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STATE OF WASHINGTON  
Case No. 80644-6 BY RONALD R. CARPENTER

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GEOFFREY AMES, M.D.,

Petitioner,

v.

WASHINGTON STATE DEPT. OF HEALTH

Respondent.

**AMICUS CURIAE BRIEF OF:**

- (1) AMERICAN ASSOCIATION OF HEALTH FREEDOM;**
- (2) CITIZENS FOR HEALTH; AND**
- (3) WA CHOICE**

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## TABLE OF CONTENTS

|   | PAGE |
|---|------|
| I. Introduction   | 1    |
| II. Issues Presented  | 2    |
| III. Legal Analysis   |      |
| A. Introduction to the<br>Legal Analysis  | 3    |
| 1. Due process is thwarted here.  | 4    |
| 2. The consequences of bad law.   | 5    |
| 3. Exclusive reliance on orthodoxy<br>is a bane to healthcare.  | 8    |
| 4. The regulation of healthcare is<br>deeply out of sync.   | 8    |
| B. In the Absence of Actual Harm,<br>Due Process Requires Real Evidence,<br>including Expert Testimony, to<br>prove the Unreasonable Risk of<br>Harm.                   | 10   |
| 1. <i>Brown</i> is bad law.   | 11   |
| 2. <i>Brown</i> violates due process,<br>especially in the absence of<br>actual harm.   | 17   |
| C. Turning to the Question of<br>Efficacy For a New Modality,<br>the Government's Burden of<br>Proof Also Requires Competent,<br>Properly Qualified Expert<br>Evidence. | 24   |
| 1. Washington State's policy on<br>Complementary Medicine<br>embodied in RCW 18.120.  | 24   |

|     |   |    |
|-----|---|----|
| D.  | Without proof of harm, the DOH uses the authority of <i>parens patriae</i> under the guise of police power. | 25 |
| IV. | Conclusion  | 27 |

## TABLE OF AUTHORITIES

### Washington Cases

|  |                    |
|--|--------------------|
| <i>Born v. Thompson</i> ,<br>154 Wn. 2d 749 (2005)                           | page 26            |
| <i>In re Brown</i> ,<br>94 Wn. App. 7 (1998)                                 | pp. 11, 14, 17, 18 |
| <i>Clausing v. State</i><br>90 Wn. App. 863 (1998)                           | page 19            |
| <i>Davidson v. DOL</i> ,<br>33 Wn. App. 783 (1983)                           | page 13 & 22       |
| <i>DaVita v. DOH</i> ,<br>137 Wn. App. 174 (2007)                            | page 19            |
| <i>Havsy v. State Board</i> ,<br>Division I no. 53198-1-I<br>(Sept. 27 2004) | page 19            |
| <i>Johnston adv. Medical Board</i><br>99 Wn. 2d 466 (1983)                   | pp. 14 & 15        |
| <i>Nguyen v. DOH</i> ,<br>144 Wn. 2d 516 (2001)                              | pp. 10, 19-21, 23  |

### Federal and Out-of-State Cases

|  |         |
|--|---------|
| <i>Addington v. Texas</i><br>441 U.S. 418 (1979)       | page 26 |
| <i>Gibson v. Berryhill</i> ,<br>411 U.S. 564 (1973)    | page 27 |
| <i>Jaffe v. State DOH</i><br>64 A. 2d 330 (Conn. 1949) | page 15 |
| <i>Jutkowitz v. DOH</i> ,<br>596 A. 2d 374, 387 (1991) | page 15 |

|  |               |
|--|---------------|
| <i>Mathews v. Eldridge</i><br>424 U.S. 319, 332 (1976) | pages 21 & 22 |
| <i>Rogers v. State</i><br>371 So. 2d 1037 (Fla. 1979)  | page 8        |
| <i>Stanley v. Illinois</i><br>405 U.S. 645 (1972)      | page 22 & 23  |

#### Statutes

|                        |               |
|------------------------|---------------|
| RCW 18.120             | pp. 24 & 25   |
| RCW 18.130.180(4)      | page 16       |
| RCW 34.05.461(4) & (5) | pp. 12-14, 19 |

#### Treatise

|   |         |
|---|---------|
| <i>Administrative Law</i> , 2 <sup>nd</sup> ed.,<br>Aman & Mayton; West Publishing,<br>2001, Chapter 7, Section 7.5.1, p. 167 | page 27 |
|---|---------|

|   |          |
|---|----------|
| Tribe, <i>The Curvature of<br/>Constitutional Space</i> ,<br>Harvard Law Rev. Vol. 103, # 1,<br>Nov. 1989 | page 8-9 |
|---|----------|

#### Appendices

A. Report of the White House Commission on  
Complementary & Alternative Medical Practice:  
Executive Summary

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B. Expert Witness Standards of the Washington State  
Medical Association

