

NO. 43552-7-II

IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

LLOYD V. OLSON, M.D.,

Appellant,

v.

STATE OF WASHINGTON DEPARTMENT OF HEALTH,
MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

BRIEF OF APPELLANT

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INTRODUCTION

A surgical technician, Jamie Roy, accused an anesthesiologist, Dr. Lloyd Olson, of inappropriately “molesting” two patients’ breasts for *one to two minutes* in an open Operating Room with a surgeon, nurses, and other technicians present. At that time, Dr. Olson had been practicing for 30 years, and had never received a complaint or been disciplined. The surgeon denied that this could have happened without him seeing it. No other witness saw anything inappropriate, and a nurse was standing right next to Dr. Olson when he briefly touched one patient’s upper chest to insure her identity, and she saw nothing inappropriate.

No witness supported Roy’s story. Indeed, the Department’s own expert, Dr. Kennard, said he could not imagine it. Dr. Olson’s expert said simply that Roy’s allegations are “Impossible.”

The Medical Quality Assurance Commission (MQAC) believed Roy and disbelieved Dr. Olson, and in a rush to judgment, suspended his license after a four-week investigation. This violates due process. MQAC entered no findings regarding the dozen-plus witnesses who contradicted Roy. This violates the APA and does not meet the required “highly probable” standard. This Court should reverse and dismiss, or at least remand for a new hearing.

ASSIGNMENTS OF ERROR

1. MQAC erred in ruling that the “ultimate issue” in this matter was simply whether it believed Roy or Dr. Olson. AR 1786.
2. MQAC erred in ignoring and utterly failing to make credibility findings regarding the testimony of ten witnesses either directly contradicting Roy’s testimony or directly supporting Dr. Olson’s testimony: Nurses Wissenbach, Wertman, and Carter; Doctors Droesch, Ortolano, Lorenzo, Kennard and Ebert; anesthesiology assistant Covington; and Patient Three.¹
3. MQAC erred in finding that there is “no medical justification” for touching the patients’ “breasts,” disregarding numerous witnesses’ testimony, and failing to make supporting findings. AR 2359 (F/F 1.16), 2362 (F/F 1.24, 1.25, 1.26).
4. MQAC erred in finding that “Dr. Ortolano does not remember the amount of time” Dr. Olson spent at the foot of the operating table. AR 2364 (F/F 1.29).
5. MQAC erred in entering Findings 1.13, 1.22, and 1.32, to the extent that it concluded that these findings are clear, cogent and convincing (or “highly probable”) evidence . AR 2358, 2361.

¹ The Findings, Conclusions and Order are attached as Appendix A.

6. MQAC erred in entering Findings 1.14, 1.17, 1.26, to the extent that it concluded that these findings are clear, cogent and convincing (or “highly probable”) evidence. AR 2358-59, 2362-63.

7. MQAC erred in concluding that there was clear, cogent and convincing (or “highly probable”) evidence of “unprofessional conduct” under RCW 18.130.180(7) & (24). AR 2366.

8. MQAC erred in concluding that there was clear, cogent, and convincing (or “highly probable”) evidence that Dr. Olson engaged in “sexual contact” under WAC 246-919-630(2(e)). AR 2366.

9. MQAC erred in concluding that there was clear, cogent, and convincing (or “highly probable”) evidence that Dr. Olson engaged in “forceful contact” under WAC 246-16-308. AR 2367.

10. MQAC erred in entering its Findings of Fact, Conclusions of Law and Final Order on September 7, 2010, and its Order Denying Request for Reconsideration on November 29, 2010. AR 2350-71, 2744-45.

ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. Must this Court determine whether the department presented clear, cogent and convincing evidence in light of the “highly probable” standard?

2. Must MQAC make express credibility findings under RCW 34.05.461(3) sufficient to meet the “highly probable” standard?
3. Under RCW 34.05.570(3), do MQAC’s “investigation” and Findings, Conclusions and Order
 - (a) violate “constitutional provisions on its face or as applied,”
 - (b) “fail to follow a prescribed procedure,”
 - (c) “erroneously interpret[] or appl[y] the law,”
 - (d) fail to decide “all issues requiring resolution by the agency”?; and are they
 - (e) “not supported by evidence that is substantial when viewed in light of the whole record before the court” and
 - (f) “arbitrary and capricious”?

STATEMENT OF THE CASE

A. Standard of Proof.

The Department’s burden to justify depriving Dr. Olson of his right to practice medicine is clear, cogent and convincing evidence. ***Nguyen v. Dep’t of Health***, 144 Wn.2d 516, 534, 29 P.3d 689, *cert. denied*, 535 U.S. 904 (2002). As further discussed *infra*, this means that MQAC must make findings supported by evidence so substantial that it makes them “highly probable.” See, e.g., ***In re***

Sego, 82 Wn.2d 736, 739, 513 P.2d 831 (1973). Indeed, the Department conceded below that this is the appropriate standard. See AR 1652 (Department's Response to Motion to Dismiss (citing, *inter alia*, **Sego**)).

B. Kadlec Operating Room 4 (OR 4) witness identification.

i. Appellant Dr. Lloyd Olson, anesthesiologist.

At the time of the allegations relevant to this appeal (April 2010) the Appellant, Dr. Lloyd Olson, had been practicing medicine for about 30 years. Administrative Record (AR) 74, 3886. He was licensed to practice in nine states, including Washington; he had moved for career and family opportunities. AR 74, 3886-95.

Dr. Olson is board certified in both emergency medicine and anesthesiology. AR 74. He had practiced in emergency rooms, and in family practice, for roughly 12 years, and then practiced as an anesthesiologist for about 13 years, including several years in Port Angeles. AR 74-75, 3886, 3891. Until this case, he had never been the subject of any complaints, and he had never received any discipline in any jurisdiction. AR 74, 3888, 3891.

Dr. Olson began working at Kadlec Medical Center (Kadlec) in Richland, Washington, on January 18, 2010. AR 75, 3187. He was the anesthesiologist on duty at Kadlec's Operating Room 4

(OR 4) on the day the relevant events allegedly occurred, April 1, 2010. AR 3681. Dr. Olson saw nothing inappropriate occur that day. AR 3895-96.

ii. Dr. Droesch, OR 4 surgeon.

Dr. John Droesch is a board certified general and laparoscopic surgeon in Richland, and is on staff at Kadlec. AR 3503-04, 3547. He is also the trauma director at Kadlec. AR 3505. Dr. Droesch worked with Dr. Olson only a few times. AR 3507-08. He was the surgeon in OR 4 on April 1, 2010, and he saw nothing inappropriate occur that day. AR 3505, 3532.

iii. Amber Wissenbach, OR 4 surgical nurse.

Amber Wissenbach is an operating-room circulating nurse at Kadlec. AR 3261-62. Her primary duties are to interview the patients, to prepare the operating room, and to insure patient and staff safety during operations. AR 3262. She also maintains the Flowsheets, recording when people enter and leave the operating room. AR 3262. She explained that the specific time entries on her Flowsheets are accurate and that she is "a little bit OCD" about getting them right. See, e.g., AR 3321, 3323.

Nurse Wissenbach is very aware of her surroundings in the OR and very protective of her patients' privacy. AR 3289. She

worked with Dr. Olson on roughly ten to 15 days. AR 3266. She was working in OR 4 on April 1, 2010, and she saw nothing inappropriate occur that day. AR 3267, 4337-43.

iv. Natalie Wertman, Registered Nurse.

Natalie Wertman, RN, worked at Kadelec for six years. AR 3826. On April 1, 2010, she was a circulating nurse in OR 4. AR 3827-28. While she has no specific recollection of that day, the Flowsheet shows her relieving Nurse Wissenbach in OR 4 from 9:07 to 9:24 a.m. AR 3828, 3831, 4051. Nurse Wertman was assigned to help set up the operating room, position the patient, and do the initial count with the scrub tech, so she would have been in OR 4 earlier than the Flowsheet shows. AR 3828-29, 4051. These duties required her to be in OR 4 both prior to the patients' arrival (at 8:52 a.m.) and after she arrived. AR 3829-30, 4050.

Nurse Wertman worked with Dr. Olson more than once. AR 3830. She never saw him touch any patient inappropriately. *Id.*

v. Jamie Lynn Roy, OR 4 surgical assistant.

Jamie Lynn Roy is a surgical technician at Kadlec. AR 3185. She scrubs in and sets up the sterile supplies for operations, helps maintain the OR, assists with surgeries, and helps with patient flow.

Id. She did this at various places for seven years. AR 3186. She was in OR 4 on April 1, 2010. AR 3189.

By that time, Roy had worked with Dr. Olson roughly 10 times, but she did not like him. AR 3187-88, 3214. She thought he was condescending. AR 3188. She also thought he had been “rude” towards her. AR 3212. Although she said that he “put up a wall” and was hard to get along with, she did not know that he was married with children, new in town, and knew no one. AR 3212-13.

Roy testified that Dr. Olson was “unusually rough” with patients, by which she meant that “he didn’t really want to take the time to care about his patients” (*i.e.*, she was referring to his “bedside manner”). AR 3188, 3213, 3251, 3256. She told Kadlec’s chief and assistant chief anesthesiologists that Dr. Olson was “rough with patients.” AR 3213. Yet Roy admitted that Dr. Olson was about like other surgeons she had known in this regard. AR 3251-52. Indeed, she testified that, “He was careful not to hurt – physically hurt the patient.” AR 3258. And she admitted that she is never present when Dr. Olson interacts with patients prior to their surgeries. AR 3259.

In sum, in just three short months Roy had concluded that Dr. Olson was not a good anesthesiologist and that she did not like

him, based on virtually no evidence. AR 3214. In addition to telling this to Dr. Olson's superiors, she also told her supervisors and co-workers. AR 3215. Her allegations regarding what occurred on April 1, 2010, are discussed *infra*.

C. April 1, 2010, OR 4 patient identification.

It is crucial to correctly identify the relevant patients. Indeed, as will be further discussed *infra*, Dr. Olson finds himself in these difficulties in part because he discussed Roy's allegations with the police and with Kadlec personnel, and even filed an affidavit, without first looking at the medical records to determine which patients Roy was talking about. Although he was simply confused, MQAC found him not credible.²

On April 1, 2010, Dr. Drosch had four surgeries in OR 4. AR 3681-82. The first surgery was a laproscopic hernia. AR 3291-92, 3682. It has nothing to do with the allegations in this case.

² As will be discussed *infra*, Dr. Olson recognizes that he cannot challenge credibility determinations on appeal. Nonetheless, the Court must understand all of the facts in order to properly analyze the legal issues presented: whether the findings are "highly probable."

His second surgery (on "Patient A")³ was a "Medi-Port" placement scheduled to begin at 9:05 a.m. AR 3292, 3509. Patient A had been diagnosed with a rare appendiceal cancer at age 30. AR 3511-12. The Medi-Port is placed between the collar bone and the top of the breast. AR 3513. Patient A had no history of breast implants, and in part due to her cancer, she was very thin, and no one looking at her would have any question that she did not have breast implants. *See, e.g.*, AR 3200, 3512-13.

Dr. Drosch's third surgery (on "Patient Three") was a mastectomy scheduled at 10:20 a.m. AR 3292. Patient Three had cancer in her left breast. AR 3522. She also had an "unusual medical history": she had breast implants inserted, and then removed a few days later, back in the 1980s. *Id.*

His fourth surgery (on "Patient B") was a wire-localized left-breast biopsy scheduled at 12:10 p.m. AR 3292, 3516, 4112. She had a mass in her left breast that was not palpable, so a wire was placed to indicate the area to be biopsied. AR 3516-17. Patient B also had undergone breast augmentation surgery. AR 3517.

