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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
STEVEN ARTHUR LaTULIPPE, MD )  
LICENSE NO. MD22341, Licensee ) ORDER OF EMERGENCY  
SUSPENSION OF LICENSE AND  
NOTICE OF OPPORTUNITY FOR  
HEARING

**By order of the Oregon Medical Board, the license of Steven A. LaTulippe, 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.

**AUTHORITY**

1.1 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. Under ORS chapter 677, the Board has the duty to protect the public and to exercise general supervision over the practice of medicine. Steven Arthur LaTulippe, MD (Licensee) is a licensed physician in the State of Oregon.

1.2 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 public health and safety, the Board relies upon sources that are well recognized in the medical community and are relied upon by physicians in

1 their delivery of care to patients. For this case, the Board relies upon basic principles of  
2 transmission of respiratory viruses and of respiratory physiology, as well as formal SARS-CoV-2  
3 (COVID-19) guidelines published by the Oregon Health Authority (OHA), and the  
4 corresponding rules for workplace safety promulgated by the Oregon Safety and Health  
5 Administration (OSHA).

### 6 3.

7 3.1 The spread of COVID-19 is a global pandemic. While most people only  
8 experience mild symptoms from COVID-19, some become severely ill and die from the  
9 infection. COVID-19 is highly contagious. There are medications that help patients with severe  
10 illness but there is no effective treatment at this time.

11 3.2 COVID-19 is spread from symptomatic and asymptomatic people primarily  
12 through respiratory droplets expelled when an infected person talks, coughs, or sneezes. These  
13 droplets infect others through contact with moist surfaces in one's nose, mouth, throat, eyes or  
14 lungs. Infection most commonly happens when people are near each other – within six feet.  
15 COVID-19 can also be transmitted when one touches an object with virus present and then  
16 touches one's own mouth, eyes, or nose. Although masks vary in effectiveness, even the simplest  
17 mask can be expected to contain the largest, most infectious droplets. The effectiveness of masks  
18 has been scientifically shown to decrease disease transmission in the current pandemic.

19 3.3 When infected with COVID-19 patients can have a wide range of symptoms.  
20 Infected persons often experience no symptoms at all or have very mild symptoms resembling a  
21 cold or flu. Others experience severe symptoms that require hospitalization, medication and  
22 sometimes placement on a ventilator. Most of those who develop severe, life-threatening  
23 symptoms are older and have underlying health conditions. However, there have been cases of  
24 children and young, otherwise healthy, adults who have experienced severe disease and required  
25 hospitalization.

26 3.4 Every member of the public is at risk – this virus is easily transmitted from person  
27 to person. It has even been shown to be transmitted by individuals with few or no symptoms. The

1 elderly, those with chronic health conditions, those living in group care settings, and health care  
2 workers are particularly at risk for developing life threatening illness. Steps to protect oneself  
3 and others include: Covering the nose and mouth by wearing a mask when in public, washing or  
4 sanitizing hands frequently, remaining at least six feet away from people outside of one's  
5 household, avoiding crowds, staying home and away from others if sick, elderly, or have  
6 underlying medical conditions.

7           3.5     As OHA and OSHA have set forth, public health and safety requires health care  
8 practitioners to wear masks and require patients and staff to wear masks in the clinical setting.  
9 Health care providers must also adopt, enforce, and post COVID-19 transmission prevention  
10 policies and protocols.<sup>1</sup>

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11 <sup>1</sup> OHA has promulgated guidance in health care settings. OSHA administrative rules OAR 437-001-0744 and  
12 Appendices require all employers to follow OHA guidance on COVID-19. OHA Guidance includes but is not  
13 limited to:  
14 Effective July 20, 2020 – All health care clinics must: have and enforce policies that require all individuals who  
15 enter the health care office to wear a face mask, face covering or face shield while inside, including when in a  
16 private examination room, except as follows: If a patient cannot tolerate any form of face mask, face covering or  
17 face shield due to a medical condition, strict physical distancing must be observed until the patient can be placed or  
18 roomed in an area that minimizes risk to others. A face mask, face covering or face shield is not required to be worn  
19 during an examination or procedure in which access to parts of the face that are covered by a face mask, face  
20 covering or face shield is necessary. A face mask, face covering or face shield is required to be worn as soon as the  
21 examination or procedure in question has completed; have and enforce policies that require health care personnel to  
22 wear appropriate personal protective equipment (PPE) for the care of patients with suspected COVID-19, confirmed  
23 COVID-19, or a known exposure to COVID-19. All health care providers must: Wear a face mask or face covering  
24 that covers the nose and mouth at all times while in the health care office, except when in a private office by  
25 themselves; face masks should be prioritized over face coverings because they offer both source control and  
26 protection for the health care provider from potentially infectious droplets, splashes, or sprays; cloth face coverings  
27 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

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

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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 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.

