

No. 71516-0

COURT OF APPEALS, DIVISION I
STATE OF WASHINGTON

JONATHAN V. WRIGHT, M.D., Appellant,

v.

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

BRIEF OF APPELLANT
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I. INTRODUCTION

Petitioner Dr. Jonathan V. Wright, M.D. requests judicial review of the improper administrative disciplinary action taken against him by the Washington Medical Quality Assurance Commission (MQAC). Dr. Wright asks this Court to review and reverse MQAC's final Order (AR 2330-2349), including but not limited to MQAC's specific sanctions.

Dr. Wright is the medical director¹ of the Tahoma Clinic in Renton, Washington. He has long been a target of MQAC investigations and administrative action. This is the first case in which MQAC has sanctioned him.

MQAC held Dr. Wright responsible for aiding and abetting the unlicensed activity of another doctor (Roby Mitchell) at the Tahoma Clinic. MQAC held Dr. Wright responsible for aiding and abetting, even though MQAC's own Presiding Officer summarily held as a matter of undisputed fact that Dr. Wright did not possess knowledge about Mitchell's unlicensed activity necessary for MQAC to sustain an *aiding and abetting* charge.

¹ The title of "medical director" has no specific legal definition, per se.

Dr. Wright did not possess the knowledge required to substantiate aiding and abetting because Mitchell had lied to him about Mitchell's own licensing status. The effect of Mitchell's lie was exacerbated by MQAC itself; Tahoma Clinic staff had asked MQAC about Mitchell's licensing status, and MQAC represented that his application was open, pending and clear, i.e. indicating there was no adverse action against him anywhere.

There is no dispute about these events. Still, the MQAC hearing panel ignored Dr. Wright's lack of knowledge about Mitchell's status and the Clinic's efforts to investigate Mitchell with MQAC. Instead, in the context of Dr. Wright's lack of knowledge and his efforts to check with MQAC, the MQAC litigation team altered the charge against Dr. Wright, without notice, mid-stream of the adjudication. Further, MQAC issued a novel, unprecedented interpretation of the medical licensing statute to shoehorn the new charges into the medical licensing statute. This *aiding and abetting* outcome was a result-oriented process with a predetermined outcome.

In addition to the aiding and abetting charge, MQAC added unsubstantiated findings and conclusions that Dr.

Wright failed to cooperate. MQAC set this charge up by first misinforming Dr. Wright that MQAC's early inquiries to him about Mitchell were not part of a sanctioned investigation because no "determination of merit" for investigation had been issued by the Commission. This was false; MQAC was already underway with its investigation of Dr. Wright's purported aiding and abetting. MQAC had issued a "determination of merit." The import of this is that this subterfuge eventually led to Dr. Wright to question the legitimacy of MQAC's warrantless administrative search for medical records considering MQAC's representation that its questions were not part of a sanctioned investigation.

The evidence proves Dr. Wright answered questions and provided documents over the course of 15 months of MQAC investigation. He never refused to cooperate. After 15 months of prolonged investigation, Dr. Wright through legal counsel asked (while maintaining the willingness to cooperate) the grounds of MQAC's warrantless administrative search for irrelevant medical records. That is when MQAC invoked non-cooperation charges.

Using the combination of charges for aiding and abetting along with non-cooperation, MQAC issued an arbitrary, capricious and unconstitutional sanction against him. Among the sanctions, MQAC is compelling Dr. Wright to issue a written statement to MQAC about the benefits of licensing, forcing Dr. Wright to endorse MQAC and thereby adopt the government's position. This violates the U.S. Constitution.

The result was predetermined. MQAC's final order against Dr. Wright should be summarily reversed for the reasons explained next.

II. ASSIGNMENTS OF ERROR AND ISSUES FOR REVIEW

- a. MQAC engaged in an unlawful proceeding contrary to due process: MQAC charged Dr. Wright for aiding and abetting unlicensed practice based on his alleged actual knowledge of Mitchell's Texas status, but added a different substantive charge without notice that was unrelated to Dr. Wright's actual knowledge;
- b. MQAC committed errors of law at Conclusion 2.5 in its interpretation of (i) the out-of-state exemption to Washington's medical licensing statute; and (ii) the

elements of aiding and abetting under the Uniform Disciplinary Act;

- c. MQAC engaged in an unlawful procedure by engaging in retroactive “rulemaking by adjudication,” in that the panel issued an interpretation of the licensing statute that is not established by regulation, guideline or other lawful notice;
- d. MQAC engaged in an unlawful proceeding by inferring the existence of facts that were not entered into evidence;
- e. MQAC’s charges, conclusions at Conclusion 2.4 and sanction in regard to the non-cooperation charge against Dr. Wright are based on unconstitutional warrantless administrative search procedures, and violate the U.S. and Washington Constitutions, both facially and as applied, based on 4th Amendment due process and the “unconstitutional conditions” doctrine.
- f. MQAC’s charges, conclusions at Conclusion 2.4 and sanction in regard to the non-cooperation charge against Dr. Wright are based on warrantless administrative search procedures that violate Washington statutory provisions.
- g. MQAC’s sanction was arbitrary and capricious and violated the precedent MQAC established for implementing its own sanction guidelines.

III. STATEMENT OF THE CASE

A. Dr. Wright's history with MQAC.

MQAC has conducted numerous investigations of Dr. Wright over a long period of time. (AR 848-849; see specifically, the list at 849) These investigations have resulted in legal action on more than one occasion. (See e.g. 2008 legal proceeding at AR 826-836 and reference at AR 923) During this time, Dr. Wright has questioned MQAC's methods and motives. (AR 921-923: Dr. Wright's blog post about MQAC). MQAC included these materials in its investigative file for this matter.

In one of MQAC's 2008 legal actions against Dr. Wright that preceded the present case, Dr. Wright's prior attorney drew a line in the sand about MQAC's illegal warrantless administrative search and seizure procedures. (AR 826-836, generally, and specifically AR 835 at lines 1-2). As explained below, MQAC has adopted an illegal search and seizure procedure that holds doctors strictly liable if the doctors fail to produce medical records at MQAC's unfettered command. Washington judges at the superior court and appellate court levels (consistent with U.S. Supreme Court

precedent) have called MQAC's procedure into question. See e.g. Appendix A to this Brief. MQAC's illegal search and seizure of medical records was a battle-ground in the prior matter, and it is one of the issues that MQAC leveraged against Dr. Wright in this case.

Dr. Wright's dealings in this same prior case also brought to MQAC's attention that Mitchell was working at the Clinic. (AR 834)

B. Dr. Roby Mitchell's work at the Clinic.

1. The Clinic's Independent Contract with Mitchell.

In the September of 2007, Mitchell arrived in Washington and entered into an independent contractor agreement with the Clinic.² Prior to entering into the contract, Mitchell misrepresented to Dr. Wright that he was licensed to practice medicine in Texas.³ Mitchell told Dr. Wright that he was visiting Washington temporarily while exploring permanent status in Washington.⁴

² AR 932

³ AR 797-801, ¶5.

⁴ *Id.* at ¶¶5-6.

Pursuant to the exemption under RCW 18.71.030(6), which authorizes the temporary practice of medicine by a physician licensed in another state, Dr. Wright believed Mitchell was authorized to practice and entered into a contractual relationship with him on September 27, 2007.⁵ Between September of 2007 and March of 2009, Mitchell cared for Clinic patients under the supervision of Dr. Wright.⁶ Throughout that time, Mitchell continued to maintain that (1) he had an active Texas medical license, and (2) he continued to actively pursue his Washington license.⁷ Mitchell discontinued his work at the Clinic in March of 2009.⁸

What Dr. Wright later learned only after MQAC filed non-cooperation charges against him was that Mitchell's Texas license had been revoked by Texas authorities in 2005.

2. **MQAC failed to disclose Mitchell's status to Dr. Wright and the Clinic.**

Throughout Mitchell's tenure at the Clinic, Mitchell's statement concerning his Texas medical license and the

⁵ *Id.* at ¶9.

⁶ *Id.* at ¶13.

⁷ *Id.*

⁸ *Id.* at ¶8.

pursuit of his Washington license were corroborated by MQAC.⁹ The Clinic made inquiries to MQAC in 60-day intervals Mitchell's Washington medical license application.¹⁰ MQAC response was the same each time the Clinic inquired, i.e., that Mitchell's application for a Washington medical license was active and pending.¹¹

As MQAC Staff Attorney Mike Bahn stated later “[The Clinic’s] periodic license checks never showed anything but an open application and no denial.” AR 1347.

Nevertheless, MQAC knew in 2007 that Mitchell's Texas license had been revoked.¹² MQAC's standard practice is to pull information from the National Practitioner's Data Bank or the American Medical Association as soon as a license is requested; accordingly, MQAC knew Mitchell's Texas status as early as September of 2007.¹³

⁹ *Id.* at ¶8.

¹⁰ *Id.*.

¹¹ *Id.*

¹² AR 1034-1052; (Transcript of the Deposition of Catrina Murphy, AR 1041; Ins.5-9, AR 1048; Ins. 23-25, AR 1049; Ins.1-7).

¹³ AR 0991-1007: Transcript of the Deposition of Betty Elliot, AR 1001, p.44 Ins. 24-25; AR 997, p. 25 ln. 1-8; AR 994, p. 13-14 Ins.1-18.

C. MQAC's Investigation of Dr. Wright

May 4 2009: MQAC investigator Joy Johnson wrote to Dr. Wright regarding Dr. Mitchell and Mitchell's role at the Clinic. AR 2929-2930. Specifically, Ms. Johnson described the complaint as follows:

[MQAC] has received a complaint alleging that you have Roby Mitchell, MD, working at your Tahoma Clinic in Renton, WA and billing for his medical services; however, to date, Dr. Mitchell is not currently licensed by the Washington State Department Health [sic] to practice as a medical physician. AR 2929.

May 14, 2009. Through his attorney, Dr. Wright requested from Ms. Johnson MQAC's file and MQAC's determination of merit to investigate. AR 29332.

May 21, 2009. Ms. Johnson refused Dr. Wright's request for MQAC's file and further indicated that a determination of merit had not been issued. AR 2934. Evidence obtained later in discovery (AR 229-289) proved that MQAC had issued a determination of merit to investigate Dr. Wright for aiding and abetting.

May 28, 2009. Dr. Wright responded fully by letter to Ms. Johnson's requests for information. (AR 3174-75) MQAC's staff attorney has stated under oath that this

response from Dr. Wright fully satisfied Johnson's inquiry of May 3, 2009. AR 1009-1032.

Dec. 17, 2009. Dr. Wright received more questions. (AR 3177-78). Dr. Wright responded on Feb. 26, 2010. (AR 3180-81). Mr. Bahn has testified that Dr. Wright's February 26th response answered Bahn's Dec. 17th questions in full and without evasion. (AR 1009-1032: Bahn deposition, p. 58, lines 1, 14-25 and p. 59-60).

March 9, 2010. Dr. Wright received more questions. (AR 3185):

Please provide us with a more detailed explanation of how Dr. Wright interacted with Dr. Mitchell to provide supervision. Also, please forward a sample of patient records *that would show Dr. Wright's supervisory input* on the patients that Dr. Mitchell saw during this period. You can redact the patient names as that is not material to our inquiry. [Emphasis added.]

Bahn's request for medical records was not bona fide as (1) it did not relate to any aspect of the investigation; and (2) a sanctioned investigation was disclaimed by MQAC in the first place.

March 26, 2010. Dr. Wright's attorney responded. (AR 3187). That letter concluded with the following observation and request:

In closing, I believe Dr. Wright and the Clinic have answered all material questions posed to us about Dr. Mitchell's status. **If there is some other basis for MQAC's investigation now other than Dr. Mitchell's status**, please advise. (Bold added for emphasis.)

Bahn responded that same day. (AR 3190). With regard to the request for records, he stated as follows:

[I]n this particular matter, the Tahoma Clinic could provide us with records, reflecting Dr. Mitchell's involvement, that have the patient names elided, i.e. redacted, since we are not interested in the patients per se.

April 14, 2010. Dr. Wright responded with questions about the basis for the records request. This letter repeated Dr. Wright's willingness to cooperate, although with concern about whether the request for medical records was authorized and lawful. That letter included an express statement that Dr. Wright's legal team was "in the dark" about what MQAC was investigating, and requested clarification in order to "find a way around this current dilemma." See AR 3192-93.

July 15, 2010. Dr. Wright supplied heavily redacted records of three (3) Clinic patients to Bahn. (AR 3200-3210).

These documents redacted all references to patient names and the patient's private, protected personal medical information.

Mr. Bahn testified under oath that this production responded to Bahn's request for production of records. (AR 1009-1032: Bahn p. 77, l. 23-25; p. 78; p. 79, l. 1-3).

August 30, 2010. Ms. Johnson wrote to Dr. Wright's attorney, demanding a complete list of patients seen at the Clinic by Mitchell, along with copies of 30 unredacted and unaltered medical records of patients seen by Dr. Mitchell. (AR 3212-12).

September 30, 2010. Dr. Wright's attorney wrote to Ms. Johnson. The first part of the letter (AR 3215-18) sets forth the chronology of the investigation as described above here. The letter requested specific information based on Washington law in order to "fairly consider [Dr. Wright's] rights and responsibilities." This letter expressed Dr. Wright's continued willingness to cooperate pending MQAC's response to the aforementioned questions.

MQAC's response was to file non-cooperation charges 8 months later.

D. MQAC's charges against Dr. Wright

On March 16, 2011, MQAC filed a Statement of Charges¹⁴ against Dr. Wright, charging him with non-cooperation under RCW 18.130.180(8)(a).¹⁵ During the non-cooperation adjudication, MQAC was forced by the Presiding Officer to produce its investigative file, at which point Dr. Wright learned for the first time that MQAC had issued a determination of merit for investigation of an aiding and abetting charge.

Thereafter, the attorneys reached an agreement whereby Dr. Wright furnished five un-redacted records to MQAC with the explicit understanding that if they needed more information, MQAC would so inquire. MQAC has made no additional requests. On June 25, 2012, MQAC amended the Statement of Charges against Dr. Wright adding a charge for aiding or abetting an unlicensed person to practice when a license is required. AR 551-554.

¹⁴ AR 1-13.

¹⁵ The statute defines unprofessional conduct as “Failure to cooperate with the disciplining authority by: (a) Not furnishing any papers, documents, records, or other items.

Specifically, at AR 553-54 at ¶1.12, MQAC's aiding and abetting charge stated:

Respondent allowed an unlicensed individual, Roby Mitchell, to regularly use Respondent's clinic . . . to treat patients. . . Roby Mitchell's Texas license had been revoked effective September 2005, and Mitchell held no active medical license in Washington or any other state while practicing at Respondent's Clinic. (underline added.)

E. Pre-hearing adjudication of substantive issues narrowed the case.

In the Fall of 2012, Dr. Wright filed two dispositive motions. The first motion sought dismissal of MQAC's non-cooperation charges. In the second motion, Dr. Wright sought dismissal of the aiding or abetting charge.

On December 24, 2012, the Presiding Officer denied Dr. Wright's motions for summary judgment. (AR 2086-2098.) The Presiding Officer found the following: (1) MQAC knew the day that Mitchell filed for a Washington license that Mitchell's Texas license was revoked,¹⁶ (2) MQAC never revealed this fact to Dr. Wright or his staff¹⁷, and (3) MQAC knew Mitchell was practicing in Washington.¹⁸ The Presiding

¹⁶ AR 2090 at ¶ 1.7.

¹⁷ AR 2091 at ¶ 1.9.

¹⁸ *Id.*

Officer also made the following relevant conclusions of law: (A) the charge of aiding or abetting requires knowledge and intent and (B) there is “no document or evidence before the Presiding Officer that [shows Dr. Wright] knew Dr. Mitchell’s Texas license had been revoked.”¹⁹

Still, the Presiding Officer held that a “material fact question” existed about whether there was “a common practice in the profession . . . concerning having out-of-state physicians practicing in a respondent’s clinic or office.” AR 207 at ¶2.10.

F. The Disciplinary Hearing

At the hearing, MQAC offered no evidence and no witness concerning the “material fact question” stated by the Presiding Officer about whether there was “a common practice in the profession . . . concerning having out-of-state physicians practicing in a respondent’s clinic or office”.

As for the medical records on which MQAC’s non-cooperation charges were based, those medical records were never used, addressed or mentioned at the hearing. MQAC’s

¹⁹ AR 2096 at ¶ 2.9.

request for medical records was void of any connection to MQAC's investigation and charges.

G. Final Order

In its final Order, MQAC found Dr. Wright strictly liable for non-cooperation because he did not comply with the request for 30 medical records fifteen months after MQAC's investigation started.

In regard to the aiding and abetting charge, MQAC found Dr. Wright guilty. MQAC's Findings and Conclusions did not focus on the status of Mitchell's Texas license. AR 2343 at ¶1.12. Rather, MQAC's Order states that Mitchell's Texas license revocation and Dr. Wright's lack of knowledge had no bearing on its decision. *Id.*

Instead, MQAC's finding and conclusion against Dr. Wright was that Mitchell did not qualify for the out-of-state exemption under RCW 18.71.030(6), and that Dr. Wright was responsible for that shortcoming. The panel rendered its decision on that new charge without evidence. The panel rendered that decision by declaring a novel, unprecedented and erroneous interpretation of the out-of-state exemption at RCW 18.71.030(6).

Further, the hearing panel altogether ignored the Presiding Officer's earlier ruling about the sole issue of fact: what is "common practice" for investigating on out-of-state doctor's license? At the hearing and within its final Order, MQAC failed to identify any regulation, guideline or professional "common practice" for how this statutory licensing exemption is applied. Nevertheless, MQAC applied its unilateral interpretation to Dr. Wright. In summary, despite the Presiding Officer's summary judgment order stating that the "common practice" for out-of-state physicians was fact issue, MQAC offered no evidence, no finding and no conclusion pertaining to the common practice in the profession.

1. The Sanctions.

The hearing panel declared that this case was not governed by a sanction guideline, and so it used *its judgment* to dole out the sanctions. AR 2345. MQAC sanctioned Dr. Wright by:

- Suspending him from practice for 90 days;
- Placing him on 30-months probation thereafter;
- Requiring him to write a paper about the benefits of

professional licensing;

- Requiring him to submit an office protocol for verifying employee credentials;
- Fining him \$7,500.

These sanctions are arbitrary and capricious, as well as unconstitutional, for the reasons described below.

IV. LEGAL ANALYSIS

A. MQAC's Aiding and Abetting Charge was unfounded, contrary to law and due process.

There is no dispute; Dr. Wright did not know Dr. Mitchell's Texas license was suspended. MQAC's staff noted in MQAC's file as early as May 29, 2009, that neither Dr. Wright nor his attorney was aware Dr. Mitchell's Texas license was revoked.²⁰ As Dr. Wright argued to the Presiding Officer in its administrative summary judgment, MQAC had to prove knowledge and could not do so. See e.g. *Barrett v. Board of Osteopathic Examiners*, 4 Cal. App. 2d 135, 40 P.2d 923 (1935), as cited to the Presiding Officer.

The Presiding Officer agreed in his written decision, wherein he wrote, "to aid and abet requires knowledge and

²⁰ AR 851.

intent.”²¹ The order further states, there was “no document or evidence before the Presiding Officer that [shows Dr. Wright] knew Dr. Mitchell’s Texas license had been revoked.”²² This effectively should have ended MQAC’s aiding and abetting charge.

However, the Presiding Officer crafted a new, fact-based “common practice” allegation – i.e. should the Clinic have done more to investigate Mitchell’s Texas status than rely on MQAC’s disclosure? This allegation of “administrative negligence” was never charged, and certainly never proved.

MQAC could not prove Dr. Wright’s knowledge about Mitchell’s Texas license, and it could not prove a “common practice.” Instead, MQAC retroactively developed unprecedented, novel standards for the out-of state licensing exemption of RCW 18.71.030(6), and then held Dr. Wright guilty of violating those standards, although that violation had never been charged.

1. **MQAC violated due process by prosecuting an uncharged offense against Dr. Wright without**

²¹ See footnote 22, supra.

²² Id.

notice.

The government must provide notice of its charge under the U.S. and State Constitutions. *U.S. v. Cruikshank*, 92 U.S. 542 (1876); *State v. Berlin*, 133 Wn. 2d 541 (1997). The government cannot try a defendant for an uncharged offense. *State v. Perez*, 130 Wn. App. 505 (2005). If a charging document alleges only one means of committing a violation, it is error for the court to consider an uncharged alternative, regardless of the evidence. *Perez*, at 507; *State v. Chino*, 117 Wn. App. 531, 540 (2003); *State v. Bray*, 52 Wn. App. 30, 34 (1988). Such an error is presumed to be prejudicial. *Perez*, at 507; *Bray*, at 34-35.

