BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of: )

FRANKLIN HARVEY ROSS JR., MD ) DEFAULT FINAL ORDER
LICENSE NO. MD09961 )

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. Franklin Harvey Ross Jr., MD, (Licensee) is a licensed physician in the state of
Oregon.

2.

On January 11, 2008, the Board issued an Order of Emergency Suspension. This Order
granted Licensee 90 days within which to request a hearing. Licensee did not request a hearing. On
January 23, 2008, the Board issued an Amended Complaint and Notice of Proposed Disciplinary
Action in regard to certain alleged conduct by Licensee. This Notice designated the Board’s file on
this matter as the record for purposes of a default order and granted Licensee an opportunity for a
hearing, if requested in writing within 21 days of service of the Notice. Licensee did not request a
hearing. As a result, the requisite 21 days to request a hearing have lapsed and Licensee stands in
default. The Board elects in this case to designate the record of proceeding to date, which consists of
Licensee’s file with the Board, as the record for purposes of proving a prima facie case.

3.

In the Complaint and Notice of Proposed Disciplinary Action, the Board proposed to take
disciplinary action pursuant to ORS 677.205 against Licensee for violations of the Medical
Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in
ORS 677.188(4)(a), (b) and (c); ORS 677.190(6) conviction of an offense punishable by
incarceration in a federal prison; ORS 677.190 (14) gross or repeated acts of negligence; ORS
677.190(18) willfully violating a provision of the Medical Practice Act or any rule adopted by
the Board, Board order, or failing to comply with a Board request, pursuant to ORS 677.320; and
ORS 677.190(26) failure by Licensee to report to the Board any adverse action taken against the
Licensee by another licensing jurisdiction or any peer review body, health care institution,
professional or medical society or association, governmental agency, law enforcement agency or
court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary
action under the Medical Practice Act.

4.

NOW THEREFORE, after considering the Board’s file relating to this matter, the Board
enters the following Order.

FINDINGS OF FACT

The evidence of record establishes the following findings of fact:

4.1 Patient A, a 66-year-old woman and a seven-year survivor of breast cancer, was
first seen by Licensee in 2003 and continued under his care until July of 2005. Licensee
repeatedly treated Patient A with his version of “photophoresis” therapy without documenting
the medical need for such treatment or its efficacy. Rather than recommend annual
mammograms, Licensee relied upon thermography to screen Patient A for breast cancer.
Licensee failed to meet the standard of care by failing to conduct or document that Patient A
received an annual breast examination and mammogram for the two years that she was under his
care. Licensee failed to adequately screen Patient A for breast cancer by relying exclusively upon
a technology that has not been proven in peer-reviewed clinical studies to be effective.
Licensee’s failure to conduct a physical examination, or ensure that Patient A received an annual
mammogram, had the potential of causing harm to this patient who was at high risk for breast
cancer recurrence. Licensee also subjected Patient A to an undue risk of harm by treating her
with progesterone and estrogen, despite her history of having an estrogen-sensitive breast tumor.
4.2 Licensee treated Patient B on multiple occasions at the clinic with his version of
photophoresis treatments, in which 5 ml to 90 ml of blood was drawn from the patient’s vein and
then exposed to ultraviolet (UV) light. After exposing the blood to UV light, Licensee mixed the
blood with heparin, an anticoagulant medication, and injected the blood back into the patient.
Licensee failed to document the medical need for these treatments, failed to establish the efficacy
for this form of treatment and failed to note the amount of heparin used and the blood volume
treated by UV light during these multiple treatments. Licensee also treated Patient B with
supplemental thyroid, even though his work-up did not reveal any evidence of hypothyroidism.

4.3 Licensee evaluated and treated Patient C, a patient with a history of hypertension,
diabetic neuropathy and progressive renal failure. Licensee treated Patient C with thyroid
medications without medical justification, and he failed to effectively follow Patient C’s
hypertension, diabetes and renal failure.