³ Pseudonyms were used in these proceedings (and will be used here) to protect the patients' privacy; but the medical records (in the ARs) do reveal the relevant patients' names, so it may be helpful for the Court to know that the second patient, Patient A, has the initials S.B., mastectomy "Patient Three's" initials are D.H.R., and the fourth patient's ("Patient B's") initials are L.F. AR 3509-10.

D. Roy alleged that Dr. Olson, with Roy, Dr. Droesch, and Nurse Wissenbach (and perhaps others) present, reached over the heads of two patients and “fondled” their breasts for “one-and-a-half to two minutes,” yet no one else saw it, and Roy said nothing to anyone.

i. Layout of OR 4.

There is a drawing of OR 4 at AR 4256, which is attached to this brief as Appendix B, and which fairly accurately depicts the location of some of the staff as they appeared on April 1, 2010. AR 3269. There are also representative photos. AR 4258-84. As these photos show, OR 4 was a large, open room, with no curtains or other obstructions around the operating table. *Id.*

ii. Patient A (Medi-Port).

On April 1, 2010, a nurse reviewed Patient A’s pre-op orders at or around 7:00 a.m.⁴ AR 4024. A specimen was taken at 7:36. AR 4025-26. The pre-op nurse signed off on Patient A’s Pre-Operative Registration Orders at 7:38. AR 4004. Another nurse interviewed her at 7:58. AR 4033. An IV was started at 8:15. AR 4035. The nurse checked her vitals and placed her on a stretcher

⁴ Nurse Wissenbach’s Flowcharts give precise times at which events occurred, so the Patient A and Patient B sections are unusually detailed, minute by minute. See, e.g., AR 3316-17. As explained *infra*, Roy identified the key time for Patient A as the four minutes between 9:02, when Dr. Droesch entered OR 4, and 9:06, when a “time out” was called.

at 8:18. AR 4035-37. Her history and physical were reviewed at 8:30 a.m. AR 216.

Dr. Olson then interviewed Patient A roughly 15 to 30 minutes before she arrived in OR 4 (8:52 a.m.). AR 3295, 3688-89, 4050. Then Nurse Wissenbach interviewed her. AR 3295.

Nurse Wissenbach brought Patient A into OR 4 at 8:52 a.m. AR 3222-23, 4050. Roy, Dr. Olson, and Nurse Wertman were already there. AR 2376-77, 3689, 3829-30. When Patient A arrived, Roy began scrubbing in, preparing sterile instruments, and setting up the sterile field. AR 3191. Nurse Wertman was present for the set up, positioning the patient, and assisting with the initial count. AR 3223-24. Dr. Olson began attaching monitors, preparing medications, checking the anesthesia machine, and generally preparing to induce anesthesia. AR 3690. He then induced anesthesia. AR 829, 3222-23, 4016, 4050. It typically takes from two to four minutes to put the patient under. AR 4389.

Dr. Droesch entered OR 4 at 9:02 a.m. AR 829, 4050. Roy said a "time out"⁵ is usually done right after the patient's skin has been surgically prepped, while they are waiting for the prep to dry.

⁵ A "time out" is an opportunity, just before every surgical procedure, for everyone to verify that they have the correct patient, consent form, procedure, antibiotics, etc. See, e.g., AR 3208, 3274, 3514-15.

AR 3209. Thus, Patient A's surgical prep likely occurred in the four minutes between 9:02 and 9:06, when her time out was called. AR 829, 4037. No one raised any concerns during Patient A's time out. AR 3514, 3737.

The surgery began at 9:07, and ended at 9:37. AR 829, 833. During the surgery, Nurse Wertman relieved Nurse Wissenbach, from 9:07 until 9:24. AR 830. Nurse Wissenbach, Dr. Droesch, Dr. Olson, and Nurse Wertman, each testified that Dr. Olson did nothing unusual or inappropriate at any time before, during, or after Patient A's surgery. AR 3278, 3532, 3697-98, 3830.

But Roy testified that after Dr. Droesch entered OR 4 (at 9:02), and before the time out (at 9:06), Dr. Olson

. . . kind of looked up at the sky and said, "I wonder if this patient has breast implants."

AR 3197; *see also* AR 3242 (Roy says Dr. Droesch was present when this occurred); AR 3209 (Roy says that this occurred before the time out was called at 9:06). She allegedly heard him say this from roughly eight feet away, while Dr. Droesch was only five feet away from Dr. Olson. AR 1694, 3228, 4256. Yet Dr. Droesch denied that Dr. Olson said anything at all about Patient A. AR 3514-16. Nurse Wissenbach does not recall any such comment.

AR 3271-72, 3279. Everyone agreed that no one would suspect that Patient A had breast implants. See, e.g., AR 3200, 3512-13.

Roy also asserted that right after he made this comment, Dr. Olson – who was standing at the head of the operating table – then reached over Patient A's head (AR 3249), and

reached in with both hands grabbing one hand on each breast and started to fondle her breasts inappropriately.

...

And his hands were moving around in a massaging motion for at – **at least a minute and a half to two minutes** of time.

AR 3197, 3198 (emphasis added). Roy was “in shock” and “couldn’t believe what [she] was seeing,” which was “completely unnecessary.” AR 3200. But she said nothing to anyone. *Id.*

Dr. Olson testified that he did not inappropriately touch Patient A. AR 3697-98.⁶ Despite the significant length of time Roy alleged this to have occurred during the four minutes immediately prior to the start of surgery, Nurses Wertman and Wissenbach saw nothing inappropriate. AR 3278, 3830. And Dr. Droesch testified that he saw no inappropriate touching and that, if what Roy said was true, he would have seen it. AR 3532-33.

⁶ Dr. Olson did (mistakenly) make other statements that he did (appropriately) touch Patient A's upper chest, which are discussed *infra*.

iii. Patient Three (mastectomy).

Patient Three was the mastectomy patient with the unusual medical history of having breast implants inserted and removed. AR 3522, 3703. This raised a concern about patient identity for Dr. Olson. AR 3704-05. He noted that Patient Three did not appear to have implants, and he briefly touched her upper chest, about three inches below her clavicle, to confirm her identity. AR 3704-07.

Dr. Droesch confirmed that Patient Three's visual appearance would not indicate whether she had implants, confirmed that Dr. Olson asked about whether she had implants, and confirmed that he told Dr. Olson that she had them removed. AR 3523, 3536, 3548, 3563. Roy did not recall whether this conversation occurred, but she did not deny it. AR 3220-21. No one else testified about this conversation.

Patient Three did testify. AR 3663-77. She is 59 years old and has suffered a number of cancer recurrences. AR 3664. She confirmed having implants inserted and removed within a week in the early 1980s. AR 3666-67. She remembers telling the anesthesiologist not to give her too much medication, but does not recall discussing her surgical history with him. AR 3668. She felt very strongly that if the anesthesiologist (or anyone else) had any

doubts, she would “not have any problem with them touching, checking, fondling [her breasts] to make sure that I am who I am and what is being done to me is being done correctly.” AR 3677.

iv. Patient B (wire-localized biopsy)

Nurse Wissenbach brought Patient B into OR 4 at 12:42 p.m. AR 3307. Patient B had a wire sticking out of her left breast to assist the surgeon in finding the proper place to biopsy. AR 3318, 3335-36. Dr. Olson had an assistant anesthesiology technician, Brad Covington, who assisted with Patient B’s induction, which also began at 12:42 p.m. AR 3307, 4109. A different scrub tech (Penor) had relieved Roy, but she came back in at 12:44. AR 3307-08, 4109. In addition to Nurse Wissenbach, another circulating Nurse (Michael Carter) was also present. AR 3306, 4109. Dr. Droesch entered at 12:53. AR 3308-09. The time out was called at 12:59, the surgery began at 1 p.m., and it ended at 1:22 p.m. AR 3309, 4112-13.

Roy again testified that Dr. Olson improperly touched Patient B (AR 3204):

Dr. Olson said – I believe this time he said that she had breast implants, and he again reached down with both hands, one on each breast, and in a massaging motion, cupping her breasts, nipples in his hands, felt her breasts.

She again said that he did this for “from a minute to two minutes.” AR 3205. Again, she said nothing to anyone. AR 3206.

While he denied these allegations, Dr. Olson testified that he did not have a present recollection of whether he briefly pressed on Patient B’s upper chest to confirm that she did have implants, just as he had done with Patient Three. AR 3714, 3715, 3718, 3733.⁷ None of the five other people in OR 4 (Dr. Droesch, Nurses Wissenbach and Carter, technicians Penor and Covington) testified that Dr. Olson did anything remotely resembling Roy’s allegation. Again, Dr. Droesch saw no such thing, and believes that he would have seen it if it had happened. AR 3531-33.

Nurse Wissenbach heard Dr. Olson state that Patient B (unlike Patient Three) did have breast implants as he briefly touched her upper chest. AR 3339-41. She was standing right next to him at the time. AR 3340-41. Dr. Olson said this testimony was consistent with his best recollection. AR 3730.

None of the other witnesses testified at trial, but in admitted depositions, Nurse Carter stated that he never saw Dr. Olson do anything inappropriate (AR 4407), and anesthesiology tech

⁷ Again, Dr. Olson made other statements without the benefit of reviewing the medical records, which will be discussed *infra*.

Covington said that he worked with Dr. Olson “quite a bit,” but never saw him do anything inappropriate (AR 4390).

v. Roy makes more allegations on April 2.

Roy also alleged that the following day, Friday, April 2, 2010, she was again in OR 4 with Dr. Olson. AR 3206. Two patients had vaginal surgery. AR 3237. Dr. Olson left the head of the table and stood behind the surgeon, watching the surgery for “10 minutes.” AR 3238-39. Roy acknowledged that it is not unusual for anesthesiologists to move around and observe surgeries and check for blood loss, but she nonetheless thought Dr. Olson’s behavior was “creepy.” *Id.* But the two surgeons that day, Doctors Lorenzo and Ortolano, stated that Dr. Olson observed their surgeries for “30 seconds” (Dr. Lorenzo) and perhaps two minutes (Dr. Ortolano). AR 3855, 4344.⁸ Roy first reported her allegations about April 1 on April 2. AR 756-57, 3206, 3236, 3624-25.

⁸ This evidence directly contradicts MQAC’s Finding 1.29, stating that “Dr. Ortolano does not remember the amount of time” Dr. Olson stood at the foot of the table. AR 2364. Nor did Dr. Ortolano deny remembering the amount of time in his deposition. AR 4361-69. He was not asked.

- E. Dr. Olson spoke to Kadlec and police, and even filed an affidavit, without first examining the medical records, and so misstated the facts out of confusion, but later withdrew and corrected those mistaken statements.**

Much was made at the hearing of the fact that Dr. Olson had spoken to various people, and had even filed an affidavit on May 14, 2010, without looking at the patients' medical records to confirm which patients Roy was discussing. See, e.g., AR 3699-3701, 3709-3714, 3721-22, 3905-10, 3919-21, 3926, 3931-33, 3936-37, 3943-44, 3946, 3947-49, 3962-63. Dr. Olson repeatedly testified that in making these various statements, he had mistaken Patient A for Patient Three. See, e.g., AR 3933, 3944.

i. Kadlec call terminating Dr. Olson on April 5.

On April 5, 2010, Dr. Olson was on a ski trip when he received a call from Premier in which a "Hummel" (a Premier Vice President whom Dr. Olson did not know) told him that Premier was terminating his contract. AR 3897. Hummel gave a "laundry list" of reasons, including the way Dr. Olson allegedly spoke to a nurse, concerns about allegedly under-medicating patients, an untimely response to a page, and alleged inappropriate touching of a patient. AR 3898-3900, 3936. Hummel gave Dr. Olson no details. *Id.* Olson had no idea of what Roy was actually alleging at this point. AR 3900.