Here, MQAC charged Dr. Wright with aiding and abetting Mitchell because Mitchell did not have an active license due to Mitchell's revoked Texas license. See MQAC's Amended Statement of Charges; AR 553-54 at ¶1.12. MQAC did not charge Dr. Wright with violating its retroactive interpretation of the out-of-state exemption to the licensing statute at RCW 18.71.030(6); such a charge would have required MQAC to allege that Dr. Wright was complicit in misrepresenting Mitchell's Texas license, and/or that Dr.

Wright was complicit in establishing Mitchell's residency in Washington; and/or opening for Mitchell his own medical office.

These evidentiary elements represent "a different means of committing the alleged violation," and MQAC failed to charge them. Nevertheless, that is the charge for which MQAC found Dr. Wright guilty.

2. **MQAC erred in its interpretation of the statutory licensing exemption.**

The MQAC hearing panel committed several additional errors. First, MQAC issued an interpretation of the licensing exemption statute at RCW 18.71.030(6), which allows out-of-state practitioners to practice in Washington, does not mean what it says. Second, MQAC still persisted in finding without evidence that the Clinic should have done more than rely on MQAC to determine Mitchell's licensing status.

As to the first of these two points, MQAC has committed an error of law.

a. **RCW 18.71.030(6) allowed Mitchell to practice as an out of state physician but for his Texas license revocation.**

RCW 18.71.030 states in relevant part:

Nothing in this chapter shall be... construed to

prohibit:

(6) The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state;

If a statute's meaning is plain on its face, the court gives effect to that plain meaning as an expression of legislative intent. *State ex rel. Citizens Against Tolls (CAT) v. Murphy*, 151 Wn.2d 226, 242, 88 P.3d 375 (2004). The court discerns plain meaning not only from the provision in question but also from closely related statutes and the underlying legislative purpose. *Murphy*, 151 Wn.2d at 242, 88 P.3d 375.

RCW 18.71.030(6) does not limit a physician licensed in another state from working as an independent contractor in a Washington office while being supervised under a Washington licensed physician. Contrary to MQAC's conclusion, RCW 18.71.030(6) contains no time-limitations on how long the out-of-state physician may practice under the authority of this statute. In fact, the statutory and administrative context of RCW 18.71 and the corresponding

provisions of the Washington Administrative Code contained in WAC 246-12 confirm that a physician licensed in another state can practice under the supervision of Washington physician as long as they do not open their own discrete practice in their own office.

For instance, WAC 246-12-050 enables a number of healthcare professionals²³ to obtain a **temporary** practice permit under certain conditions. Under subparts (3)(a)-(c), the WAC limits the duration of the temporary practice permit to 180-days, or earlier if the license application is resolved before 180-days.

Physicians are noticeably absent from the list of healthcare professionals to which this time-limitation applies. That is, physicians are not subject to the requirements and limitations of the WAC 246-12-050 temporary practice permit because the broader permissions of RCW 18.71.030(6) apply to physicians. RCW 18.71.030(6) specifically allows physicians licensed in another state to practice medicine in Washington as long as they do not run afoul of the statute's

²³ Those professions without a board or commission, i.e. those listed under RCW 18.130.040(2)(a) – the Secretary professions as opposed to the Board professions.

prohibitions. This is the only way to reconcile the statutes and regulations. MQAC could have rendered a regulation clarifying and standardizing a time limitation for out-of-state physicians, just as the DOH did for Secretary professions. MQAC has never done so, and it cannot do so now under the guise of ad hoc, retroactive rulemaking by adjudication.

3. **MQAC rendered without any evidence its Findings and Conclusions about the Clinic's reliance on MQAC.**

In a quasi-criminal case such as this, the burden is on the government to prove the factual elements of the charges with clear, cogent and convincing evidence. *Nguyen v. MQAC*, 144 Wn.2d 516 (2001). Conviction by presumption without evidence violates Constitutional principles. *Matthews v. Eldridge*²⁴, and *Stanley v. Illinois*²⁵. MQAC used presumption alone, without evidence, to find Dr. Wright responsible for not doing more to discover Mitchell's Texas status beyond relying on MQAC.

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

²⁴ 424 U.S. 319, 332 (1976).

²⁵ 405 U.S. 645, 656-657 (1972).

deference to past formalities, it needlessly risks running roughshod over the important interests . . . [Such a procedure] therefore cannot stand.

Stanley, at 656-657; Accord, *Robinson v. Seattle*, 102 Wn. App. 795, 826 (2000).

a. **The Administrative Procedure Act requires evidence before agency discretion can be exercised.**

RCW 34.50.461 requires actual evidence in order to determine findings of fact. Subparts (4) and (5) are quoted below:

(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. . . .

(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 MQAC do not qualify as evidence.

Next, Subpart (5) does not allow the agency's expertise to replace the qualified evidence required by Subpart (4). Subpart (5) allows only for the agency's expertise to bear on an evaluation of that evidence. Furthermore, in that the

factual issue at hand does not involve standard of care, the hearing panel's expertise about Clinic administration is dubious, at best.

Few cases have addressed RCW 34.05.461(5).²⁶ In each of these cases, the adjudicators heard and relied on actual evidence. The plain meaning of RCW 34.05.461(5) bears repeating. MQAC may use its expertise to evaluate the weight given to evidence. The statute does not authorize MQAC to dispense with evidence altogether. This is especially true when, as here, the Presiding Officer expressly stated the very issue of fact about "common practice" that MQAC was required to prove. MQAC offered no evidence regarding the "common practice" standard which it contends must be used by Washington physicians to verify out-of-state licenses.

4. **MQAC's unprecedented interpretation of the licensing exemption creates a new rule through ad hoc adjudication, and applies that rule retroactively contrary to law and due process.**

MQAC has never issued rules, regulations or guidelines pertaining to the out-of-state exemption to physician

²⁶ See e.g., *Clausing v. State*, 90 Wn. App. 863 (1998); *DaVita v. DOH*, 137 Wn. App. 174 (2007).

licensing requirements of RCW 18.71, *et. seq.*, although the Department of Health has seen fit to do so with the non-Board professions. Yet MQAC found that Dr. Wright violated what the Presiding Officer described as a “common practice” standard that has never been proved or even articulated. MQAC’s actions violate the retroactive application of rulemaking through ad hoc adjudications. This step violates due process, is an error of law and results in an arbitrary and capricious result against Dr. Wright.

a. **Rulemaking is the only Proper Method to Establish General Policy. Adjudication is Disfavored.**

Cases across the country have long stated under circumstances like those presented here, that an agency should establish standards and guidelines of general application by the APA rulemaking procedure.

[W]hen the subject matter of an agency determination concerns matters transcending those of individual litigants and involving general administrative policies . . . rulemaking procedures are implicated.²⁷

²⁷ *In the Matter of Sheriff's Officer*, 543 A.2d 462 (N.J. Super. A.D. 1988)

The Texas Supreme Court stated it well:

A presumption favors adopting rules of general applicability through the formal rulemaking procedures as opposed to administrative adjudication. See *Amarillo Indep. Sch. Dist. v. Meno*, 854 S.W. 2d 950, 958 (Tex. App.—Austin 1993, writ denied.) Allowing an agency to create broad amendments to its rules through administrative adjudication rather than through its rulemaking authority undercuts the Administrative Procedure Act (APA).²⁸

...

[A]n agency determination must be considered an administrative rule . . . in many or most of the following circumstances, (1) is intended to have wide coverage encompassing a large segment of the regulated or general public, rather than an individual or a narrow select group; (2) is intended to be applied generally and uniformly to all similarly situated persons; (3) is designated to operate only in future cases, that is, prospectively; (4) prescribes a legal standard or directive that is not otherwise expressly provided by or clearly and obviously inferable from the enabling statutory authorization; (5) reflects an administrative policy that (i) was not previously expressed in any official and explicit agency determination, adjudication or rule, or (ii) constitutes a material and significant change from a clear, past agency position on the identical subject matter; and (6) reflects a decision on administrative regulatory policy in the nature of the interpretation of law or general policy. These relevant factors can, either singly or in combination, determine in a given case whether the essential agency action must be rendered through rule-making

²⁸ *Rodriguez v. Lloyds*, 997 S.W. 2d 248 (Tx. 1999).

or adjudication.²⁹

These factors are present here.

b. **Even when Permitted, Guidelines Established by Adjudication are Prospective only.**

[An agency should not] “give its later decisions retroactive effect, especially when to do so would adversely affect actions taken and rights and interests acquired by private persons on the faith of the earlier decisions . . .”

Linkletter v. Walker, 381 U.S. 618, 622-24 (1965).

In *Retail, Wholesale & Department Store Union v. NLRB*, 466 F.2d 380 (D.C. Cir. 1972), [that] court went a step further and held that . . . a reviewing court could require an agency to give a rule established by adjudication prospective effect only. The court adopted the balancing test enunciated by the Supreme Court in *Chenery*³⁰: “(The effects of retroactivity must be balanced against the mischief of producing a result which is contrary to a statutory design or to legal and equitable principles.” The court further held that the application of this test “**is in each case a question of**

²⁹ *Id.*

³⁰ *SEC v. Chenery*, 332 U.S. 194, 203 (1947).

law, resolvable by reviewing courts with no overriding obligation of deference to the agency decision.”³¹

MQAC’s Order against Dr. Wright involves improper retroactive rulemaking by adjudication. MQAC’s retroactive application of a new standard to punish Dr. Wright violated his due process rights by failing to give required notice of novel standards.

B. MQAC’s warrantless administrative search and seizure procedure is unconstitutional and in violation of statute.

Before the Mitchell issue surfaced, MQAC knew Dr. Wright had expressed challenges to MQAC’s warrantless administrative search and seizure procedures. See AR 921-923. The reasons for Dr. Wright’s challenge to MQAC’s warrantless administrative search include the following:

- MQAC’s imposition of strict liability against a physician for even challenging MQAC search and seizure of medical records is an unconstitutional condition to a physician’s Constitutionally-protected license to practice;
- MQAC’s imposition of strict liability violates the 4th Amendment to the U.S. Constitution;

³¹ *McDonald v. Watt*, 653 F. 2d 1035 (5th Cir. 1981).

- MQAC's imposition of strict liability violates Washington statutes that protect patient privacy, which require MQAC to issue a subpoena for records, which subpoena gives both physicians and patients notice and the opportunity to be heard in regard to a protective order.

1. **MQAC's search and seizure of patient records is governed by the U.S. and State Constitutions.**

MQAC's search and seizure of patient medical records is a "warrantless administrative search" governed by regulation, statute and the 4th Amendment of the U.S. Constitution. See *Seymour v. Dept. of Health & Dental Quality Assur. Com'n*, 152 Wn.App. 156, 216 P.3d 1039 (2009). MQAC's administrative search procedure is set forth in self-generated regulations, not the legislature's statutes. The specific self-generated regulation upon which MQAC's warrantless administrative searches is based is WAC 236-919-620.³²

³² WAC 246-919-620: (1) A licensee must comply with a request, under RCW 70.02.050, for health care records or documents from an investigator who is acting on behalf of the disciplining authority pursuant to RCW 18.130.050(2) by submitting the requested items within fourteen calendar days of receipt of the request by the licensee or the licensee's attorney, whichever is first. If the licensee fails to comply with the request within

2. **MQAC's self-generated search and seizure procedures create strict liability to physicians who raise any question about compliance.**

Under WAC 236-919-620(1)(b), if a physician fails to comply with MQAC's demand, "a statement of charges *shall* be filed. . .". In other words, failure to comply with MQAC's unfettered discretion results in strict liability. Any attempt by the physician to question MQAC authority, or protect patient privacy, results in strict liability. This regulatory scheme is especially disconcerting when MQAC itself has self-generated the complaint on which its investigation is based. In other words, MQAC can self-generate a complaint, demand whatever it wants during the investigation, and then "go fishing." Any attempt by the physician to question MQAC authority, or protect patient privacy, results in strict liability, subjecting the physician's license to sanction.

3. **MQAC's search and seizure regulation violates the 4th Amendment of the U.S. Constitution.**

fourteen calendar days, the investigator shall contact the licensee or the licensee's attorney by letter as a reminder.

(b) If the licensee fails to comply with the request within three business days after the receipt of the written reminder, a statement of charges **shall** be issued pursuant to RCW 18.130.180(8). [Emphasis added.]

MQAC's regulation violates the 4th Amendment as articulated by the *Yoshinaka*, *Carlson* and *Seymour* decisions:

In *Client A. v. Yoshinaka*³³, the Department of Health started an investigation of a psychologist based on a complaint from the mother of a patient. The Department requested the patient's treatment records under the authority of RCW 70.02.050(2) and the Uniform Disciplinary Act. The psychologist cooperated by providing information to the investigator and by answering questions, just as Dr. Wright did here. But, the psychologist refused to turn over records. A lawsuit ensued concerning the Constitutional and statutory issues involved in the Department's request. Although the court never reached the constitutional arguments raised, the court found:

[T]he Board must balance the substantial privacy and confidentiality interests of health professionals and their patients with the State's significant interest in protecting the public health. Any procedure must also ensure that the records are needed for a properly authorized investigation to determine compliance with state or federal licensing requirements.³⁴

³³ *Client A v. Yoshinaka*, 128 Wash.App. 833, 836, 116 P.3d 1081 (2005)

³⁴ *Id.* at 844.

The *Carlson*³⁵ court stated the following about the subpoena process:

An administrative subpoena for records does not require a warrant, but the Fourth Amendment requires it to be “sufficiently limited in scope, relevant in purpose, and specific in directive so that compliance will not be unreasonably burdensome.” *Donovan v. Lone Steer, Inc.*, 464 U.S. 408, 415, 104 S.Ct. 769, 78 L.Ed.2d 567 (1984) (quoting *See v. City of Seattle*, 387 U.S. 541, 544, 87 S.Ct. 1741, 18 L.Ed.2d 930 (1967)). The right of a person served with a subpoena to challenge it in court before compliance serves as an adequate safeguard of his or her Fourth Amendment rights.³⁶

The problem with MQAC’s warrantless administrative search regulation, in this case and on its face, is that MQAC does not issue a subpoena; it simply issues a demand, to which any resistance is met with strict liability. This does not comport with the requirements for warrantless administrative searches and seizures, as held by the *Seymour*³⁷ court, which stated:

- Demands for records are seizures under the Fourth Amendment. *Id.* at 171.
- A warrantless administrative search is valid only if

³⁵ *Carlson v. WA Dept. of Health*, 2008 WL 5068654 (W. D. Wash., 2008).

³⁶ *Id.* at *4.

³⁷ *Seymour v. Dept. of Health & Dental Quality Assur. Com’n*, 152 Wn.App. 156, 216 P.3d 1039 (2009).

authorized by a statute that adequately serves as a substitute for the protection afforded by the Fourth Amendment's warrant requirement. *Id.* at 160.

- To be valid under the Fourth Amendment, a proper regulatory scheme, “rather than leaving the frequency and purpose of inspections to the unchecked discretion of Government officers ... establishes a predictable and guided ... regulatory presence.” *Donovan*, 452 U.S. at 604. Hence, the person subject to the inspection “is not left to wonder about the purposes of the inspector or the limits of his task.” *Biswell*, 406 U.S. at 316. The “regulatory statute must perform the two basic functions of a warrant: it must advise the owner . . . that the search is being made pursuant to the law and has a properly defined scope, and it must limit the discretion of the inspecting officers. *Id.* at 167-168.

Clark County Superior Court Judge Wulle in *Hughes v. MQAC*, Clark County Superior Court Cause No. 12-2-00991-4 addressed the scope of MQAC’s warrantless administrative search and seizures of medical records with these comments in response to a request for injunction halting MQAC’s records demand. Judge Wulle’s comments have weight and bearing here:

THE COURT: . . . I understand the dynamic of the Department having a need to monitor doctors and the methodologies they do use and make sure they're approved methods and the role that they play. . . My concern, and I'm going to hit you straight on, is that if I go to a doctor and I get treated for something for me, there is a doctor-patient confidentiality, okay, and I have an expectation that my information isn't going to be willy-nilly sent out there so that tomorrow in "The Columbian" I read, "Judge Wulle had a kidney stone." . . . And so in [MQAC's] process of doing their job, the problem I have, and I'm going to be straight about this, is to ask someone to just randomly give me -- give them access to all of my records for all

these patients, and then to randomly select 15 and then divulge the doctor's information about his or her treatment of that particular patient, **violating my right to privacy** if I'm one of these 15. [Emphasis added.]

Appendix A: pg.16, ln.18 – pg.17, ln.16

THE COURT: . . . I would take a very dim view if you assert your rights under the law to have review of this decision if the Department was to take an action that said simply because you're asking for judicial review that that's uncooperative, therefore they shall bring charges. I think that would be totally inappropriate under the law. . . to exercise my rights in a court of law should not be used against me and then trigger some other action because I chose to defend myself. . . I'm simply pointing out that that would be how I would respond to your statement about the failure to cooperate stuff. [Emphasis added.]

Appendix A: pg.47, ln.25 – pg.48, ln. 20

4. **MQAC's search and seizure regulation is an unconstitutional condition on a physician's license to practice.**

By imposing strict liability on physicians for non-compliance with MQAC's warrantless search and seizure procedure for medical records, MQAC creates an *unconstitutional condition* on a physician's Constitutionally-protected license to practice. That is, MQAC requires physicians to waive 4th Amendment rights against unreasonable searches and seizures in order to preserve their license. This is unconstitutional under the "*unconstitutional conditions*" doctrine.

Recognized in *In Re Dyer*, 175 Wn.2d 186, 283 P.23d 1103 (2012), “[t]he doctrine of *unconstitutional conditions* provides that the government cannot condition the receipt of a government benefit on waiver of a constitutionally protected right.” *Id.* 203 (citing to *Perry v. Sindermann*, 408 U.S. 593, 597, 92 S.Ct. 2694, 33 L.Ed.2d 570 (1972)). *Accord*, *Butler v. Kato*, 137 Wn. App. 515, 530 (2007).

The 9th Circuit has ruled in the same fashion:

It may be tempting to say that such transactions - where a citizen waives certain rights in exchange for a valuable benefit the government is under no duty to grant- are always permissible and, indeed, should be encouraged as contributing to social welfare. . . . But our constitutional law has not adopted this philosophy wholesale. The “unconstitutional conditions” doctrine . . . limits the government's ability to exact waivers of rights as a condition of benefits, even when those benefits are fully discretionary. Government is a monopoly provider of countless services, notably law enforcement, and we live in an age when government influence and control are pervasive in many aspects of our daily lives. Giving the government free rein to grant conditional benefits creates the risk that the government will abuse its power by attaching strings strategically, striking lopsided deals and gradually eroding constitutional protections. Where a constitutional right “functions to preserve spheres of autonomy ... [u]nconstitutional conditions doctrine protects that [sphere] by preventing governmental end-runs around the barriers to direct commands. (Citations omitted)

U.S. v. Scott, 450 F.3d 863, 866 -867 (9th Cir. 2006).

MQAC's strict-liability warrantless administrative search and seizure procedure is an unconstitutional condition, facially and as applied in this case. MQAC's procedure is especially onerous considering that state statute provides a Constitutional alternative that MQAC's regulation disregards, i.e. the administrative subpoena.

5. **MQAC's search and seizure regulation violates State statutes.**

The U.S. Constitution and Washington State law confer on citizens the general right to keep their personal health care information private and free from unnecessary government intrusion. See generally, *Griswold v. Connecticut*, 381 U.S. 479 (1965), cited with approval by *Carlson v. WA Dept. of Health*.³⁸ Medical providers have standing to assert and protect their patients' rights. *Griswold* at 481; *accord*, *Carlson*, at *24.

In fact, not only do medical providers have standing to assert their patients' rights to privacy, they have an affirmative obligation to maintain that privacy and

³⁸ 2008 U.S. Dist. LEXIS 95739 (USDC for West. Dist of WA, 2008).

confidentiality, except in certain specific circumstances. For example, in Washington State, the following statutes pertain to a patient's right to privacy for personal health care information³⁹:

RCW 70.02.005: The legislature finds that:

(1) Health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy, health care, or other interests.

...

(3) In order to retain the full trust and confidence of patients, health care providers have an interest in assuring that health care information is not improperly disclosed and in having clear and certain rules for the disclosure of health care information.

RCW 70.02.020:

(1) Except as authorized in RCW 70.02.050, a health care provider . . . may not disclose health care information about a patient to any other person without the patient's written authorization.

RCW 70.02.050: Disclosure without patient's authorization

(2) A health care provider shall disclose health care information about a patient without the patient's

³⁹ The Washington authorities have defined "health care information" as oral or recorded information that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care. RCW 70.02.010(6) and *Doe v. Group Health Coop.* 85 Wn. App. 213 (1997).

authorization if the disclosure is:

(a) To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws; or when needed to protect the public health;

(b) To federal, state, or local law enforcement authorities to the extent the health care provider is required by law.

...
(e) Pursuant to compulsory process in accordance with RCW 70.02.060.⁴⁰

The Washington State legislature has also stated that patients have rights against health care providers who wrongfully disclose health care information:

RCW 70.02.170: Civil remedies.