## **I. INTRODUCTION**

Millions of people have developed healing relationships with holistic physicians, chiropractors, acupuncturists, energy workers and other similar healthcare practitioners whose work does not squarely fit into the metrics of orthodox medicine. The appeal and effectiveness of complementary health care is so compelling that the National Institute of Health (NIH) created 10 years ago the National Center for Complementary & Alternative Medicine (NCCAM).<sup>1</sup> In 2002, The White House established the White House Commission on Complementary & Alternative Medical Practice (WHCCAMP) to study ways to support these beneficial practices.<sup>2</sup>

It is on behalf of the millions of important healing relationships between citizens and their complementary holistic healthcare providers that Amici file this Brief. Indeed, there is no realm where the imbalances wrought by over-zealous regulation are more tenuous, where the stakes are higher, than in health care today. This Court's decision in this case will determine not only the future of Dr. Ames

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<sup>1</sup> See e.g. [nccam.nih.gov](http://nccam.nih.gov)

<sup>2</sup> See WHCCAMP Report cited at footnote 6 below.

and his patients, but also the future of health care in Washington State for generations to come. The issues here call for immediate judicial intervention, specifically the rejection of the unconstitutional procedures that the regulatory bodies are using for the adjudication of complementary healthcare<sup>3</sup> cases.

## II. ISSUES PRESENTED

A. Does the government have the burden of proof on all elements of its disciplinary charges against a healthcare practitioner?

B. Must the government produce evidence on all elements of those charges?

C. Does existing law allow the government to avoid production of evidence on all elements of the charges?

D. Does a legal procedure that purportedly allows the government to avoid production of evidence shift the burden of proof in violation of due process?

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<sup>3</sup> As noted in Amici's Motion for Leave to File this Brief, many names are used to describe the holistic healthcare modalities that Amici support here: complementary & alternative medicine (a/k/a CAM); integrative healthcare; natural healthcare, etc. As suggested by the White House Commission on Complementary & Alternative Medical Practice in its 2002 report, "[T]he Commission recognizes that the term [CAM] does not fully capture all of the diversity with which these systems, practices and products are being used."

E. Without evidence of actual harm or expert testimony about the risk of harm, does the government improperly usurp the power to determine what is good and healthy as *parens patriae*?

### III. LEGAL ANALYSIS

#### A. Introduction to the Legal Analysis

In the pages that follow, Amici will explore the following points:

- In cases involving holistic, complementary healthcare modalities, where no actual harm is alleged, the risk of harm can only be proved by expert testimony.
- The expert testimony necessary to prove risk of harm must be qualified in the holistic modality at issue.
- In the unique circumstances involving holistic, complementary healthcare modalities where no actual harm is alleged, the Commission's Order and the decisions of the Courts below allow the government to shift the burden of proof to healthcare practitioners in violation of due process.

- By allowing the orthodox-oriented Commission members who have no expertise or familiarity with new holistic modalities to determine the risk of harm without any qualified expert testimony, the government is acting illegally and without justification as *parens patriae* to determine what is good and healthy for citizens.

**1. Due process is thwarted here.**

In a quasi-criminal case, the burden is on the government to prove *harm* and *inefficacy*. The burden is not on the practitioner to prove *safety* and *efficacy*. But an improper shift in this burden is what happened in this case.

The Commission and the Courts below have allowed the government to dispense with expert testimony altogether, even though expert testimony is the only evidence that can possibly prove the elements of the charges against the practitioner.

Within a system built by and for traditional, orthodox medicine, the due process error is too easy to ignore and perpetuate. As stated in Amici's Motion for Leave to File this Brief, the tension between orthodox medicine (and the

market forces that protect it) on the one hand, and the compelling need for complementary healthcare (and the public's demand for it) on the other hand, is so systemic as to require thorough judicial scrutiny.

**2. The consequences of bad law.**

As stated above, it is Amici's premise that the prima facie burden of proving *safety* and *efficacy* has been placed at the feet of the complementary practitioner in this case, notwithstanding the lip service given to the letter of the law which says that the government has the burden of proving *harm* and *inefficacy*.

When an error like this happens in complementary health cases like this one, at least two adverse consequences result. First, every complementary healthcare practitioner's constitutional right to due process and the constitutionally-protected property interest to practice is taken away. That threat in a quasi-criminal proceeding like this one conjures the stuff of star chambers, chilling the advancement of cutting edge modalities and driving practitioners underground or out of business altogether.

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As caustic as that first consequence is to Constitutional rights and interests, Amici contends that the second

consequence is even more disconcerting and dangerous. It is important to understand the context in order to understand this second consequence. First, to reiterate, this is a quasi-criminal proceeding. Next, we must understand that the majority of adjudicators evaluating the quasi-criminal case come from a pool of traditional, orthodox practitioners. In fact, these practitioners are largely competitors of any complementary practitioner who might be charged by the DOH.

Then, and most important for understanding the context in a case like this one – unique to complementary healthcare cases - there is no actual harm involved or at issue in the case. The risk of harm is entirely conceptual.

This last point cries for special attention. When no actual harm is at issue, as is the case here and in many complementary healthcare cases, the only question left to be considered is, “what is the unreasonable risk of harm.” The discretion imbedded in this question is profound. Only experts can establish the facts necessary to support the charge of liability in a case where no actual harm is involved.