Dr. Olson resigned. AR 3791. He and his wife had been in the process of moving from Colorado to Washington, but he just went back home to Colorado. AR 3894-95, 3900. He took no medical records with him. AR 3701.

ii. Langston's risk management call on April 9.

On April 9, 2010, Dr. Olson received a conference call from Kadlec's head of risk management, Debra Langston, Christy Arden (legal analyst for risk management), and Dr. Ahuja, head of the anesthesiology group. AR 3408, 3410, 3418, 3620, 3760. The entire conversation lasted five to seven minutes. AR 3422. When Langston said it was about inappropriate touching of two patients' breasts, Dr. Olson immediately said this was a lie. AR 3411.

Langston vaguely testified that she "basically went over both cases" with Dr. Olson. *Id.* Dr. Olson was "understandably . . . upset," defended his "authority" to touch the patients' "breasts" and admitted doing so, and told her they "better not" take this any further. AR 3412-13. Even though Kadlec had access to the medical records and Dr. Olson did not, Langston did not know anything about Patient Three who had her implants removed. AR 3420-21, 3725-26. No one told Dr. Olson the names of the two patients in question. AR 3420, 3782-83.

iii. Detective Shepherd's call on April 22.

Almost two weeks later, on April 22, 2010, Dr. Olson received a call on his cell phone from Detective Roy Shepherd of the Richland Police Department. AR 3350, 4193. Shepherd identified himself and asked whether Dr. Olson was familiar with "these allegations," and Dr. Olson said that he was. AR 36, 3353, 4194. Dr. Olson asked Detective Shepherd if he needed to speak to a lawyer, and Shepherd said he could not advise him on that and just wanted to get Olson's side of the story. AR 36, 3906, 4194.

Detective Shepherd did not refer to any patient by name or to their specific surgical procedures. AR 3353. Rather, Shepherd repeatedly testified that he simply assumed Dr. Olson knew which patients they were referring to because Dr. Olson had already spoken with Debra Langston. AR 3362, 3364-65, 3366, 3367. Shepherd was apparently unaware that Langston did not tell Dr. Olson who the patients were. *Compare* AR 3420, 3782-83 (Langston did not give Olson names) *with* AR 3366-67 (Shepherd assumed Langston told Olson).

Detective Shepherd acknowledged that Dr. Olson repeatedly mentioned the patient who had her breast implants removed, saying he was just checking for implants. AR 3355. But Detective

Shepherd was completely unaware of Patient Three, who had her implants removed. AR 3360. Rather, Shepherd just assumed that Dr. Olson was talking about Patient A, was just "arrogant" (saying he can do anything he wants because he is a doctor and is just "curious"), and was not caring about the patients' concerns. AR 3354, 3380-81, 3388. Shepherd even put Dr. Olson on a speakerphone so that other people in the office could hear the "outlandish" things he was saying about being a doctor entitled to do this. AR 3352, 3358, 3385.

Of course, Dr. Olson was thinking of Patient Three and Patient B when he spoke to Shepherd, not of Patient A. AR 3698-99. Shepherd's report acknowledges that Dr. Olson said he was pressing down on the edge of the "breasts" to check for implants. AR 36, 4194. On April 1, 2010, Dr. Olson was concerned because he had missed the fact that Patient Three had her implants removed and Dr. Droesch had to tell him that, and then Patient B came in, also a cancer patient with a history of breast implants, a highly unusual coincidence. AR 3716. This is what he was trying to convey to Detective Shepherd, who "threw me a curve" by talking about a 30-year-old cancer patient getting a Medi-Port, when Dr.

Olson was only remembering the two older patients with breast cancer. AR 3716, 3722.

But Dr. Olson acknowledged, "if I would have had any sense I wouldn't have spoken to him at all. I would have just said, you know, I need to talk to an attorney." AR 3722. He hired a lawyer the next day. AR 3910.

iv. MQAC summarily suspended Dr. Olson *ex parte*, and rushed through a grossly inadequate investigation.

The Richland police first called MQAC on April 22, 2010. AR 3840. Investigator Denise Gruchalla was assigned to the case the next day. *Id.* She received Detective Shepherd's report on April 26, 2010. AR 4333.

Gruchalla acknowledged that MQAC's "modus operandi" is "to charge first and ask questions second." AR 676, 3860-61. On April 30, 2010, MQAC filed an Ex Parte Motion for Order of Summary Action, seeking summary suspension. AR 19-22. Yet Gruchalla did not even interview Roy until May 3, 2010. AR 4334. That day, Dr. Olson was summarily suspended without warning. AR 3-6.

Of the 13 significant witnesses,⁹ Gruchalla interviewed only six: Roy, Nurse Wissenbach, and the four doctors. AR 3841-43, 3847, 3848, 3850, 3855, 4334. Wissenbach never saw Dr. Olson inappropriately touching anyone. AR 3845-46, 4337-38. She confirmed that she and Dr. Olson talked about Patient B's implants, but she did not see any inappropriate touching. AR 3283, 3311.

On May 12, Dr. Olson denied Roy's assertions, but (again without ever seeing Patient Three's records or the surgery schedule) asserted that he was concerned about the absence of breast implants in Patient A, and raised the issue with Dr. Droesch. AR 3848-50.¹⁰ On May 18, Dr. Droesch confirmed that – as to Patient Three, not Patient A – Dr. Olson had asked him about her missing implants, and Droesch explained that she had them removed. AR 3850-51, 4335.

At this point, Gruchalla did not bother to go back to Roy or to Olson and clarify whether they were actually talking about two different patients. AR 3851. “[W]e just did not pursue that.” *Id.* Her entire investigation took roughly four weeks. AR 4333-36.

⁹ Roy; Nurses Wissenbach, Wertman, and Carter; Drs. Droesch, Olson, Ortolano and Lorenzo; assistants Penor and Covington; patients A, Three, and B.

¹⁰ As discussed immediately below, Dr. Olson also filed a similarly mistaken declaration on May 14, 2010.

- v. **Again without looking at the medical records, Dr. Olson filed a mistaken declaration, which he later withdrew based on the medical records.**

In response to his summary suspension, Dr. Olson filed a declaration on May 14, 2010. AR 4208-12. He did not have any medical records when he signed this declaration. AR 3710. He mistakenly stated that Patient A, who was in for a Medi-Port, had previously had implants inserted and removed. AR 4209-10. Just before the patient was sterilized for surgery, he asked Dr. Droesch about the absence of implants while simultaneously briefly touching the upper chest for less than five seconds. *Id.* As noted above, Dr. Droesch reported that this conversation occurred as to Patient Three, not Patient A, and no one but Roy heard Dr. Olson say anything about Patient A, who had no history of breast implants.

As to Patient B, the May 14 declaration correctly identifies her as the patient in for a breast biopsy, and acknowledges that just before her surgical prep, Dr. Olson briefly touched her upper chest to confirm the presence of implants. AR 4210. Again as noted above, Nurse Wissenbach confirmed this occurrence, said she was standing right next to Dr. Olson when it happened, and did not find it inappropriate. AR 3339-41. Dr. Olson also declared that his sole

purpose in briefly touching the patients was to insure patient identity. AR 4210.

Dr. Olson first obtained some medical records in this case on June 2, 2010. AR 4359. On June 4, 2010, the hearing on MQAC's charges was scheduled for July 8, 2010. AR 349.¹¹ On June 18, 2010, Dr. Olson filed a supplemental declaration and a motion to dismiss the charges. AR 4359-60. The motion to dismiss was denied. AR 1785.

This motion was also addressed as a summary judgment motion, and was properly denied due to questions of fact. AR 1786-87. But the ALJ also reached the faulty conclusion that the "ultimate issue . . . is which one of two individuals is credible or more credible." AR 1786. As further discussed *infra*, this hearing obviously involved the credibility of more than just two witnesses.

Dr. Olson's declaration (signed June 17, 2010) explained that after he obtained and reviewed some medical records, he realized that his prior statements had mistakenly attributed his recollections about Patient Three to Patient A. AR 4360. His prior

¹¹ Dr. Olson eventually had to move to compel for records regarding Patient Three and for discovery on several other witnesses. *See, e.g.*, AR 1668-69. The ALJ extended the discovery cutoff to July 6, 2010, to allow this discovery. *Id.*

statements are, however, consistent with Dr. Droesch's statements regarding Patient Three. AR 4359. Therefore, "I hereby withdraw all statements made under this mistaken belief." AR 4360.

F. Procedural History.

i. Expert Witnesses.

a. MQAC's expert, Dr. Kennard, could not imagine Roy's allegations happening.

At the hearing, the parties presented two expert witnesses, Doctors Scott Kennard and John Ebert, and a report from Dr. Jennifer Wheeler. MQAC presented Dr. Kennard, a board-certified anesthesiologist who essentially testified on direct that there was no medical or treatment reason for Dr. Olson to palpate the patients' breasts. See, e.g., AR 3438-39, 3446, 3454. But on cross, Dr. Kennard admitted that it is quite normal for anesthesiologists to touch around patients' breasts. AR 3453. He also acknowledged that if Dr. Olson did what Nurse Wissenbach testified he did, that would not be unprofessional conduct. AR 3456. And on redirect, he acknowledge that if a person's physical appearance was inconsistent with their history and physical (as with Patient Three) that is clearly an identification issue, and "would be quite frightening." AR 3459-60.

Crucially, under questioning from the panel, Dr. Kennard – MQAC’s own expert – testified that he could not imagine someone openly palpating a patient’s breasts in the operating room for 90 seconds. AR 3474-76. Even ten seconds would be “a long time.” AR 3475. “[B]ut 90 seconds . . . I just can’t imagine – .” AR 3476.

b. Dr. Ebert said Roy’s allegations were simply “Impossible.”

Dr. Olson presented Dr. John Ebert, a board-certified anesthesiologist. AR 3568. He has participated in administering the oral exam for board certification, and edited the written exam for 25 years. *Id.* He is also a tenured professor who has taught at institutions like Duke and the Mayo Clinic. AR 3568-69. He has also authored numerous articles and textbook chapters. AR 3569. He is also a full-time practicing clinician. AR 3591.

Dr. Ebert testified that if a patient’s identity is in question, it is incumbent on the anesthesiologist (or any physician in the OR) to obtain verification, up to and including physically examining the patient. AR 3571. He opined that if Dr. Olson did what he said – and what Nurse Wissenbach confirmed – touching the patients’ upper chest for five to ten seconds, that is not unprofessional conduct. AR 3573.

Dr. Ebert also testified that as to Roy's allegations regarding the vaginal surgeries on April 2, (a) that he would tend to accept the two surgeons' estimates (30 seconds and two minutes), over the scrub tech's estimate (10 minutes); (b) that the shorter period is not unprofessional; and (c) that for an anesthesiologist new to a hospital like Dr. Olson, even ten minutes would not be unprofessional, as the anesthesiologist needs to learn how long these surgeons may take to complete a surgery to properly administer anesthetic. AR 3574-78. He further noted that he would rely on the surgeons over a "scrub tech who's giving incredible time estimates on more than one occasion." AR 3594.

When asked whether it was reasonable or logical to believe that Dr. Olson could have massaged both breasts of any patient for one-and-a-half to two minutes without being seen by any of the three-to-six medical personnel in OR 4, he said one word: "Impossible." AR 3579. He later stated that he did not "believe that examining a patient's breasts for ninety seconds to two minutes is possible without being observed by anybody else who's present in the room," largely because "an operating room is like a fishbowl" with the patient at the center and everyone else there to observe her. AR 3608-09. He concluded that Dr. Olson poses no threat to

patient safety, committed no sexually motivated act, and committed no act of moral turpitude. AR 3579.

