020, Licensee's wife working under the direction of Licensee, immediately directed an elderly patient, Patient B, to remove her mask when Patient presented for her examination. Licensee's wife then told Patient B and Patient B's adult daughter who had accompanied her to the appointment, that the mask would cause CO2 issues and compromise Patient B's breathing. A short time later, while observing that the patient's adult daughter continued to wear her mask during the appointment, Licensee's wife made a comment such as "Oh, you're one of those people," effectively discouraging Patient B from wearing a mask.

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21. Patient C. In July 2020, Patient C, an Oregon Health Plan patient who had previously established care with Licensee, called the clinic to seek medical advice following a potential COVID-19 exposure. Licensee's wife working under the direction of Licensee, spoke with the patient, who reported that she had recently been camping with friends, outdoors and unmasked. Upon hearing that the patient was not experiencing any symptoms of COVID-19, Licensee's wife informed Patient C that she did not need to get a COVID-19 test, that she did not need to isolate, that being exposed to other people would provide immunities from COVID-19, and that masks are ineffective for reducing the spread of COVID-19. Patient C was concerned about the advice she received from Licensee's wife, so she called the clinic again the following day, with the hope of obtaining medical advice from someone different. Patient C again spoke with Licensee's wife, who reiterated that masks do not work. Licensee's wife also directed the patient to a YouTube video from Tammy K. Herrera Clark, titled "Destroying the Mask Narrative." One or two days later, Patient C again called the clinic, with the goal of learning the full name and credentials of the woman (*i.e.*, Licensee's wife) with whom she had spoken on the previous occasions. Patient C was again routed to speak with Licensee's wife, who appeared displeased with the patient's request for identifying information. A few days later, Patient C received a letter from the clinic, stating that she was no longer a patient at the clinic and requesting that she, her household members, and any spouses or boyfriends do not call or visit the clinic.

22. Licensee believes that approximately 75 patients he treated at the clinic in late October 2019, early November 2019, late January 2020, and early February 2020 had COVID-19. Between late November 2020 and early December 2020, Licensee reports he treated approximately 125 patients with COVID-19 in the clinic.

23. Licensee did not recommend masking to any COVID-19 infected patients he treated in 2020. Rather, he recommended isolation, distancing, avoiding contact with shared objects and people, and increased frequency of hand washing.

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24. Licensee did not perform COVID-19 testing at the clinic. The patients he treated with confirmed COVID-19 infections were tested elsewhere.

25. Licensee regularly advised, particularly for his elderly and pediatric patients, that it is "very dangerous" to wear masks because masks exacerbate COPD and asthma and cause or contribute to multiple serious health conditions, including but not limited to heart attacks, strokes, collapsed lungs, MRSA (methicillin-resistant staph aureus infection,) pneumonia, and hypertension. Licensee asserts masks are likely to harm patients by increasing the body's carbon dioxide content through rebreathing of gas trapped behind a mask.

26. In Licensee's opinion, he has been "a strong asset to the public in educating them on the real facts about this pandemic, and likewise * * * none of my patients were placed in immediate danger. I would say that at least * * * 98 percent of my patients were so extremely thankful that I did not wear a mask or demand wearing a mask in my clinic[.] They did not perceive an immediate danger."

27. In a letter dated August 13, 2020, a Board investigator notified Licensee of the Board's investigation and summarized the relevant allegations against Licensee:

> It is alleged that Licensee is not following social-distancing guidelines in his practice and care of patients. It is also alleged that Licensee is advising patients and the public that masks required under the current guidelines do not work and should not be worn.

In the letter, the investigator requested that Licensee respond to the allegations in detail, describe his adherence to social distancing guidelines in the practice setting, and explain why he has encouraged "non-compliance with a government order to limit the spread of COVID-19." Licensee responded by affirming that he would continue to refuse wearing a mask in his clinic and continue to refuse to require others to do so, and by asserting that masks are wholly ineffective in preventing the spread of COVID-19.

