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DIVISION II

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STATE OF WASHINGTON
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**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

DALE E. ALSAGER, D.O.,

Appellant,

v.

DEPARTMENT OF HEALTH,
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY,
an agency of the State of Washington, et al.,

Respondents.

BRIEF OF RESPONDENTS

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I. INTRODUCTION

After listening to the testimony and considering the evidence, the Board of Osteopathic Medicine and Surgery (Board) concluded in a Findings of Fact, Conclusions of Law, and Final Order (Final Order) that Appellant Dale E. Alsager, D.O.'s, treatment and care of Patients A through G fell below the standard of care of a reasonably prudent osteopathic physician. Dr. Alsager failed to adequately address the challenges of treating multiple members of the same family for chronic pain. These challenges include increased risk of diversion and medication sharing and the risk that children of chronic pain patients may mimic the pain and medication usage of their parents. Ultimately, Dr. Alsager's treatment of Patients A through G amounted to a dangerous practice pattern that put all of his patients at great risk of harm. Dr. Alsager's actions constituted unprofessional conduct under the Uniform Disciplinary Act, RCW 18.130.180(4), and the Board, accordingly, issued sanctions against him.

In this appeal, Dr. Alsager argues that the Board abrogated its duties when it accepted the cause of death listed on a valid death certificate, did not adopt standards of practice for every type of osteopathic conduct, made findings of fact in contrast to Dr. Alsager's

testimony, and sanctioned him for unprofessional conduct. Dr. Alsager's argument fails in every aspect. The Board was not required to adopt by formal rulemaking a standard of care for every situation prior to finding that Dr. Alsager's actions constituted unprofessional conduct. Not only would it be impossible to promulgate a rule for every situation that an osteopathic physician might encounter, but the legislature and the courts have already adopted a general definition of the appropriate standard of care against which every health practitioner in this state must be compared. The Board appropriately adhered to this standard when considering Dr. Alsager's conduct during the administrative hearing. It also adhered to the appropriate statutory and legal authority when making findings of fact about the cause of Patient A's death, as well as when it sanctioned Dr. Alsager for unprofessional conduct. For these reasons, the Board respectfully requests that its Final Order be affirmed.

II. STATEMENT OF THE ISSUES

1. May the Board accept the cause of death listed on a death certificate as the legal cause of death?
2. Must the Board promulgate by formal rulemaking all standard of care requirements for osteopathic physicians prior to determining whether an osteopathic physician's treatment constituted incompetence, negligence, or malpractice under RCW 18.130.180(4)?
3. May the Board find that Dr. Alsager committed unprofessional conduct when his treatment of Patients A through G fell below the

standard of care?

4. Do the sanctions imposed by the Board satisfy RCW 18.130.160?
5. Did the Board properly summarily restrict Dr. Alsager's license to practice as an osteopathic physician and surgeon in the State of Washington?

III. STATEMENT OF THE CASE

A. The Board's Disciplinary Authority

The Washington State Legislature created the Board to regulate the practice of osteopathic medicine and enforce the laws placed under its jurisdiction. RCW 18.57.003; RCW 18.57.005. Under the Uniform Disciplinary Act (UDA), the Board brings disciplinary proceedings against licensed osteopaths for two purposes: to protect the public and to protect the profession in the eyes of the public. RCW 18.130.040; RCW 18.130.020; *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 605, 903 P.2d 433 (1995). The UDA defines twenty-five (25) categories of unprofessional conduct for which a health professional may be sanctioned. RCW 18.130.180.

The Board conducts reviews, investigates matters, approves charges, and hears disciplinary proceedings. RCW 18.130.050. If the Board determines that unprofessional conduct may have occurred, it directs the Department to prepare a Statement of Charges. RCW 18.130.060(4). A presiding officer issues all rulings on evidentiary,

procedural and policy matters prior to and during the disciplinary hearing, but the Board ultimately decides whether professional misconduct occurred. RCW 18.130.050(10); RCW 18.130.095(3); *see also* WAC 246-11. If the Board concludes that unprofessional conduct occurred, the Board must order sanctions in accordance with RCW 18.130.160.

B. Dr. Alsager's Treatment Of Patients A Through G

On August 22, 1995, the State of Washington issued Dr. Alsager a license to practice Osteopathic Medicine and Surgery. Administrative Record ("AR") 213.¹ At all times relevant, Dr. Alsager owned his own practice in Maple Valley, Washington. AR 10379. Between 2001 and 2006, Dr. Alsager treated Patients A, B, C, D, E, F and G². AR 215–4209. Patient A was referred to Dr. Alsager by his father, Patient B. AR 10650. Dr. Alsager also provided treatment to Patient C, the wife of Patient B, and to their son and daughter-in-law, Patients E and D. AR 10719, 10880, 10346. Patients F and G, while unrelated to the five other identified patients, were involved in a long-term relationship. AR 10839.

¹ As indicated in the index to clerk's papers, the Administrative Record consists of four boxes and consists of approximately 10995 pages (which includes the transcript of the proceedings). Any reference to the Administrative Record as certified to the Court is hereinafter referred to as "AR". Any reference to the Clerk's Papers in this matter will be referred to as "CP".

² In health professional licensing matters, the patient's identity is protected. RCW 70.02.010. Patients are referred to by letter designation and are named in a Confidential Schedule attached to the Statement of Charges. AR 10.