- c. **Dr. Wheeler opined that there is no indication of sexual motivation or deviancy, and no basis to restrict Dr. Olson's right to practice medicine.**

Dr. Jennifer Wheeler, Ph.D, is a licensed psychologist and certified sex offender treatment provider. AR 1896. She performed a confidential psychosexual evaluation on Dr. Olson, at Dr. Olson's request. AR 1880-1896. Dr. Wheeler's report is sworn under penalty of perjury. AR 1896. She reviewed much of the evidence (other than testimony) presented in this case. AR 1881-82. Based on this review, together with roughly five hours of interviews with Dr. Olson, and interviews with his wife, colleagues, neighbors, and friends, and a battery psychological testing, Dr. Wheeler found no evidence of maladaptive sexual behavior and no psychological foundation for recommending any restrictions on his right to practice medicine. AR 1888-1996.

- ii. **MQAC believed Roy and disbelieved Dr. Olson, but failed to enter any findings regarding any other witnesses.**

Following the Presiding Judge's erroneous legal conclusion that the "ultimate issue in this case is which one of two individuals is credible or more credible, namely . . . Dr. Olson . . . or . . . Jamie

Roy” (AR 1786), the Panel entered findings that Roy was credible and that Dr. Olson was not credible (AR 2358-59, 2361-63), yet it entered no findings or conclusions as to the credibility of any of the other witnesses. AR 2350-71. MQAC concluded that there was clear, cogent and convincing evidence that Dr. Olson committed unprofessional conduct under RCW 18.130.180(7) (by violating WAC 246-919-630(2)(e) – “Sexual misconduct”) and RCW 18.130.180(24) (“Abuse of a client or patient or sexual contact with a client or patient”). AR 2366.

MQAC also determined that the Department failed to establish unprofessional conduct under RCW 18.130.180(1), involving the “commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person’s profession, whether it constitutes a crime or not.” It is obviously difficult to reconcile this conclusion with MQAC’s conclusion that Dr. Olson committed “sexual misconduct” with and “abused” patients.

In any event, MQAC suspended Dr. Olson’s license until he completed certain training. AR 2368-69.

iii. The trial court affirmed MQAC.

The trial court affirmed. CP 317-18. Dr. Olson timely appealed. CP 319-23.

ARGUMENT

A. Standard of Review.

The Washington Administrative Procedure Act (APA), Chapter 34.05 RCW, governs judicial review of disciplinary proceedings under the Uniform Disciplinary Act. RCW 18.130.100. Dr. Olson bears the burden of establishing the decision is invalid under one or more of the criteria under the APA. RCW 34.05.570(1)(a). Here, MQAC's Findings, Conclusions and Order (RCW 34.05.570(3)):

(a) . . . is in violation of constitutional provisions on its face or as applied;

(c) The agency has engaged in unlawful procedure or decision-making process, or has failed to follow a prescribed procedure;

(d) The agency has erroneously interpreted or applied the law;

(e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;

(f) The agency has not decided all issues requiring resolution by the agency; [and]

(i) The order is arbitrary or capricious.

In reviewing these challenges, this court "sits in the same position as the superior court, applying the standards of the WAPA directly

to the record before the agency.” *Tapper v. Employment Sec. Dep’t*, 122 Wn.2d 397, 402, 858 P.2d 494 (1993).

As noted above, the standard of proof below was clear, cogent and convincing evidence. As further discussed *infra*, the evidence presented here did not come close to meeting the “highly probable” test, and the findings are completely inadequate to permit review. The Court should reverse and remand for a new hearing.

B. The standard of proof and the APA together require findings as to all of the witnesses who contradicted the sole witness who testified that Dr. Olson committed unprofessional conduct.

“The function of a standard of proof ... is to ‘instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.’” *Nguyen*, 144 Wn.2d at 524 (quoting *Addington v. Texas*, 441 U.S. 418, 423, 99 S. Ct. 1804, 60 L. Ed. 2d 323 (1979) (quoting *In re Winship*, 397 U.S. 358, 370, 90 S. Ct. 1068, 25 L.Ed.2d 368 (1970) (Harlan, J., concurring))). But if the standard of review is not enforced on appeal, factfinders may consider themselves free to ignore it.

Normally, this Court reviews findings for substantial evidence, and where, as here, the burden of proof is clear, cogent

and convincing evidence, then the evidence must be so substantial that the trier could reasonably find the fact to be “highly probable.” See, e.g., ***In re Det. of LaBelle***, 107 Wn.2d 196, 208-09, 728 P.2d 138 (1986):

the evidence must be more substantial than in the ordinary civil case in which proof need only be by a preponderance of the evidence, in other words, the findings must be supported by substantial evidence in light of the “highly probable” test. Accordingly, we will not disturb the trial court's findings . . . if supported by substantial evidence which the lower court could reasonably have found to be clear, cogent and convincing.

(quoting ***In re Pawling***, 101 Wn.2d 392, 399, 679 P.2d 916 (1984));

Sego, 82 Wn.2d at 739:

the question to be resolved is not merely whether there is “substantial evidence” to support the trial court’s ultimate determination of the factual issue but whether there is “substantial evidence” to support such findings in light of the “highly probable” test.

Division One may have refused to apply this appropriate standard of review (at least) twice, stating both that the APA says findings are reviewed for “substantial evidence” and also (without analysis) that the Legislature establishes the standard of review. See ***Faghih v. Dep’t of Health***, 148 Wn. App. 836, 850, 202 P.3d 962, *rev. denied*, 166 Wn.2d 1025 (2009) (citing ***Ancier v. Dep’t of Health***, 140 Wn. App. 564, 573 n.12, 166 P.3d 829 (2007) (citing RCW 18.130.100 (saying the APA applies) and “see also RCW

34.05.570(3)(e)” (discussed *infra*). Division One’s conclusion appears to be legally and factually incorrect.

Legally, separation of powers should preclude the Legislature from dictating the *appellate* standard of review. The Legislature has never purported to overrule **Sego** or its progeny, and implied overrulings are disfavored. See, e.g., **State v. Ervin**, 169 Wn.2d 815, 825, 239 P.2d 354 (2010) (citing **State v. Bobic**, 140 Wn.2d 250, 264, 996 P.2d 610 (2000)). And where the Supreme Court first required the clear, cogent and convincing standard in its 2002 **Nguyen** decision, a pre-existing APA standard cannot control.

Factually, the APA simply says that one of the challenges that an appellant may bring is that the evidence is not substantial in light of the whole record (RCW 34.05.570(3)(e)):

The court shall grant relief from an agency order in an adjudicative proceeding only if it determines that:

...

(e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;

This says nothing about what test this Court should apply in determining whether the evidence is substantial. **Sego** answers that question: the highly probable test.

Of course, appellate courts do not second-guess credibility determinations or reweigh evidence, so the factfinder must find the evidence “highly probable.” See, e.g., **Sego**, 82 Wn.2d at 739-40. Nonetheless, where, as here, the **Nguyen** Court has required clear, cogent and convincing evidence, the evidence must support a reasonable conclusion that a given finding is highly probable. Here, the key findings are highly improbable at best, and there are no findings at all regarding a great deal of material evidence.

Under RCW 34.05.461(3), “final orders shall include a statement of findings and conclusions, and the reasons and basis therefor, on **all the material issues of fact**,” and “**Any** findings based substantially on credibility of evidence or demeanor of witnesses shall be so identified.” (Emphasis added). MQAC fails to make findings on **most** of the material issues of fact in this case or to give reasons or bases, and fails to explain its credibility determinations with regard to the many witnesses who contradicted Roy's testimony. Without any of this, an appellate court simply cannot determine whether the evidence was substantial, *i.e.*,

sufficient to persuade a fair-minded, rational person of the truth of the declared premise in light of the highly probable standard. See, e.g., **Bering v. Share**, 106 Wn.2d 212, 220, 721 P.2d 918 (1986) (substantial evidence standard); **Sego**, 82 Wn.2d at 739.

As further discussed below, the complete lack of sufficient findings as to numerous independent witnesses' material testimony renders MQAC's decision indecipherable, unsupported, and insupportable. This Court should reverse and remand for a new hearing and proper findings.

C. MQAC erred in ruling that this case was simply about which of two witnesses was credible, or more credible.

Credibility determinations are solely for the trier of fact. But the issue here is whether MQAC properly entered findings as to all material facts and credibility determinations as the APA requires. While MQAC may properly determine whether Dr. Olson or Roy was more credible, that is only one of the material issues in this case. Where, as here, it is not just one witness's word against another's, but one witness' word against a great many witnesses' words, against the great weight of the evidence, and frankly against simple common sense, two credibility findings cannot amount to

clear, cogent and convincing evidence that this highly improbable allegation actually occurred.

For instance, Dr. Droesch said three key things that directly contradict Roy's testimony and directly support Dr. Olson's testimony: (1) if what Roy said happened actually did happen, he would have seen it; (2) he and Dr. Olson had no conversation at all about Patient A; and (3) he and Dr. Olson did discuss the only patient who had implants inserted and removed, Patient Three. Did MQAC believe or disbelieve Dr. Droesch? He plainly had no reason to dissimulate for a former anesthesiologist whom he worked with only a few times. Without a finding or any reasoning at all, this Court cannot even review whether it is highly probable that what Dr. Droesch said is false, much less whether it is highly probable that what Roy said is true.

Similarly, Nurse Wissenbach said (1) she never saw Dr. Olson touch any patient inappropriately, and (2) she was standing right next to Dr. Olson when he confirmed that Patient B did have implants while briefly touching her upper chest, which she did not find inappropriate. Since this directly contradicts Roy's testimony on obviously material factual issues, RCW 34.05.570(3)(e) required

findings as to why MQAC did not accept her testimony. Again, Nurse Wissenbach had no reason to lie.

The same is true for Nurse Wertman. She did not recall Dr. Olson saying anything about Patient A, directly contradicting Roy's assertion that Dr. Olson said it loud enough for her to hear eight feet away. Wertman also saw nothing inappropriate. Did MQAC reject her testimony? This Court has no way to know.

As **both parties'** experts testified, Roy's allegations are unimaginable, and frankly impossible. Why did MQAC refuse to accept either expert's testimony? Without findings or other explanations, this Court has nothing to review.

This Court should reverse and remand for a new hearing, requiring proper findings as to all material facts, particularly the many witnesses who contradicted Roy. Anything less violates the APA and makes it impossible to review whether there is "highly probable" evidence supporting MQAC's findings. That is, this order violates Dr. Olson's constitutional right to due process under **Nguyen** by permitting MQAC to take his license without proper findings and adequate appellate review under the proper standards, fails to follow the prescribed procedure to make findings on all material facts and credibility determinations; misinterprets and

misapplies the law requiring findings on all material facts; fails to decide all issues requiring resolution by the agency; and simply renders the order arbitrary and capricious. RCW 34.05.570(3).

D. MQAC's "charge first ask questions second" rush to judgment also deprived Dr. Olson of due process.

A "fair trial in a fair tribunal is a basic requirement of due process." *Withrow v. Larkin*, 421 U.S. 35, 46, 95 S. Ct. 1456, 43 L. Ed. 2d 712 (1975) (citing *In Re Murchison*, 349 U.S. 133, 136, 75 S. Ct. 623, 99 L. Ed. 942 (1955)). "This applies to administrative agencies which adjudicate as well as to courts." *Id.* at 46-47 (citing *Gibson v. Berry-Hill*, 411 U.S. 564, 579, 93 S. Ct. 1689, 36 L. Ed. 2d 488, (1973)). This due process principle is codified in CrR 8.3(b), permitting a court to dismiss a criminal prosecution where there is (1) arbitrary conduct or governmental misconduct, and (2) prejudice to the accused. *State v. Michielli*, 132 Wn.2d 229, 239-40, 937 P.2d 587 (1987). A license revocation proceeding is "quasicriminal" in nature, and should be afforded the same sort of due process protections. See, e.g., *Nguyen*, 144 Wn.2d at 523 (citing *Wash. Med. Disciplinary Bd. v. Johnston*, 99 Wn.2d 466, 474, 663 P.2d 457 (1983)).