28. In a letter to Licensee dated November 9, 2020, the Board's Medical Director stated, in part:

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> It has come to the attention of the [Board] that you may be in direct and active violation of current Governor Executive Orders, to include Executive Order 20-22 and 20-59. These Executive Orders specify that elective and non-urgent procedures across all care settings that utilize PPE are allowed, but only to the extent they comply with guidance or administrative rules issued by the Oregon Health Authority. These rules require all people to wear properly fitted facemasks when indoors in any care setting. Masking has been shown to significantly reduce the spread of the novel coronavirus responsible for the current worldwide pandemic.
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> It is the expectation of the Board that you immediately comply not only with the legal mandate, but with practices and professional conduct appropriate to the standards of medical care expected for a licensed medical professional in the state of Oregon.
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> The current standard of practice in a primary care setting includes, at a minimum, pre-appointment and pre-entry screening of all patients to identify those who are or may be infectious with SARS-CoV-2; appropriate sequestration of such patients; appropriate protection of all staff with PPE; and thorough cleaning of instruments and surfaces between patients. Care that you provide to your patients that is not consistent with the standards may be found to be negligent and may also constitute unprofessional or dishonorable conduct in that it does or might constitute a danger to the health or safety of a patient or the public, and may be subject to administrative sanctions.

29. On December 2, 2020, a Board investigator visited Licensee's clinic and observed: neither patients nor health care providers were wearing masks; no screening procedures were in place or being conducted (e.g., taking patient temperatures on or before entering the clinic); no hand sanitizer was available in the waiting area; a sign was posted in the public area of the clinic with "warning signs" of CO_2 toxicity; an article was posted in the public area of the clinic, with a portion of the article highlighted that claims 94% of the individuals who will experience serious effects of COVID-19 have co-morbidities.

30. On December 4, 2020, the Board emergently suspended Licensee's medical license, based on Licensee's actions and the actions of his staff in his medical clinic, as described above, creating an immediate and serious danger to public health and safety.

31. Licensee has confirmed that he will refuse to abide by the state's COVID-19 protocols in the future as well, affirming that in a choice between losing his medical license

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versus wearing a mask in his clinic and requiring his patients and staff to wear a mask in his clinic, he will, "choose to sacrifice my medical license with no hesitation."[5]

32. The degree of care, skill, and diligence of an ordinarily careful family medicine physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness -- includes wearing a mask in the physician's medical clinic. The degree of care, skill, and diligence of an even minimally careful family medicine physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness -- includes wearing a mask in the physician's medical clinic when treating patients whom the physician believes to be positive for and actively ill with COVID-19.

33. The degree of care, skill, and diligence of an ordinarily careful family medicine physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness -- includes requiring patients, visitors, and staff to wear masks in the medical clinic.[6]

34. The degree of care, skill, and diligence of an ordinarily careful family medicine physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness transferred via respirator droplets – does not include counseling patients that masks are ineffective to prevent transfer of respiratory droplets.

35. The degree of care, skill, and diligence of an ordinarily careful family medicine physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness transferred via respiratory droplets – does not include counseling ordinary patients that wearing masks is dangerous, more dangerous than a potential COVID-19 infection, and even potentially fatal.

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[5] On May 4, 2021, after a contested case hearing on the matter, the Board confirmed its Order of Emergency Suspension of Licensee's medical license, such order to remain effective for the duration of the declared state of emergency related to COVID-19.

[6] If a patient cannot tolerate any form of face mask, face covering or face shield due to a medical condition, strict physical distancing must be observed until the patient can be placed or roomed in an area that minimizes risk to others. A face mask, face covering or face shield is not required to be worn during an examination or procedure in which access to parts of the face that are covered by a face mask, face covering or face shield is necessary

36. The degree of care, skill, and diligence of an ordinarily careful family medicine physician in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness -- does not include allowing the physician's staff to direct patients to remove their masks in the clinic, counsel patients against wearing masks in the clinic and in public, or counsel patients that COVID-19 is less dangerous than influenza.