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However, if the approach in this case is allowed to become standard Washington practice, the prosecutorial arm

of the agency and the adjudicatory arm of the agency will be permitted to dispense with experts altogether. This effectively eliminates the prosecution's burden of proof.

This pushes due process into the shadows, and then the second consequence rears its head. When actual harm is not at issue, the *concept* of risk evaluation is left in the hands of only a small few, competing professionals who are unversed and unfamiliar with new modalities of complementary healthcare.

When this happens, the prosecuting agency and the Commission are no longer protecting our citizenry from *harm*. The agency and Commission are now determining what is *good* and what is *healthy* according to their own standards. They make that determination outside the structure of rulemaking, and without the required guidance of the legislature. This is the transformation of the agency's police power into the power of *parens patriae* – government as parent - where government dictates what is good and healthy to those deemed incapable of caring for themselves.

This is particularly insidious and dangerous in the realm of healthcare, where the need for innovation and autonomy are so crucial.

**3. Exclusive Reliance on Orthodoxy is a Bane to Health Care.**

It is imperative to protect the healthcare advancements offered by complementary practitioners, as evident by these remarks from a Florida appellate judge who consider the safety and efficacy of a novel treatment:

Orthodoxy in medicine is like orthodoxy in any other professional field; it starts as a theory [and then] . . . it begins to be held as a passionate belief in the absolute rightness of that particular view. Right or wrong, a dissentient view is regarded as a criminal subversion of the truth and the holder is frequently exposed to slander and abuse by his orthodox colleagues . . . Even today, these same oppressive forces may shackle the advancement of medicine. It is so easy to hold orthodox views in the midstream of medicine. It is only on the edges of the stream of medicine in which advancement can take place.<sup>4</sup>

**4. The Regulation of Health Care is Grossly Out of Sync.**

Regulatory protection of medical orthodoxy is deeply imbedded, and thus difficult to discern. It is important that we work hard to do so. Others are sounding the alarm about a broken medical system because the symptoms are becoming more apparent, just as the need for solutions to the problem are becoming more urgent.

Noted constitutional law professor Lawrence Tribe has identified a deep expression of the challenge we face:

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<sup>4</sup> *Rogers v. State*, 371 So. 2d 1037 (Fla. 1979).

Law has not kept pace with what makes sense . . . [It] has lagged behind our intuitions, and has yet to reflect the shift . . . As a result [our legal] system is deeply out of sync.”<sup>5</sup>

Studies abound about the need for change. One of the more official and credible studies comes from The Report of the White House Commission on Complementary & Alternative Medical Practice (WHCCAMP), which states as follows:

Based on its mission and responsibilities, the Commission endorses the following guiding principles . . .

- *The healing capacity of the person.* People have a remarkable capacity for recovery and self-healing, and a major focus of health care is to support and promote this capacity.
- *Respect for individuality.* Each person is unique and has the right to health care that is appropriately responsive to him or her, respecting preferences and preserving dignity.
- *The right to choose treatment.* Each person has the right to choose freely among safe and effective care or approaches, as well as among qualified practitioners who are accountable for their claims and actions and responsive to the person's needs.
- *An emphasis on health promotion and self-care.* Good health care emphasizes self-care and early intervention for maintaining and promoting health.<sup>6</sup>

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<sup>5</sup> Tribe, *The Curvature of Constitutional Space*, Harvard Law Rev. Vol. 103, # 1, Nov. 1989.

<sup>6</sup> See Appendix A.

The front lines for this work are not in the think tanks, the capital buildings, nor in the executive mansions. The front lines are the courtrooms, where practitioners and their patients are immediately and dramatically affected.

The Amici ask this Court to intervene, using the spotlight of critical constitutional analysis. That spotlight needs to be focused on the improper tactics of the MQAC and the DOH in this case. Without this Court's intervention to correct the due process failure that has occurred below, the damage that will be done to our healthcare system cannot be overstated.

**B. In the Absence of Actual Harm, Due Process Requires Real Evidence, including Expert Testimony, to prove the Unreasonable Risk of Harm.**

At the outset of this analysis, it bears repeating that disciplinary proceedings like this one are quasi-criminal, and that this case involves the constitutionally protected property and liberty interests inherent in Dr. Ames' license. See *Nguyen*.<sup>7</sup> And further, in Washington State, we recall that the use of a nontraditional treatment by itself does not constitute unprofessional conduct, provided that it does not result in

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<sup>7</sup> *Nguyen v. DOH*, 144 Wn. 2d 516 (2001)

injury to a patient or create an unreasonable risk that a patient may be harmed. RCW 18.130.180(4).

We know that no one was injured in this case. Therefore, the questions with which we are left are: (1) was there was an unreasonable risk; and also (2) how is that risk determined.