Arbitrary conduct, or governmental misconduct, “need not be evil, venal, or dishonest; simple mismanagement is sufficient.” ***State v. Stephans***, 47 Wn. App. 600, 603, 736 P.2d 302 (1987); see also ***State v. Price***, 94 Wn.2d 810, 814, 620 P.2d 994 (1980) (fail[ure] to act with due diligence, [such that] material facts are . . . not disclosed to defendant until shortly before a crucial stage in the litigation process”). Here, the rush to judgment was palpable. Gruchalla admitted that her “modus operandi” is to charge first, ask questions second.

Guchalla questioned fewer than half of the eye witnesses. She began her investigation in early May, and Dr. Olson suffered a deprivation of his right to practice medicine only two months later. Gruchalla discovered that Dr. Olson had the precise conversation with Dr. Droesch that he said he had, but as to Patient Three rather than Patient A. Yet Gruchalla never went back and tried to determine whether Dr. Olson or Roy was simply mistaken about which patient they were discussing.

Dr. Olson did not even receive the medical records in this case until approximately a month before the hearing. He had to move to compel just a few weeks before the hearing to obtain Patient Three’s records – Gruchalla did not even know Patient

Three existed. There are also many discrepancies between her report and the witnesses' statements. See, e.g., AR 748-50. None of this is consistent with due process.

Dr. Olson raised these concerns in his motion to dismiss. See AR 738-43. He argued these points under both the due process analysis discussed above, and under the appearance of fairness doctrine. *Id.* A doctor with 30 years of distinguished service as a physician, who literally treated, cared for, and even saved the lives of thousands of patients, should not be deprived of his right to practice medicine based on flimsy allegations that are so improbable as to be impossible. This is flagrant disregard for due process. This Court should reverse and dismiss.

E. MQAC's "unprofessional conduct" and sanctions conclusions misapply the law and are totally unsupported by findings, much less clear, cogent and convincing evidence.

MQAC concluded that Dr. Olson committed unprofessional conduct under RCW 18.130.180(7) (by violating WAC 246-919-630(2)(e) – "Sexual misconduct") and RCW 18.130.180(24) ("abuse of a client or patient or sexual contact with a client or patient"). AR 2366. To justify its lengthy suspension and supervision, it also

concluded that in he engaged in “forceful contact” under WAC 246-16-830. AR 2367. None of these conclusions is correct.

The WAC forbids “[t]ouching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment.” WAC 246-919-630(2)(e). Literally no one testified that Dr. Olson had any sexual motivation when he touched these patients. There is not a scintilla of evidence in this record that Dr. Olson touched either patient “for any purpose other than appropriate examination or treatment.”

The only purpose for the touching stated anywhere in this record is Dr. Olson’s repeated and consistent insistence that he was touching these patients solely to ensure their identities. Doctors Ebert and Kennard both testified that there are legitimate reasons to touch a patient’s upper chest, especially if there is any doubt that the patient whose breast is about to be cut off is the correct patient. While there is certainly testimony that doing what Roy claimed would be inappropriate, and perhaps there could even be an inference that doing what Dr. Olson said he did is not “best practices,” that does not substitute for clear, cogent and convincing evidence that his purpose was other than appropriate.

As for “abuse,” Patient Three testified she was not offended by even “fondling” to ensure that she was the right patient. While “sexual contact with a . . . patient” might be proved by sexually motivated touching while the patient was unconscious, no one testified that Dr. Olson had any sexual motivation. On the contrary, Dr. Wheeler’s report provided uncontradicted evidence consistent with Dr. Olson’s testimony – and everyone else’s – that there is no evidence of sexual motivation or purpose here.

Finally, MQAC relied on a “sanction schedule” that lists “**severe** physical, verbal or forceful contact . . . that results in or risks significant harm or death” to impose the longest recommended suspension or supervision. See AR 2367 (citing WAC 246-16-830) (emphasis added). No evidence in this record – and certainly no finding – shows “severe physical . . . or forceful contact,” regardless of whether the patients were unconscious. And there is no evidence of even a risk of significant harm or death, much less actual significant harm or death.

Again, MQAC failed to enter any findings showing that it is “highly probable” that Dr. Olson committed “sexual misconduct” or “abused” any patient, much less engaging in “severe . . . forceful

contact" that risked or caused significant harm or death. This Court should reverse and dismiss.

CONCLUSION

For the reasons stated, this Court should reverse and dismiss, or reverse and remand for a new hearing.

RESPECTFULLY SUBMITTED this 5th day of December, 2012.

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CERTIFICATE OF SERVICE BY MAIL

I certify that I caused to be mailed, a copy of the foregoing **BRIEF OF APPELLANT** postage prepaid, via U.S. mail on the 5th day of December 2012, to the following counsel of record at the following addresses:

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Attorney for Appellant

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION**

In the Matter of:)	
)	Master Case No. M2010-471
LLOYD V. OLSON, M.D.,)	
Credential No. MD00034954,)	FINDINGS OF FACT,
)	CONCLUSIONS OF LAW
Respondent.)	AND FINAL ORDER
_____)	

APPEARANCES:

Respondent; Lloyd V. Olson, M.D., by
Garvey Schubert Barer, per
Roger L. Hillman, David H. Smith, and Heidi L. Craig, Attorneys at Law

Department of Health Medical Program (Department), by
Office of the Attorney General, per
Tracy L. Bahm and Marlee B. O'Neill, Assistant Attorneys General

COMMISSION PANEL: Susan Harvey, M.D., Panel Chair
Michael Concannon, J.D., Public Member
Frank Hensley, Public Member
Samuel Selinger, M.D.

PRESIDING OFFICER: John F. Kuntz, Review Judge

A hearing was held in this matter on July 8, 9, and 16, 2010, regarding allegations of unprofessional conduct. License suspended pending completion of specified terms and conditions.

ISSUES

Did the Respondent commit unprofessional conduct as defined in RCW 18.130.180(1), (7), and (24), and WAC 246-919-630(2)(e)?

If the Department proves unprofessional conduct by clear and convincing evidence, what sanctions are appropriate under RCW 18.130.160?

FINDINGS OF FACT,
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APPENDIX A

SUMMARY OF THE PROCEEDING

At the hearing, the Department presented the testimony of Lloyd V. Olson, M.D., the Respondent, as an adverse witness; Scott C. Kennard, M.D., expert witness; Jamie Roy, Surgical Technologist; John T. Droesch, M.D.; Amber Wissenbach, R.N.; Robin Leigh Kloth, M.D., testified by telephone; Deeraj Ahuja, M.D., testified by telephone; Debra Langston, Risk Manager, testified by telephone; Detective Roy E. Shepherd, Richland Police Department; and Detective John E. Hansens, Richland Police Department, testified by telephone.

The Respondent also testified in his case in chief and presented the testimony of John Peter Ebert, D.O., expert witness, testified by video; Natalie Wertman, R.N., testified by telephone; Denise J. Gruchalla, PA-C; and Patient Three, testified by telephone.

The Presiding Officer admitted the following Department exhibits at hearing:

- Exhibit D-1: Patient A's treatment records.¹
- Exhibit D-2: Patient B's treatment records.
- Exhibit D-3: Operating Room Schedule, dated April 1, 2010.
- Exhibit D-4: Kadlec Regional Medical Center (Kadlec) Department Specific Policy and Procedures, Pre-Operative Patients Teaching, April 2009.
- Exhibit D-5: Kadlec Department Specific Policy and Procedures, Admission of Surgical Patients, April 2009.

¹ The identity of the patients (Patient A and Patient B) is confidential and is not to be released without the consent of the named individual or individuals. RCW 42.56.240(1).

Exhibit D-6: Kadlec Department Specific Policy and Procedures, Universal Protocol, Operative/Procedural, and Site/Side Verification.

Exhibit D-7: Incident/Investigation Report of Detective Roy E. Shepherd, Richland Police Department, dated April 29, 2010.

Exhibit D-8: Declaration of Dr. Lloyd V. Olson, dated May 14, 2010.

Exhibit D-9: Curriculum Vitae of Dr. Scott Kennard.

The Presiding Officer admitted the following Respondent exhibits at hearing:

Exhibit R-1: Drawing of OR No. 4 by Dr. Robin L. Kloth (Deposition Exhibit 1).

Exhibit R-2: Drawing of OR No. 4 by Jamie Roy (Deposition Exhibit 16).

Exhibit R-3: Drawing of OR No. 4 by Jamie Roy (Deposition Exhibit 17).

Exhibit R-4: Color photographs of OR No. 4 (Deposition Exhibit 18).

Exhibit R-7: Email chain starting April 4, 2010, between Drs. Kloth and Ahuja and Norb Hummell (Deposition Exhibit 2, pages INV 00545-546).

Exhibit R-8: Internal Investigation Summary (time line) prepared by Kadlec (Deposition Exhibit 9, pages INV 00482-488).

Exhibit R-9: Medical Records of Patient A (Joint Exhibit with Department Exhibit D-1).

Exhibit R-10: Medical Records of Patient B (Joint Exhibit with Department Exhibit D-2).

Exhibit R-11: Medical Records of Patient 3.²

² The identity of Patient Three is confidential and is not to be released without the consent of the named individual. RCW 42.56.240(1)

- Exhibit R-12: Kadlec Surgery Schedule for April 1, 2010, (Deposition Exhibit 10, page INV 00807).
- Exhibit R-13: Kadlec Surgery Schedule for April 2, 2010, (page INV 00809).
- Exhibit R-14: Medical Quality Assurance Commission's June 4, 2010, "Confidential Investigative Report."
- Exhibit R-18: Denise Gruchella's Memorandum to File re her May 3, 2010 telephone interview with Amber Wissenbach (page INV 00555-557).
- Exhibit R-19: Amber Wissenbach's May 4, 2010 written statement (pages INV 00533-536).
- Exhibit R-21: Jamie Roy's May 3, 2010 written statement (page INV 00530-532).
- Exhibit R-23: Debra Langston's May 4, 2010 written statement (pages INV 00537-538).
- Exhibit R-25: Christy Arden's May 5, 2010 written statement (pages INV 00539-540).
- Exhibit R-26: Denise Gruchella's Memorandum to File re her May 5, 2010 telephone interviews of Drs. Lorenzo and Ortolano (page INV 00565).
- Exhibit R-27: Dr. Robin Kloth's May 6, 2010 written statement (pages INV 00541-544).
- Exhibit R-35: April 30, 2010 memo to the file produced by Kadlec's 30(b)(6) deponent, Ms. Arden (part of Deposition Exhibit 14).
- Exhibit R-44: Curriculum Vitae of Respondent Expert John Peter Ebert, D.O.
- Exhibit R-45: Supplemental Declaration of Lloyd V.E. Olson, date stamped received June 18, 2010.
- Exhibit R-46: Deposition upon Oral Examination of Alexander Ortolano, M.D., dated June 10, 2010.

Exhibit R-47: Deposition upon Oral Examination of Richard Lorenzo, M.D., dated June 10, 2010.

Exhibit R-48: Deposition upon Oral Examination of Brad Covington, dated June 29, 2010.

Exhibit R-49: Deposition upon Oral Examination of Michael Carter, dated June 29, 2010.

