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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
PAUL NORMAN THOMAS, MD) ORDER OF EMERGENCY
LICENSE NO. MD15689) SUSPENSION

By order of the Oregon Medical Board, the license of Paul Norman Thomas, MD to practice medicine is hereby suspended, effective December 3, 2020, at 5:15 p.m. Pacific Time. As of this date and time, Licensee must stop practicing medicine until further order of the Board.

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. The Board has the statutory duty under ORS chapter 677 to protect the public and to exercise general supervision over the practice of medicine. Paul Norman Thomas, MD (Licensee) is a licensed physician in the State of Oregon.

This order is made pursuant to 677.205(3), which authorizes the Board to temporarily suspend a license without a hearing when the Board has evidence that indicates that Licensee's continued practice constitutes an immediate danger to the public, as well as ORS 183.430(2), in that the Board has found that Licensee's continued practice of medicine by a physician presents a serious danger to the public health or safety.

2.

When making determinations about unprofessional conduct, negligence and gross negligence in the practice of medicine, the Board relies upon sources that are well recognized in the medical community and are relied upon by physicians in their delivery of care to patients.

1 Licensee's promotion of this alternative vaccination schedule exposes patients to the risk of harm
2 in violation of ORS 677.190(1)(a), as defined by ORS 677.188(4)(a).

3 3.2 Licensee is insistent and direct in his communication with parents and guardians
4 that they should accept his alternative vaccine schedule.

5 3.2.1 A patient's mother sought subsequent treatment by Provider X after
6 having been "reduced to tears" by Licensee's "bullying" her into his personal vaccine
7 schedule against her express wishes for full vaccination for her child.

8 3.2.2 Patient A's mother requested polio and rotavirus vaccinations for Patient
9 A according to CDC Recommendations, but Licensee did not have those vaccines in the
10 clinic, and Patient A would therefore not be able to get them. Patient A's mother reported
11 that the Licensee questioned why she wanted Patient A to get the polio vaccine and asked
12 whether they were traveling to Africa. During the appointment, Licensee continually
13 connected vaccines (not specific) with autism. Licensee asked her how awful she would
14 feel if Patient A got autism and she could have prevented it.

15 Licensee's false claims regarding the safety of the CDC Recommendations, his failure in
16 following these Recommendations absent unsolicited parental refusal of vaccines, his failure to
17 document any such refusal, and his failure to adequately vaccinate children is grossly negligent
18 in violation of ORS 677.190(13) and exposed his patients to the risk of harm in violation of ORS
19 677.190(1)(a), as defined in ORS 677.188(4)(a).

20 3.3 The Board's review has identified the following cases where Licensee's conduct
21 violated ORS 677.190(1)(a), as defined by ORS 677.188(4)(a), unprofessional or dishonorable
22 conduct which exposed his patients to the risk of harm, as well as gross or repeated acts of
23 negligence in violation of ORS 677.190(13).

24 3.3.1 Patient B, an 11-year-old male, was immunized on a delayed schedule
25 according to Licensee's recommendation and practice agreements. Patient B was
26 subsequently diagnosed with pertussis on September 24, 2018, requiring office visits and
27 antibiotics. Pertussis is a fully vaccine-preventable illness. Patient B's chart shows that

1 Patient B was not immunized, but there are no records of recommendations for
2 immunization or parental refusal of vaccines.

3 3.3.2 Patient C is a now 7-year-old male. He was admitted to Randall Children's
4 Hospital in August 2013 at approximately 10 weeks of life with fever and a diagnosis of
5 Kawasaki's disease. Licensee saw Patient C in clinic for three days in clinic with fever.
6 Though Dr. Thomas reevaluated Patient C daily and sent repeated labs, he made a clinical
7 decision to treat a febrile child a less than 3 months old with intramuscular ceftriaxone on
8 the basis of a "bagged" and not catharized urine sample and in the absence of blood
9 cultures. Any child of this age is at higher risk for serious bacterial infection (late onset
10 group B strep, pneumococcal bacteremia, urinary tract infection, pneumonia, meningitis)
11 as well as inflammatory illnesses such as Kawasaki's disease. Licensee breached the
12 standard of care by failing to refer Patient C to the Emergency Room or hospital for
13 definitive lab testing (guided bladder tap, blood cultures done with bedside ultrasound,
14 possible lumbar puncture) and observation. Licensee's management of Patient C's illness
15 in clinic breached the standard of care. Patient C remained non immunized for pertussis
16 and subsequently contracted pertussis when his older brother, Patient C, became ill with
17 pertussis on September 24, 2018.

18 3.3.3 Patient D, a now 9-year-old male, was completely non-immunized.
19 Patient D sustained a large, deep scalp laceration at home in a farm setting on August 8,
20 2017, and was treated with colloidal silver and with his parents suturing the wound
21 independently. Patient D subsequently developed acute tetanus requiring intubation,
22 tracheotomy, feeding tube placement and an almost two- month ICU stay at Doernbecher
23 Children's Hospital. Patient D was then transferred to Legacy Rehabilitation. Licensee
24 saw Patient D for follow-up in clinic on November 17, 2017. Licensee's notes
25 documented a referral to a homeopath, recommendation of fish oil supplements, and
26 "phosphatidyl seine." He did not document an informed consent discussion about the
27 risk/benefit of immunization for a child who had just sustained and still had sequelae of,

1 and remained vulnerable despite prior infection, to tetanus, a life-threatening and
2 disabling disease that is preventable by proper vaccination. Licensee's care placed Patient
3 D at serious risk of harm and constitutes gross negligence.