4.4 Licensee treated Patient D, a 79-year-old woman, with thyroid medication,
despite tests that revealed a normal thyroid function.

4.5 The Board has the following concerns regarding certain patterns that emerged
from its review of Licensee’s medical practice:

a. Licensee does not screen his age-appropriate female patients for breast cancer
with periodic mammograms in conjunction with a physical examination (the standard of
care) or recommend that they have this screening. He asserts without reasonable medical
justification that mammograms can cause cancer or can cause tumors to metastasize.
Instead of using mammograms, Licensee relies upon thermography to screen for breast
cancer, a technology that lacks sufficient proof of effectiveness to be relied upon as a
primary screening or diagnostic tool for the detection of breast cancer.

b. Licensee treated Patients A – D with the previously described version of
“photophoresis” therapy without documenting the medical need or efficacy of this form
of photophoresis treatment, and in a manner and for purposes that lacked an adequate
basis in medical science. Licensee also refers to his photophoresis therapy as UV Blood
Irradiation Therapy. Licensee also failed to obtain the informed consent of Patients A—
D prior to employing photophoresis treatment, to include failing to notify his patients that
the version of photophoresis therapy he employed has not been approved by the federal
Food and Drug Administration (FDA) and did not involve the same methodology as the
FDA-approved form of photophoresis, which involves the separation of white blood cells
and use of the medication methoxsalen (USADEX).

c. Licensee failed to assess and document the anticoagulation effects of heparin on
Patients A—D during the course of his version of photophoresis therapy. License also
failed to chart the exact amount of heparin that he employed for every treatment, or the
partial thromboplastin time.

4.6 Patient E, a male in his mid fifties, presented to Licensee in October 2005 with
complaints of migratory joint pain. Licensee’s diagnosis for Patient E included rheumatoid
arthritis. Licensee failed to record an adequate patient history or to conduct an adequate physical
examination. Licensee’s notes are also difficult to read. Licensee started Patient E on a
combination of vitamins, enzymes, and Ivacort, an over the counter cortisol preparation for
“adrenal support” (2.5 mgs, 16 tablets per day.) On May 18, 2006, Licensee authorized Patient E
to take 20 mg tablets of hydrocortisone (20 mgs, 100 tablets) with an authorization for refill
noted for “1 year.” The corresponding chart note reflects the following: “Emergency 20 mg
tabs—if a flare up…But if need—can take up to 200 mg/day—or 10 tabs.” Licensee also
directed Patient E to take “Isacort—12 tablets/day.” There is no chart note to reflect that
Licensee informed Patient E of the alternatives and risks associated with this treatment.
Licensee failed to follow Patient E to determine the efficacy of this treatment, or to monitor how
Patient E was utilizing this medication. Patient E refilled this prescription from May 23, 2006
through December 9, 2006 on a bi-monthly basis. Patient E subsequently developed Cushing’s
syndrome, a condition caused by chronic exposure to excessive cortisol. Licensee’s care for
Patient E was grossly negligent and caused patient harm.

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Patient F, an adult male in his late 80’s with limited financial resources, initially presented to Licensee in March 2004 with complaints of memory decline. He had previously received a diagnosis of vascular dementia and Alzheimer’s disease. Licensee asserts that an initial laboratory report reflected “possible borderline hypothyroidism (my protocol), and andropause associated hormonal decline, and parameters consistent with an increased intravascular coagulation tendency.” In fact, Patient F’s thyroid values were in the normal range. Licensee treated Patient F with supplemental thyroid without medical justification and also recommended a course of intravenous chelation and ultraviolet blood irradiation therapy. None of these treatments were medically indicated and caused Patient F to incur unnecessary expense. Licensee subjected Patient F to a significant risk of harm by treating him with supplemental thyroid, which could stress the patient’s compromised vascular system.