(1) A person who has complied with this chapter may maintain an action for the relief provided in this section against a health care provider or facility who has not complied with this chapter.

(2) The court may order the health care provider or other person to comply with this chapter. Such relief may include actual damages, but shall not include consequential or incidental damages. The court shall award reasonable attorneys' fees and all other expenses

⁴⁰ This statute requires the Dept. of Health to issue subpoenas when seeking health care information of patients. Those subpoenas must give at least 14 days notice so that the health care provider and/or the patient can seek a protective order.

reasonably incurred to the prevailing party.

In addition to these statutory protections, Washington State courts recognize a common law right to privacy, violation of which can result in a claim for damages against any person or entity who breaches that privacy. See *Reid v. Pierce County*.⁴¹ This common law right to privacy appears to extend to health care records. See *Mayer v. Huesner*⁴² and *Fisher v. Dept. of Health*.⁴³

Set against these statutory mandates in favor of procedures that protect patient privacy, MQAC's warrantless search and seizure procedure for medical records ignores due process, violates the 4th Amendment and wholly ignores the rights and duties conferred by RCW 70.02.060.

State law at RCW 70.02.060 requires a 14-day subpoena for medical records. Unlike MQAC's strict liability regulation, this statute is the only mechanism that allows both the physician and the patient both notice and an opportunity to be heard. The 14-day notice allows physicians the

⁴¹ 136 Wn. 2d 195 (1998).

⁴² 126 Wn. App. 114 (2005).

⁴³ 125 Wn. App. 869 (2005).

opportunity to inform patients that their records are the subject of governmental inspection. This procedure thus allows the physician to address the legal rights and duties attendant with competing interests: MQAC authority and patient privacy. MQAC's strict liability warrantless seizure procedure does not afford this opportunity for notice and hearing, and thus violates the Constitution, and RCW 70.02.060.

6. **Dr. Wright cooperated unequivocally for 15 months. MQAC's non-cooperation charges stem from Dr. Wright's bona fide objection to MQAC's illegal procedure.**

MQAC staff attorney Bahn testified in deposition that Dr. Wright cooperated up until his attorney's September 30th letter. Declaring Dr. Wright non-cooperative is not supported by the evidence, and exists only as an arbitrary, capricious retaliation against Dr. Wright's long-standing objection to MQAC's Constitutional violations of the 4th Amendment and patient privacy.

C. **MQAC's sanction is arbitrary, capricious and unconstitutional.**

The Fifth Amendment to the U.S. Constitution has been interpreted to prohibit the government from prosecuting a

defendant to punish the defendant for exercising a legally protected statutory or constitutional right. See e.g. *U.S. v. Goodwin*, 457 U.S. 368, 372 (1982); *U.S. v. DeMichael*, 692 F. 2d. 1059, 1061-62 (7th Cir. 1982). Clark County Judge Wulle was concerned about MQAC's tactics in this regard, as quoted above. Here, MQAC punished Dr. Wright for exercising legally protected rights. MQAC has twisted the facts and law – contrary to the evidence – to fashion a predetermined result with a retaliatory penalty.

1. **MQAC's sanction unconstitutionally compels Dr. Wright to endorse its position.**

MQAC's sanction against Dr. Wright includes compelling him to write a paper about "the benefits of professional licensing." This condition violates freedom of speech embodied in the First Amendment of the U.S. Constitution. The government may not condition rights or privileges upon a citizen's endorsement of the government's position on any idea.

The government may not prohibit the dissemination of ideas that it disfavors, nor compel the endorsement of ideas that it approves. See *R.A.V. v. St. Paul*, 505 U.S. 377, 382, (1992); *Brandenburg v. Ohio*, 395 U.S. 444, 447-448 (1969)

(per curiam); *West Virginia Bd. of Ed. v. Barnette*, 319 U.S. 624 (1943); *Wooley v. Maynard*, 430 U.S. 705, 713-715 (1977); *Riley v. National Federation of Blind of N.C., Inc.*, 487 U.S. 781, 797 (1988) (The First Amendment protects "the decision of both what to say and **what not to say**").

See Knox v. Service Employees, 567 U.S. ___, 132 S. Ct. 2277 (2012). *See also, Agency for Int'l Development v. Alliance for Open Society*, ___ U.S. ___, 133 S.Ct. 928 (2013), decided June 20, 2013; holding that the government may not condition receipt of any government benefit on a citizen's express endorsement of a belief fostered by the government – even if that benefit is the receipt of federal fundings for AIDS programs in return for an express endorsement against prostitution by the potential recipient of those funds. The U.S. Supreme Court struck that requirement down. *See Agency for Int'l Development*.

MQAC's sanction requires Dr. Wright to endorse the benefits of licensing in a written paper as a condition of securing his license. See AR 2346 at ¶3.2b. That sanction violates the First Amendment, and MQAC cannot compel Dr. Wright to endorse MQAC's political views as a condition of

preserving his Constitutionally-protected license. The issue of professional licensing is a socioeconomic issue and a religious issue. See e.g. Appendix B: Titus, *Rendering to Caesar What Is God's?*, *Journal of Biblical Ethics in Medicine*, Vol. 9, No.1; and Appendix C: Goodman, *The Regulation of Medical Care: Is the Price Too High?*, Cato Institute, 1980. This component of MQAC's sanction must be stricken.

2. **MQAC's sanction violates the precedent MQAC has established for implementing its Sanction Guidelines in similar cases.**

In all respects, MQAC has grossly over-sanctioned Dr. Wright for the charges, confirming that this proceeding has been a predetermined retaliation against Dr. Wright. With reference to Appendix D, MQAC has issued charges for aiding and abetting in several instances in the past decade. The conduct and sanctions involved in those other matters include the following:

Case no.	Name	Violation	Sanction
M2011-978	John Addison, MD	Aiding and Abetting Unlicensed Practice by employing unlicensed out-of-state	Reprimand and \$3,000 fine.

		doctor for one year.	
M2008-118519	Ann McCombs, MD	Aiding and Abetting Unlicensed Practice by allowing unlicensed physicians assistant to inject and treat.	1-year probation and \$2,000 fine.
M2007-11157	Patrick Bays, DO	Aiding and Abetting Unlicensed Practice by hiring unlicensed physicians assistant.	7 hours ethics course and \$1,000 fine.
M2000-58525	Stephan Kennedy, MD	Aiding and Abetting Unlicensed Practice by using, with knowledge , unlicensed surgeon to conduct surgery on patients at his clinic.	Reprimand. Fined \$4,000 with stipulation that he not use unlicensed
M1999-58684	James McHugh, MD	Aiding and Abetting Unlicensed Practice by using unlicensed persons to treat.	Informal disposition, requiring report about WA licensing law and payment of \$3,000 fine.
M2009-31	Dale Fetroe,	Sexual	5 year

	MD	relations with patient.	probation and \$5,000 fine.
M2009-1469	Robert Wilson, MD	Sexual relations with patient.	4 years probation and \$5,000 fine.

For MQAC to state in its final Order that there is no sanction guideline for Dr. Wright's case is false. That statement is a contrivance to justify an extraordinarily harsh sanction compared to MQAC's other "aiding and abetting" sanctions, as displayed above. To reiterate, one case listed above involved a physician who knowingly allowed an unlicensed physician to conduct surgery! That doctor received a reprimand, compared to Dr. Wright's suspension and 30-month probation. Dr. Wright's sanction is more onerous than those listed doctors who were sexually inappropriate with patients!

MQAC's aggression against Dr. Wright is unacceptable under the law and evidence. The sanctions are arbitrary, capricious and retaliatory.

3. The Rule of Lenity Prohibits the Sanctions Against Dr. Wright.

The Rule of Lenity prohibits applications of a quasi-criminal sanction when two elements are present. The first

element is satisfied when a statutory scheme under which the penalty is levied is ambiguous or when it is overly broad and fails to provide adequate due process protections. See e.g. *State v. Rhodes*, 53 Wn. App. 913 (1990) and *In re Haley*, 156 Wn.2d 324, 336 (2006), citing *In re Ruffalo*, 390 U.S. 544, 552 (1968): "absence of fair notice as to the reach of the grievance procedure" violate[s] due process rights.

The licensing exemption at RCW 18.71.030(6) allows the arrangement between Mitchell and the Clinic. Absent clarifying regulations, like those that provide temporary practice permits for other health care professionals, the licensing exemption leaves considerable room for reasonable interpretation, and is therefore ambiguous.

The second element for lenity is met when the civil sanction is penal. According to *Tellevik v. Street*, 83 Wn. App. 366 (1996), "[A] civil sanction that cannot fairly be said solely to serve a remedial purpose, but rather can only be explained as also serving either retributive or deterrent purposes, is punishment as we have come to understand the term," citing *United States v. Halper*, 490 U.S. 435, 448 (1989). See also, *State v. McLendon*, 131 Wn.2d 853 (1997).

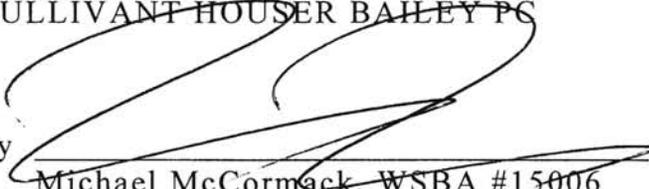
Here, the sanctions sought against Dr. Wright serve no remedial purpose because no one has been harmed. The suspension and related conditions are punitive and retributive. MQAC's sanction against Dr. Wright is a penalty. With both prongs met, the Rule of Lenity applies to bar the sanctions.

V. CONCLUSION

Neither MQAC's means nor the predetermined end result are justified or legal. MQAC's final Order should be reversed based on Constitutional principles, unauthorized proceedings, errors of law and insufficient evidence. MQAC's sanction is illegal and should be stricken.

DATED this 28th day of April, 2014.

~~BULLIVANT HOUSER BAILEY PC~~

By 

Michael McCormack, WSBA #15006

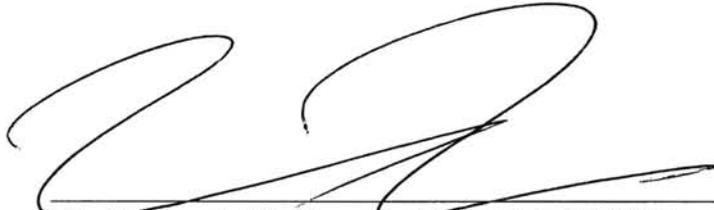
Attorney for Appellant Wright

CERTIFICATE OF SERVICE

The undersigned certifies that on this 28th day of
April, 2014, I caused the foregoing to be served to:

Kim O'Neal	<input checked="" type="checkbox"/>	via hand delivery
Assistant Attorney General	<input type="checkbox"/>	via first class mail
Office of the Attorney General	<input type="checkbox"/>	via facsimile
1125 Washington Street SE	<input type="checkbox"/>	via email
Olympia, WA 98504-0100		

I declare under penalty of perjury under the laws of the
state of Washington this 28th day of April, 2014, at Seattle,
Washington.



Michael McCormack, WSBA #15006

APPENDIX A

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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF CLARK

IN THE MATTER OF:)	
)	
SUSAN Z. HUGHES and)	
TRANSFORMATION SPA, MD, PLLC,)	
)	
Plaintiffs,)	
)	
v.)	No. 12-2-00991-4
)	
MEDICAL QUALITY ASSURANCE,)	
)	
Defendant.)	

HEARING

March 23, 2012

The Honorable John P. Wulle Presiding

Transcribed by: Shanna Barr, CETD
Reed Jackson Watkins
206.624.3005

A P P E A R A N C E S

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On Behalf of Plaintiffs:

TAMERA L. WILLIAMS

Floyd Pflueger & Ringer PS

200 West Thomas Street

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On Behalf of Defendant:

S. KIM O'NEAL

Attorney General's Office

Post Office Box 40100

Olympia, Washington 98504

1 this particular substance with something else?

2 MS. WILLIAMS: She has a different weight loss plan that
3 doesn't involve the use of hCG, and I don't really know much
4 about that one, but it's a -- it's just a different way of
5 doing it. The "protocol" just meaning hCG and the diet, the
6 restricted caloric diet.

7 THE COURT: Okay. Because I know from my own common
8 experience that most -- dieting is what people use for
9 weight loss.

10 MS. WILLIAMS: Sure.

11 THE COURT: Somebody who is built like me, I don't even
12 know about that stuff, but I'm just trying to understand
13 the --

14 MS. O'NEAL: You're very fortunate.

15 THE COURT: -- dynamic.

16 Excuse me?

17 MS. O'NEAL: You're very fortunate.

18 THE COURT: No, I'm skinny. So the -- there would be a
19 protocol of dieting, and then maybe some other substance
20 involved in the treatment of these particular patients. But
21 that doesn't get away from my fundamental question to the
22 two of you. I understand the dynamic of the Department
23 having a need to monitor doctors and the methodologies they
24 do use and make sure they're approved methods and the role
25 that they play.

1 MS. WILLIAMS: Yes.

2 THE COURT: My concern, and I'm going to hit you straight
3 on, is that if I go to a doctor and I get treated for
4 something for me, there is a doctor-patient confidentiality,
5 okay, and I have an expectation that my information isn't
6 going to be willy-nilly sent out there so that tomorrow in
7 "The Columbian" I read, "Judge Wulle had a kidney stone."

8 MS. WILLIAMS: Right.

9 THE COURT: Okay. And so in their process of doing their
10 job, the problem I have, and I'm going to be straight about
11 this, is to ask someone to just randomly give me -- give
12 them access to all of my records for all these patients, and
13 then to randomly select 15 and then divulge the doctor's
14 information about his or her treatment of that particular
15 patient, violating my right to privacy if I'm one of these
16 15.

17 MS. WILLIAMS: Well, Your Honor --

18 THE COURT: And that's my concern --

19 MS. WILLIAMS: Yeah.

20 THE COURT: -- to be quite honest about it.

21 MS. WILLIAMS: It is Dr. Hughes's --

22 MS. O'NEAL: I'm not trying to take away from the
23 Department, but it does seem to me that the Department is
24 reaching to do a job that they're legitimately doing for --
25 on behalf of the citizens of this state, but they're doing

1 THE COURT: Can the Department sweep in on any doctor here
2 in town and say, "We want to do a practice review with you"?
3 Must they have a triggering moment, a complaint or something
4 of that sort?

5 MS. WILLIAMS: The statute says that if there is a
6 complaint or if they have reason to believe that
7 unprofessional conduct occurred that they may conduct an
8 investigation.

9 THE COURT: That's pretty broad.

10 MS. WILLIAMS: It is.

11 THE COURT: I mean, it really seems to indicate -- and
12 again, I'll defer to the AG. Does not there need to be a
13 trigger more than just "We feel like it"? Doesn't have to
14 somebody complain or bring some information forward?

15 MS. O'NEAL: It does say "complaint." It says "reason to
16 believe." So just because we feel like it is not
17 sufficient. There isn't -- it isn't the case, especially in
18 this case, but in any case, the Commission does not go in
19 and do a practice review unless they are investigating a
20 complaint. Now, sometimes they do a practice review to
21 determine whether a physician is complying with a previous
22 order that they've entered. That's another --

23 THE COURT: Yeah. That would be appropriate.

24 MS. O'NEAL: That's another time when they might do it.
25 But other than during an investigation, which is what the

1 have a basis for this investigation.

2 If she doesn't cooperate, she will be issued a statement
3 of charges. Under WAC 246-919-620, if she doesn't cooperate
4 the investigator shall contact with a letter as a reminder.
5 If within three business days they still haven't cooperated,
6 the charges shall be filed. The statement of charges is the
7 moment when harm to Dr. Hughes occurs, as per the
8 declaration of my partner. The panoply of things that
9 happen once a statement of charges is public record. The
10 answer is not public record. Patients can access that
11 information. Insurers will begin investigations and may
12 revoke the preferred provider status of the physician,
13 directly affecting their right to property and the
14 livelihood, reputation, all of that. So if we wait till
15 this is final, until a whole hearing has been held and a
16 commission has issued the decision, it's too late. The
17 damage has already been done. And a statement of charges is
18 an inevitability in this case under the WAC and based on
19 what the staff attorney said to me.

20 THE COURT: Is your plan to take my -- given what I've
21 already said, would your plan be to take it to the Court of
22 Appeals to review it?

23 MS. WILLIAMS: I don't know, Your Honor. That's something
24 I have to consult with the client about, obviously.

25 THE COURT: Okay. The reason I say that is because -- and

1 I'll say this for the purpose of everyone involved. I would
2 take a very dim view if you assert your rights under the law
3 to have review of this decision if the Department was to
4 take an action that said simply because you're asking for
5 judicial review that that's uncooperative, therefore they
6 shall bring charges. I think that would be totally
7 inappropriate under the law. The whole notion of our law --

8 As you well know, Ms. O'Neal.

9 -- is that the notion that if we cannot resolve our
10 issues, we resolve them in a court of law --

11 MS. WILLIAMS: Um-hum.

12 THE COURT: -- in an environment. And to exercise my
13 rights in a court of law should not be used against me and
14 then trigger some other action because I chose to defend
15 myself.

16 MS. WILLIAMS: Yes.

17 THE COURT: Okay. So I'm just putting that out there.
18 I'm not saying that that's occurred. I'm simply pointing
19 out that that would be how I would respond to your statement
20 about the failure to cooperate stuff.

21 MS. WILLIAMS: Yes. And I don't --

22 THE COURT: Okay.

23 MS. WILLIAMS: -- believe the Department would be wise to
24 issue a statement of charges for failure to cooperate while
25 this is being litigated in the courts. I don't think they

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STATE OF WASHINGTON)
) ss
COUNTY OF KING)

I, the undersigned, under my commission as a Notary Public in and for the State of Washington, do hereby certify that the foregoing recorded statements, hearings and/or interviews were transcribed under my direction as a transcriptionist; and that the transcript is true and accurate to the best of my knowledge and ability; that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this day of , 2013.

NOTARY PUBLIC in and for
the State of Washington,
residing at Redmond.
My commission expires 6-23-15.

1 IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

2 IN AND FOR THE COUNTY OF CLARK

3 -----
4 IN THE MATTER OF:)

5 SUSAN Z. HUGHES and)
6 TRANSFORMATION SPA, MD, PLLC,)

7 Plaintiffs,)

8 v.)

No. 12-2-00991-4

9 MEDICAL QUALITY ASSURANCE,)

10 Defendant.)

11 -----
12 HEARING ON MOTION FOR RECONSIDERATION

13 May 18, 2012

14 The Honorable John P. Wulle Presiding
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24 Transcribed by: Shanna Barr, CETD
25 Reed Jackson Watkins
206.624.3005

A P P E A R A N C E S

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S. KIM O'NEAL

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Olympia, Washington 98504

1 and --

2 MS. O'NEAL: And as we described, Your Honor --

3 THE COURT: At this point, I'm not throwing a rock at your
4 people. I'm simply pointing out that that concerns me, that
5 we have structures of due process in these professional
6 settings that match that which appears in a criminal
7 setting. In other words, if a criminal has due process
8 rights, certainly a doctor has due process rights, too. So
9 we start from that premise. So I'm paying close attention
10 to how your agency provides due process to this doctor.

11 Counsel, I believe that it is premature for this court to
12 be involved at this level of an investigatory process, so
13 I'm allowing them to make the request. However, if there is
14 a refusal, and I will deal with that at that time, I've got
15 jurisdiction here.

16 So I don't expect to see the issuing of a statement of
17 charges without a visit here first to discuss the current
18 state of people's levels of cooperation and people's
19 authority and due process questions, okay? So what I'm
20 doing is I'm looking both at your rights to investigate, but
21 the manner in which you provide due process to someone who
22 may or may not be accused of doing something that's
23 professionally uncalled for, okay?

24 MS. WILLIAMS: Understood, Your Honor.

25 MS. O'NEAL: Okay. I have one question.

1 THE COURT: You understand that?

2 MS. O'NEAL: I do.

3 THE COURT: I don't want them issuing anything until we've
4 talked.

5 MS. O'NEAL: In terms of failure to cooperate. In terms
6 of failure to provide the records that we've asked for. But
7 there is -- the Commission has the authority to bring
8 charges based upon the case that they have already reviewed.
9 If the Commission authorizes charges based on a failure to
10 meet the standard of care in treating the patient based on
11 the records that we already have, is the Court enjoining
12 that as well?

13 THE COURT: No. That one may proceed on its own because
14 it sounds like an investigation is pretty much concluded.
15 Now, I'm not trying to put words in your mouth, Counsel, but
16 that's the assumption --

17 MS. O'NEAL: I just wanted to clarify what --

18 THE COURT: Yeah. No. I'm just --

19 MS. O'NEAL: -- what the Court is --

20 THE COURT: -- talking about that question of I refuse to
21 give my records versus automatic, you know, statement of
22 charges. I'm saying in that process -- I don't know what my
23 authority is, okay. But as the court's function is to
24 review the agency action at the ultimate level after it's
25 concluded it, I'm just interjecting myself a little sooner

1 and saying before we do things in the public eye, before we
2 charge somebody and have them embarrassed because "The
3 Columbian" doesn't like them, okay, let's visit together
4 again before that action is requested or taken by the
5 Commission.