37. Licensee's instruction and example to patients to shun masks actively promoted transmission of the COVID-19 virus within the extended community.

38. Licensee's advice to patients regarding the failure of masks to prevent viral transmission and potential patient harm due to masks, were counter to basic principles of epidemiology and physiology and undermine acceptability among Licensee's patients of one of the primary measures known to significantly diminish viral transmission.

PAIN, ADDICTION, AND PSYCHIATRIC PRACTICE

39. Licensee's charts from 2017 to 2020 were reviewed for the following patients.

40. Patient D. Patient D is a male in his 50s diagnosed with: osteoarthritis of the knee; arthralgia of the knee, patella, tibia, and fibula; cervical spondylosis; generalized anxiety disorder; social phobia; and mild recurrent depression. He was prescribed 2.5 mg of methadone three times per day (MME[7] = 22.5). Licensee executed a long-term opioid agreement with Patient D on or about February 11, 2019, and obtained several urine drug screens (UDS) over the course of his care of Patient D.

41. There is no record of conservative (non-opioid) treatment of Patient D by Licensee, no review of old medical records, no imaging supporting conditions that require long-term opioid use, no consultation with specialists, no material risk notices (MRN), and no review of Patient D's prescription drug monitoring program records (PMDP). In most of Licensee's chart notes on Patient D from 2017 to 2019, exam of Patient D's knee was normal except for pain on palpation. Most of Licensee's chart notes were similar or identical. The history of present illness regularly reports mental health and social problems, but Patient D's present illness

[7] Morphine Milligram Equivalents

history is often inconsistent with Patient D's social history. Licensee frequently notes having reviewed Patient D's current medication list and yet, the list is not current; various medications, including methadone, are frequently omitted.

42. Patient E. Patient E is a woman in her 50s who Licensee was treating for anxiety, irritable bowel syndrome, fibromyalgia, migraine headaches, lumbar disc degeneration, low back pain, opioid dependence, insomnia, thoracolumbar spondylosis, and menopause. Licensee prescribed Patient E 10 mg of oxycodone three times per day (MME = 45). Licensee completed a long-term opioid agreement with Patient E on or about January 3, 2019, and completed a Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R) for Patient E on or about October 23, 2019.

43. Licensee obtained several UDS on Patient E, but on February 8, 2018, May 1, 2019, and several others during 2019, screens were positive for methamphetamines, amphetamines, oxycodone, and benzodiazepines. Patient E attributed these findings to inadvertent consumption and Licensee failed to further investigate or make changes in prescribing.

44. There was no imaging included in Patient E's records to support diagnoses requiring chronic opioids. There were no MRNs or review of Patient E's PDMP records in the patient records.

45. On Patient E's first exam, she had normal shoulder, lumbar spine, and cervical spine exams, except for tenderness to palpation. On July 9, 2018, Licensee ordered a shoulder x-ray to evaluate Patient E's pain, but the x-ray was negative. On March 8, 2019, Patient E had a knee x-ray that was normal except for a small effusion, and an ankle x-ray that was normal. On multiple subsequent visits, Licensee performed comprehensive physical examinations of Patient E which were normal except for pain on palpation. On May 30, 2019, Licensee referred Patient E to an orthopedic surgeon for knee pain. The following discrepancies are evident in Licensee's records on Patient E: under the patient's history or present illness, Licensee records the patient drinking alcohol significantly, but his social history of the patient reports no drinking; Licensee's

chart notes repeat this discrepancy; and Licensee's October 8, 2018, chart notes on Patient E provides, both: "Lumbosacral spine exhibited spasm of paraspinous muscles" and "Lumbosacral spine exhibited no muscle spasms."