I. FINDINGS OF FACT

1.1 On June 9, 1997, the state of Washington issued the Respondent a credential to practice as a physician and surgeon. In April 2010, the Respondent was employed by Premier Anesthesia, which has a contract to provide anesthesiology services to Kadlec in Richland, Washington.

General Duties of Anesthesiologist

1.2 An anesthesiologist is a physician who administers an anesthetic agent to a patient to cause the patient's partial or complete loss of consciousness. The anesthetic agent may be given by injection or inhalation. The anesthesiologist is part of the medical team providing care to a patient during surgical procedures.

1.3 An anesthesiologist performs his or her duties at three separate stages of a surgical procedure. In the first (or pre-surgical) stage, the anesthesiologist speaks with the patient prior to surgery to ensure the identity of the patient (whether it is the patient scheduled for the surgery in question) and the surgical procedure (whether it is the correct procedure for that patient). The anesthesiologist also verifies the patient's identity by examining the patient's wrist band.

1.4 The anesthesiologist reviews the patient's medical records (known as the history and physical) with the patient to determine whether the patient has a prior

surgical history and whether the patient has any medicine or anesthesia sensitivities. The anesthesiologist then conducts a basic examination (checks the patient's heart and lungs) to confirm that the patient can tolerate the anesthesia being used during the scheduled surgery.

1.5 In the second (or surgical) stage, the anesthesiologist induces the anesthetic agent (gives the patient the intravenous or inhalation agent). Inhalation agents are delivered through a laryngeal mask or through the use of a tube (called intubation) inserted in the trachea. During the surgery the anesthesiologist monitors the patient's unconscious state by monitoring the patient's blood pressure and oxygen levels. During the second stage, the anesthesiologist spends most of his or her time at the head of the surgical table to monitor the equipment used to monitor the patient's condition while in the unconscious state. An anesthesiologist may leave the head of the surgical table to observe the procedure being performed, normally at the request of the surgeon. The anesthesiologist may also walk to the foot of the surgical table to monitor or observe the amount of the patient's blood loss resulting from the surgical procedure.

1.6 Prior to the second (or surgical) stage, it is standard practice in every surgery to conduct what is known as a "time out" procedure. In the time out procedure, the surgeon asks the entire surgical team (including the anesthesiologist, circulating nurse, and surgical technician) to stop whatever that team member is doing to verify the identity of the patient on the operating table and identify the surgical procedure scheduled for that patient. The time out procedure takes place after the patient is placed under anesthesia (rendered unconscious) and prior to the initiation of surgery.

This time out process allows any member of the surgical team to stop the surgery from going forward if there is any doubt regarding the identity of the patient or procedure.

1.7 In the third (post-surgical) stage, the anesthesiologist conducts a post-surgical examination of the patient to ensure that the patient is recovering from (regaining consciousness) the anesthetic agent. The anesthesiologist will also address any of the patient's pain issues arising from the surgery by prescribing pain relieving medication (if the anesthesiologist has not already addressed this issue during the pre-surgical phase of the procedure).

April 1, 2010 Surgical Schedule

1.8 On April 1, 2010, John Droesch, M.D., was scheduled to perform four surgeries at Kadlec in Richland, Washington. The surgeries were conducted in the following order: a hernia surgery; a mediport placement (Patient A); a mastectomy³; and a wire localized breast biopsy (Patient B). The Respondent was the anesthesiologist for all four of Dr. Droesch's surgeries.

Patient A

1.9 Patient A, a 30-year-old-female, was scheduled for the surgical placement of a mediport for use in the chemotherapy treatment of her stage 4 cancer. The mediport is a catheter (tube) inserted into the patient's vein to permit the insertion of the chemotherapy agent. The placement of the mediport was just below Patient A's clavicle

³ During the hearing, the mastectomy patient was identified (for confidentiality purposes) as Patient Three. See Exhibit R-11.

(or collarbone) on her left side. The Respondent was the anesthesiologist assigned to the case.

1.10 The Respondent met with Patient A prior to her entering the operating room to review the patient's chart (including the patient's history and physical status) with Patient A. At this pre-surgical stage, the Respondent did not raise any concerns regarding Patient A's identity or what surgical procedure was being performed. Patient A's chart, specifically Patient A's surgical history, does not reveal any history of breast augmentation (breast implant) surgery. Patient A did not have any scars that would suggest breast augmentation surgery. Dr. Droesch described Patient A as thin in appearance and a visual inspection clearly revealed that Patient A did not have any breast augmentation. The Respondent intubated Patient A and took her to the operating room for the scheduled surgery.

1.11 The Respondent administered anesthesia to render Patient A unconscious. Prior to beginning surgery, Dr. Droesch initiated the time out process so that the surgical team could verify the presence of the correct patient (Patient A) and the correct surgical procedure (the mediport placement). The Respondent did not raise any issues regarding Patient A's identity (or scheduled surgery) with Dr. Droesch during the time out process. Having received confirmation of the patient and procedure, Dr. Droesch performed the mediport placement surgery on Patient A.

1.12 The surgical technician assigned to Patient A's surgery was Jamie Lyn Roy. Ms. Roy knew or was familiar with Patient A's treatment history because of Patient A's rare type of cancer. Ms. Roy and Patient A are approximately

the same age and both have children. Ms. Roy related to or felt an emotional bond with Patient A for these reasons.

1.13 As the surgical technician, Ms. Roy was present in the operating room throughout Patient A's surgery. Ms. Roy had an unobstructed view of Patient A (who was unconscious) on the operating table. Prior to the beginning of the mediport surgery, Ms. Roy saw the Respondent place a hand over each of Patient A's breasts and proceed to fondle or massage Patient A's breasts for approximately one and one half to two minutes. Ms. Roy also remembers hearing the Respondent say that he wondered if Patient A has breast implants. Based on the totality of the evidence in this matter (including the consistency of her statements and demeanor at the hearing), the Commission finds Ms. Roy's testimony credible.

1.14 The Respondent admitted on May 14, 2010, to touching Patient A's upper breast and chest area to check if the patient had breast implants.⁴ The Respondent also admitted this conduct to Detective Roy Shepherd on April 22, 2010 (which was overheard by Detective John Hansens).⁵ The Respondent's stated reason for doing so was to allow him to confirm the identity of the patient.⁶ He later denied touching Patient A on June 14, 2010, stating he confused her with the mastectomy patient scheduled for surgery between Patients A and B.⁷ Based on the totality of the

⁴ See Exhibit D-8.

⁵ See Exhibit D-7.

⁶ See Exhibit D-8.

⁷ See Exhibit R-45.

evidence, the Commission does not find credible the Respondent's denial that he touched Patient A's breasts.

1.15 The evidence clearly shows that Patient A had no history of breast augmentation surgery, a fact the Respondent knew or should have known from his review of Patient A's history and physical record immediately prior to the surgery. Additionally, Patient A's physical appearance clearly showed that she did not have any breast augmentation.

1.16 Even if Patient A did have breast augmentation, there is no medical justification to touch Patient A's breasts. The issue whether Patient A had breast augmentation or implants does not affect the Respondent's ability to perform his duties as an anesthesiologist.

1.17 In addition, whether Patient A had breast augmentation cannot address or verify the identity of the patient. Verifying the patient's identity is a simple matter of asking the conscious patient or examining the patient's wrist band. If the Respondent did have any question regarding the identity of Patient A, he did not raise that issue during the time out process immediately prior to the surgery or clarify the issue during his pre-surgery examination of the patient, when the patient was conscious and able to directly respond to the question of her identity. Based on the totality of the evidence, the Commission does not find credible the Respondent's testimony regarding his conduct toward Patient A.

1.18 Ms. Roy was shocked by the Respondent's conduct, as she had never observed an anesthesiologist engage in such conduct during her seven years as a

surgical technician. Ms. Roy was uncertain what action to take at this point in Patient A's procedure.

Patient B

1.19 Patient B, a 58-year-old-female patient, was scheduled to undergo a wire localized breast biopsy (the excision of a small piece of living tissue for microscopic examination) on her left breast. Prior to entering the operating room Patient B had a wire inserted under digital x-ray guidance for the purpose of localizing the area to be biopsied. The wire acts as a locator for the breast biopsy procedure, so that the surgeon (in this case, Dr. Droesch) could locate the mass in the patient's breast. In addition to the localized wire, Patient B's medical records included a diagnostic mammogram (an x-ray of the breast) in the event Dr. Droesch needed further information regarding the location of mass.

1.20 The Respondent met with Patient B prior to her entering the operating room. Consistent with his standard practice, the Respondent spoke with Patient B and reviewed her patient records (including her history and physical status). At this pre-surgical stage, the Respondent did not raise any issues regarding Patient B's identity or what surgical procedure would be performed. Patient B's records, specifically her surgical history, clearly show that Patient B underwent breast augmentation surgery (sub-pectoral breast implants) in 2002. Additionally, Dr. Droesch stated that it was apparent from the shape and size of Patient B's breasts that she had undergone breast augmentation (breast implants). The Respondent intubated Patient B and took her to the operating room.

1.21 The Respondent administered anesthesia to render Patient B unconscious. Dr. Droesch initiated the time out process prior to starting the surgery so that the surgical team could verify the identity of the patient (Patient B) and verify whether the correct procedure (wire localized breast biopsy) was scheduled. When the time out was initiated, the Respondent did not raise any issues regarding Patient B's identity with Dr. Droesch. Following the time out procedure, Dr. Droesch performed the wire localized breast biopsy surgery on Patient B.

1.22 Ms. Roy was the surgical technician assigned for Patient B's wire localized breast biopsy procedure. Ms. Roy saw Patient B prior to the beginning of the surgery and had a clear and unobstructed view of Patient B on the surgical table. Ms. Roy observed the Respondent place both hands over both of Patient B's breasts, and the Respondent proceeded to fondle or massage Patient B's breast for approximately one to two minutes. Based on the totality of the evidence in this matter (including the consistency of her statements and demeanor at the hearing), Ms. Roy's testimony is found to be credible.

1.23 On May 14, 2010, the Respondent admits pressing on Patient B's upper breast and chest area to determine whether the patient had implants.⁸ At hearing the Respondent also admitted pressing on Patient B's upper chest to determine whether Patient B had implants.⁹ The Respondent knew or should have known Patient B's

⁸ See Exhibit D-8.

⁹ This admission was confirmed by Richland Police Detectives Shepherd Hansens. See Exhibit D-7.

surgical history regarding breast implants from his review of the history and physical records that he reviewed immediately prior to Patient B's surgery. Additionally, the Respondent knew or should have known that Patient B had breast augmentation from her physical appearance.

1.24 Even though Patient B had breast augmentation or implants, there is no medical justification for touching Patient B's breasts. The issue of Patient B's breast augmentation or implants did not assist or impede the Respondent's ability to conduct his duties as an anesthesiologist during the surgery. In fact, it is not possible to confirm whether a patient has sub-pectoral breast implants (the type Patient B had received) in the manner described by the Respondent.

1.25 Additionally, the Respondent admits he pressed on Patient B's breast and chest area to confirm Patient B's identity. Verifying the patient's identity is a simple matter of asking the conscious patient what the patient's name is or verifying the patient's identity by looking at the patient's wrist band. If the Respondent had any concerns regarding Patient B's identity, he did not raise them with Patient B during his pre-surgical interview with her. Neither did he raise any issue regarding Patient B's identity during the time out process.

1.26 Even if it was possible, touching a woman's breast to determine the patient's identity is not an appropriate examination or treatment. If the Respondent did have any question regarding the identity of Patient B, he did not raise that issue during the time out process immediately prior to the surgery or clarify the issue during his pre-surgical examination of the patient, when the patient was conscious and able to

directly respond to the question of her identity. There is no medical justification to touch a woman's breasts to verify her identity. Based on the totality of the evidence, the Commission does not find credible the Respondent's explanation for why he touched Patient B's breasts.