6 MS. WILLIAMS: Understood, Your Honor.

7 THE COURT: Okay?

8 MS. O'NEAL: I understand.

9 MS. WILLIAMS: We'll fashion an order in that regard.

10 THE COURT: Fairness is what I'm looking for here in this
11 process.

12 MS. O'NEAL: And I just -- just to answer the Court's
13 question, and I think we put it in our original briefing,
14 the Medical Commission separates itself into two separate
15 panels. The charging panel that reviews the investigation
16 and decides whether to charge is completely separate from
17 the panel from whom hearing panel members would be picked.
18 There is no --

19 THE COURT: That's an important part of due process.

20 MS. O'NEAL: There is no participation in that
21 decision-making process by anyone that's had previous
22 contact with the materials about the case.

23 THE COURT: Okay. But again, that -- you know, we're
24 looking at these -- manner in which we're doing these
25 processes.

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STATE OF WASHINGTON)
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IN WITNESS WHEREOF, I have hereunto set my hand and seal this day of , 2013.

NOTARY PUBLIC in and for
the State of Washington,
residing at Redmond.
My commission expires 6-23-15.

APPENDIX B

Journal of Biblical Ethics in Medicine

Vol. 9 • No. 1

FRANKLIN E. (Ed) PAYNE, M.D.
Editor

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Journal History

This *Journal* was published four times each year from 1987-1993 (Volumes 1-7). There were three issues in 1994 (Volume 8). These years are available in two bound volumes (1987-1990 and 1991-1994) from Biblical Medical Ethics, Inc. for \$39.00 each.

No issues were published in 1995. Publishing resumes with this issue, Volume 9, No. 1, and the *Journal* will henceforward be published as sufficient articles are submitted. If you wish to receive new issues, write to the above address. You will be charged \$5.00 per issue.

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Editor's Note

- 1) After almost 2 years, this *Journal* again enters the battle of ethical ideas in modern medicine. There is no need to explain the hiatus, but please read the explanation of volume and issue numbers in the column to the left. We had hoped that others would develop and promote Biblical medical ethics, but no one has.
- 2) *We are on the World Wide Web.* About half of the back issues are posted there for your perusal and downloading. Depending upon surfers' interest and coordination with our other projects, all back issues may eventually be placed there. Net address is:
http://www.usit.net/public/capo/friendly/jbem/intro_pa.htm.
While there, peruse the other listings of CAPO (Center for Paleo-Orthodoxy), whose sponsors were instrumental in getting us up and running.
- 3) While you have a new Editor, Dr. Terrell remains intimately involved as Associate Editor. His contributions and reviews add substance that is invaluable.

We welcome original articles which present a Biblical perspective on medical ethics. Manuscripts should be typed, double spaced, accompanied by appropriate bibliographical information, and submitted in duplicate. Brief biographic information on the author should be submitted with manuscripts. Upon request, articles will be reviewed by referees blinded to author identification. Receipt of manuscripts will be acknowledged within four weeks, with up to eight additional weeks required for editorial reviewers. Also welcome are letters and thoughtful reviews of books pertinent to our subject matter.

The Purposes of Biblical Medical Ethics, Inc., are:

- to recognize the authority of the inerrant, infallible Word of God over the practice of medicine,
- to uncover and advocate the Biblical principles upon which medicine must rest,
- to encourage physicians and patients to undertake the prevention and treatment of illness in accordance with Scripture,
- to challenge existing ideologies which teach the autonomy of man or the sufficiency of reason,
- to disestablish the mechanical view of man or any other view of man that fails to acknowledge accountability to God, and,
- to affirm God's provision of mercy through Biblical medicine as a secondary agency.

Medical Licensure: Reporting to Caesar What Is God's?

* *Forecast* is highly recommended for those interested in legal and constitutional issues. For more information, write to: 5209 Indian River Rd., Virginia Beach, VA 23464 - Ed.

Jesus taught that one has to be careful not to assume that because someone is ill, that person has committed a particular sin which has caused that illness. Jesus addressed that issue with regard to the man who was born blind. The question was, "Who sinned, this man or his parents?" He answered, "Neither, it's for the glory of God." That fact does not in any way indicate that illness and sin are *disconnected*. It just means that the connection between illness and sin is a rather complex one; there is no question that there is a connection. Mark 2:3-12 records the story of the man whom Jesus not only forgave of his sin but whose body he healed. Further, in John 5:2-15 there is presented the 38-year-old man at the pool who always tried to get into the healing waters but couldn't quite make it.

Jesus asked the man the question, "Will you be whole?" And He said, "Rise up and take up thy bed and walk." In the close of the encounter with the man, Jesus said, "... Sin no more, lest a worse thing come upon thee." In the ministry of Jesus we can see a close connection between the problem of sin and the problem of illness.

Proverbs 17:22 says, "A merry heart doeth good like a medicine, but a broken spirit drieth the bones." Proverbs 3:7-8 says, "Fear the Lord and depart from evil; it shall be health [for medicine] to thy navel and marrow to thy bones." This connection between the spiritual dimension of man—the image-bearing nature of man, his sinful condition, and his physical body—is proved throughout the Old and the New Testaments. As an example, remember what Jesus said in Mark 1:44, after He healed the leper, "Go ... show yourself to the priest." This requirement affirms the relationship between the priesthood—the priests were the leaders of the spiritual life in Israel—and the problem of disease in Israel. Indeed, in Leviticus chapters 13 and 14 we find a close connection between leprosy and the exercise of the priestly authority and a close connection between the physical and the spiritual. There is a physical diagnosis, a hygienic prescription, and a sacrifice of a turtle dove, or other animal. Notice that it is all handled by the same official.

This trail of evidence leads toward something—that in the nation of Israel there was recognition that what we call the practice of medicine really belonged to the priests. For Old Testament Israel, God says in II Chronicles 19:11, "And behold, Amariah, the chief priest is over you in all matters of the Lord. And, Zebédiah,

the ruler of the house of Judah, for all the king's matters." Notice that disease was a matter for the priest. If you had a sickness, whether it was spiritual or physical or a combination, you went to the priest. This practice was carried out because the priest was given authority by God in that particular area; he had the authority to deal with that. It did not belong to the king.

The king is the representative of the State. He is the one who has civil authority. He is comparable to a governor, a legislator, or a president. In the Old Testament, matters of spiritual health and physical health belonged to God, and God ordained priests as the ones who had authority to minister to those needs of the people. Another way of putting it is that medicine belongs to the Lord and is administered through the priesthood rather than through the king. Medicine is administered through the Church, not through the state, to use modern terms.

What has happened to that concept in 20th-century America? Medicine has been divorced from the Church. Medicine as a profession has been developing a dichotomy of the physical from the spiritual. The State licensure system is the centerpiece of that divorcement of physical from spiritual. When a State licensure came in the early 20th century, it divorced the physical health of the people from

their spiritual health. Could we, by contrast, envision in America a licensing system for the pastors of churches? Imagine the outrage across this land if state authorities were to institute a licensing system as to whether someone could preach the gospel of Jesus Christ! Everyone would be upset—even the American Civil Liberties Union.

What we have today through the state licensure system of physicians is a state orthodoxy of physical health.

This system would introduce a state orthodoxy of spiritual health. Yet, what we have today through the state licensure system of physicians is a state orthodoxy of physical health. The only justification for that is if one can truly divorce the physical from the spiritual—that what God said belonged to the priesthood in the Old Testament Israel no longer belongs to the priesthood but now belongs to the state. That change is the key issue raised by state licensing of the medical profession.

Prior to licensure in the United States (for example, in the 1847 American Medical Association [AMA] statement concerning ethics), there was recognition of a diversity of opinion as to what was the proper standard with regard to health. There were various schools; three major ones were the regular school, the eclectic, and the homeopathic. People of that day recognized that differences of opinion existed as to what was a standard of care for one's physical health. When a state licensure system is introduced, the state necessarily will sort out the schools of physician care and will determine which practices satisfy the state. Therefore, diversity of opin-

ion is no longer allowed, unless, of course, the state itself accepts such diversity in its standard for the practice of medicine.

It is the same thing that would happen if you had a licensing system for the preaching of the Gospel. In that case people would have to figure out what the true Gospel is. The history of the Church has been divided on that question. There are so many denominational views in the midst of even the *orthodox* Christian community, much less the question of what is a cult and all other kinds of questions with regard to those matters! It is important to recognize that one cannot avoid this conflict over truth with regard to a standard of practice by introducing a licensure system. A licensure system invokes the principles that are embodied in the prohibition against the establishment of religion and the free exercise thereof.

We have forgotten what religion really means, because we find ourselves accepting definitions that are essentially sociological or psychological.

Today, we have forgotten what religion really means, because we find ourselves accepting definitions that are essentially sociological or psychological. As an example, on the one occasion in which the United States Supreme Court attempted a definition of religion, it came up with what was essentially a psychological definition. That definition is, "... those things that are ultimate in one's belief system." Lawrence Tribe, a constitutional scholar at my *alma mater*, Harvard, likes a sociological definition. He likes to talk about "religious views." Indeed, he'll make a distinction between communion and transcen-

ental meditation, because sociologically, communion in America is religious. But, sociologically, transcendental meditation in America can be non-religious, because we're not living in a Hindu society in which transcendental meditation is inevitably religious. So, he uses a sociological definition. Christianity is always at the short end of the stick with a sociological definition of religion.

The term "religion" in the Constitution is a legal word.

That is *not* what "religion" means in a legal and political document. The first amendment of the United States Constitution says, "Congress shall pass no law establishing a religion or prohibiting the free exercise thereof." The Constitution is a legal document and, therefore, we must understand that the term "religion" in it is a legal word. Indeed, it is a political-legal word. It is placed in a political-legal document for the purpose of determining those things that do not belong under the civil government's authority. This principle is spelled out in the Virginia Constitution, Article 1, Section 16, which says, "Religion, or the duty that we owe to our Creator enforceable by reason and conviction, not by force or violence . . ." **Thus we say that it is the nature of the duty that determines whether or not it is religion.** Notice that the Virginia Constitution adds to the political and legal dimension a theological dimension. **Ultimately, law and politics are theological.** Ultimately, that is where we must go—to theology. There is a distinction between a duty that is enforceable by nature, by reason, and by conviction and one enforceable by coercion or violence.

Why is there this distinction? Romans 13:4 tells us that God authorized the civil government to use force

as a sanction for wrongdoing. The very nature of civil power is force. Do we pay our taxes voluntarily? We know what would happen if we did not pay our taxes. What about our tithe? We know the same thing doesn't happen if we don't tithe. We know that we can not pay our tithe and get away with it, at least with human authority. We know we can't refuse to pay our taxes. They'll get us somehow. There is a distinction between the nature of the duty to pay a tax as contrasted to the nature of the duty to pay a tithe. A tithe, by definition, must be paid out of one's reason and conviction—voluntary choice—else what good is a tithe but wood, hay, and stubble?

We don't pay our tax because we love the government.

Romans 13, by contrast, says that one should pay his taxes because he *owes* it, not because he loves the IRS. We should love IRS *agents*, but we don't pay our tax because we love the government. It is not an obligation of love. It is a debt service. It is an obligation that can be backed up by sanctions. This is the key in understanding the nature of the authority of the state. **Any licensing system of physicians lines the state up with certain schools of thought on what is "appropriate medical practice."** Necessarily, it means that the state backs up a certain position with regard to what is a right way to practice medicine and what is a wrong way. It forces state-sanctioned authority upon what ought to be a matter of *voluntary* choice. It's a matter that belongs to God exclusively.

Return to the II Chronicles 19:11 passage mentioned above. Even in Israel—theocratic Israel—were some

things that belonged exclusively to God and which were to be administered through the priesthood of Aaron. (Many people are erroneously afraid of theocratic states because they presume liberty to be precluded from them.) These things did *not* belong to the king. One of those things was the practice of medicine, because medicine rightfully understood was intimately and inextricably intertwined with the spiritual life of man. One couldn't be divorced from the other. Therefore, it wasn't a matter that should be subject to state licensure but, rather, it would be *immune* from state licensure just as would be the case with regard to the licensing of pastors.

What we understand to be the nature of medicine and its relationship to the image-bearing nature of man, and what we understand to be the nature of authority and the distinction between authority that God has given to civil society, as contrasted to what God gives to the Church, is absolutely critical in assessing whether or not the state has authority to license physicians.

By way of contrast, consider that lawyers are a bit different professionally, because they hold a civil office. Namely, they are officers of the court, and one could distinguish lawyers on the grounds that, if they are officers of the court, then they should meet certain eligibility standards that civil officers should meet. In Exodus 18 Moses formed the first government of Israel before the people went into the Promised Land. There were standards of eligibility for those who were going to rule over thousands, over hundreds, and over tens. They had to be men of good moral character (we certainly could use more of those in the legal profession) and who were capable of rule. There is thus a distinction between a licensing system for

lawyers and a licensing system for physicians, because lawyers hold an office in the civil order itself, as contrasted to physicians, who hold an office within the church or the voluntary portion of society that God has ordained for Himself.

There is thus a distinction between a licensing system for lawyers and a licensing systems for physicians.

The **first proposition** then is this: that the guarantee of free exercise of religion, the guarantee of no establishment of religion, contained in the first amendment of the United States Constitution and reflected in most of the other state constitutions is a guarantee that physicians are to be free from the licensing authority of the state. It is not the state's business to determine the criteria by which the art of healing is to be practiced. Physicians are engaged in the *art* of healing.

As scientific as medicine is today, it remains an art. Even when a physician brings to bear the best science to physical illness there is a spiritual dimension to practice that is absolutely crucial in order for the healing process to take place. For a physician to ignore that spiritual dimension is to fail in the art of healing. I believe that's the reason why that proverb originated in Israel, "Physician, heal thyself." Physicians had lost their way with regard to the relationship between the spiritual state of their patients and the physical manifestation of the spiritual in their bodies, whether it was individual sin or whether it was just simply the general consequence of sin.

As scientific as medicine is today, it remains an art.

Moving from this question of religion to the question of freedom of contract let us see that there is **another dimension** that must be addressed in assessing the freedom of physicians in the practice of the healing arts. The Declaration of Independence says that "all men are created equal and endowed by their Creator with certain unalienable rights," among which are life, liberty, and the pursuit of happiness. While the phrase "pursuit of happiness" has been much debated, it is quite defensible to argue that the pursuit of happiness means those areas of economic life that belong to the people generally, that are to be protected and secured by the government, not *usurped* by it.

Consider this language from the constitution of the Commonwealth of Virginia, written one month before the Declaration of Independence. "... that all men are by nature equally free and independent and have certain inherent rights, of which when they enter into a state of society they cannot deprive or divest their posterity, namely, the enjoyment of life and liberty with the means of acquiring and possessing property and pursuing and obtaining happiness and safety." The pursuit of happiness and the ownership of property—the right to acquire it, possess it and dispose of it—was considered to be a right given by God before human beings ever came into civil society. The civil society does not *create* the right to property. It is in civil society because it was given by God, and the purpose of civil society is to *secure* that right, not to redefine it, reshape it, and make it work for whatever purpose the civil society desires.

It is amazing in America today, after we have seen the collapse of Communism, and the socialistic economic system that Communism

supported, that we seem to be continuing in the same direction of that collapsing society. One of the main reasons is we've forgotten that the pursuit of happiness—the right to acquire, possess, and dispose of property—is a God-given unalienable right. Notice, it is unalienable; you can't even *give* it away! You certainly can't give it away for your children. This is what it says in Virginia—you can't even divest your *posterity* of that right. Yet, we find much divestiture of our posterity in America today as we mortgage ourselves into such incredible debt that our children and our children's children will have to pay when they become adults.

The civil society does not create the right to property.

This particular principle of liberty of contract is found in Article 1, Section 10, of the U.S. Constitution, and the language reads thus: "No state shall pass any law impairing the obligation of contract." Chief Justice Marshall in the only case in which he did not concur with the majority opinion of the Court in the entire time that he sat on the court—he "lost" this case—claimed that this *obligation* of contract guarantee was a guarantee of a *liberty* of contract. The way that he put it was that every human being has the right to choose with whom and upon what terms to enter into a contract. The parties choose whether or not to agree and upon what terms. The legislature is limited to providing, (1) remedies for breach, (2) rules regarding proof of the agreement, and (3) prohibitions against illegal purposes. Notice that a medical licensure statute by definition limits the liberty of contract because, if you seek healing from someone who does not have a license from the state, you can't enter into a contract with that person, no matter how well-informed you are and no matter how good the

proposed method of healing might be. You are allowed to enter into contract only with someone who has the appropriate license. It would be much the same as if the state licensed grocers.

Every human being has the right to choose with whom and upon what terms to enter into a contract.

It is true that cities do have licenses for businesses, but you are entitled as a matter of right to such a license. **Cities don't screen you to see whether or not you know something about the grocery business.** You can get into the grocery business and know nothing about the grocery business. It is left to the consumers to determine whether or not they want to buy groceries from you. In today's world we're concerned that consumers are so stupid and foolish that they don't know anything about what their needs are. The state has become big brother. We say, "We're going to make sure that you're not so foolish as to enter into a contract with someone whom we do not think would be a good one for you to contract with."

In their 1847 code of ethics the AMA championed voluntary associations. They did not champion state licensure. They said, "Let's get those who are in a certain school of the healing arts and say we are all in agreement that this is the proper school. Our challenge is to demonstrate to the public that this is the best healing opportunity that you have." But, they recognized that there could be other competing schools and it was, of course, their responsibility to make the case that theirs was the best healing opportunity. However, they recognized that there would be healthy competition among the various

schools. Indeed, there was a commitment to a community of relationship between the doctor and patient built upon this notion of voluntary association. Chapter one of the 1847 code of ethics has this heading: "Of the Duties of Physicians to their Patients and of the Obligations of Patients to their Physician." What we have today are doctors who have duties to their patients and patients who have no obligation to the physician. It is a one-way requirement for physicians today. This is a breaking up of the community relationship of obligation of a patient to a physician and of a physician's duty to a patient, and it comes about because they have freedom of contract. They have liberty to enter into the terms of mutual satisfaction.

In their 1847 code of ethics the AMA championed voluntary associations.

Again, from the AMA's 1847 code of ethics, "A physician should be ever ready to obey the call to the sick, imbued with the greatness of his mission and of the responsibility he habitually incurs in his discharge. Those obligations are the more deep and enduring because there is no other tribunal other than his own conscience to adjudge penalties for carelessness or neglect." What happens in a licensure system is the development of a notion that holds the view, "Well, *they'll* take care of the standards. *They'll* do it." Voluntary association of mutual respect and mutual obligation, on the other hand, builds a community standard that comes out of the principle of self-government. Are there going to be problems? Of course! People are going to make mistakes. It is a fallen world. Man is finite. No system is going to usher in a perfect relationship in which problems are not going to arise. But, has *licensure* solved the problems?

It is much the same issue that is raised when a similar position is taken with regard to public schools. Public schools are unconstitutional and unbiblical. As Thomas Jefferson says, "To tax a man to propagate opinions with which he disagrees is sinful and tyrannical." I am always asked the question, "Well, if you don't have public schools, what will happen to the children?" My response is, "Look what's happening to them now!" The assumption is that we must have a tax-supported public school system in order to educate children. Many people would oppose ridding the medical profession of the licensure standards on the grounds of, "What will happen? Why, we'll have all these quacks." I'm not so sure that the current state of affairs is all that good in the relationship between physicians and their patients. The point I'm making here is really a point of principle. That is, God, in ordaining the realm of property—the realm of agreements, the realm of contracts left all that to the self-governing individuals. Each individual bearing the image of God has the capacity to make wise and informed choices. The duty of the medical profession as well as any other service-oriented profession is to make available the best possible service and to make it available in the most informed way so people can make wise choices.

"To tax a man to propagate opinions with which he disagrees is sinful and tyrannical."

What we find today is that the licensing system has ushered into the practice of medicine a code of ethics in which community is not emphasized as it was in the case in the 1847 code of ethics. Physicians know well that oftentimes things are done with a patient not because it is in the interest

of the patient but because of the danger that might arise if something should go wrong and the patient would come back with a malpractice claim.

A **third principle** is at issue. There is not only a question of freedom of religion properly understood, and not only a question of liberty of contract, but also a concern about *special privileges*. There is a principle that can be found in almost every state constitution and in the United States Constitution that reflects the principle embodied in the Declaration of Independence that all men are created equal. One of the most pernicious violations of that principle was the special privileges that the king gave to his favorites. Indeed, many people occupied monopoly positions not because they had achieved it through hard work but because they had been the favorite of the king or the queen.