46. Patient F. Patient F is a woman in her 60s whom Licensee was treating for bipolar disorder, spondylosis, chronic obstructive pulmonary disease (COPD), hypertension, fibromyalgia, irritable bowel syndrome, lumbar disc disease, low back pain, insomnia, thoracolumbar spondylosis, and recovering drug addiction. Licensee prescribed Patient F 10 mg of methadone four times a day (MME = 120) and 5 mg of oxycodone per day (MME = 7.5).

47. Licensee entered a long-term opioid agreement with Patient F on January 8, 2019, and filed a SOAPP-R for this patient on October 22, 2019. Licensee obtained multiple UDSs on Patient F. However, there was no record of an MRN or of Licensee reviewing her PDMP records. Most of Licensee's chart notes show normal musculoskeletal exams except for pain on palpation. Licensee notes having reviewed Patient F's medication list, but it is not up-to-date and omits methadone and oxycodone.

48. Patient G. Patient G is a man in his 60s whom Licensee was treating for Stage 3 kidney disease, lumbar disc degeneration and spondylosis, peripheral neuropathy, opioid dependence, post laminectomy syndrome, obesity, hypogonadism, and recovering alcoholism. Licensee prescribed Patient G 10 mg of methadone four times per day (MME = 120). On or about October 7, 2019, Licensee and Patient G executed a long-term pain management agreement. However, Licensee obtained only one UDS from Patient G. There is no report of old record review, an MRN or any review of Patient G's PDMP in the patient's medical records. Nor was there any imaging or other diagnostic study in Patient G's records supporting diagnoses requiring long-term opioid use.

49. Licensee saw Patient G periodically, often conducting comprehensive musculoskeletal exams with normal results. Patient G had an abnormal neurologic exam, but no subsequent work up. The social history Licensee documented in the medical record states that Patient G is a recovering alcoholic whose last drink was taken in June of 2007. This social

history is inconsistent with Licensee's documentation of the history of present illness, which frequently reports that Patient G is consuming alcohol.

50. Patient H. Patient H is a man in his late 50s whom Licensee was treating for lumbar spondylosis and degenerative disc disease, polyarthritis, cervical spondylosis, PTSD, depression, anxiety, bipolar disorder, diabetes with neuropathy, hypertension, obesity, peptic ulcer disease, and idiopathic pulmonary fibrosis. Licensee prescribed Patient H 10 mg of oxycodone four times per day (MME = 60).

51. Licensee and Patient H executed a long-term pain management agreement on or about January 7, 2019, and Licensee filed a SOAPP-R on or about October 17, 2019. Licensee obtained frequent UDSs on Patient H, who, on or about May 15, 2019, tested positive for hydrocodone and hydromorphone, yet Licensee did not appropriately address the discrepancies. There is no record of: conservative treatment; review of old records; imaging supporting diagnoses requiring chronic opioids; consultation for complex mental health conditions; any MRNs; or any review of Patient H's PDMP records. Most of Patient H's visits were related to mental health issues, not chronic pain, yet Licensee made no referral to a mental health practitioner for consultation or treatment.

52. In most of Patient H's visits, he had normal musculoskeletal exams except for pain on palpation. Licensee's charting for Patient H is inconsistent: it reports alcohol dependence with continued drinking, yet also reports recovering alcoholism; it records a diagnosis of idiopathic pulmonary fibrosis, but idiopathic pulmonary fibrosis is not included in the problem list and there is no consultation or work up; and the medication and problem lists are frequently inaccurate, although Licensee claims to have reviewed them. There is no record of ongoing management of Patient H's diabetes with peripheral neuropathy or of comprehensive care of his diabetes. Patient H's chart shows he has continued consuming alcohol, tobacco, cannabis, and methamphetamines.