Licensee was indicted with four misdemeanor counts of failing to file his federal tax returns for tax years 2000, 2001, 2002 and 2003. The federal criminal investigation revealed that Licensee failed to report his income derived from his medical practice in Ashland for these four tax years. On August 14, 2007, Licensee pled guilty in U. S. District Court, District of Oregon, to count 4 of failure to file his federal income tax return, in violation of 26 USC § 7203. As part of the plea agreement, the United States dismissed counts 1, 2 and 3. On October 29, 2007, Licensee was sentenced to 10 months of confinement, restitution of more than $149,000 and one year of probation.

Licensee was served with a federal grand jury subpoena in February of 2005, when he was notified that he was the subject of an official federal criminal investigation regarding his previously alleged failure to his file tax returns from 2000 through 2003. Licensee testified at a federal grand jury hearing in April 2005, and on April 11, 2007, Licensee was indicted with charges of four counts of failing to file timely income tax returns.

a. Licensee failed to inform the Board in a timely manner, and upon requests, that he was the subject of a federal criminal investigation; that he was indicted; and that he was convicted of one count for failing to file a tax return for 2003 with his guilty plea entry.
When requested to respond to the Board’s investigation on his federal tax case, Licensee was tardy in submitting a written summary and court documents.

b. Licensee was personally interviewed at the Board’s office on Thursday, November 2, 2006, regarding a Board investigation of his care of Patients A-D. When Licensee was questioned whether he has been the subject of any other investigation, Licensee’s attorney responded in answer to the Board’s Investigative Committee that Licensee is not aware of any other investigation, to include the IRS. Licensee’s attorney stated that the “IRS concerns” were merely a matter that was “resolved by updating tax returns,” despite having knowledge that Licensee was served a federal Grand Jury subpoena in February of 2005 that notified Licensee he was the subject of an official federal criminal investigation, and despite having knowledge that Licensee testified at a federal Grand Jury hearing in April of 2005 regarding the aforementioned federal criminal investigation.

5.

CONCLUSIONS OF LAW

5.1 Licensee’s conduct breached well recognized standards of ethics of the medical profession and could have culminated in serious patient harm. Licensee’s conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a), (b) and (c); ORS 677.190(6) conviction of an offense punishable by incarceration in a federal prison; ORS 677.190 (14) gross or repeated acts of negligence; ORS 677.190(18) willfully violating a provision of the Medical Practice Act or any rule adopted by the Board, Board order, or failing to comply with a Board request, pursuant to ORS 677.320; and ORS 677.190(26) failure by Licensee to report to the Board any adverse action taken against the Licensee by another licensing jurisdiction or any peer review body, health care institution, professional or medical society or association, governmental agency, law enforcement agency or court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action under the Medical Practice Act.
5.2 Licensee’s manner of practice in regard to Patients A-F subjected patients to medically unjustified treatments, exposed a patient to the risk of harm by failing to perform annual screening tests (Patient A), and actually caused serious patient harm (Patient E). In addition, Licensee’s failure to file his federal income tax returns, his indictment and conviction, and his failure to inform the Board or to accurately report to the Board about this matter reflect poorly upon his integrity and honesty. Every violation described above demonstrates that Licensee cannot be trusted as a physician.

5.3 The Board also finds that the substandard care provided to Patients A – F provided a reasonable basis for the Board to conclude that his continued practice constituted an immediate danger to the health and safety of the public. The Board acted appropriately in immediately suspending him from the practice of medicine on January 11, 2008.

6.

ORDER

IT IS HEREBY ORDERED THAT the Oregon medical license of Franklin Harvey Ross, Jr., MD is reprimanded and revoked, and he is ordered to pay a civil penalty of $10,000 within 90-days from the date this Order is signed by the Board Chair.

DATED this 11th day of April, 2008.

OREGON MEDICAL BOARD
State of Oregon

PATRICIA L. SMITH
BOARD CHAIR

Right to Judicial Review

NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.482. If this Order was personally delivered to you, the date of service is the day it was mailed, not the day you received it. If you do not file a petition for judicial review within the 60 days time period, you will lose your right to appeal.

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