From the constitution of Maryland (the first constitution of that state) we have the following: "... that monopolies are odious, contrary to the spirit of a free government and the principles of commerce, and ought not to be suffered." In Virginia, it was stated this way: "... That no man or set of men is entitled to exclusive or separate privileges from the community." Or, in Maryland, that "... No title of nobility ought to be granted in this state." Indeed, the United States Constitution, both in Article 1, Section 9, and Article 1, Section 10, denies to both the state and the United States governments the authority to grant a title of nobility. On first glance, one might think that to be a quaint prohibition. After all, England still has its lords and its barons and its "Sirs." We in the United States don't have any "ladies," "lords," baronesses, or barons. On reflection, however, we *are* a nation of nobility, because there are people in America who get the benefits of having the

label, "Sir" or "Lord." Indeed, I think we are the most "noble"—we're full of all kinds of noble classes.

Monopolies are odious, contrary to the spirit of a free government and the principles of commerce.

The practice of giving someone the label "Sir" or "Lord" wasn't just the name. If one is labeled a "Lord," for example, he is given a political privilege, namely, he gets to sit in the House of Lords. The House of Lords is comparable to the United States Senate. Not only does one get a special political privilege, but one also receives special economic privileges. Oftentimes nobles receive a home and large grounds and economic benefits. Alexander Hamilton said this about the prohibition against titles of nobility, in *The Federalist*, No. 84: "This [that is, the prohibition against titles of nobility] may truly be denominated the cornerstone of republican government. For so long as they are excluded there can never be serious danger that the government will be of any other than that of the people."

Study of the U.S. government recently reveals that one of the major problems of government is special interests. We've become the government of the special interests, by the special interests, for the special interests. James Madison wrote against this prohibition against titles of nobility in *The Federalist*, No. 39: "It is essential to such a government that it be derived from the great body of the society, not from a favored class of it. ... A government that grants entitlements will be controlled by special interests and will cease to be a republican government." What is the nature of a license, especially the nature of a license that is designed to exclude by an entitlement to engage in a particular kind of occupation to the exclusion

of competition that doesn't meet those standards? It is a special privilege.

The problem of entitlements is a problem that is *pervasive* in our society.

This is not true of physicians only. We have "Sir" Tip O'Neill and "Lord" Carl Albert, just to name two, who today don't live like ordinary citizens. They have a special privilege. Indeed, Carl Albert, who at one time was the Speaker of the House, earns more money today than he *ever* did in that office. Many of those in the House of Representatives have special privileges that the remainder of us don't have. Bouncing checks without having to pay the \$20 fee is one. The problem of entitlements is a problem that is *pervasive* in our society. Think of the subsidies enjoyed by senior citizens under Social Security, farmers with price supports, single mothers with dependent children, children of middle and upper middle class families who go to college. Justice John Paul Stevens (who is not one of my favorite Supreme Court Justices) wrote of the problem of titles of nobility in America today when he addressed the question of affirmative action that guaranteed a certain amount of business to minority business enterprise. He said, "The ten percent set-aside [for minority businesses] contained in the public works employment act of 1977 creates monopoly privileges in a 400 million dollar market for a class of investors defined solely by racial characteristics. The economic consequences of using noble birth as a basis for classification in 18th-century France, though disastrous, were *nothing* compared with the terror that was engendered in the name of *egalite* and *fraternite*. Our historic aversion to titles of nobility is part of our commitment of the proposition that the Sovereign must govern impartially." We have forgotten the legacy of our

forefathers with regard to what happens to a nation when, through monopoly licenses and through other kinds of entitlements, we lose the sense of impartiality that comes when such entitlements are not available to special classes of people.

Not until the 1870s and the early 1900s was there a medical licensure system.

Not until the 1870s and the early 1900s was there a medical licensure system. It, in effect, introduced a meritocracy with monopoly privileges in a particular area of economic life. But for the fact that lawyers hold a civil office you could make the same charge with regard to them. Lawyers are officers of the court and, therefore, are much like any other civil office. There are some limitations with regard to that, but that is not so with regard to physicians if there is an important relationship between physical health and spiritual health. In the name of health and welfare, an economic monopoly has been established by law. Recent studies have emphasized that this is true. There are increasing economic barriers to entry into the medical profession. The liability insurance requirements alone in many states raise *significant* economic barriers to the practice of medicine. Medical education is probably the most expensive in America. Even lawyers can go to school for less money than medical doctors. If you begin to factor in the various government subsidies with regard to health care in terms of establishing hospitals and Medicare and Medicaid programs you can begin to see that it is a system that is *rife* with subsidies and entitlements. The future implications, of course, are vast, including socialized medicine—the ultimate entitlement program. Socialized medicine comes when a state-created monopoly is affirmed and then those who need that service

are subsidized with tax monies so everyone can afford the service of the favored enterprise.

It is a system that is *rife* with subsidies and entitlements.

In summary, careful evaluation of the licensure system asks these questions: Does the practice of medicine belong to the state? Should the state have the authority to set the criteria by which the art of healing is practiced? Or, is the practice of medicine so intimately and inextricably inter-

twined with the spiritual dimension of man that it really belongs in the realm of religion—a duty owed to the Creator enforceable by reason and conviction and not by force or violence. Secondly, of course, is the whole question of the freedom of people to make mistakes, the freedom of people to make choices, especially in the area of healing, where there are differences of opinion with regard to particular practices. Can we not, with the general principles of contract law, protect people from those who might take advantage of the general populace? Finally, there is the concern that

comes from any licensing system—that it will produce a system of monopoly power and all that such entails, including the ultimate loss of freedom for the masses and authority being given to those who wield the economic privilege. That is the real root of the problem today with regard to socialized medicine. If we are going to give a monopoly license to physicians then, inevitably, we invite government subsidy and control of the entire area of the practice of medicine. Once we've crossed that line of licensure, it is inevitable.

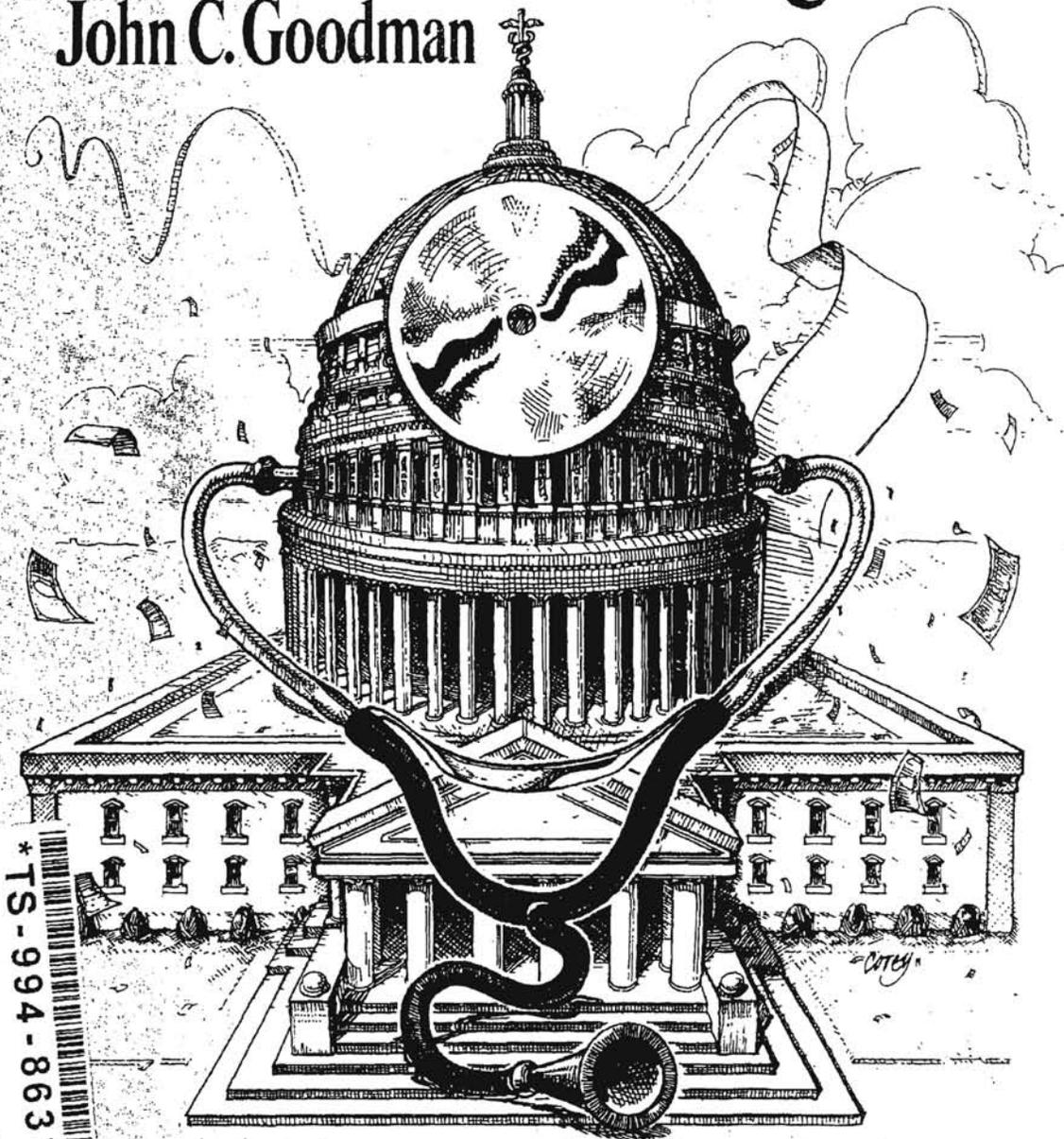
APPENDIX C

CATO
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STUDIES IN
DOMESTIC ISSUES
AND EDUCATION

The Regulation of Medical Care: Is The Price Too High?

John C. Goodman



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The Regulation of Medical Care: Is The Price Too High?

John C. Goodman

Cato Public Policy Research Monograph No. 3

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I. INTRODUCTION

My thesis is that a congeries of legislatively and professionally conceived and executed trade restraints have heretofore prevented the market from functioning with close to its potential effectiveness and that restoration of a market regime offers the best hope for solving the nation's health care problem in all of its dimensions.

Clark C. Havighurst
"HMOs and the Market
for Health Services"

That there is a crisis in the American health care system seems to be widely acknowledged. Within the last year *Time* and *Newsweek* magazines devoted cover stories to the so-called crisis, and ABC "World Nightly News" spent five straight nights exploring its various dimensions.

Much of what is considered a "crisis" in our health care system is not really a crisis at all. The fact that we are spending more of our national income on health care than ever before is hardly surprising. It is natural and inevitable that as we become more wealthy, we will want to spend more of our income on health care. This is a historical phenomenon that has been observed in all countries over time. Nor is it surprising that what we casually refer to as "health care" is becoming more expensive. New innovations and inventions in medical science have expanded the range of services that doctors and hospitals can offer, and the real cost of this new technology is frequently quite high. But the advent of new medical technology can hardly be described as a "crisis." These developments in no way make us worse off. They do not destroy old options, they merely create new ones.

Nonetheless there is a genuine crisis, or at least a major problem, in the health care marketplace. The problem is that we do not get our money's worth for the dollars we spend on health care. Under a different set of institutions, we could get more health care for the dollars we are now spending; or, put alternatively, we could obtain the same quantity and quality of health care we now receive at a lower cost.

Why does this problem exist? Most public discussions of the issue imply that the failures of our health care system are failures inherent in a free market for medical care. Such a conclusion inevitably points in the direction of an age-old "solution": more government regulation.

The thesis of this book is quite different: Most of the problems we encounter in the market for health care arise not because the free market has failed but because it has not yet been tried.

As the reader will soon discover, I place much, but not all, of the blame for this state of affairs squarely at the feet of organized medicine, which has, for over 100 years, sought and obtained special privileges from government. These special privileges take the form of restrictions on free competition in the marketplace. Although organized medicine's long and extensive involvement with government deserves much of the blame for the current state of affairs, this book should not be taken as an indictment of the medical profession itself. On the contrary, there are a great many medical practitioners today who would gladly trade their status as regulated professionals for the opportunity to freely compete in an unhampered health care market.

VI. THE EFFECTS OF PROFESSIONAL CONTROL: PROVIDERS VERSUS THE PUBLIC

Each of us is a producer and also a consumer. However, we are much more specialized and devote a much larger fraction of our attentions to our activity as a producer than as a consumer. We consume literally thousands if not millions of items. The result is that people in the same trade, like barbers or physicians, all have an intense interest in the specific problems of this trade and are willing to devote considerable energy to doing something about them. . . . The groups that have a special interest . . . are concentrated groups to whom the issue makes a great deal of difference. The public interest is widely dispersed. In consequence, in the absence of any general arrangements to offset the pressure of special interests, producer groups will invariably have a much stronger influence on legislative action and the powers that be than the widely spread consumer interest. Indeed from this point of view, the puzzle is not that we have so many silly licensure laws, but why we don't have far more. The puzzle is how we ever succeeded in getting the relative freedom from government controls over the productive activities of individuals that we have had and still have in this country, and that other countries have had as well.

Milton Friedman
Capitalism and Freedom

In the previous chapters we have seen that organized medicine has used the coercive powers of government to promote the financial self-interest of physicians in many ways. By influencing the enactment of stiff licensing laws and by controlling the nation's medical schools, the AMA has succeeded in erecting formidable entry barriers to prospective physicians. Licensing laws have also been instrumental in preventing nurses and other paraprofessional personnel from performing tasks they are perfectly capable of performing in a safe and satisfactory manner, but which would enlarge the supply of physicians' services and thus lessen the financial return to the practice of medicine. By maintaining control of the accreditation of internship and residency

programs, organized medicine has played an unclear, but probably substantial, role in the demise of the proprietary hospital and in the limiting of competition among public and voluntary hospitals. Through the use of both state regulatory powers and government-derived monopoly powers, organized medicine has curtailed the inclination of commercial health insurance companies to review claims aggressively and control medical costs.

A primary objective of organized medicine has been to maximize the income of physicians by maintaining an effective cartel among medical care providers. The cartel functions not only to maintain a monopolistic pricing structure for medical services, but also to price discriminate among patients with differing demands for those services. Organized medicine has attempted to pursue these objectives by disciplining those providers who compete for patients by cutting prices, by advertising, or by using any other technique that threatens to undermine the cartel. It has used its powers of license suspension and/or revocation and its control over access to hospitals to discipline individual physicians. Its control over hospital accreditation for physicians' training programs, as well as its influence in government regulatory agencies, serves as a threat to hospital managers who otherwise might be tempted to compete aggressively for patients. In some instances it has used the regulatory powers of the state to outlaw prepaid insurance schemes and in other instances to promote a health insurance market in which errant insurance companies are threatened with extinction if they challenge AMA-sanctioned policies.

How has the market for medical care been affected, overall, by the power of organized medicine? In this chapter we will briefly consider the impact of AMA policies on physicians' incomes and health care costs.

Physicians' Incomes

Given the apparent power of organized medicine to control supplier behavior in the medical marketplace, it might seem that the practice of medicine would be extremely profitable. It is true that physicians have high incomes — about five times as high as the average wage paid in manufacturing — but when their incomes are matched against the investment required for their training, the profitability of medical practice is rather modest. How can this be? Consider the analogies provided by two other markets in which a long history of government intervention intended to raise the producer's profit has had little positive effect: airlines and oil.

Since 1938 the Civil Aeronautics Board (CAB) appears to have had one overriding objective: to secure a "reasonable" or "fair" rate of return for the commercial airline companies. This objective was pursued in two principal ways: by prohibiting new entry into the market and by keeping airline fares high above the competitive level. In its first forty years of operation, the CAB did not allow a single new carrier into the interstate market.¹ One economic study estimated that between 1969 and 1974 first class and coach fares would have been from 22 to 52 percent lower without CAB price regulation.²

Despite these efforts the rate of return on invested capital in the airline industry in the years prior to the recent deregulation efforts was, on the average, less than the average rate of return for all manufacturing industries.³ The major reason that the airlines were not more profitable is that they engaged in costly quality competition. Unable to compete with each other on the basis of price, the airlines competed by scheduling more flights between cities and by providing costly amenities to attract customers. Because the airlines were unable to compete to bring price down to the level of average production costs, they simply reversed the process: They competed to bring average cost up to the level of price. CAB regulations were costly to consumers — about \$2 billion per year by one estimate — but the airlines apparently realized very little long-run benefit.⁴

A similar phenomenon occurred in the oil industry. Prior to the Arab oil embargo of 1973, the oil industry had managed over the years to secure a series of favorable regulations designed to raise oil company profits. The depletion allowance was the most notorious of these: Producers were able to take large tax deductions that bore no relationship to any production costs they incurred. Less well known, but probably more lucrative, was the IRS treatment of intangible drilling costs — the deductions allowed here were way out of line with tax policy in other industries. In addition, the government instituted an import quota system in 1959 that limited the amount of foreign oil brought into the United States. Import licenses, required for all foreign oil, were

¹John Goodman and Edwin Dolan, *Economics of Public Policy: The Micro View* (St. Paul: West Publishing Co., 1979), p. 148.

²Comptroller General of the United States.

³George W. Douglas, "Regulation of the U.S. Airline Industry: An Interpretation," in James Miller III, ed., *Perspectives on Federal Transportation Policy* (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1975), pp. 71-83.

⁴Comptroller General of the United States.

simply given to the oil companies under a formula that ensured that most of the import rights went to the largest oil companies. The value of this subsidy has been estimated at \$1 million per day. Congress also put its stamp of approval on the Oil Compact, a euphemism for a domestic oil cartel. Under this arrangement, regulatory commissions in such states as Texas, Louisiana, and Oklahoma were allowed to formulate coordinated policies designed to keep oil production down and oil prices up, all for the benefit of producers in the industry.⁵

The government, then, granted a great many favors to the oil producers, but it did not control the many ways that companies could spend money to compete with each other. Like airline regulation, government regulation of oil was costly to consumers, but it did little to improve the long-run profits of the producers. The ten-year (1963-72) average return on net wealth in petroleum production and refining was only 11.7 percent, while the average for all U.S. manufacturing companies for the same period was 12.2 percent.⁶ Apparently political favoritism produced only temporary gains that quickly evaporated as many firms competed to enjoy them.

Like regulation in the airline and oil industries, regulation of the medical marketplace has been more costly to consumers than it has been profitable for physicians. Although physicians fees have been high, individual practitioners have responded by working longer hours, by taking more years of postgraduate training, and by incurring larger outlays for office equipment and services designed to attract patients.

One way of assessing the profitability of medicine is to treat the investment in medical training like any other investment and ask what rate of return the prospective medical student can expect to receive.⁷ Health economist Keith Leffler has recently done this, and his results are shown in the second column of table 6.1. Leffler's estimates show what rate of return a college graduate, age twenty-two, can expect to earn if he embarks on a career as a general practitioner in each of the indicated years. In calculating the estimates, Leffler made adjustments for number of hours worked, length of training period, anticipated

⁵Goodman and Dolan, pp. 120-21.

⁶Shyam Sunder, *Oil Industry Profits* (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1977), p. 67.

⁷An *internal rate of return* on an investment is that interest rate which makes the present worth of future income equal to the investment's cost.

TABLE 6.1
Internal Rate of Return and Profitability
at 10 Percent Discount Rate of Five Years of Medical Training,
Selected Years 1947-1973

Year	Internal Rate of Return ¹ (Percent)	Profitability ²	Year	Internal Rate of Return ¹ (Percent)	Profitability ²
1947	7	11,464	1967	14	32,610
1951	10½	2,622	1969	14	29,389
1955	10	2,003	1970	15	37,904
1959	10½	4,542	1971	15½	38,369
1961	11	7,015	1972	14	26,040
1963	11½	9,739	1973	15	30,740
1965	12	15,366			

SOURCE: Keith Leffler, *Explanations in Search of Facts: A Critique of "A Study of Physicians' Fees,"* (Coral Gables, Florida: Law and Economics Center, University of Miami School of Law, 1978), table 4, p. 12. Reprinted by permission.

¹Estimated to closest ½ percent.

²Real (1976=100) dollars.

mortality, progressive income taxation, probability of being drafted, and tuition and scholarships at medical schools.⁸

As table 6.1 shows, the rate of return to medical training was 7 percent in 1947, 10 to 12 percent between 1951 and 1965, and 14 to 15.5 percent thereafter. To evaluate these numbers it is necessary to compare them to the rate of return paid on comparable investments, such as undergraduate education. Estimates of the rate of return from undergraduate education range from 8 to 13 percent.⁹ Prior to the introduction of Medicaid and Medicare in 1965, then, rates of return on medical education appear to have been quite reasonable.

The third column in table 6.1 presents another way of looking at the profitability of medical training. This column gives estimates of the value of admission to medical school at a 10 percent rate of discount. As the numbers show, the profitability of medical school training was quite modest prior to the introduction of Medicaid and Medicare, ranging from \$2,003 to \$9,739 between 1951 and 1965.