53. Patient I. Patient I is a man in his 50s whom Licensee treated for cervicalgia, depression, lumbar disc degeneration, low back pain, lumbar spondylosis, nicotine dependence,

restless leg syndrome, and bilateral knee pain. Patient I had multiple prior surgeries, including on: left shoulder, right shoulder, low back, right wrist, right hand, right knee, left knee, and a hernia. Licensee prescribed Patient I 10 mg of methadone four times per day (MME = 120). Licensee and Patient I executed long-term opioid agreements on or about January 3, 2019, and January 1, 2020. Licensee obtained several UDSs from Patient I and completed a SOAPP-R on October 9, 2019. Although Patient I had multiple surgeries, his records contained no imaging supporting a diagnosis .that required chronic opioids. There were no MRNs and no reviews of the patient's PDMP records. Licensee referred Patient I to an orthopedic surgeon for knee pain, and the orthopedic surgeon performed a complete knee arthroplasty; however, the orthopedic surgeon expressed concern over the patient's methadone use.

54. In several of Patient I's chart notes, Licensee indicates having reviewed the medications lists, yet the lists are inaccurate. On January 9, 2019, Licensee begins Patient I on metformin[8] but Licensee assigns no clear diagnosis and does not add diabetes to the patient's problem list. Lab reports show the patient had four glycosylated hemoglobin tests, one (January 18, 2019) with a result of 6.5, which meets the criteria for diabetes. Licensee subsequently noted the patient has neuropathy, but completed no work up.

55. Patient J. Patient J is a woman in her late 40s whom Licensee treated for major depression, PTSD, migraine headaches, fibromyalgia, generalized anxiety, osteoarthritis of both ankles, paranoid schizophrenia, arthralgia, insomnia, panic disorder with social phobia, and cannabis dependence. Licensee prescribed Patient J 5 mg of oxycodone four times per day (MME = 30). Licensee and Patient J executed a long-term opioid agreement on or about August 2, 2019, and Licensee reviewed a SOAPP-R on or about October 16, 2019. Patient J completed multiple UDSs over a two-year period, but failed four of them in 2019, including 3 for presence of methamphetamines. Licensee noted the failed UDSs resulting from inadvertent exposure to methamphetamine. Licensee failed to document discussion and advice for avoiding inadvertent exposure after the first failed test, then failed to institute interventions upon repeated failures.

[8] Often prescribed for Type 2 diabetes.

There were no MRNs or reviews of Patient J's PDMP records in the file. There were no imaging or other diagnostic studies supporting the use of chronic opioids.

56. Licensee consistently recorded Patient J's social history and review of symptoms as essentially normal, yet in her history of present illness, mental health and family issues are regularly noted. Despite Patient J's serious and complex mental health diagnoses, Licensee did not consult with or refer Patient J to a mental health specialist. Patient J regularly reported symptomatic schizophrenia, but Licensee did not consult or refer Patient J to a psychiatric specialist.

57. In several chart notes, Patient J's exams for cervical spine, lumbar spine, and ankles were negative except for pain on palpation. Patient J's neurological exam was also normal. In many chart notes, Licensee often reports reviewing or reconciling Patient J's medication list, yet the medication lists were not up to date. They included errors related to such things as Depakote, propranolol, and hydroxyzine on multiple occasions.

58. Patient K. Patient K is a man in his 50s whom Licensee was treating for PTSD, dysthymic disorder, anxiety, lumbar degenerative disc disease and spondylosis, lumbar canal stenosis with neurogenic claudication, panic disorder with agoraphobia, paranoid schizophrenia, schizophreniform disorder, generalized anxiety, bipolar I disorder, fibromyalgia, cervical spondylosis, and cervical degenerative disc disease. Licensee entered a long-term opioid agreement with Patient K on February 4, 2019, and filed a SOAPP-R on October 26, 2019. Patient K frequently had normal or near-normal musculoskeletal exams and on January 22, 2019, an MRI showing that Patient K's degenerative disc disease did not include significant disc bulging or protrusion, nerve root impingement or canal stenosis, yet Licensee prescribed him 10 mg of oxycodone twice per day (MME = 30). There is no MRN or review of Patient K's PDMP. There is no record of conservative treatment, review of old records, or imaging studies that supports chronic opioid use.