**1. *Brown is bad law.***

As we know, the DOH offered no expert evidence to prove the “unreasonable risk of harm” in this case, and accordingly the Commission considered no such evidence. The Commission’s conclusion that Dr. Ames was guilty of unprofessional conduct came from a purported finding that he created an unreasonable risk of harm. That finding came not from the expert evidence, but from the Commission members exclusively. Other than conclusions disguised as factual findings, the only apparent factual finding to support the Commission’s conclusion was that Dr. Ames used the LISTEN device for diagnostic purposes.<sup>8</sup>

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<sup>8</sup> The problems and inconsistencies with the Commission’s Order in this case are troubling. For instance, the Order clearly states that Dr. Ames used the LISTEN device to assist with his diagnosis, and that he used acupressure to *treat* Patient One’s allergy. Nevertheless, the Commission and Division III persist with the mischaracterization that Dr. Ames used LISTEN as the exclusive means of treatment, and that this treatment constituted the unreasonable risk of harm.

The Commission and the Courts below relied primarily on *In re Brown*<sup>9</sup> to justify the lack of expert evidence. Amici offer a different, though complementary critique of *Brown* from the one offered by Dr. Ames briefing. Upon close inspection, we see that *Brown* sits on three broken legs of a fragile, ill-crafted stool.

a. RCW 34.05.461(5)

The first leg of this stool is purportedly RCW 34.05.461(5). Division III's opinion below states that RCW 34.05.461(5) justifies the DOH's decision, and the Commission's attendant ability, to dispense with expert testimony about the risk of harm. But RCW 34.50.461(5) says nothing of the sort that would allow such a result, nor could it in light of the due process considerations addressed in later sections of this Brief.

For now, we consider just the statute on its face. And in order to give full and fair context to the situation, we cite both subparts (4) and (5) of RCW 34.05.461:

(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. . . the

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<sup>9</sup> 94 Wn. App. 7 (1998), in which the court there purportedly held that a Commission may utilize its own expertise in lieu of expert testimony.

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. (Italics added.)

Subpart (4) requires that all findings of fact be based on evidence in the record, *exclusively*. The opinions and expertise of the Commission do not qualify.

Next, Subpart (5) does not allow the agency's expertise to replace the qualified evidence required by Subpart (4), contrary to the interpretations of the Commission and the courts below in this case. Subpart (5) allows only for the agency's expertise to bear on an evaluation of that evidence.

Lest there be any doubt as to the significance of this important distinction, Amici asks this Court to consider the few cases that have addressed RCW 34.05.461(5) prior to this one.<sup>10</sup> In each of these cases, the adjudicators heard and

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<sup>10</sup> See e.g., *Clousing v. State*, 90 Wn. App. 863 (1998); *DaVita v. DOH*, 137 Wn. App. 174 (2007) and *Hausy v. State Board, Division I* no. 53198-1-I (Sept. 27 2004; unpublished; provided for illustrative purposes only.) Under the pre-1988 predecessor to RCW 34.05.461(5) [RCW 34.04.100(4)], *In re Davidson* dispensed with expert testimony altogether. However, the *Davidson* case concerned actual harm in the form of sexual abuse. In addition, none of these cases under RCW

relied on expert testimony. In other words, this is the first case in which addressed RCW 34.05.461(5) has been used to justify a complete lack of expert evidence altogether.

The plain meaning of RCW 34.05.461(5) bears repeating. The Commission may use its expertise to evaluate the weight given to qualified expert testimony. The statute does not authorize the Commission to dispense with required testimony altogether, nor does it authorize the Commission to replace entirely its purported expertise for that of qualified expert witnesses.

In the absence of actual harm when only qualified expert testimony can supply the facts of “unreasonable risk of harm,” no other interpretation of RCW 34.05.461(5) can stand.

b. *Med. Board v. Johnston*<sup>11</sup>

The second leg of the *Brown* stool is the *Johnston* case. However, just like RCW 34.05.461(5), *Johnston* is not justification for abandoning expert testimony about “risk of harm.” Here’s what the *Johnston* Court actually said:

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34.05.461 or 34.04.100 involved allegations about the unreasonable risk of harm involved with a novel, complementary healthcare modality.

<sup>11</sup> 99 Wn. 2d 466 (1983).

[S]ince [the statute] permits agencies to utilize the specialized knowledge of their members in evaluating *evidence presented to them*, we believe it is logical and proper for the State Medical Disciplinary Board to draw its own conclusions as to acceptable surgical standards. As to such specialized matters, we give deference to administrative expertise. [citation omitted.] Additionally, we note that some *testimony on acceptable surgical standards in this area was elicited and placed on the record*. [Italics added.]

Clearly, the *Johnston* Court did not sanction either the abandonment of required expert testimony, or the attendant abandonment of due process.<sup>12</sup>

c. *Jaffe v. State DOH*.<sup>13</sup>

As noted in the Ames' Briefing, *Jaffe* has been modified by its own "home court" which at least now requires that a commission of medical experts consist of a majority from the profession in question if expert testimony is to be abandoned.<sup>14</sup>

Amici will add only this important comment in regard to this last point: expert evaluation about the standards of care for any modality, and most especially new complementary healthcare modalities, must include experts

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<sup>12</sup> Further complementary analysis of the *Johnston* decision is supplied by Dr. Ames's briefing and so will not be repeated here.