⁸See Keith Leffler, *Explanations in Search of Facts: A Critique of "A Study of Physicians' Fees,"* (Coral Gables, Florida: Law and Economics Center, University of Miami School of Law, 1978), pp. 11-12.

⁹*Ibid.*, p. 13.

The effects of Medicaid and Medicare on physicians' incomes have apparently been substantial. These effects are operating on the demand side of the market and not on the supply side, however, and thus they are largely independent of the restrictive policies of the AMA. In addition, it is possible that Leffler's estimates of the value of admission to medical school in the early 1970s are too high. They do not, for example, take into account the rapid increase in the number of foreign medical school graduates entering the United States during these years — probably in response to the high physicians' incomes generated by the Medicare and Medicaid programs. They do not take account, either, of the growth of substitute medical services, such as biofeedback therapy, competing at the periphery of the medical marketplace. And they do not take account of the recent expansion in medical school capacity, which has increased the annual output of physicians by 60 percent since 1965.¹⁰ Each of these factors has led to an increase in the supply of physicians' services and thus can be expected to decrease the incomes of physicians. Since 1970 the incomes of general practitioners have not kept pace with inflation. Between 1970 and 1975, for example, there was a decline of 8 percent in real earnings for general practitioners.¹¹

Medical Costs

What has been the overall effect on the costs of medical care of professional control over the medical marketplace? Virtually all health economists agree that restrictive AMA policies have substantially increased health care costs. Estimating precisely how much the activities of organized medicine have increased our health care bill is a near-to-impossible task — and no one has tried it. Nevertheless, insight into the magnitude of the effect can be gained by looking at some studies of specific restrictive practices.

Take the ban on advertising, for example. Although no one has studied the direct effect of this ban on physician and hospital fees, studies have been done in related fields. John Cady recently compared the experience of states that allow price advertising for prescription drugs with states that prohibit such advertising. He found little difference between these two groups of states in the range and quality of services offered by pharmacists, but there was a significant difference in prices. In 1976 consumers in states that prohibited advertising paid

¹⁰Ibid., p. 14.

¹¹Ibid.

\$380 million more for prescription drugs.¹² Similar studies, with comparable results, have been done on the market for eyeglasses.¹³

Studies have also been done on the effects of Blue Cross-Blue Shield domination of the market for health insurance. One study found that, on the average, the Blues' current market share causes hospital costs per patient per day to be about 10 percent higher than they otherwise would be. The distortion is much greater in those states where the Blues' share of the market reaches up to 80 percent. The study estimates that if the Blues achieved total dominance of the market, per diem charges would rise by more than 22 percent.¹⁴ Of course, no one really knows what the effect would be of reverting to truly free market competition of the type that flourished in Oregon in the 1930s.

Numerous studies have also been made of the effects of so-called over-insurance, that is, excessive health insurance coverage induced by, among other things, federal income tax policy and Blue Cross-Blue Shield policies. Although there is some disagreement on how large these effects are, virtually all health economists believe that expanded health insurance bears some responsibility for increasing hospital costs.¹⁵ A recent study by Martin Feldstein indicates the possible magnitude of this increase. Feldstein estimates that if third party coverage of hospital costs rises by just four percentage points — from 88 percent of charges to 92 percent — the per diem price of hospital care will rise by 37 percent.¹⁶

Studies of prepaid group plans, long opposed by organized medicine as unethical but nevertheless flourishing because of a number of important legal changes, also indicate that past AMA policies have been costly for consumers. Studies of HMOs, for example, show that their members have total medical costs that are from 10 to 40 percent

¹²John Cady, *Restricted Advertising and Competition: The Case of Retail Drugs* (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1976), p. 20. See also John Cady, *Drugs on the Market: The Impact of Public Policy on the Retail Market for Prescription Drugs* (Lexington, Mass.: D.C. Heath and Co., 1975), p. 95.

¹³See Lee Benham, "The Effect of Advertising on the Price of Eyeglasses," *Journal of Law and Economics* 15 (October 1972): 338-39.

¹⁴H. E. Frech and Paul Ginsburg, "Competition Among Health Insurers," in Warren Greenberg, ed., *Competition in the Health Care Sector: Past, Present, and Future* (Germantown, Md.: Aspen Systems Corporation, 1978), p. 181.

¹⁵Stuart H. Altman and Sanford L. Weiner, "Regulation as a Second Best," in Greenberg, p. 343 ff. See also Martin Feldstein and Amy Taylor, *The Rapid Rise of Hospital Costs* (Cambridge, Mass.: Harvard Institute of Economic Research, 1977).

¹⁶Martin Feldstein, "Quality Change and the Demand for Hospital Care," *Econometrica* 45 (October 1977): 1699.

lower than the annual health costs for comparable groups covered by conventional insurance.¹⁷ The reduction of health costs that accompanies membership in such plans may be a mixed blessing, however. HMOs have lower surgical rates, but it is not clear that all of the reduction is the result of the elimination of unnecessary surgery.¹⁸ Nonetheless, the AMA's past policies have clearly deprived consumers of a less costly option.

The policies of organized medicine have also resulted in other costs that are hard to measure in money terms. In chapter 5 we noted that the current system of medical insurance, largely the product of AMA policies, has encouraged many small hospitals to offer a wide range of surgical services, despite the fact that certain services may be performed infrequently and result in higher mortality rates when they are. One recent study shows that the mortality rates are quite high at small hospitals that perform certain kinds of surgery infrequently.¹⁹ Consumers rarely know these facts, however, because hospital mortality rates are not made public. Even though the public disclosure of this information would improve the efficiency of the health care market and save a great many lives as well, organized medicine ardently resists.²⁰

Is Medical Licensing Necessary?

We have presented in this and in preceding chapters a number of examples of how professional control of the market for medical care imposes higher costs on consumers. Is it possible, however, that government intervention has also produced benefits for consumers? That is, has government intervention in the medical marketplace resulted in any improvements over what would have occurred in a free market?

The position of the AMA and a number of health economists is that consumers are too ignorant to make adequately informed choices about health care.²¹ They argue that if the free market were allowed to

¹⁷Harold S. Luft, "How Do Health Maintenance Organizations Achieve Their Savings?" *New England Journal of Medicine* 298 (June 1978): 1337.

¹⁸HMOs are considered more fully in chapter 7.

¹⁹Harold S. Luft, John P. Bunker, and Alain C. Enthoven, "Should Operations be Regionalized?" *New England Journal of Medicine* 301 (December 1979): 1364-69.

²⁰See Clark Havighurst, "Regulation of Health Facilities and Services by Certificate of Need," *Virginia Law Review* 59 (October 1973): 1163, n. 76. See, however, Clark Havighurst and Laurence R. Tancredi, "Medical Adversity Insurance: A No-Fault Approach to Medical Malpractice and Quality Assurance," *Milbank Memorial Fund Quarterly* 51 (1973): 131.

²¹See, for example, Uwe Reinhart, "Comment," in Greenberg, pp. 128-29.

allocate health care resources, consumers would often fall victim to quacks and charlatans. After all, so the argument goes, if consumers are ignorant about matters of quality, they will be unable to distinguish between good and bad doctors. Medical licensure and other forms of professional control, then, help ensure that consumers make the choices they would have made were they well-informed.

There are several problems with this argument. First, it is not clear that consumers, on the average, are any less well-informed about medical care than they are about numerous other products, for which the market seems to work quite well. Mark V. Pauly has recently observed, "I know even less about the works of a movie camera than I know about my own organs; yet I feel fairly confident in purchasing a camera for a given price as long as I know that there are at least a few experts in the market who are keeping the sellers reasonably honest."²² Pauly has also persuasively argued that there is little reason to believe that a free market for most medical services cannot operate as successfully as a free market for most other goods and services.²³

Second, even if there were a justification for government action on the question of quality, the licensing of physicians and hospitals is still completely unwarranted. As Milton Friedman pointed out almost two decades ago, if government must do something, it could simply provide consumers with the information it thinks they should have.²⁴ Rather than establish by law who may or may not practice medicine, government might *certify* the skills and abilities of medical providers. A common example of certification is the warning label on cigarette packages. Consumers are given the surgeon general's opinion, but they may also seek other opinions and ultimately make their own decisions.

Third, licensing as such has little effect on the amount of fraud in the medical marketplace. In fact, given the alleged "conspiracy of silence" and the plethora of sanctions that may be imposed on physicians who testify in medical malpractice suits, medical fraud may be more prevalent today than it would have been in the absence of medical licensure. The almost daily succession of Medicaid and Medicare scandals suggests that medical fraud may be widespread. There are

²²Mark V. Pauly, "The Behavior of Nonprofit Hospital Monopolies: Alternative Models of the Hospital," in Clark Havighurst, ed., *Regulating Health Facilities Construction* (Washington, D.C.: American Enterprise Institute, 1974), pp. 145-46.

²³See Mark V. Pauly, "Is Medical Care Different?" in Greenberg, pp. 11-35.

²⁴Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), chapter 9.

also effective ways to expose it. Pennsylvania, for example, employs a number of "medical detectives" who pose as patients and attempt to uncover fraudulent practices.²⁵

Finally, as we noted in chapter 2, no one has succeeded in providing convincing evidence that medical licensure has in fact improved the average *quality* of patient care. There is evidence that medical licensure has increased the *price* of medical care — a quite different effect from the stated objectives of the AMA and the state legislatures.

²⁵"Medical Sleuths Help Pennsylvania to Deal with Incompetent Doctors," *Wall Street Journal*, 1 May 1979, p. 1.

APPENDIX D

CASE/DOCKET NO.**PHYSICIAN NAME**

M2011-978

John Hamilton Addison, MD

M2008-118519

Ann B. McCombs, DO

M2007-11157

Patrick N. Bays, DO

00-03-A-1100MD

Stephen Campbell Kennedy, MD

99-06-A-1002MD

James William McHugh, MD

M2009-31

Dale Thayne Fetroe, MD

M2009-1469

Robert A. Wilson, MD

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

In the Matter of the License to Practice
as a Physician and Surgeon of:

No. M2011-978

JOHN H. ADDISON, MD
License No. MD00018359

**STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND
AGREED ORDER**

Respondent.

The Medical Quality Assurance Commission (Commission), through James McLaughlin, Department of Health Staff Attorney, and Respondent, represented by Carla DewBerry, Attorney at Law, stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On September 15, 2011, the Commission issued a Statement of Charges against Respondent. On September 21, the Commission issued a Corrected Statement of Charges, correcting the license number in the caption of the pleading.

1.2 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(10).

1.3 The Commission is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.5 The Commission has the authority to impose sanctions pursuant to RCW 18.130.160 if the allegations are proven at a hearing.

1.6 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order).

1.7 Respondent waives the opportunity for a hearing on the Statement of Charges if the Commission accepts this Agreed Order.

1.8 This Agreed Order is not binding unless it is accepted and signed by the Commission.

ORIGINAL

1.9 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Databank (HIPDB)(45 CFR Part 61), the Federation of State Medical Boards' Physician Data Center and elsewhere as required by law. HIPDB will report this Agreed Order to the National Practitioner Data Bank (45 CFR Part 60).

1.10 This Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2. FINDINGS OF FACT

Respondent and the Commission acknowledge that the evidence is sufficient to justify the following findings, and the Commission makes the following findings of fact.

2.1 On July 9, 1980, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

2.2 Respondent is the owner and director of Northwest Geriatrics (NWG). From approximately December 2008 through December 2009, Respondent employed Dr. Robert Moon at NWG. While in Respondent's employ, Dr. Moon provided primary care for patients in Respondent's clinic, as well as patients in nursing homes and assisted living facilities, all within the state of Washington.

2.3 Dr. Moon, while continuously maintaining a home in California, relocated from California to the state of Washington. Respondent did not have a license to practice medicine in the state of Washington. Dr. Moon applied for a Washington license in December of 2008, the same month he began working as a locum tenens and seeing patients at NWG. Dr. Moon periodically returned to California and never worked 90 or more days consecutively for NWG. The Commission's decision on Dr. Moon's Washington application was delayed for several months due to a pending disciplinary

action before the Medical Board of California. Respondent was unaware of the pending disciplinary action in the state of California, or the issues underlying that action.

2.4 Respondent continued to employ Dr. Moon to see patients in the state of Washington for approximately one year despite the fact that Dr. Moon was not licensed to practice medicine in Washington.

2.5 Dr. Moon's employment with Respondent and NWG terminated in December 2009.

2.6 Unknown to Respondent, in May of 2010, Dr. Moon entered into a "Stipulated Settlement and Disciplinary Order" with the Medical Board of California. The Stipulated Settlement and Disciplinary Order was based upon Dr. Moon's: (a) conviction in August 2008 of two counts of "petty theft" and one count of "petty theft with a prior" (Dr. Moon had been also been convicted of petty theft in April 2004); (b) history of mental health diagnoses, one of which had caused him to be unable to work for one and a half years, and a history of substance abuse; and (c) failure to disclose the 2004 convictions and the mental health issues in an application for hospital privileges in 2008. The Medical Board of California adopted the Stipulated Settlement and Disciplinary Order, and it was effective on July 14, 2010.

2.7 The Commission became aware of Dr. Moon's misconduct and the resulting action of the California Board through the licensing process. On July 29, 2010, the Commission issued a Notice of Decision, denying Dr. Moon's application for licensure in Washington.

3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(10).

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order.

4.1 **Reprimand.** The Commission reprimands Respondent for aiding and abetting unlicensed practice by employing a physician who was unlicensed in the state of Washington.

4.2 **Protocol.** Within 3 months of the effective date of this Agreed Order, Respondent will provide the Commission with a written office protocol designed to verify that all employees or other individuals that Respondent supervises have appropriate licensure. This protocol will also provide for periodic verification that licensed individuals have renewed their licenses as required by law. The Commission or the Commission's designee must approve the protocol.

4.3 **Paper.** Within 3 months of the effective date of this Agreed Order, Respondent shall submit a paper explaining how his employment of Dr. Moon was in violation of the statutes and laws requiring licensure in the state of Washington. The paper shall communicate an understanding of the laws related to licensure of health care providers in the state of Washington, and shall make specific citations to appropriate rules and statutes. The Commission or its designee must approve this paper. Respondent shall sign the paper acknowledging that he understands the contents. Respondent shall submit the paper to the Commission at the following address: Compliance Officer, Department of Health, Medical Quality Assurance Commission, P.O. Box 47866, Olympia, Washington 98504-7866.

4.4 **Fine.** Within 3 months of the effective date of this Agreed Order, Respondent will pay a fine to the Commission in the amount of \$3,000.00. Respondent will pay the fine with a certified or cashier's check or money order, made payable to the Department of Health and mailed to the Department of Health, Medical Quality Assurance Commission, at P.O. Box 1099, Olympia, Washington 98507-1099.

4.5 **Obey Laws.** Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.6 **Costs.** Respondent is responsible for all costs that he incurs in complying with this Agreed Order.

4.7 **Violation.** If Respondent violates any provision of this Agreed Order in any respect, the Commission may initiate further action against Respondent's license.

4.8 **Change of Address.** Respondent shall inform the Program and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

4.9 **Termination.** Upon successful completion of the terms of this Agreed Order, the Commission shall terminate this Agreed Order without petition or appearance by Respondent. The Commission will terminate this Agreed Order by entering an Order of Termination at a regular Commission meeting following Respondent's completion of the requirements. If the Commission does not terminate this Agreed Order on its own initiative, due to a dispute regarding compliance, Respondent may petition the Commission for termination and appear before the Commission in person for a hearing on the petition.

4.10 **Effective Date.** The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies the sanction rules, WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Under the rules, the Commission uses conduct specific sanction schedules to determine appropriate sanctions. However, when the conduct at issue is not described in a schedule, the Commission uses its own judgment to determine appropriate sanctions. WAC 246-16-800(2)(d). Aiding and abetting unlicensed practice is not addressed in any schedule within the sanction rules. The Commission has therefore used its own judgment to determine that a reprimand and fine will act as deterrents to future misconduct, the paper will educate Respondent on the relevant laws, and the protocol will implement what is learned. These sanctions are tailored and appropriate for the conduct at issue.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in

suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

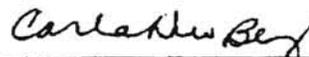
7. RESPONDENT'S ACCEPTANCE

I, JOHN H. ADDISON, Respondent, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.



JOHN H. ADDISON
RESPONDENT

11/10/12
DATE



CARLA NEWBERRY, WSB#15746
ATTORNEY FOR RESPONDENT

11/10/2012
DATE

8. COMMISSION'S ACCEPTANCE AND ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

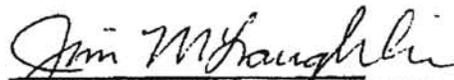
DATED: Jan 12, 2012.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION



PANEL CHAIR

PRESENTED BY:



JAMES MCLAUGHLIN, WSBA #27349
DEPARTMENT OF HEALTH STAFF ATTORNEY

Jan 12, 2012
DATE

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY

In the Matter of

ANN B. MCCOMBS
Credential No. DO.OP.00001238

Respondent

No. M2008-118519

**STIPULATION TO INFORMAL
DISPOSITION**

1. STIPULATION

1.1 The Executive Director of the Board of Osteopathic Medicine and Surgery (Board), on designation by the Board, has made the following allegations.

A. On July 14, 1989, the state of Washington issued Respondent a credential to practice as a doctor of osteopathic medicine and surgery. Respondent's credential is currently active.

B. Patient A was treated from December 13, 2005, through May 1, 2006. During that time, Respondent allowed Employee A to draw blood, inject patients, and perform intravenous therapies, but he had no health care credential during that time.

C. At times pertinent hereto, Respondent has advertised that she is board certified in pain management. Respondent has never been certified in pain management by a board recognized by either the American Osteopathic Association or the American Medical Association.

1.2 Respondent admits the allegations in Paragraph 1.1.A. Respondent does not admit the allegations in paragraph 1.1.B and 1.1.C. This Stipulation to Informal Disposition (Stipulation) shall not be construed as a finding of unprofessional conduct or inability to practice.

1.3 Respondent acknowledges that a finding of unprofessional conduct or inability to practice based on the above allegations, if proven, would constitute grounds for discipline under RCW 18.130.180(3), (4), (7), (10) and (14) and WAC 246-853-100(1).

//

1.4 Respondent agrees that pursuant to RCW 18.130.172 any sanction as set forth in RCW 18.130.160, except subsections (1), (2), (6), and (8), may be imposed as part of this stipulation, but the Respondent may agree to reimburse the disciplinary authority the costs of investigation and processing the complaint up to an amount not exceeding one thousand dollars per allegation.

1.5 The parties wish to resolve this matter by means of this Stipulation pursuant to RCW 18.130.172(1).

1.6 This Stipulation is of no force and effect and is not binding on the parties unless and until it is accepted by the Board.

1.7 This Stipulation is not formal disciplinary action. However, if the Board accepts this Stipulation, it will be reported to the Health Integrity and Protection Databank (45 CFR Part 61), and elsewhere as required by law. It is a public document and will be placed on the Department of Health's website and otherwise disseminated as required by the Public Records Act (Chap. 42.56 RCW).

1.8 The Board agrees to forego further disciplinary proceedings concerning the allegations.

1.9 Respondent agrees to successfully complete the terms and conditions of this informal disposition.

1.10 Respondent understands that a violation of this Stipulation, if proven, would constitute grounds for discipline under RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

2. COMPLIANCE WITH SANCTION RULES

2.1 The disciplinary authority applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. WAC 246-16-800(2)(c) requires the disciplinary authority to impose terms based on a specific sanction schedule unless "the schedule does not adequately address the facts in a case."

2.2 Respondent's alleged conduct falls in Tier A of the "Practice Below Standard of Care" schedule, WAC 246-16-810. The sanction range associated with that tier does adequately address the alleged facts of this case.

2.3 The disciplinary authority considered the following aggravating factors:

A. Experience in practice.

2.4 The disciplinary authority considered the following mitigating factors:

- A. Patient A was not injured.
- B. Inadvertent rather than intentional act.
- C. No past disciplinary record.
- D. Potential for successful rehabilitation.
- E. Present competence to practice.

3. INFORMAL DISPOSITION

The parties agree to the following:

3.1 Respondent's credential to practice as a doctor of osteopathic medicine and surgery in the state of Washington shall be placed on **PROBATION** for at least one (1) year commencing on the effective date of this Stipulation. During the course of probation, Respondent shall comply with all of the following terms and conditions.

3.2 Respondent shall reimburse costs to the Board in the amount of two thousand dollars (\$2,000.00) which must be received by the Board within one (1) year of the effective date of this Stipulation. The reimbursement shall be paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to the Department of Health, Board of Osteopathic Medicine and Surgery at PO Box 1099, Olympia, Washington 98507-1099. Credit or Debit cards can also be used for payment at the front counter of the Department of Health building at 310 Israel Road SE, Tumwater, Washington 98501, during regular business hours.