59. Licensee's chart on Patient K contains multiple internal conflicts regarding mental health, social problems, family discord, alcohol use and both notations of Patient K's paranoid

schizophrenia and notations that Patient K has no paranoid schizophrenia. Patient K misused prescriptions, including haloperidol.[9] Despite ongoing, serious, and complex mental health issues including troubling episodic visual and auditory hallucinations, Licensee did not consult or refer Patient K to a mental health specialist. Patient K had severe cycles of depression and Licensee prescribed multiple psychoactive medications for Patient K – again, without psychiatric consult or referral. On March 13, 2018, Patient K reported to Licensee a recent visit to an emergency room for a panic attack and hallucinations including hearing voices, but Licensee did not subsequently consult with or refer Patient K to a psychiatrist or other mental health specialist.

60. The degree of care, skill, and diligence of an ordinarily careful family medicine physician treating patients with chronic opioid medications, includes: clearly establishing the diagnosis or diagnoses that require treatment with opioid medications; monitoring for changes in such diagnoses; clearly defining the goals of treatment; exploring, trialing, and evaluating the effectiveness of non-opiate and alternative treatment modalities; regularly assessing and documenting the benefits of treatment or lack thereof; regularly monitoring compliance by checking the Oregon PDMP and performing drug screens and documenting results thereof; appropriately addressing and managing evidence of noncompliance; annually updating material risk notification and patient controlled substance agreements; and seeking expert consultation for patients with complex mental health comorbidities.

61. The degree of care, skill, and diligence of an ordinarily careful family medicine physician requires maintaining thorough, accurate, and relevant patient charts.

62. The degree of care, skill, and diligence of an ordinarily careful family medicine physician treating patients with severe, complex, and chronic and acute mental illness requires consultations with and referrals to psychiatric and other mental health specialists, and coordinating those patients' care with psychiatric and other mental health specialists.

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[9] An anti-psychotic medication.

APPLICABLE LAW

1. ORS 677.190(1)(a) and (13), and ORS 677.205(1)(b) and (2)(b) to (f) authorize the Board to place conditions on, suspend or revoke a license to practice, place a licensee on probation, and take other disciplinary action, including assessment of the costs of the disciplinary proceedings or a civil penalty of up to $10,000 for the reasons of: unprofessional or dishonorable conduct; and repeated acts of negligence in the practice of medicine. As a Licensee of the Oregon Medical Board, Licensee is subject to the laws, rules, and standards established by the Oregon Medical Board, including but not limited to Oregon Revised Statutes chapters 676 and 677 and Oregon Administrative Rules chapter 847.

2. Under ORS 677.188(4)(a), unprofessional or dishonorable conduct means conduct unbecoming a person licensed to practice medicine, or detrimental to the best interests of the public, and includes:

Any conduct or practice contrary to recognized standards of ethics of the medical or podiatric profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition which does or might adversely affect a physician's ability to safely and skillfully practice medicine.

3. Professional negligence in Oregon occurs when a professional breaches the standard of care. *See, e.g., Getchell v. Mansfield*, 260 Or 174, 179, 489 P2d 953 (1971). ORS 677.095(1) and ORS 677.265(1)(c) define the standard of care as "that degree of care, skill and diligence that is used by ordinarily careful physicians in the same or similar circumstances in the community of the physician or a similar community."

4. Professional gross negligence in Oregon is an error "of such magnitude or recurrence" that a willful indifference to the consequences of the act may be inferred. *Hambleton v. Bd. of Engineering Examiners*, 40 Or App 9, 12, 594 P2d 416 (1979).