1.27 Ms. Roy was conflicted regarding the Respondent's conduct toward Patient B (and Patient A) and was uncertain whether she should report the Respondent's conduct to her supervisors. Ms. Roy did not report the Respondent's conduct to her supervisors or take any other action on April 1, 2010. It was not until Ms. Roy observed the Respondent's conduct on April 2, 2010, that she decided to report the Respondent's actions toward Patients A and B.

April 2, 2010 Surgery Schedule

1.28 Ms. Roy also worked as the surgical technician on two vaginal surgeries (including a vaginal hysterectomy and a laparoscopically assisted vaginal hysterectomy) performed by Alexander Ortolano, M.D., and Richard Lorenzo, D.O., on April 2, 2010.¹⁰ The Respondent was the anesthesiologist for both surgeries.¹¹

1.29 Both Dr. Ortolano and Dr. Lorenzo remember the Respondent leaving the head of the surgical table (the normal location for an anesthesiologist to observe the monitoring equipment) and coming to the foot of the surgical table to observe both of the surgeries. The Respondent's behavior struck Dr. Ortolano as a bit odd.

¹⁰ According to Dr. Lorenzo's deposition testimony on June 10, 2010, Dr. Ortolano was assisting Dr. Lorenzo in the surgeries. See Exhibit R-47.

¹¹ The April 2, 2010 surgeries are not part of the Department's Statement of Charges against the Respondent.

Dr. Ortolano does not remember the amount of time but does remember the Respondent walking to the foot of the operating table on several occasions.¹²

Dr. Lorenzo noted the Respondent's behavior but did not characterize the Respondent's behavior as odd or unusual.¹³

1.30 It is not unusual for an anesthesiologist to observe a surgery for a short time period to check on blood loss on sponges and in the suction canisters. Additionally, surgeons may ask the anesthesiologist or other surgical team member to observe the procedure for educational purposes. There is no evidence that either Dr. Ortolano or Dr. Lorenzo asked the Respondent to observe the procedures being done on April 2, 2010.

1.31 Dr. Robin Kloth, an anesthesiologist employed by Premier Anesthesiology (the Respondent's employer in April 2010) entered the operating room to provide the Respondent his morning break and saw the Respondent observing one of the surgical procedures. At the time, Dr. Kloth thought the Respondent's conduct was odd as most of the anesthesiologists in the Premier group stay close to the anesthesia machine and patient monitors. However, Dr. Kloth did not know how long the Respondent had been standing and observing the surgery.

1.32 On April 2, 2010, Ms. Roy had a clear and unobstructed view of the operating table. Ms. Roy observed the Respondent spent approximately ten minutes observing each of the two vaginal surgeries. Ms. Roy felt this amount of time was

¹² See Exhibit R-46.

¹³ See Exhibit R-47.

"inappropriate and creepy." Following the Respondent's conduct on April 2, 2010 (along with the Respondent's conduct regarding Patients A and B on April 1, 2010), Ms. Roy reported the Respondent's conduct to Dr. Kloth.

Post-Surgery Action by Premier Anesthesia

1.33 On April 4, 2010, Dr. Kloth notified Executive Vice-President Norb Hummel and Anesthesia Director Deeraj Ahuja, M.D., of the Respondent's conduct by email. On April 5, 2010, Dr. Kloth participated in a conference call with members of Premier Anesthesia management and Kadlec's risk management staff. The Respondent was then contacted by telephone. Based on the Respondent's reported conduct of April 1, 2010 (and other complaints previously made against the Respondent¹⁴), a decision was made to terminate the Respondent's contract. The Respondent resigned his position in lieu of termination.

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject matter of this proceeding. RCW 18.130.040.

2.2 The standard of proof in a professional disciplinary proceeding is clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516 534, *cert. denied* 535 U.S. 904 (2002).

2.3 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

¹⁴ The other complaints included the Respondent's failing to return a page while acting as the on-call anesthesiologist on April 3, 2010, and the reported inadequate treatment of post-operative patient pain).

2.4 The Department proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(7), which states:

Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

The administrative rule regulating the medical profession here is WAC 246-919-630(2), which states:

WAC 246-919-630 Sexual misconduct.

....

- (2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:

....

- (e) Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment.

2.5 The Department also proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(24), which states that unprofessional conduct includes the "[a]buse of a client or patient or sexual contact with a client or patient."

2.6 The Department failed to prove with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(1), which states:

The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

2.7 In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160.

2.8 The Commission applies WAC 246-16-800 through 246-16-890, to determine appropriate sanctions. The Commission concludes:

A. The Respondent's unprofessional conduct under RCW 18.130.180(7) (incorporating WAC 246-919-630) can be adequately addressed by the sanctions contained in Tier B of WAC 246-16-820. The Respondent engaged in inappropriate contact with Patients A and B because there was no medical reason (no appropriate examination or treatment reason) to touch either patient on the breasts.

B. The Respondent's unprofessional conduct under RCW 18.130.180(24) can be adequately addressed by the sanctions contained in Tier B of WAC 246-16-830. Tier B includes or addresses conduct by a licensee that is considered "forceful contact." The Respondent engaged in forceful contact with Patients A and B because of the physical state of the

patients. Both Patients A and B were each under anesthesia (that is, unconscious) and therefore unable to give informed consent.

2.9 The Commission considered the following aggravating factors in determining sanctions in this matter: the vulnerability of the patients (unconscious and seriously ill) and the abuse of trust of the patients.

2.10 The Commission considered the following mitigating factor in determining sanctions in this matter: the Respondent has no prior disciplinary record.

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED:

3.1 Suspension of License. The Respondent's license to practice medicine in the state of Washington is SUSPENDED. The Respondent may apply for reinstatement of his credential once the following conditions are met.

A. The Respondent shall enroll in the Center for Personalized Education for Physicians (CPEP) Program in Denver, Colorado. The Respondent shall fully cooperate with a clinical skills assessment, including any recommendation for continuing education or preceptor program, and will provide CPEP with any charts, documents, and releases that are requested.

B. The Respondent releases CPEP to discuss any matters relating to the Respondent's evaluation with the Commission and waives any privileges or privacy rights he might have under federal or state law to that end. CPEP shall provide a copy of its evaluation to the Commission and shall communicate with

the Commission or Commission's medical director regarding the Respondent's progress.

C. The Respondent must attend and successfully complete (an unconditional pass) the ProBE course offered by the CPEP in Colorado within six months from the effective date of this Order. Unsatisfactory performance in the course will be considered non-compliance with the terms of the Order. The course shall not count toward the Respondent's statutorily mandated minimum continuing education requirements in Washington State.

3.2 Probation. At such time as the medical consultant (Dr. George Heye or his successor) to the Commission has given written notice to the Respondent that the Respondent has successfully completed the CPEP evaluation and ProBE course requirements contained in Paragraph 3.1 above, and determines that the Respondent is prepared to implement any continuing practice or education requirements required by CPEP, the Respondent's license to practice as a physician shall be put on probation and the suspension shall be lifted. The probationary period shall be for a period of no less than 36 months. The Respondent may seek modification of the conditions after the first 24 months of the probationary period. During the probationary period, the Respondent shall comply with the terms and conditions set forth below.

A. The Respondent is prohibited from touching the breast or breasts of any female patient to which he administers anesthesia, except when the Respondent is required to place EKG monitors or other similar monitoring instrument on the patient.

B. The Respondent shall appear before the Commission on an annual basis and present proof that he is complying with the Order, including the requirements and recommendations of CPEP. The Respondent shall continue to appear annually unless otherwise instructed in writing by the Commission.

C. The Respondent shall give a copy of the Order to the administrator and/or medical director of the clinic or group in which he practices, and all hospital administrators and chiefs of staff of the hospitals at which he has privileges. As part of the Respondent's compliance appearance schedule, the Respondent shall provide letters from the administrator/medical director/hospital administrator/chief of staff (as the case may be) advising the Commission whether there have been any complaints from the hospital staff or patients with respect to the Respondent's practice or conduct.

3.3 Obey All Laws. The Respondent shall obey all federal, state, and local laws, and all rules governing the practice of the medical profession in the state of Washington.

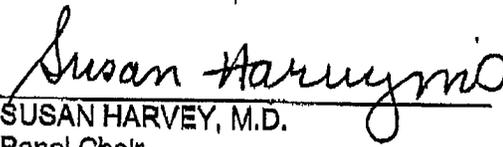
3.4 Compliance Costs. The Respondent shall assume all costs associated with the compliance of this Order.

3.5 Change of Address. The Respondent shall submit written notification to the Commission of any employment or residence address changes. The notification must include the complete new address and telephone number. The notification must be made within 20 days of the change of employment or residence address.

3.6 Effective Date of Order. The effective date of this Order is that date the Adjudicative Service Unit places the signed Order into the U.S. mail. The Respondent shall not submit any fees or compliance documents until after the effective date of the Order.

3.7 Failure to Comply. Protecting the public requires practice under the terms and conditions imposed in this Order. Failure to comply with the terms and conditions of this Order during any probationary period may result in suspension and/or revocation of the Respondent's credential after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this Order, the Commission may hold a hearing. At that hearing, the Respondent must show cause why his credential should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 7 day of September, 2010.


SUSAN HARVEY, M.D.
Panel Chair

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APPENDIX A

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CLERK'S SUMMARY

<u>Charge</u>	<u>Action</u>
RCW 18.130.180(1)	Not Violated
RCW 18.130.180(7)	Violated
RCW 18.130.180(24)	Violated
WAC 246-919-630(2)(e)	Violated

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Medical Program
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

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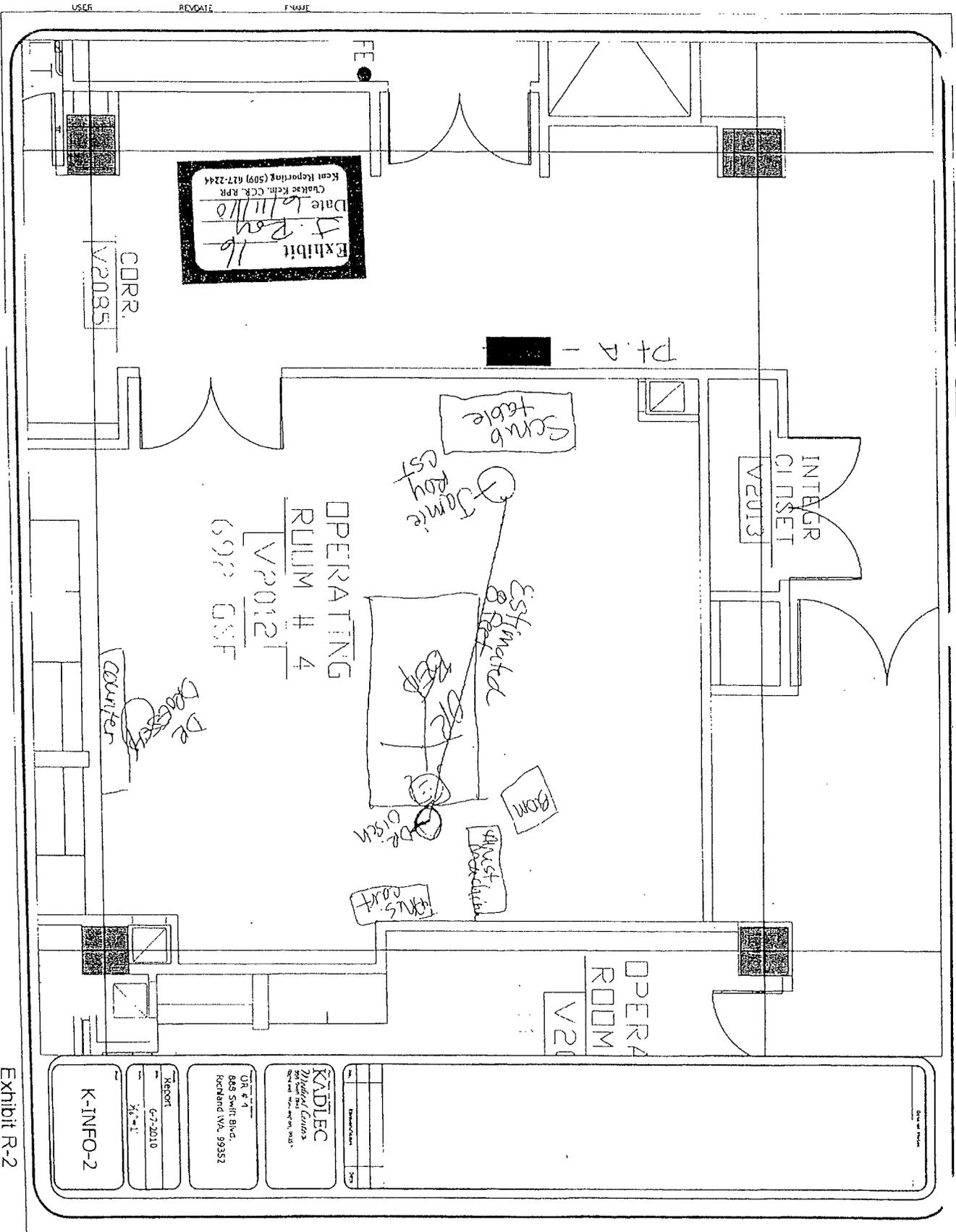
Master Case No. M2010-471