3.3 Respondent shall not employ un-credentialed individuals to work as health care providers in her office.

3.4 Respondent shall insure that credentialed health care providers who work in her office practice within the scope of his or her health care credential.

3.5 Within ten (10) business days of the effective date of this Stipulation, Respondent shall verify in writing to the Board the names and credential numbers of employees who work as health care providers in her office, and shall verify in writing the scope of practice of these individuals.

3.6 Within two (2) weeks before the end of the PROBATIONARY period, Respondent shall again verify in writing to the Board the names and credential numbers

of employees who work as health care providers in her office, and shall verify again in writing the scope of practice of these individuals.

3.7 Within ten (10) business days of the effective date of this Stipulation, Respondent shall submit copies of any advertising, including web sites, business cards, and brochures to the Compliance Unit. The Board or its designee shall review the documents and determine whether they are within the requirements of Washington law.

3.8 Within two (2) weeks before the end of the PROBATIONARY period, Respondent shall again submit copies of any advertising, including web sites, business cards, and brochures to the Compliance Unit. The Board or its designee shall review the documents and determine whether they are within the requirements of Washington law.

3.9a If the Board of Osteopathic Medicine and Surgery has completed a jurisprudence examination within ninety (90) days of the end of Respondent's probationary period, Respondent shall pass with a score of one hundred per cent (100%) the jurisprudence examination for new licensees.

3.9b If the Board has not adopted the jurisprudence examination in its final version within ninety (90) days of the date that Respondent's probationary period is to end, Respondent shall submit to the Board for its approval a paper, typewritten in ten or twelve point font, of 500 to 1,000 words, demonstrating that she has reviewed the statutes and regulations pertaining to physician's assistants and other ancillary medical staff and the requirements of supervising them. If the Board does not approve Respondent's paper and asks her to redo it, the Board shall be specific in its objections and requirements. Respondent shall not have completed her probationary period until the Board has approved the paper.

3.10 All documentation required by this Stipulation shall be sent to Department of Health, Compliance Unit, P.O. Box 47873, Olympia, WA 98504-7873.

3.11 Respondent is responsible for all her costs of complying with this Stipulation.

3.12 Respondent shall inform the Board and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

3.13 The effective date of this Stipulation is the date the Adjudicative Clerk Office places the signed Stipulation into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Stipulation.

4. RESPONDENT'S ACCEPTANCE

I, ANN B. MCCOMBS, have read, understand and agree to this Stipulation. This Stipulation may be presented to the Board without my appearance. I understand that I will receive a signed copy if the Board accepts this Stipulation.

Ann B. McCombs
ANN B. MCCOMBS
RESPONDENT

2-1-10
DATE

Jan C. Kirkwood
JAN C. KIRKWOOD, WSBA #11092
ATTORNEY FOR RESPONDENT

February 1, 2010
DATE

5. BOARD ACCEPTANCE

The Board accepts this Stipulation to Informal Disposition. All parties shall be bound by its terms and conditions.

DATED: March 19, 2010.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE AND
SURGERY

William Aant
PANEL CHAIR

PRESENTED BY:

Jane Marie WSBA #17246 for
JUDY L. YOUNG, WSBA #3797
DEPARTMENT OF HEALTH STAFF ATTORNEY

3/19/2010
DATE

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY

In the Matter of

PATRICK N. BAYS
Credential No. DO.OP.00001343

Respondent

No. M2007-11157

**STIPULATION TO INFORMAL
DISPOSITION**

1. STIPULATION

1.1 The Executive Director of the Board of Osteopathic Medicine and Surgery (Board), on designation by the Board, has made the following allegations.

A. On December 19, 1991, the state of Washington issued Respondent a credential to practice as an osteopathic physician and surgeon. Respondent's credential is currently active.

B. From approximately December 13, 2004 through June 2005, Respondent employed Heidi Lundeen to work in his office. Although trained and educated as an osteopathic physician assistant, Ms. Lundeen was not licensed with the Board nor had the Board approved a practice arrangement plan regarding Ms. Lundeen's work. During this time, Respondent allowed Ms. Lundeen to provide physician assistant services to patients, including Patients A through O. Ms. Lundeen's services included taking patient histories and physicals, charting examinations, giving injections, and/or prescribing medications.

1.2 Respondent does not admit any of the allegations in the Statement of Allegations and Summary of Evidence or in paragraph 1.1 above. This Stipulation to Informal Disposition (Stipulation) shall not be construed as a finding of unprofessional conduct or inability to practice.

1.3 Respondent acknowledges that a finding of unprofessional conduct or inability to practice based on the above allegations, if proven, would constitute grounds for discipline under RCW 18.130.180(10).

ORIGINAL

1.4 Respondent agrees that any sanction as set forth in RCW 18.130.160, except subsections (1), (2), (6) and (8), may be imposed as part of this stipulation, but the Respondent may agree to reimburse the disciplinary authority the costs of investigation and processing the complaint up to an amount not exceeding one thousand dollars (\$1,000.00) per allegation.

1.5 The parties wish to resolve this matter by means of this Stipulation pursuant to RCW 18.130.172(1).

1.6 This Stipulation is of no force and effect and is not binding on the parties unless and until it is accepted by the Board.

1.7 This Stipulation is not formal disciplinary action. However, if the Board accepts this Stipulation, it will be reported to the Health Integrity and Protection Databank (45 CFR Part 61), the National Practitioner Databank (45 CFR Part 60) and elsewhere as required by law. It is a public document and will be placed on the Department of Health's website and otherwise disseminated as required by the Public Records Act (Chap. 42.56 RCW).

1.8 The Board agrees to forego further disciplinary proceedings concerning the allegations.

1.9 Respondent agrees to successfully complete the terms and conditions of this informal disposition.

1.10 Respondent understands that a violation of this Stipulation, if proven, would constitute grounds for discipline under RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

2. INFORMAL DISPOSITION

The parties agree to the following:

2.1 Within one (1) year of the effective date of this Stipulation, Respondent shall complete a minimum of seven (7) hours of continuing education, pre-approved by the Board or its designee, in the area of Medical Ethics. Respondent shall provide the Board with proof of completion of such course-work within thirty (30) days of completion. Failure to timely complete and confirm completion of such continuing education shall constitute violations of this Stipulation. This continuing education shall be in addition to mandatory continuing education hours required for credential renewal.

2.2 Within thirty (30) days of completing the above-referenced continuing education, Respondent shall write and submit to the Board or its designee an authoritative paper of a minimum of 1,000 words incorporating what Respondent learned from the continuing education, reflecting on his responsibility for supervising auxiliary staff, and explaining how he will incorporate what he learned into his practice.

2.3 Respondent shall reimburse costs to the Board in the amount of one thousand dollars (\$1,000.00) which must be received by the Compliance Unit within six (6) months of the effective date of this Stipulation. The reimbursement shall be paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to the Department of Health, Osteopathic Board at PO Box 1099, Olympia, Washington 98507-1099. Credit or Debit cards can also be used for payment at the front counter of the Department of Health building at 310 Israel Road SE, Tumwater, Washington 98501, during regular business hours.

2.4 All documents required by this Stipulation shall be mailed to the Department of Health, Osteopathic Board Compliance Unit, PO Box 47873, Olympia, Washington, 98504-7873.

2.5 Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

2.6 Respondent shall assume all costs of complying with this Stipulation.

2.7 If Respondent violates any provision of this Stipulation in any respect, the Board may take further action against Respondent's credential.

2.8 Respondent shall inform the Board and the Adjudicative Service Unit in writing, of changes in his residential and/or business address within thirty (30) days of such change.

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

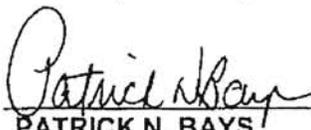
2.10 Respondent is responsible for all costs of complying with this Stipulation.

2.11 Respondent shall inform the Department of Health and the Adjudicative Clerk Office in writing of changes in Respondent's residential and/or business address within thirty (30) days of the change.

2.12 The effective date of this Stipulation is the date the Adjudicative Clerk Office places the signed Stipulation into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Stipulation.

3. RESPONDENT'S ACCEPTANCE

I, PATRICK N. BAYS, have read, understand and agree to this Stipulation. This Stipulation may be presented to the Board without my appearance. I understand that I will receive a signed copy if the Board accepts this Stipulation.



PATRICK N. BAYS
RESPONDENT

August 5, 2009
DATE

_____, WSBA #
ATTORNEY FOR RESPONDENT

DATE

4. BOARD ACCEPTANCE

The Board accepts this Stipulation to Informal Disposition. All parties shall be bound by its terms and conditions.

DATED: 9/25/09, 2009.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE AND
SURGERY



PANEL CHAIR

PRESENTED BY:

Judy L. Young WSBA #3797 for
JO ANNE MINOR, WSBA #17246
DEPARTMENT OF HEALTH STAFF ATTORNEY

September 25, 2009
DATE

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of:)	
)	Docket No. 00-03-A-1100MD
)	
STEPHEN C. KENNEDY, MD)	STIPULATED FINDINGS OF FACT,
License No. MD00017870)	CONCLUSIONS OF LAW AND
)	AGREED ORDER
Respondent.)	
)	

The Medical Quality Assurance Commission, (Commission), by and through Michael L. Farrell, Department of Health Staff Attorney and Stephen C. Kennedy, MD, represented by Thomas Fain, attorney at law, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

- 1.1 Stephen C. Kennedy, MD, Respondent, was issued a license to practice as a physician and surgeon by the State of Washington in September 1979.
- 1.2 In April 2000, the Commission issued a Statement of Charges against Respondent.
- 1.3 The Statement of Charges alleges that Respondent violated RCW 18.130.180(10).
- 1.4 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.
- 1.5 Respondent understands that he has the right to defend himself against the allegations in the Statement of Charges by presenting evidence at a hearing.
- 1.6 Respondent understands that, should the State prove at a hearing the allegations in the Statement of Charges, the Commission has the power and authority to impose sanctions pursuant to RCW 18.130.160.

1.7 Respondent and the Commission agree to expedite the resolution of this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.8 Respondent waives the opportunity for a hearing on the Statement of Charges contingent upon signature and acceptance of this Agreed Order by the Commission.

1.9 This Agreed Order is not binding unless and until it is signed and accepted by the Commission.

1.10 Should this Agreed Order be signed and accepted it will be subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate/national reporting requirements.

1.11 Should this Agreed Order be rejected, Respondent waives any objection to the participation at hearing of all or some of the Commission members who heard the Agreed Order presentation.

Section 2: STIPULATED FACTS

The State and Respondent stipulate to the following facts:

2.1 Respondent is a plastic surgeon in Vancouver, Washington.

2.2 In December 1998, Respondent permitted Paul Cenac, MD, then licensed to practice medicine and surgery in the state of Washington, to use his office to see patients and to perform surgical procedures in his office.

2.3 On March 8, 1999, the Commission revoked Dr. Cenac's license to practice medicine in the state of Washington.

2.4 On March 18, 1999, the Commission notified Respondent that it had revoked Dr. Cenac's license to practice medicine in the state of Washington.

2.5 On April 10, 1999, a patient came into Respondent's office complaining that a breast implant was extruding from her right breast.

2.6 Despite knowing that Dr. Cenac did not have a license to practice medicine in the state of Washington, Respondent permitted Dr. Cenac to perform surgery on the patient to remove the implant from Patient Two's breast. Respondent assisted Dr. Cenac in this surgery.

Section 3: CONCLUSIONS OF LAW

The State and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent acknowledges that evidence is sufficient to justify a finding of a violation of RCW 18.130.180(10), which defines as unprofessional conduct:

Aiding or abetting an unlicensed person to practice when a license is required.

3.3 The above violation is grounds for the imposition of sanctions under RCW 18.130.160.

Section 4: AGREED ORDER

Based on the preceding Stipulated Facts and Conclusions of Law, Respondent agrees to entry of the following Order:

4.1 The Commission reprimands Respondent for permitting an unlicensed person to practice medicine in his office.

4.2 Respondent agrees not to aid and abet unlicensed persons to practice a profession for which a license, certification or registration is required. Respondent agrees to ensure that his employees practice within the scope of their license, certification or registration.

4.3 Pursuant to RCW 18.130.160(8), Respondent shall pay a fine in the amount of \$4000 within ninety (90) days of the effective date of this Agreed Order. The fine shall be payable to the State Treasurer and sent to the following address:

Department of Health
Post Office Box 1099
Olympia, Washington 98507-1099.

4.4 Within 10 days of the effective date of this order, Respondent shall thoroughly complete the attached Healthcare Integrity and Protection Data Bank Reporting Form (Section 1128 of the Social Security Act) and return it to the disciplining authority.

4.5 Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.6 Respondent shall assume all costs of complying with this Order.

4.7 If Respondent violates any provision of this Order in any respect, the Commission, may take further action against Respondent's license.

4.8 Respondent shall inform the Commission, and the Adjudicative Clerk Office in writing, of changes in his residential address.

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I, Stephen C. Kennedy, MD, Respondent, certify that I have read this Stipulated Findings of Fact, Conclusions of Law and Agreed Order in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree

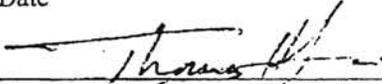
to all of it; and that it may be presented to the Commission without my appearance. If the Commission accepts the Stipulated Findings of Fact, Conclusions of Law and Agreed Order, I understand that I will receive a signed copy.



Stephen Q. Kennedy, MD
Respondent

11 SEPT 2000

Date



Thomas Fain WSBA # 07117
Attorney for Respondent

September 14, 2000

Date

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Section 5: ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

REDACTED

DATED this 5th day of October 2000

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Robert Newell

Panel Chair

Presented by:

Michael L. Farrell

Michael L. Farrell WSBA # 16022
Department of Health Staff Attorney

Oct 11, 2000
Date

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS: 99-06-0076MD

REDACTED

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of)	
)	Docket No. 99-06-A-1002MD
)	
JAMES W. McHUGH, M.D., <i>License No. 20907</i>)	STIPULATION TO INFORMAL DISPOSITION
)	
Respondent.)	
_____)	

Section 1: STIPULATION

The parties to the above-entitled matter stipulate as follows:

1.1 James W. McHugh, M.D., Respondent, is informed and understands that the Program Manager, on designation by the Commission, has made the following allegations:

1.1.1 From on or about July 28, 1998 through August 18, 1998, Respondent regularly caused a person in his employ, not licensed under Chapter 18.89 RCW, to perform measurements of patients' respiratory volumes, pressures and flows.

1.1.2 From on or about July 28, 1998 through August 18, 1998, Respondent regularly caused a person in his employ, not licensed as a physician or other practitioner authorized under RCW 69.41, to prescribe legend drugs to patients.

1.2 Respondent is informed and understands that the Commission has alleged that the conduct described above, if proven, would constitute violations of RCW 18.130.180 (7) and (10).

1.3 The parties wish to resolve this matter by means of a Stipulation to Informal Disposition pursuant to RCW 18.130.172(1).

1.4 Respondent agrees to be bound by the terms and conditions of the Stipulation to Informal Disposition.

1.5 This Stipulation to Informal Disposition is of no force and effect and is not binding on the parties unless and until the Commission accepts this Stipulation to Informal Disposition.

1.6 Respondent does not admit any of the allegations in the Statement of Allegations and Summary of Evidence or in paragraph 1.1 above. This Stipulation to Informal Disposition shall not be construed as a finding of unprofessional conduct or inability to practice.

1.7 This Stipulation to Informal Disposition is not formal disciplinary action, is not intended and should not be construed as an action which "revokes or suspends (or otherwise restricts) a physician's license or censures or reprimands, or places on probation" as those words are used in Sec. 422 of the Health Care Quality Improvement Act of 1986, 42 USC 11132 and is therefore not subject to any reporting requirements to the National Practitioner Data Bank, or under RCW 18.130.110 or any interstate/national reporting requirement.

1.8 This Stipulation to Informal Disposition is releasable to the public upon request pursuant to the Public Records Act, chapter 42.17 RCW.

1.9 The Commission agrees to forego further disciplinary proceedings concerning the allegations contained in section 1.1 above.

1.10 Respondent agrees to successfully complete the terms and conditions of this Informal Disposition.

1.11 Respondent is advised and understands that a violation of the provisions of section 2 of this Stipulation to Informal Disposition, if proved, would constitute grounds for discipline under RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

Section 2: INFORMAL DISPOSITION

Pursuant to RCW 18.130.172 (2) and based upon the foregoing stipulation, the parties agree to the following Informal Disposition. After TWO YEARS, the Commission's oversight and monitoring of the Respondent in regard to this Informal Disposition shall automatically terminate pending the Respondent's satisfactory completion of the terms and conditions denominated herein.

2.1 The Respondent shall, within SIXTY DAYS of the effective date of this Informal Disposition, review the laws of the State of Washington regarding the respective scopes of practice of physicians, health care assistants, and respiratory care practitioners. The Commission shall supply materials for such review. Questions concerning the specific focus of such review by the Respondent shall be directed to the Commission's designee. Thereafter, the Respondent shall submit a written report to the Commission detailing the legal practice parameters of those health professions in the state of Washington, showing his understanding of appropriate application of the law to his practice of medicine. The report shall be typewritten, double-spaced, and shall be no shorter than five pages in length. The written report shall be submitted to the Commission's designee for approval no later than ninety (90) days after the effective date of this Informal Disposition.

2.2 The Respondent shall pay a cost recoupment in the amount of \$3000 by certified check, made out to the State Treasurer, mailed to PO Box 41099, Olympia, WA 98504-1099, within 90

days of the effective date of this Informal Disposition. Failure to remit the fine within the specified time shall constitute a violation of RCW 18.130.180 (9).

2.3 The Respondent shall see to it that all care delivered to his patients falls within acceptable standards of medical practice. The Respondent shall obey all federal, state, and local laws and all administrative rules governing the practice of medicine in Washington

2.4 The Respondent shall provide to the Commission a current home and business address and telephone number and shall immediately notify the Commission of any changes in address or telephone number.

2.5 The Commission reserves the right to conduct periodic reviews of the Respondent's practice to assure his compliance with Title 18 RCW, including unannounced inspections of Respondent's office during regular business hours. Respondent agrees to cooperate with such reviews and cause his office staff to cooperate with any such inspection. Such reviews shall occur at the discretion of the Commission.

I, James W. McHugh, M.D., Respondent, certify that I have read this Stipulation to Informal Disposition in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Commission without my appearance.

If the Commission accepts the Stipulation to Informal Disposition, I understand that I will receive a signed copy.



James W. McHugh, M.D.
Respondent
6/16/99

Date

Section 3: ACCEPTANCE

The Commission accepts this Stipulation to Informal Disposition. All parties shall be bound by its terms and conditions.

DATED this 19th day of August, 1999

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION



Panel Chair

Presented by:

Marcia G. Stickler, WSBA # 20712
Department of Health Staff Attorney

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBER:

98-09-0045MD

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of

DALE T. FETROE, MD
License No. MD00018950

Respondent

No. 2009-31

**STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND
AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through James McLaughlin, Department of Health Staff Attorney, and Respondent, represented by W. Scott Lowry, Attorney at Law, stipulate and agree to the following:

1. PROCEDURAL STIPULATIONS

1.1 On April 22, 2009, the Commission issued a Statement of Charges against Respondent.

1.2 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(1), (4), (7), and (24); and WAC 246-919-630.

1.3 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent understands that if the allegations are proven at a hearing, the Commission has the authority to impose sanctions pursuant to RCW 18.130.160.

1.5 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.6 Respondent waives the opportunity for a hearing on the Statement of Charges provided that the Commission accepts this Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order).

1.7 The parties agree to resolve this matter by means of this Agreed Order.

1.8 Respondent understands that this Agreed Order is not binding unless and until it is signed and accepted by the Commission.

1.9 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Databank (45 CFR Part 61), the National Practitioner Databank (45 CFR Part 60) and elsewhere as required by law. It is a public document

and will be placed on the Department of Health's website and otherwise disseminated as required by the Public Records Act (Chap. 42.56 RCW) and the Uniform Disciplinary Act, RCW 18.130.110.

1.10 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2: FINDINGS OF FACT

Respondent and the Program stipulate to the following facts:

2.1 On February 18, 1981 the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

2.2 On or about September 17, 2007, Respondent began treating Patient A at his clinic in Walla Walla, Washington.

2.3 At the time the Respondent began treating Patient A, Patient A had been diagnosed with depression and adult attention deficit hyperactive disorder ("ADHD"). Patient A was also experiencing stress arising from her marital dissolution.

2.4 During the course of his treatment of Patient A, Respondent prescribed Wellbutrin and Adderall for the patient's depression and ADHD. Respondent's prescribing was a continuation of the medications prescribed by her previous provider.

2.5 Beginning in approximately January of 2008, Respondent engaged in a social and dating relationship with Patient A that continued for approximately six months. The relationship included multiple instances of sexual contact.