<sup>13</sup> 64 A. 2d 330 (Conn. 1949).

<sup>14</sup> See *Jutkowitz v. DOH*, 596 A. 2d 374, 387 (1991).

well versed in the specialty at issue. An organization no less significant than the Washington State Medical Association (WSMA) has guidelines for expert testimony along these lines. The WSMA Guidelines state that a qualifying expert witness shall be fully trained in, and familiar with the clinical practice of, the specialty at issue in a given case.<sup>15</sup> Expert testimony must be based on personal experience, on specific clinical reference or on generally accepted opinion in the specialty field. *Id.*

Obviously, these standards aren't met if no expert testimony is offered in the first place. And these standards certainly go unmet if the expert discretion is left to Commission members who don't qualify in the specialty at issue.

Although these WSMA standards do not have the force of law, they are worthy of attention. These standards bear directly on this case and on the regulation of all complementary health care, now and in the future. To restate, the medical profession itself in this State not only recognizes that expert testimony is necessary to evaluate standards of care, but it holds its members to a guideline that

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<sup>15</sup> See WSMA Judicial Opinion 9.15 at Appendix B.

such testimony must come from a professional trained and experienced in the specialty at issue.

These standards reflect a principle born from the growing diversity in healthcare. Standards of safety and efficacy for any healthcare modality, and especially novel ones, should be evaluated only on the basis of expert evidence from those who are qualified in the specialty at issue.<sup>16</sup> That principle is one we ignore to the detriment of complementary health care, to the detriment of complementary healthcare consumers, and to the detriment of due process and equal protection.

**2. *Brown* violates due process, especially in the absence of actual harm.**

In cases like this one where a violation can only be proved with expert testimony, how does a practitioner charged with a violation respond to a prosecution that dispenses with expert testimony altogether?

In this case, we know there was no actual harm to Patient One. That's unchallenged.

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<sup>16</sup> In this case, Amici content that the DOH could have sought expert testimony from any of the specialties identified in Finding of Fact 1.1.

Second, what was the risk of harm to Patient One (or to any of Dr. Ames' patients) from the LISTEN device? The Order does not say; it only concludes that there was an unreasonable risk. That risk could not have been the potential for economic harm because it's undisputed that Dr. Ames did not charge for his use of the LISTEN device. Therefore, the risk of harm must have been for physical injury.

Next, we find that the Order lacks any indication of what the risk of physical harm was. There is no finding that the LISTEN device could cause harmful electrical shock. The only finding that Dr. Ames' use of LISTEN created an unreasonable risk of harm is found in Finding 1.29. The elements of that finding are that Dr. Ames: (i) made a false medical diagnosis; (ii) provided an ineffective treatment; and (iii) gave misinformation about a cure.

Amici is mindful that Dr. Ames' own briefs address the wholesale lack of evidence to support these findings. Amici will not repeat those important points here. Also, we will not belabor the inherent contradiction within the Commission's Order wherein the Commission admits that the LISTEN device was used only as an aide in diagnosis, but bases its

criticism on the unsubstantiated allegation that he used the device for treatment.

Rather, it is the due process issues that are of greatest concern to Amici. These due process issues are:

(a) It is the government's burden to prove the elements of Finding 1.29 by clear and convincing evidence.

See *Nguyen*.

(b) The DOH can only meet that burden with evidence entered into the record. RCW 34.05.461(4)

The evidence required must be qualified and competent. And specifically in this case, that evidence must include (though it's not limited to) testimony about the status of Patient One's allergies both before and after Dr. Ames' acupuncture treatment. How else could the elements of Finding 1.29 be established?

Nothing approaching this kind of evidence was offered by the government or addressed by the Commission's Order. This lack of evidence would not pass muster in a civil court proceeding in which the burden on the plaintiff is a preponderance of the evidence. As a rule, it certainly cannot

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pass muster here in a quasi-criminal proceeding where the burden on the government is “clear and convincing” evidence.

When this kind of approach is sanctioned - i.e, the prosecution is allowed to “prove” the elements of unreasonable risk without expert testimony - a presumption of harm is effectively created. That presumption improperly shifts the burden of proof to the respondent. And that shift is especially insidious and damaging in cases involving new holistic complementary healthcare modalities.

- a. The procedural approach sanctioned by this case shifts the burden of proof to the Respondent in violation of due process.

The most recent and instructive case in Washington about due process in the context of health care licensing is *Nguyen v. DOH*.<sup>17</sup> *Nguyen* was about the *standard* of proof, i.e. which of the three standards (preponderance, clear/cogent or “beyond reasonable doubt”) is to be used in a licensing proceeding like this one. The issue of *standard* of proof is different from the issue of *burden* of proof.

Notwithstanding any lingering controversy about *Nguyen* and which of the three *standards* of proof should

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<sup>17</sup> 144 Wn. 2d 516 (2001).

apply in health care licensing cases, the question about who possesses the *burden* of proof is not close.