APPENDIX A

2372

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

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RCW 18.130.100

Hearings — Adjudicative proceedings under chapter 34.05 RCW.

The procedures governing adjudicative proceedings before agencies under chapter 34.05 RCW, the Administrative Procedure Act, govern all hearings before the disciplining authority. The disciplining authority has, in addition to the powers and duties set forth in this chapter, all of the powers and duties under chapter 34.05 RCW, which include, without limitation, all powers relating to the administration of oaths, the receipt of evidence, the issuance and enforcing of subpoenas, and the taking of depositions.

[1989 c 175 § 69; 1984 c 279 § 10.]

RCW 18.130.180

Unprofessional conduct.

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

- (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
- (2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
- (3) All advertising which is false, fraudulent, or misleading;
- (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
- (5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
- (6) Except when authorized by RCW 18.130.345, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
- (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
- (8) Failure to cooperate with the disciplining authority by:

- (a) Not furnishing any papers, documents, records, or other items;
- (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
- (c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
- (d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;
- (9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
- (10) Aiding or abetting an unlicensed person to practice when a license is required;
- (11) Violations of rules established by any health agency;
- (12) Practice beyond the scope of practice as defined by law or rule;
- (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
- (14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
- (15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;
- (16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;
- (17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
- (18) The procuring, or aiding or abetting in procuring, a criminal abortion;
- (19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

[2010 c 9 § 5; 2008 c 134 § 25; 1995 c 336 § 9; 1993 c 367 § 22. Prior: 1991 c 332 § 34; 1991 c 215 § 3; 1989 c 270 § 33; 1986 c 259 § 10; 1984 c 279 § 18.]

RCW 34.05.461

Entry of orders.

(1) Except as provided in subsection (2) of this section:

(a) If the presiding officer is the agency head or one or more members of the agency head, the presiding officer may enter an initial order if further review is available within the agency, or a final order if further review is not available;

(b) If the presiding officer is a person designated by the agency to make the final decision and enter the final order, the presiding officer shall enter a final order; and

(c) If the presiding officer is one or more administrative law judges, the presiding officer shall enter an initial order.

(2) With respect to agencies exempt from chapter 34.12 RCW or an institution of higher education, the presiding officer shall transmit a full and complete record of the proceedings, including such comments upon demeanor of witnesses as the presiding officer deems relevant, to each agency official who is to enter a final or initial order after considering the record and evidence so transmitted.

(3) Initial and final orders shall include a statement of findings and conclusions, and the reasons and basis therefor, on all the material issues of fact, law, or discretion presented on the record, including the remedy or sanction and, if applicable, the action taken on a petition for a stay of effectiveness. Any findings based substantially on credibility of evidence or demeanor of witnesses shall be so identified. Findings set forth in language that is essentially a repetition or paraphrase of the relevant provision of law shall be accompanied by a concise and explicit statement of the underlying evidence of record to support the findings. The order shall also include a statement of the available procedures and time limits for seeking reconsideration or other administrative relief. An initial order shall include a statement of any circumstances under which the initial order, without further notice, may become a final order.

(4) Findings of fact shall be based exclusively on the evidence of record in the adjudicative proceeding and on matters officially noticed in that proceeding. Findings shall be based on the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. Findings may be based on such evidence even if it would be inadmissible in a civil trial. However, the presiding officer shall not base a finding exclusively on such inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence. The basis for this determination shall appear in the order.

(5) Where it bears on the issues presented, the agency's experience, technical competency, and specialized knowledge may be used in the evaluation of evidence.

(6) If a person serving or designated to serve as presiding officer becomes unavailable for any reason before entry of the order, a substitute presiding officer shall be appointed as provided in RCW 34.05.425. The substitute presiding officer shall use any existing record and may conduct any further proceedings appropriate in the interests of justice.

(7) The presiding officer may allow the parties a designated time after conclusion of the hearing for the submission of memos, briefs, or proposed findings.

(8)(a) Except as otherwise provided in (b) of this subsection, initial or final orders shall be served in writing within ninety days after conclusion of the hearing or after submission of memos, briefs, or proposed findings in accordance with subsection (7) of this section unless this period is waived or extended for good cause shown.

(b) This subsection does not apply to the final order of the shorelines hearings board on appeal under RCW 90.58.180(3).

(9) The presiding officer shall cause copies of the order to be served on each party and the agency.

[1995 c 347 § 312; 1989 c 175 § 19; 1988 c 288 § 418.]

RCW 34.05.570

Judicial review.

(1) Generally. Except to the extent that this chapter or another statute provides otherwise:

(a) The burden of demonstrating the invalidity of agency action is on the party asserting invalidity;

(b) The validity of agency action shall be determined in accordance with the standards of review provided in this section, as applied to the agency action at the time it was taken;

(c) The court shall make a separate and distinct ruling on each material issue on which the court's decision is based; and

(d) The court shall grant relief only if it determines that a person seeking judicial relief has been substantially prejudiced by the action complained of.

(2) Review of rules. (a) A rule may be reviewed by petition for declaratory judgment filed pursuant to this subsection or in the context of any other review proceeding under this section. In an action challenging the validity of a rule, the agency shall be made a party to the proceeding.

(b)(i) The validity of any rule may be determined upon petition for a declaratory judgment addressed to the superior court of Thurston county, when it appears that the rule, or its threatened application, interferes with or impairs or immediately threatens to interfere with or impair the legal rights or privileges of the petitioner. The declaratory judgment order may be entered whether or not the petitioner has first requested the agency to pass upon the validity of the rule in question.

(ii) From June 10, 2004, until July 1, 2008:

(A) If the petitioner's residence or principal place of business is within the geographical boundaries of the third division of the court of appeals as defined by RCW 2.06.020(3), the petition may be filed in the superior court of Spokane, Yakima, or Thurston county; and

(B) If the petitioner's residence or principal place of business is within the geographical boundaries of district three of the first division of the court of appeals as defined by RCW 2.06.020(1), the petition may be filed in the superior court of Whatcom or Thurston county.

(c) In a proceeding involving review of a rule, the court shall declare the rule invalid only if it finds that: The rule violates constitutional provisions; the rule exceeds the statutory

authority of the agency; the rule was adopted without compliance with statutory rule-making procedures; or the rule is arbitrary and capricious.

(3) Review of agency orders in adjudicative proceedings. The court shall grant relief from an agency order in an adjudicative proceeding only if it determines that:

(a) The order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied;

(b) The order is outside the statutory authority or jurisdiction of the agency conferred by any provision of law;

(c) The agency has engaged in unlawful procedure or decision-making process, or has failed to follow a prescribed procedure;

(d) The agency has erroneously interpreted or applied the law;

(e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;

(f) The agency has not decided all issues requiring resolution by the agency;

(g) A motion for disqualification under RCW 34.05.425 or 34.12.050 was made and was improperly denied or, if no motion was made, facts are shown to support the grant of such a motion that were not known and were not reasonably discoverable by the challenging party at the appropriate time for making such a motion;

(h) The order is inconsistent with a rule of the agency unless the agency explains the inconsistency by stating facts and reasons to demonstrate a rational basis for inconsistency; or

(i) The order is arbitrary or capricious.

(4) Review of other agency action.

(a) All agency action not reviewable under subsection (2) or (3) of this section shall be reviewed under this subsection.

(b) A person whose rights are violated by an agency's failure to perform a duty that is required by law to be performed may file a petition for review pursuant to RCW 34.05.514, seeking an order pursuant to this subsection requiring performance. Within twenty days after service of the petition for review, the agency shall file and serve an answer to the petition, made in the same manner as an answer to a complaint in a civil action. The court may hear evidence, pursuant to RCW 34.05.562, on material issues of fact raised by the petition and answer.

(c) Relief for persons aggrieved by the performance of an agency action, including the exercise of discretion, or an action under (b) of this subsection can be granted only if the court determines that the action is:

(i) Unconstitutional;

(ii) Outside the statutory authority of the agency or the authority conferred by a provision of law;

(iii) Arbitrary or capricious; or

(iv) Taken by persons who were not properly constituted as agency officials lawfully entitled to take such action.

[2004 c 30 § 1; 1995 c 403 § 802; 1989 c 175 § 27; 1988 c 288 § 516; 1977 ex.s. c 52 § 1; 1967 c 237 § 6; 1959 c 234 § 13. Formerly RCW 34.04.130.]

WAC 246-16-830

Sanction schedule — Abuse — Physical and emotional.

ABUSE -- Physical and/or Emotional				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least  greatest	A – Verbal or nonverbal intimidation, forceful contact, or disruptive or demeaning behavior, including general behavior not necessarily directed at a specific patient or patients	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Abusive unnecessary or forceful contact or disruptive or demeaning behavior causing or risking moderate mental or physical harm, including general behavior not directed at a specific patient or patients.	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
	C – Severe physical, verbal, or forceful contact, or emotional disruptive behavior, that results in or risks significant harm or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390, 09-15-190, § 246-16-830, filed 7/22/09, effective 8/22/09.]

WAC 246-919-630

Sexual misconduct.

(1) Definitions:

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Physician" means a person licensed to practice medicine and surgery under chapter 18.71 RCW.

(c) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.

(2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:

(a) Sexual intercourse or genital to genital contact;

(b) Oral to genital contact;

(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

(f) Examination or touching of genitals without using gloves;

(g) Not allowing a patient the privacy to dress or undress;

(h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;

(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;

(j) Soliciting a date;

(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the physician.

(3) A physician shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the physician:

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.

(4) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors, including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the physician;

(f) The nature of the patient's health problem;

(g) The degree of emotional dependence and vulnerability.

(5) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

(6) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(7) A violation of any provision of this rule shall constitute grounds for disciplinary action.

MASTERS LAW GROUP

December 06, 2012 - 11:53 AM

Transmittal Letter

Document Uploaded: 435527-Appellant's Brief.pdf

Case Name: olson v. state of washington

Court of Appeals Case Number: 43552-7

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- Objection to Cost Bill
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- Personal Restraint Petition (PRP)
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