2.6 During the course of Respondent's relationship with Patient A, he prescribed medication for Patient B, the sister of Patient A, without examining Patient B, and without keeping a medical record. Patient B resides in Ohio. In approximately May of 2008, Respondent learned from Patient B that she had been diagnosed with oral herpes by two separate doctors (an ear, nose, and throat specialist and an urgent care physician). Without personally examining Patient B, Respondent prescribed Valtrex, acyclovir, prednisone and hydrocodone (a controlled substance), and provided some medication samples by mail. Respondent understood that these medications were consistent with what was prescribed by the examining physicians. Respondent did not keep a chart for Patient B.

2.7 In approximately June of 2008, Respondent diagnosed Patient C, the six year old son of Patient A, with herpetic stomatitis and a chest infection. Respondent prescribed Acyclovir and an antibiotic. Respondent did not keep a chart for Patient C.

2.8 On or about November 10, 2008, Respondent terminated the physician-patient relationship with Patient A.

3. CONCLUSIONS OF LAW

The State and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), (7), and (24); and WAC 246-919-630.

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order:

4.1 Probation. Respondent's credential to practice as a physician and surgeon in the state of Washington is placed on PROBATION for a period of five years. During this probationary period, and until this Agreed Order is terminated by the Commission, Respondent will comply with the following terms and conditions.

4.2 Psychological Evaluation. Within six months of the effective date of this Agreed Order, Respondent shall undergo a comprehensive psychological evaluation, to be conducted by a Commission-approved evaluator. The following psychologists are pre-approved as evaluators:

- (1) Leslie Rawlings, Ph.D.
1001 Broadway, Suite 315
Seattle, Washington 98122
(206) 323-0905
- (2) Robert Wheeler, Ph.D.
19195 - 36th Avenue, Suite 206
Lynnwood, Washington 98036
(206) 771-0970.

4.3 Materials For Evaluation. Respondent shall provide the Commission with reasonable prior notice of the date and time of his psychological evaluation. The Commission will provide the evaluator with a copy of this Agreed Order and the Department's investigative file, prior to the evaluation. Respondent may submit additional materials for the evaluator's consideration if he so chooses.

4.4 Evaluation Report. The evaluator shall prepare a written report to the Commission stating in detail his opinions, and the basis for those opinions, regarding any diagnosis and prognosis. The evaluator shall send the written report directly to the Commission. The evaluator shall opine as to whether, as a practicing physician, Respondent poses a risk to the public health and safety, and as to whether practice restrictions or conditions would alleviate the danger. The report shall state whether the evaluator recommends a counseling plan and the necessary elements of the recommended plan. The evaluator may make other recommendations if he concludes they are necessary to provide effective treatment or to otherwise protect the public health and welfare. Respondent shall follow all recommendations made by the psychological evaluator.

4.5 Written Statement to Patients. Within thirty days of the effective date of this Agreed Order, Respondent will submit to the Commission a written office policy statement to be distributed to female patients. The policy statement must be pre-approved by the Commission through its Medical Consultant. Upon Commission approval, the policy statement will be distributed to each female patient upon their first visit following the Commission's approval. Respondent will ensure that each patient receiving the statement signs the statement, and will place the signed copy in the patient's chart. The policy statement will include a clearly identifiable and unmitigated statement that Respondent does not participate in social or personal relationships with female patients that are considered by the Medical Quality Assurance Commission to be outside of the appropriate physician-patient boundary. The statement will further indicate that Respondent will not meet alone with female patients outside of the office or outside of office hours, except in emergency or home care circumstances. This provision will not apply to patients that do not receive on-going care from Respondent,

such as patients seen in the hospital only, or call-group coverage settings. Respondent will ensure that office staff members are aware of the terms of this Agreed Order.

4.6 Medical Records and Examination. Respondent will not prescribe for any person without keeping a patient chart. Respondent will not prescribe for any person, except in emergent circumstances, without first conducting a patient history and physical examination.

4.7 Medical Ethics and Boundaries Course. Respondent shall complete an intensive workshop in medical ethics approved by the Commission or its designee, which will include education regarding the maintenance of appropriate professional boundaries and relationships. Respondent will submit proof of completion of this course to the Commission within twelve months of the effective date of this Agreed Order. The course may count toward Respondent's statutorily mandated minimum continuing medical education requirements in Washington. The following courses are pre-approved: (1) "Maintaining Proper Boundaries," co-sponsored by The University of Texas Southwestern Medical Center and Santé Center for Healing; (2) Professional/Problem Based Ethics Course (ProBE), by the Center for Personalized Education for Physicians; and (3) The "Maintaining Proper Boundaries" course taught by the Center for Professional Health at Vanderbilt Medical Center.

4.8 Fine. Respondent shall pay a fine of \$5,000, which is to be paid within one year of the effective date of this Agreed Order. Respondent's check will be submitted to the Department of Health, Accounting Department, P.O. Box 1099, Olympia, WA 98507-1099.

4.9 Quarterly Declarations. Respondent will provide the Commission with quarterly declarations attesting that he is in compliance with all terms and conditions of this Agreed Order, including compliance with any recommendations made by the psychological evaluator. Respondent will submit the declarations on or before the first day of January, April, July, and October of each year.

4.10 Compliance Appearances. Respondent shall appear in person before the Commission in approximately six months from the effective date of this Agreed Order, at a date and location designated by the Commission. Respondent shall present proof that he is complying with this Agreed Order, and present information concerning the nature of

his practice. Thereafter, Respondent shall appear before the Commission annually, or at a frequency otherwise designated by the Commission.

4.11 Petition to Modify or Terminate. Respondent may not petition to modify or terminate this Agreed Order for a period of five years from its effective date. Upon a written petition to modify or terminate, Respondent shall appear in person before the Commission and provide proof that he has complied with this Agreed Order, and that there is not a reasonable risk that this misconduct will occur in the future.

4.12 Obey All Laws and Rules. Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.13 Costs Incurred By Respondent. Respondent is responsible for all costs of complying with this Agreed Order.

4.14 Violation of Order. If Respondent violates any provision of this Agreed Order in any respect, the Commission may take further action against Respondent's license.

4.15 Change of Address. Respondent shall inform the Program and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty days of the change.

4.16 Effective Date. The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

5. COMPLIANCE WITH SANCTION SCHEDULE

5.1 The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. The conduct in this case falls within Tier B of the "Sexual Misconduct Or Contact" schedule found at WAC 246-16-820, and within Tier B of the "Practice Below Standard of Care" schedule found at WAC 246-16-810.

5.2 Tier B of both schedules requires terms that range from a minimum of two years of Commission oversight (with terms that may include probation, practice restrictions, training, monitoring, evaluation, etc.) to a maximum of five years of oversight or revocation. The terms in this Agreed Order are within that range. The position of

these terms within the sanction range is consistent with the following aggravating and mitigating factors:

Aggravating Factors:

- a. There is an increased risk of harm in crossing boundaries with a patient who is receiving psychiatric medications, and
- b. Respondent's conduct constituted an abuse of the trust needed in the physician-patient relationship.

Mitigating Factors

- a. Treatment in this case did not include the particularly intimate areas of psychotherapy or gynecological treatment, and treatment for depression and ADHD was limited to continuing previously prescribed medications;
- b. The evidence does not suggest that the patient expressed increased vulnerability or incapacity;
- c. Respondent has been licensed for more than 28 years without prior disciplinary action;
- d. Respondent has extensive practice experience, including previously serving as Chief of Staff of Walla Walla General Hospital, Medical Director of the Washington State Penitentiary, Medical Director of Sunrise Nursing Home, and Medical Director of Student Health at Whitman College;
- e. There is no evidence that Respondent has engaged in boundary crossings with any other patient in a 28 year history;
- f. Respondent has fully admitted key facts;
- g. Respondent has expressed remorse and awareness that his misconduct was wrong; and
- h. Respondent has volunteered to take remedial steps to make sure that the misconduct that is the subject of this order does not occur in the future.

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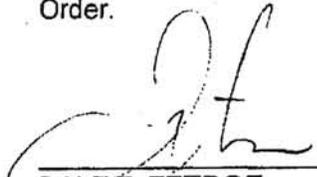
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6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. ACCEPTANCE

I, Dale T. Fetroe, Respondent, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.



DALE T. FETROE
RESPONDENT

7-15-09

DATE



W. SCOTT LOWRY, WSBA #6403
ATTORNEY FOR RESPONDENT

7/15/09

DATE

8. ORDER

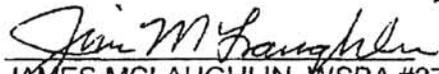
The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED: 16 July, 2009.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION


RANEL CHAIR

PRESENTED BY:


JAMES MCLAUGHLIN, WSBA #27349
DEPARTMENT OF HEALTH STAFF ATTORNEY

7/16/09
DATE

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

In the Matter of the License to Practice
as a Physician and Surgeon of:

ROBERT A. WILSON, MD
License No. MD00032057

Respondent

No. M2009-1469

**STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND
AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through James McLaughlin, Department of Health Staff Attorney, and Respondent, represented by Patrick Sheldon, Attorney at Law, stipulate and agree to the following:

1. PROCEDURAL STIPULATIONS

1.1 On July 13, 2010, the Commission issued an Amended Statement of Charges against Respondent.

1.2 In the Amended Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(1), (4), (6), (7), (12), (20) and (24); and WAC 246-919-630.

1.3 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent understands that if the allegations are proven at a hearing, the Commission has the authority to impose sanctions pursuant to RCW 18.130.160.

1.5 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.6 Respondent waives the opportunity for a hearing on the Statement of Charges provided that the Commission accepts this Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order).

1.7 The parties agree to resolve this matter by means of this Agreed Order.

1.8 Respondent understands that this Agreed Order is not binding unless and until it is signed and accepted by the Commission.

1.9 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Databank (HIPDB)(45 CFR Part 61), the Federation of State

Medical Board's Physician Data Center and elsewhere as required by law. HIPDB will report this Agreed Order to the National Practitioner Data Bank (45 CFR Part 60).

1.10 This Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's listserv, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2: FINDINGS OF FACT

Respondent and the Program stipulate to the following facts:

2.1 On July 28, 1994 the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is board certified in family medicine.

2.2 Respondent is employed at the Lopez Island Medical Clinic on Lopez Island, a small community of approximately 2,200 residents. Respondent first saw Patient A as a patient in June of 2002. Over the next several years, Respondent provided care for Patient A for various medical issues. Patient A also saw an ARNP at the clinic for gynecological and other issues.

2.3 During the course of her physician-patient relationship with Respondent, Patient A revealed personal and confidential information to Respondent, including information about problems in her marriage. Respondent also revealed personal information to Patient A, including issues concerning his marriage. In October 2008, Respondent and Patient A began having telephone conversations and meeting each other socially.

2.4 From approximately October or November of 2008 until late March or early April of 2009, Respondent engaged in a romantic and sexual relationship with Patient A.

2.5 Although the last charted office visit between Respondent and Patient A occurred on June 3, 2008, before their sexual relationship began, the physician-patient

relationship between Respondent and Patient A continued during the course of the sexual relationship. Respondent continued to prescribe for Patient A throughout the course of their sexual relationship.

2.5.1 On June 3, 2008, Respondent documented that Patient A needed to follow-up with her primary care provider regarding "depression, anxiety, etc other issues." Nevertheless, Respondent renewed Patient A's longstanding prescription for Effexor (an anti-depressant), without documenting this treatment, by issuing a prescription for Effexor (venlafaxine).

2.5.2 During the course of their sexual relationship, Respondent increased Patient A's dose of depression medication from 75 mg. of Effexor (venlafaxine) per day to 112.5 mg. per day. These prescriptions for an increased dose of depression medication were written on or about February 20, 2009, and on or about March 25, 2009, within the time period of the sexual relationship. Respondent did not document these prescriptions, or his rationale for the increase, in the patient's chart.

2.5.3 Respondent also failed to document a prescription for sulfamethoxazole issued to Patient A on or about January 20, 2009.

2.5.4 On March 25, 2009, Respondent prescribed Xanax (alprazolam), an anti-anxiety medication, for Patient A. This prescription followed a telephone call from Patient A during which she expressed her anxiety. The call from Patient A and the prescription were documented by Respondent in the patient chart.

2.6 In late March of 2009, Patient D and his wife discovered Respondent and Patient A trespassing on their property and having sexual intercourse. Following this incident, Respondent may have revealed to Patient A that Patient D was a patient of his, and may have revealed information concerning a medical condition suffered by Patient D.

2.7 The romantic and sexual relationship concluded shortly after the discovery by the property owners. Patient A was subsequently subjected to ridicule by residents of the island community.

3. CONCLUSIONS OF LAW

The State and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (1), (4), (7), (20) and (24); and WAC 246-919-630.

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order:

4.1 Probation. Respondent's credential to practice as a physician and surgeon in the state of Washington is placed on PROBATION for a period of four years from the effective date of this Agreed Order.

4.2 Psychological Evaluation. Within six months of the effective date of this Agreed Order, Respondent shall undergo a comprehensive psychological evaluation, to be conducted by a Commission-approved evaluator. The following psychologists are pre-approved as evaluators:

- (1) Leslie Rawlings, Ph.D.
1001 Broadway, Suite 315
Seattle, Washington 98122
(206) 323-0905
- (2) Robert Wheeler, Ph.D.
19195 - 36th Avenue, Suite 206
Lynnwood, Washington 98036
(206) 771-0970.
- (3) Jennifer Wheeler, Ph.D
1370 Steward Street
Seattle, WA 98109
(206) 484-2194

4.3 Materials For Evaluation. Respondent shall provide the Commission with reasonable prior notice of the date and time of his psychological evaluation. The Commission will provide the evaluator with a copy of this Agreed Order and the Department's investigative file, prior to the evaluation. Respondent may submit additional materials for the evaluator's consideration if he so chooses.

4.4 Evaluator's Recommendations. Respondent will follow any treatment or practice recommendations made by the evaluator. If Respondent disputes any of the evaluator's recommendations, Respondent can petition the Commission in writing to modify this Agreed Order regarding the sole issue of the psychological evaluator's recommendations. Following a petition under this provision, Respondent will appear in person before the Commission at a date and location designated by the Commission and present evidence as to why the disputed recommendations should not be required. Following any such hearing, the Commission will issue an order specifying which of the evaluator's recommendations must be followed.

4.5 Ethics Course. Within six months of the effective date of this Agreed Order, Respondent shall complete the Professional/Problem Based Ethics Course (ProBE), at the Center for Personalized Education for Physicians (CPEP). To satisfy this provision, Respondent must obtain an "unconditional pass" as an assessment following the course. Respondent shall permit CPEP to communicate with the Commission regarding his participation in this course, and shall provide the Commission with a copy of the essay that Respondent writes as part of the course.

4.6 Written Protocol. Respondent will practice only at offices or facilities that have a written protocol or policy specifying that the office or facility prohibits healthcare practitioners from having sexual relationships with patients.

4.7 Notification of Agreed Order. Respondent will provide a copy of this Agreed Order to all staff members in his office and to the Chief of Staff or supervising body of any facility at which Respondent provides healthcare services or has privileges. Within 30 days of the effective date of this Agreed Order, Respondent will provide attestations signed by each of the individuals or groups identified in this paragraph confirming that they have received a copy of this Agreed Order. Respondent will also cause his supervising authority to provide a letter to the Commission, on a quarterly basis, attesting to Respondent's compliance with this Agreed Order.

4.8 Chaperone. Respondent will continue to use a female chaperone during sensitive examinations of female patients (including breast or pelvic examinations). The chaperone's presence will be documented in the patient chart and the documentation will be initialed by the chaperone.

4.9 Medical Care for Respondent and Family. Respondent will continue to have a personal physician who oversees Respondent's personal medical care. Respondent will not prescribe for himself or family members or provide health care to family members except in emergency circumstances.

4.10 Fine. Respondent shall pay a fine of \$5,000, which is to be paid within one year of the effective date of this Agreed Order. Respondent's check will be submitted to the Department of Health, Accounting Department, P.O. Box 1099, Olympia, WA 98507-1099.

4.11 Compliance Appearances. Respondent shall appear in person before the Commission in approximately six months from the effective date of this Agreed Order, at a date and location designated by the Commission. Respondent shall present proof that he is complying with this Agreed Order, and present information concerning the nature of his practice. Thereafter, Respondent shall appear before the Commission annually, or at a frequency otherwise designated by the Commission.

4.12 Obey Laws. Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.13 Costs. Respondent is responsible for all costs that he incurs in complying with this Agreed Order.

4.14 Violation of Order. If Respondent violates any provision of this Agreed Order in any respect, the Commission may take further action against Respondent's license.

4.15 Change of Address. Respondent shall inform the Program and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

4.16 Modification. Except as specified in paragraph 4.4, Respondent may not petition to modify this Agreed Order for at least three years from its effective date. A petition to modify must be in writing. The Commission will determine whether a personal appearance by Respondent is required to resolve a petition for modification under this paragraph.

4.17 Termination. Respondent may not petition to terminate this Agreed Order earlier than four years from its effective date. A petition to terminate must be in writing.

Upon a petition to terminate, Respondent will appear in person before the Commission at a date and location designated by the Commission.

4.18 Effective Date. The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

5. COMPLIANCE WITH SANCTION RULES

The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Tier B of the "Sexual Misconduct or Contact" schedule, WAC 246-16-820, applies to cases where there is sexual contact or a romantic relationship between the physician and patient that creates a risk of, or results in, patient harm. Tier B of the "Practice Below Standard of Care" schedule, WAC 246-919-810, applies to cases where the substandard care caused moderate patient harm or resulted in the risk of moderate to severe patient harm.

Tier B of both the Sexual Misconduct schedule and the Practice Below Standard of Care schedule applies to this case. By engaging in a romantic and sexual relationship with Patient A who suffered from depression and anxiety, and failing to document medications prescribed for or dispensed to Patient A, Respondent created the risk of harm to Patient A, and Patient A actually suffered harm in at least the following ways: (1) it moderately to severely damaged or risked moderate to severe damage to the trust Patient A has for her physician and the medical community; (2) it created the risk of severe harm to Patient A's marriage, and actually harmed (at least moderately) Patient A's marriage; (3) it damaged Patient A's reputation and ultimately resulted in Patient A being ostracized in a small community where Respondent is greatly respected as the only physician; and (4) the failure to document created the risk of moderate to severe harm in the form of cross reactions or overdosing of medications obtained through potential subsequent healthcare providers who were unaware of the entirety of the medications prescribed or dispensed by Respondent.

Tier B in the Sexual Misconduct and the Below Standard of Care schedules both require sanctions ranging from two to five years of oversight with terms and conditions, or revocation. The sanctions rules, at WAC 246-16-800(3)(d), specify that the duration of the

order should be determined by beginning in the middle of the range, and moving right (longer duration) or left (shorter duration) based upon the balance of aggravating and mitigating factors.

This Agreed Order includes a four year probation with terms and conditions, and is therefore toward the right end of the Tier B range. This position within the range is required by the fact that the aggravating factors in this case outweigh the mitigating factors. The aggravating factors include the following: (1) the significant damage to the standing of the medical profession in the eyes of the community, when Respondent, a physician, was discovered having sex with a patient in a field; (2) the vulnerability of Patient A who suffered from depression and anxiety; (3) the severity of the damage to Patient A's standing in the small island community; and (4) the abuse of trust when Respondent engaged in an affair with Patient A, a married patient who had trusted Respondent as her physician with information regarding her marriage.

The above aggravating factors, although equal in number, outweigh the following mitigating factors: (1) Respondent has been licensed in the state of Washington since 1994 with no prior disciplinary actions; (2) Respondent has acknowledged his misconduct and expressed remorse; (3) Respondent cooperated with the Commission's investigation; and (4) Respondent has taken remedial measures by self-referring for evaluation by Dr. Glen Gabbard, MD, at the Baylor College of Medicine. Dr. Gabbard concluded that Respondent was a very low risk for repeating any kind of serious boundary violation. However, Dr. Gabbard did not review materials from the Commission's investigative file during his evaluation. Dr. Gabbard made recommendations, and Respondent has voluntarily followed and is following all recommendations made by Dr. Gabbard. These mitigating factors provide for public protection without suspension or restriction, and justify a four year period of supervision rather than the maximum five year period.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the

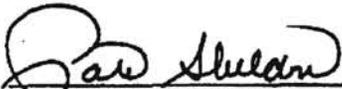
Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. RESPONDENT'S ACCEPTANCE

I, Robert A. Wilson, MD, Respondent, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.


ROBERT A. WILSON, MD
RESPONDENT

2/10/11
DATE


PATRICK SHELDON, WSBA #11398
ATTORNEY FOR RESPONDENT

2/17/2011
DATE

8. COMMISSION'S ACCEPTANCE AND ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED: March 3, 2011

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

Frederick H. Dore MD
PANEL CHAIR

PRESENTED BY:

Jim McLaughlin
JAMES MCLAUGHLIN, WSBA #27349
DEPARTMENT OF HEALTH STAFF ATTORNEY

3/3/11
DATE