CONCLUSIONS OF LAW

1. By refusing to wear a mask in his medical clinic in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness, Licensee engaged in conduct

which does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

2. By refusing to wear a mask in his medical clinic when treating patients whom he believed were positive for and actively ill with COVID-19 -- a deadly and contagious respiratory illness, Licensee engaged in conduct which does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

3. By counseling patients that masks are ineffective to prevent transfer of respiratory droplets or that COVID-19 is less dangerous than influenza, both generally and specifically in his care of Patient A, Licensee engaged in conduct which does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

4. By counseling patients that wearing masks is dangerous, more dangerous than a potential COVID-19 infection, and even potentially fatal, both generally and specifically in his care of Patient A, Licensee engaged in conduct that does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

5. Licensee's instruction and example to patients to shun masks, which actively promoted transmission of the COVID-19 virus within the extended community, is a practice that does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

6. Licensee's advice to patients regarding the failure of masks to prevent viral transmission and potential patient harm due to masks, which was counter to basic principles of epidemiology and physiology, and which undermined acceptability among Licensee's patients of one of the primary measures known to significantly diminish viral transmission, was a practice

that does or might does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

7. Licensee's treatment of serious and complex psychiatric and addiction conditions for Patient J without consulting with and referring the patient to psychiatric and other mental health specialists, and without coordinating his care of the patient with psychiatric and other mental health specialists, was a practice that does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

8. Licensee's treatment of serious and complex psychiatric and addiction conditions for Patient K without consulting with and referring the patient to psychiatric and other mental health specialists, and without coordinating his care of the patient with psychiatric and other mental health specialists, was a practice that does or might constitute a danger to the health or safety of a patient or the public. The conduct was therefore unprofessional and dishonorable under ORS 677.188(4)(a) and is grounds for discipline under ORS 677.190(1)(a).

9. Licensee breached the standard of care and thereby engaged in professional negligence by refusing to wear a mask his medical clinic in the midst of a global pandemic caused by COVID-19 -- a deadly and contagious respiratory illness.

10. Licensee breached the standard of care and thereby engaged in professional negligence by refusing to wear a mask his medical clinic when treating patients whom he believed were positive for and actively ill with COVID-19 -- a deadly and contagious respiratory illness.

11. Licensee breached the standard of care and thereby engaged in professional negligence by counseling patients that masks are ineffective to prevent transfer of respiratory droplets or that COVID-19 is less dangerous than influenza, both generally and specifically in his care of Patient A.

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12. Licensee breached the standard of care and thereby engaged in professional negligence by counseling patients that wearing masks is dangerous, more dangerous than a potential COVID-19 infection, and even potentially fatal, both generally and specifically in his care of Patient A.

13. Licensee breached the standard of care and thereby engaged in professional negligence on three occasions by allowing his staff to direct patients to remove their masks in clinic, to counsel patients against wearing masks in the clinic and in public, and to counsel patients that COVID-19 is less dangerous than influenza, both generally and specifically in the care of Patients A, B, and C.

14. Licensee breached the standard of care and thereby engaged in professional negligence on eight occasions in his treatment of chronic opioid patients D, E, F, G, H, I, J, and K by failing to: clearly establish the diagnosis or diagnoses that required treatment with opioid medications; monitor for changes in such diagnoses; clearly define the goals of treatment; explore, trial, and evaluate the effectiveness of non-opiate and alternative treatment modalities; regularly assess and document the benefits of treatment or lack thereof; regularly monitor compliance by checking the Oregon PDMP and performing drug screens and documenting results thereof; appropriately address and manage evidence of noncompliance; and annually update material risk notification and patient controlled substance agreements.

15. Licensee breached the standard of care and thereby engaged in professional negligence on two occasions in his treatment of chronic opioid patients with mental health comorbidities F and H by failing to seek psychiatric or mental health expert consultation on those patients.

16. Licensee breached the standard of care and thereby engaged in professional negligence on two occasions in his treatment of chronic opioid patients with severe, complex, and chronic and acute mental illness, J and K, by failing to consult with and refer those patients to psychiatric or other mental health specialists, and by failing to coordinate those patients' care with psychiatric and other mental health specialists.