4 3.3.4 Patient E is a 10-year-old female who received minimal immunization in
5 Licensee's clinic. She required hospitalization for rotavirus gastroenteritis in April 2011.
6 This was potentially a vaccine-preventable hospitalization. She also had a severe cough
7 and was treated empirically for pertussis without testing by another physician who was
8 working in Licensee's clinic. The care provided to Patient E in Licensee's clinic
9 breached the standard of care and exposed the patient to the serious risk of harm.

10 3.3.5 Patient F is a 7-year-old female who Licensee followed in clinic for
11 constipation, food allergies, mold allergies and possible "chronic Lyme disease. Review
12 of her chart from Licensee's clinic reveals that she was nonimmunized. Licensee ordered
13 repeated IgE allergy panels and recommended elimination diets, vitamin supplements and
14 provided antibiotics for acute infections. Licensee failed to provide an appropriate
15 referral to a pediatric gastroenterologist to exclude a diagnosis of malabsorption or celiac
16 disease, a referral to pediatric allergy/immunology or to pediatric nutrition. Licensee's
17 neglect to seek consultative support and oversight, and his failure to address Patient F's
18 lack of immunizations, placed the health of this patient at serious risk and was grossly
19 negligent.

20 3.3.6 Patient G and Patient H, twins, were born at 35 weeks gestation. They had
21 no chronic medical conditions that would justify medical immunization exemptions.
22 Both Patient G and Patient H became infected with rotavirus gastroenteritis when they
23 were 10 months of age. They were suffering from severe dehydration and serum
24 electrolyte abnormalities and required five days of hospitalization (April 25-30, 2019) at
25 an area children's hospital. Rotavirus infection is fully vaccine-preventable. Licensee's
26 clinic chart contains documentation of parental refusal of vaccines, but they are
27 inconsistent regarding specific vaccines and their timing. In addition, Patient G and

1 Patient H's mother stated during hospitalization that she thought her children had
2 received rotavirus vaccine. Failure to adequately document specific parental refusal and
3 lack of providing parental clarity constitute acts of negligence.

4 3.4 Licensee provided a spreadsheet to the Board containing deidentified data
5 describing a study of antibody responses to a single dose of MMR vaccines. Licensee obtained
6 serum antibody levels ("titers") to measles, mumps, and rubella on 905 patients between
7 February 17, 2002, and July 23, 2015. Except for rare cases of suspected immune deficiency,
8 there is no clinical indication for assessment of antibody titers. The ordering of unnecessary
9 testing is a violation of ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in
10 ORS 677.188(4)(c) willful and repeated ordering or performance of unnecessary laboratory tests.

11 3.5 In Licensee's data sheet, 122 patients are identified as having had an inadequate
12 response to the mumps vaccine. Of these, 32 are identified as having received the appropriate
13 second dose of mumps vaccine. The remaining 90 are identified as having received no
14 additional vaccination. Regardless of antibody titers, the standard of care requires a second dose
15 of the recommended MMR vaccination. Licensee failed to ensure these patients were given the
16 required second dose of MMR as soon as he obtained the test results. Knowingly leaving these
17 children inadequately protected against a preventable, potentially debilitating illness constitutes
18 90 acts of gross and repeated negligence in violation of ORS 677.190(13) and constitutes
19 unprofessional or dishonorable conduct in violation of ORS 677.190(1)(a), as defined in ORS
20 677.188(4)(a) any conduct or practice which does or might constitute a danger to the health or
21 safety of a patient or the public.

22 4.

23 The Board has determined from the evidence available at this time that Licensee's
24 continued practice of medicine would pose an immediate danger to the public and to his patients.
25 Therefore, it is necessary to immediately suspend his license to practice medicine. To do
26 otherwise would subject Licensee's patients to the serious risk of harm while this case remains
27 under investigation.

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5.

Licensee has a right to a formal hearing to contest this suspension order. To have a hearing, Licensee must request one in writing. If requested, the hearing will be held pursuant to ORS chapter 183. Licensee has the right to demand the hearing be held as soon as practicable after the Board receives the written request. The written request for hearing must be received within 90 days from the date this order is served on Licensee personally or mailed by certified mail. Licensee will be notified of the time, place and date of hearing. Failure by Licensee to timely request a hearing, failure to appear at any hearing scheduled by the Board, withdrawal of the request for hearing, or failure to appear at any hearing scheduled by the Board on time will constitute waiver of the right to a contested case hearing. In that event, the record of proceeding to date, including Licensee's file with the Board and any information on the subject of the contested case, automatically becomes a part of the contested case record for the purpose of proving a prima facie case per 183.417(4) and this emergency suspension order.

6.

NOTICE TO ACTIVE DUTY SERVICEMEMBERS: Active duty Servicemembers have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office through <http://legalassistance.law.af.mil>. The Oregon Military Department does not have a toll-free telephone number.

IT IS SO ORDERED THIS 4th day of December, 2020.

OREGON MEDICAL BOARD
State of Oregon


KATHLEEN HARDER, MD
BOARD CHAIR