The procedural approach sanctioned here absolves the government of the most basic obligation to put on a prima facie case with competent evidence, in a quasi-criminal case no less. By any measure, *Nyugen* and its foundations in U.S. Supreme Court do not allow the government to do what it did here.

For instance, the *Nyugen* Court recognized the 3-part test articulated in *Mathews v. Eldridge*<sup>18</sup>, used “to examine the minimum constitutional process due in a variety of procedural situations.” *Nguyen*, at 526.

In *Mathews*, 424 U.S. at 335, the Court considered whether a hearing prior to administrative termination of social security benefits was constitutionally required. The Court structured its consideration on three relevant factors: (1) the private interest that will be affected by the official action; (2) the risk of erroneous deprivation of such interest through the procedures used; and (3) the governmental interest in the added fiscal and administrative burden that additional process would entail.

*Id.*

The third of the *Mathews* factors deserves an especially close look in this case, i.e. the added fiscal and

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<sup>18</sup> 424 U.S. 319, 332 (1976)

administrative burden that additional due process procedures would entail. We emphasize this because the only stated rationale for dispensing with expert testimony is that judicial efficiencies justify an agency's ability to avoid expert testimony since the Commission could disregard the experts anyway.<sup>19</sup>

This rationale has been explicitly considered and explicitly rejected by the U.S. Supreme Court, and here in Washington State.

Indeed, almost in anticipation of this 3<sup>rd</sup> element of the *Mathews* test, the U.S. Supreme Court decided *Stanley v. Illinois*<sup>20</sup> just a few years earlier than *Mathews*. The *Stanley* case concerned the due process requirements involved in parentage cases. The Court there addressed the specific question of whether the State could forego due process requirements in the interest of efficiency. Here, in a quote that seems to have anticipated not only *Mathews* but this case also, the *Stanley* court said this:

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<sup>19</sup> See e.g., *Davidson v. DOL*, 33 Wn. App. 783 (1983), as cited by *Brown* at 14.

<sup>20</sup> 405 U.S. 645, 656-657 (1972).

The establishment of prompt efficacious procedures to achieve legitimate state ends is a proper state interest worthy of cognizance in constitutional adjudication. But the Constitution recognizes higher values than speed and efficiency. Indeed, one might fairly say of the Bill of Rights in general, and the Due Process Clause in particular, that they were designed to protect the fragile values of a vulnerable citizenry from the overbearing concern for efficiency and efficacy that may characterize praiseworthy government officials no less, and perhaps more, than mediocre ones.

Procedure by presumption is always cheaper and easier than individualized determination. But when, as here, the procedure forecloses the determinative issues . . . when it explicitly disdains present realities in deference to past formalities, it needlessly risks running roughshod over the important interests . . . [Such a procedure] therefore cannot stand.

Accord, *Robinson v. Seattle*, 102 Wn. App. 795, 826 (2000).

The procedural approach sanctioned to this point in this case allows the DOH and the Commission to shift the burden of proof altogether out of mere efficiency. By voiding the prosecution's burden to produce expert testimony on the core determinative issue in this case, we witness a clear violation of due process as articulated by *Nguyen, Matthews and Stanley*. This approach must be overturned.

**C. Turning to the Question of Efficacy For a New Modality, the Government's Burden of Proof Also Requires Competent, Properly Qualified Expert Evidence.**

It is equally disquieting that the State can bypass due process on the issue of efficacy. As with safety, the burden on efficacy is shifted without due process to the Respondent when the Commission can make decisions without any qualified, competent evidence. This is contrary to Washington State's express legislative policy about complementary healthcare.

1. Washington State's policy on Complementary Medicine embodied in RCW 18.120.

RCW 18.120 is designed to protect CAM practitioners from the overreaching, arbitrary and capricious actions of DOH regulators:

The legislature believes that all individuals should be permitted to enter into a health profession unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. . .

A health profession should be regulated by the state only when: (a) unregulated practice can clearly harm or endanger the health, safety and welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument . . .

See RCW 18.120.010(1) and (2).

This statutory language holds the key to understanding the real healthcare policy of this State, a policy that is always more properly expressed by a transparent Legislature as opposed to by a discrete commission whose operations are obscured by layers of administrative bureaucracy.

It is not coincidence that the cited language from RCW 18.120 mirrors proper due process considerations: Harm must be proved. It must be easily recognizable, and neither remote nor tenuous. The principles of RCW 18.120 – like the principles of due process – are the very antithesis of what the Commission and the DOH have perpetrated in this case. And it is what they will continue to perpetrate to the detriment of complementary practitioners and their clients in this State for years to come if this Court does not intervene.

**D. Without proof of harm, the DOH uses the authority of *parens patriae* under the guise of police power.**

The State uses its police power to protect citizens from harm and the unreasonable risk of harm. A similar power is conferred on the State as *parens patriae* – government as parent – to determine what is good and healthy for citizens

who are deemed unfit to care for themselves. See e.g. *Addington v. Texas*<sup>21</sup>, and *Born v. Thompson*<sup>22</sup>.