3.7 Licensee treats Oregon Health Plan (OHP) patients who have limited resources and limited or no ability to transfer their care to another provider.

4.

## FINDINGS OF FACT

The Board finds Licensee engaged in unprofessional conduct or dishonorable conduct, as defined in ORS 677.188(4)(a), as conduct that is contrary to medical ethics and does or might constitute a danger to the health or safety of the public and committed multiple acts of negligence and gross negligence in the practice of medicine as follows:

4.1 On or about July 02, 2020, Patient A – a member of the OHP – contacted Licensee’s medical clinic to request guidance on when and if to be tested for COVID-19. Patient A was told asymptomatic persons should not be tested, that wearing masks does not prevent transmission of COVID-19, and was directed not to self-isolate because being around other people would provide Patient A with immunity to COVID-19. On or about July 23, 2020, after Patient A had questioned the appropriateness of the COVID-19 advice provided, Patient A was terminated as a patient.

4.2 Licensee and the staff in his clinic refuse to wear masks in the clinic and urge persons who enter the clinic wearing masks to remove their masks.

4.3 Licensee regularly tells his patients that masks are ineffective in preventing the spread of COVID-19 and should not be worn. Licensee further asserts that, because virus particles are so small, they will pass through the recommended N95 masks and most other face coverings people are choosing to wear. Licensee directs patients to a YouTube video providing false information about mask wearing.

4.4 Licensee regularly advises, 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, pneumonia, and hypertension. Licensee asserts masks are likely

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1 to harm patients by increasing the body's carbon dioxide content through rebreathing of gas  
2 trapped behind a mask.

3 4.5 Licensee's COVID-19 protocols for his clinic call for patients to be masked only  
4 if they present with cough, fever, or "suspicious" viral illness and do not call for any of the  
5 health care providers to wear masks unless these conditions exist.

6 4.6 Signage posted in Licensee's clinic asserts the clinic is complying with  
7 (unspecified) COVID-19 protocols, but does not include any information on what those  
8 protocols are.

9 4.7 On December 2, 2020, a Board investigator visited Licensee's clinic and  
10 observed: neither patients nor health providers were wearing masks; no screening procedures  
11 were in place or being conducted (e.g., taking patient temperatures on or before entering the  
12 clinic); no hand sanitizer was available in the waiting area; a sign was posted in the public area  
13 of the clinic with "warning signs" of CO<sub>2</sub> toxicity; an article was posted in the public area of the  
14 clinic, with a portion of the article highlighted that claims 94% of the individuals who will  
15 experience serious effects of COVID-19 have co-morbidities.

16 5.

17 CONCLUSIONS OF LAW

18 The Board finds Licensee's continued practice constitutes an immediate danger to the  
19 public, and presents a serious danger to the public health and safety as follows:

20 5.1 During the pandemic, patients will inevitably present to Licensee's clinic with  
21 known, suspected, or occult infection with SARS-CoV-2; and

22 5.2 Such patients present a clear and present health risk to other patients and staff;  
23 and

24 5.3 Licensee's active discouragement of mask wearing by patients and elimination of  
25 mask wearing by staff and Licensee represent a failure to take appropriate steps to reduce the risk  
26 of transmission, thereby posing an unnecessary and preventable risk to patients, staff, and  
27 Licensee; and

5.4. Licensee's instruction and example to patients to shun masks actively promotes transmission of the virus within the extended community; and

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

5.6 Licensee's OHP patients are assigned to physicians by OHP and, if assigned to Licensee, have limited ability to transfer their care to a different provider. These particularly vulnerable patients are, therefore, largely forced to endure Licensee's unsafe practices while his medical license remains active.

6.

## NOTICE OF RIGHTS

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.

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

8 IT IS SO ORDERED THIS 4<sup>th</sup> day of December, 2020.

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10 OREGON MEDICAL BOARD  
11 State of Oregon  
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13 KATHLEEN M. HARDER, MD  
14 BOARD CHAIR  
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