17. Licensee breached the standard of care and thereby engaged in professional negligence on three occasions in his treatment of patients D, E, and F by failing to maintain thorough, accurate, and relevant patient charts.

18. Repeated acts of negligence in the practice of medicine, which Licensee has committed as detailed in the 22 occurrences above, is grounds for discipline under ORS 677.190(13).

19. Licensee's commission of negligence in the practice of medicine on 22 occasions, in his treatment of 11 different patients, is a pattern of errors of such recurrence that Licensee's willful indifference to the consequences of his acts may be inferred. Licensee thereby committed gross negligence in the practice of medicine, which is grounds for discipline under ORS 677.190(13).

20. Licensee's instruction and example to patients to shun masks, which actively promoted transmission of the COVID-19 virus within the extended community was an error of such magnitude that Licensee's willful indifference to the consequences of his acts may be inferred. Licensee thereby committed gross negligence in the practice of medicine, which is grounds for discipline under ORS 677.190(13).

21. Licensee's advice to patients regarding the failure of masks to prevent viral transmission and potential patient harm due to masks, which was counter to basic principles of epidemiology and physiology, and which undermined acceptability among Licensee's patients of one of the primary measures known to significantly diminish viral transmission, was an error of such magnitude that Licensee's willful indifference to the consequences of his acts may be inferred. Licensee thereby committed gross negligence in the practice of medicine, which is grounds for discipline under ORS 677.190(13).

22. Licensee's treatment of serious and complex psychiatric and addiction Patient J without consulting with and referring the patient to psychiatric and other mental health specialists, and without coordinating his care of the patient with psychiatric and other mental health specialists, were errors of such magnitude that Licensee's willful indifference to the

consequences of his acts may be inferred. Licensee thereby committed gross negligence in the practice of medicine, which is grounds for discipline under ORS 677.190(13).

23. Licensee's treatment of serious and complex psychiatric and addiction Patient K without consulting with and referring the patient to psychiatric and other mental health specialists, and without coordinating his care of the patient with psychiatric and other mental health specialists, were errors of such magnitude that Licensee's willful indifference to the consequences of his acts may be inferred. Licensee thereby committed gross negligence in the practice of medicine, which is grounds for discipline under ORS 677.190(13).

24. Committing dishonorable or unprofessional conduct, repeated negligence in the practice of medicine, and gross negligence in the practice of medicine are grounds for license discipline up to and including revocation, civil penalties up to $10,000 per violation, and the costs of the proceeding under ORS 677.205(1) and (2).

ORDER

Any of Licensee's acts of unprofessional or dishonorable conduct, any single instance of Licensee's commission of gross negligence in the practice of medicine, or Licensee's repeated negligence in the practice of medicine is each individually a sufficient basis for revocation of his Oregon medical license. Therefore, for the reasons above, the Board HEREBY: **revokes the Oregon medical license of Steven Arthur LaTulippe**, MD, medical license number MD22341. In addition, the Board HEREBY **assesses a civil penalty in the amount of $10,000** against Steven Arthur LaTulippe, MD, for 8 instances of unprofessional or dishonorable conduct, 22 instances of negligence in the practice of medicine, and 5 instances of gross negligence in the practice of medicine.

Dated this 2nd day of September 2021.

OREGON MEDICAL BOARD
State of Oregon

[redacted]

KATHLEEN M. HARDER, MD
Board Chair

NOTICE

Civil penalties imposed under this order are due and payable to the Oregon Medical Board 10 days after the order becomes final by operation of law or on appeal. See ORS 183.745

APPEAL RIGHTS

You are entitled to judicial review of this order in accordance with ORS Chapter 183.482 (*see* ORS 183.480 *et seq.*). You may request judicial review by filing a petition with the Court of Appeals in Salem, Oregon within 60 days from the date of service of this order. The date of service is the day this order is mailed, not the day you receive it. The phone number for the Oregon Court of Appeals is 503-986-5555.