When state entities like the DOH and the Commission here exploit their police power in the absence of harm, and in the absence of authentic, qualified and credible expert evidence about the unreasonable risk of harm, those state entities cast themselves not as the arbiters of what is harmful, but as the arbiters of what is good and healthy. They cast themselves as the *parens patriae* of healthcare for all citizens. Amici submit that nothing could be more systemically damaging and offensive, much less unconstitutional, to the burgeoning and valuable healing relationships that now exist between millions of citizens and their complementary healthcare practitioners.

The exploitation of *parens patriae* is particularly dangerous in administrative cases:

“In these licensing boards . . . history has turned around, and the guilds of the middle ages replicated: ‘The thrust of occupational licensing . . . is toward decreasing competition by restricting access . . . toward a definition of occupational [privilege] that will debar others from sharing in

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<sup>21</sup> 441 U.S. 418 (1979).

<sup>22</sup> 154 Wn. 2d 749 (2005).

them; toward attaching legal consequences to essentially private determinations of what are ethically or economically permitted practices.”

“Accordingly, in *Gibson v. Berryhill*, the [U.S. Supreme] court found that the chance of an occupational licensing board to act in its own self-interest so tainted the board’s decisional process as to violate due process.”<sup>23</sup>

## VI. CONCLUSION

Few things in life are static. The lessons of nature and history alike teach us that all things either grow, or atrophy and die. In the realm of health care, evidence has been mounting for some time that the direction we are taking between growth and atrophy is neither promising nor what we intended.

We’re in new territory insofar as the benefits of complementary healthcare are concerned. The threat of this new territory to the old regime of orthodox health care is understandable, but not reason to reject it. It is certainly not a reason to dispense with due process.

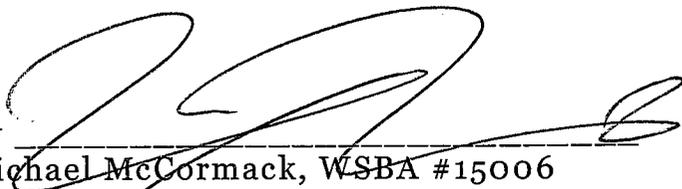
Proper Constitutional analysis guides us through this

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<sup>23</sup> *Administrative Law*, 2<sup>nd</sup> ed., Aman & Mayton; West Publishing, 2001, Chapter 7, Section 7.5.1, p. 167, citing W. Gellhorn, *Individual Freedom and Gov’t Relations*, 114 (1956) and *Gibson v. Berryhill*, 411 U.S. 564 (1973)

territory by clarifying, correcting and overturning that which takes us off course. This case calls for an unequivocal course adjustment. This case calls for judicial intervention. This case should be overturned for the reasons set forth here and in Dr. Ames' own briefing. No other branch will, or can, do what is necessary here – protect due process, and thereby the health of our future and the future of our health.

DATED this 9<sup>th</sup> day of February, 2009.

  
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# APPENDIX A

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## *White House Commission on Complementary and Alternative Medicine Policy*

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PDF VERSION

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TABLE OF CONTENTS

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- Cover
  - Transmittal Letters
  - Acknowledgements
  - Commission Members
  - Chairman's Vision
  - Executive Summary
- 

1. Introduction
  2. Overview
  3. Coordination of Research
  4. Education & Training of Health Care Practitioners
  5. Information Development & Dissemination
  6. Access & Delivery
  7. Coverage & Reimbursement
  8. Wellness and Health Promotion
  9. Coordinating Federal CAM Efforts
  10. Recommendations & Actions
- 

- Acronyms
- 

APPENDICES

- A.
    - Executive Order
    - Commission Charter
  - B.
    - 10 Rules for Health Care Reform
    - Pew Task Force Recommendations
- 

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### Executive Summary

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The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive Order No. 13147 in March 2000. The order states that the Commission is to provide the President, through the Secretary of Health and Human Services, with a report containing legislative and administrative recommendations that will ensure public policy maximizes the potential benefits of complementary and alternative medicine (CAM) to all citizens. The report of the Commission is to address:

- The coordination of research to increase knowledge about CAM products,
- The education and training of health care practitioners in CAM,
- The provision of reliable and useful information about CAM practices and products to health care professionals, and
- Guidance regarding appropriate access to and delivery of CAM.

The Commission's 20 Presidentially-appointed members represented an array of health care interests, professional backgrounds, and knowledge. Health care expertise was provided by both conventional and CAM practitioners.

To accomplish its mission, the Commission held four Town Hall meetings (San Francisco, Seattle, New York City, and Minneapolis) to listen to testimony from hundreds of individuals, professional organizations, societies, and health care organizations interested in Federal policies regarding CAM. In addition to the town hall meetings, the Commission invited expert testimony during its 10 regular meetings held in the Washington, D.C. area. The Commission asked clinicians, researchers, medical educators, representatives of health insurers and managed care organizations, benefits experts, regulatory officials, and policymakers to provide informational recommendations and documentation to support them. The Commission also solicited testimony from the public at each of its regular meetings. Finally, the Commission conducted a number of site visits to see first-hand how various medical institutions are integrating CAM into clinical practice and collaboration between CAM and mainstream health care providers.

To develop recommendations, the Commissioners divided into work groups, each addressing a particular topic. The work groups' recommendations were then presented to the whole Commission, discussed, and used as a basis for developing final recommendations.

Based on its mission and responsibilities, the Commission endorsed the following

- C. Commission Meetings
  - D. General & Town Hall Meeting Participants
  - E. Organizations Providing Information on Education and Training
  - F. Workgroup Members
  - G. Statement from Commissioners
- 

10 guiding principles to shape the process of making recommendations and to focus the recommendations themselves:

1. A wholeness orientation in health care delivery. Health involves all aspects of life-mind, body, spirit, and environment-and high-quality health care must support care of the whole person.
2. Evidence of safety and efficacy. The Commission is committed to promoting the use of science and appropriate scientific methods to help identify safe and effective CAM services and products and to generate evidence that will protect and promote the public health.
3. The healing capacity of the person. People have a remarkable capacity for recovery and self-healing, and a major focus of health care is to support and promote this capacity.
4. Respect for individuality. Each person is unique and has the right to health care that is appropriately responsive to him or her, respecting preferences and preserving dignity.
5. The right to choose treatment. Each person has the right to choose freely among safe and effective care or approaches, as well as among qualified practitioners who are accountable for their claims and actions and responsive to the person's needs.
6. An emphasis on health promotion and self-care. Good health care emphasizes self-care and early intervention for maintaining and promoting health.
7. Partnerships as essential to integrated health care. Good health care requires teamwork among patients, health care practitioners (conventional and CAM), and researchers committed to creating optimal healing environments and to respecting the diversity of all health care traditions.
8. Education as a fundamental health care service. Education about prevention, healthy lifestyles, and the power of self-healing should be made an integral part of the curricula of all health care professionals and should be made available to the public of all ages.
9. Dissemination of comprehensive and timely information. The quality of health care can be enhanced by promoting efforts that thoroughly and thoughtfully examine the evidence on which CAM systems, practices, and products are based and make this evidence widely, rapidly, and easily available.
10. Integral public involvement. The input of informed consumers and other members of the public must be incorporated in setting priorities for health care and health care research and in reaching policy decisions, including those related to CAM, within the public and private sectors.

CAM is a heterogeneous group of medical, health care, and healing systems other than those intrinsic to mainstream health care in the United States. While "complementary and alternative medicine" is the term used in this report, the

# APPENDIX B

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**PRINCIPLES OF MEDICAL ETHICS**  
**AND**  
**OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL**  
**OF THE**  
**WASHINGTON STATE MEDICAL ASSOCIATION**

**PREFACE**

This edition of the Opinions and Reports of the Judicial Council of the Washington State Medical Association replaces all previous editions which were last published in 2001. It is intended as an adjunct to the revised Principles of Medical Ethics that were adopted by the American Medical Association in 2001 and by the House of Delegates of the Washington State Medical Association in 2005.

Medical ethics involves the professional responsibilities and obligations of physicians. The Opinions expressed by the Judicial Council are intended as guidelines to responsible professional behavior, but they are not presented as the sole or only route to medical morality.

An attempt is made to relate the Judicial Council's Opinions to relevant Principles of Medical Ethics in the parentheses at the end of each Opinion. However, no one Principle can stand alone or be individually applied to a situation. In all instances, it is the conglomerate intent and influence of the Principles of Medical Ethics which shall measure ethical behavior for the physician. Judicial Council Opinions are issued under the Council's authority to interpret the Principles of Medical Ethics and to investigate general ethical conditions in all matters pertaining to the relations of physicians to one another and to the public.

The Judicial Council encourages comments and suggestions for future editions of its Opinions and Reports.

\* \* \* \*

4. Sexual or romantic relationships between a physician and a former patient or key third party may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients or key third parties are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.
5. Key third parties include, but are not limited to, spouses or partners, parents, siblings, children, guardians, and proxies.

#### 9.15 EXPERT WITNESS STANDARDS.

##### Qualifications

1. Possess a current, valid and unrestricted license in the state in which he/she practices.
2. Fully trained in the specialty and a diplomat in a relevant ABMS recognized specialty board and demonstrated competence in the subject of the case.
3. Be familiar with the clinical practice of the specialty or the subject matter of the case, and be actively involved in the clinical practice of the specialty for at least 3 of the previous 5 years at the time of the testimony.

##### Standards For Testimony

1. Thoroughly review the medical information in the case and testify to its content fairly and impartially.
  2. Review the standards of practice prevailing at the time of the occurrence.
  3. Be prepared to state the basis of the testimony presented, and whether it is based on personal experience, specific clinical references, or generally accepted opinion in the specialty field.
  4. The expert witness is expected to be impartial, and should not adopt a position as an advocate.
  5. Compensation should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. An expert witness may not link compensation to outcome of the case.
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6. Testimony is public record and subject to peer review.
7. Make a clear distinction between malpractice and adverse outcomes. Assess the relationship of the alleged substandard practice to the patient's outcome.