1. Patient A

Patient A, a 21-year-old man, presented to Dr. Alsager as a new patient on or about October 11, 2001. AR 10151. At the time of Patient A's visit, Dr. Alsager noted that Patient A complained of lower back pain with numbness to his left knee. *Id.* Without conducting any diagnostics other than a routine physical examination and without noting Patient A's previous exposure to narcotic medications, Dr. Alsager started Patient A on two opioids, Duragesic and Percocet. AR 10152. Two days later, Dr. Alsager increased Patient A's prescriptions for the Duragesic and Percocet. AR 10154. Dr. Alsager also added a prescription for Clonazepam, a benzodiazepine. AR 10155. The combination of high dose opioids and benzodiazepines created a high potential for an overdose. AR 10122-25; AR 10155.

Patient A left Dr. Alsager's care in 2004, returning in 2005. AR 10159. Dr. Alsager again prescribed a combination of opioids and benzodiazepines – Oxycodone, Xanax, and Alprazolam. AR 10159-60. The only diagnosis provided by Dr. Alsager to justify the high levels of pain medications prescribed to Patient A was colitis³, a diagnosis he made without sufficient examination. AR 10162.

³ Colitis: "inflammation of the colon". Stedman's Online Medical Dictionary, available at <http://www.stedmans.com/section.cfm/45> (last accessed August 20, 2009).

In August, 2005, Patient A was involved in a motor vehicle accident. AR 10162. In two subsequent visits, Patient A appeared in Dr. Alsager's office with facial lacerations and a broken nose. AR 10165. Even though Dr. Alsager asked Patient A to undergo alcohol reduction consumption counseling, Dr. Alsager documented no attempt to reduce or eliminate Patient A's medications. AR 10163-64. Instead, Dr. Alsager continued to prescribe a rotating regime of benzodiazepines in spite of Patient A's numerous accidents. AR 10165-66.

On September 13, 2005, Patient A made his last visit to Dr. Alsager's office. AR 10166. Patient A reported that he was in pain and that he had run out of his medications. AR 10166. Patient A left Dr. Alsager's office with prescriptions for Oxycodone and benzodiazepines, as well as a fentanyl patch provided directly by Dr. Alsager. AR 10169.

Patient A died in the early morning of September 14, 2005. AR 5163. The autopsy revealed a fentanyl patch positioned on Patient A's anterior chest, as well as the absence of an anatomic cause of death. AR 10120, 10122. Relying on the drug concentration levels in Patient A's body, as well as historical and autopsy findings, the medical examiner concluded that Patient A died of acute intoxication due to the combined

effects of fentanyl, diazepam, oxycodone, and carbamazepine. AR 10122-23; AR 5163-64.

Throughout his treatment of Patient A, Dr. Alsager failed to create a treatment program to help improve Patient A's functional abilities. AR 10172. Dr. Alsager also never recommended consultations with specialists, including specialists in orthopedic surgery, neurosurgery, neurology, or addiction medicine, to determine if other treatment options would be more successful. AR 10173. Viewed as a whole, Dr. Alsager's treatment of Patient A resulted in no improvement in Patient A's condition. AR 10175. Instead, Dr. Alsager's treatment caused an unreasonable risk of harm to Patient A. AR 10170.

2. Patient B

Patient B approached Dr. Alsager for treatment of back pain after undergoing numerous failed surgeries. AR 10346, 10178. Dr. Alsager prescribed Patient B high doses of opioids, an acceptable course of treatment due to Patient B's history of use. AR 10178. In addition to the opioids, Dr. Alsager also prescribed multiple benzodiazepines. AR 10178. Rather than improving Patient B's function, the benzodiazepines increased Patient B's fatigue, malaise, and depression. AR 10178.

Dr. Alsager also treated Patient B for colitis. AR 10179. On at least 20 occasions, Dr. Alsager prescribed intravenous or oral antibiotics

for Patient B for colitis related complaints. AR 10179. Despite Patient B's high risk for constipation due to his high doses of opioids and Patient B's report of passing pills in his stools, Dr. Alsager failed to provide any counseling regarding constipation. AR 10179-80. And, despite Patient B's high risk of bowel rupture, Dr. Alsager failed to refer Patient B for any type of evaluation. AR 10179. Dr. Alsager's actions increased Patient B's risk of a catastrophic bowel problem. AR 10180.

Throughout his treatment of Patient B, Dr. Alsager frequently administered B12 and folate injections. AR 10180. Dr. Alsager administered these injections without checking Patient B's levels for deficiencies and without establishing a diagnosis supporting the treatment. AR 10180.

Dr. Alsager primarily managed Patient B's care through medication. AR 10183. During his treatment of Patient B, Dr. Alsager failed to refer Patient B for a pain management consultation. AR 10183-84. Dr. Alsager also failed to utilize other referrals that may have been helpful in creating a functional treatment plan for Patient B. AR 10183.

3. Patient C

Dr. Alsager treated Patient C over the course of a long-term patient/doctor relationship. AR 10189. Although Dr. Alsager treated Patient C for a wide variety of ailments, including chronic pain,

Dr. Alsager never diagnosed Patient C with anything other than an anxiety disorder. AR 10190. Dr. Alsager prescribed multiple benzodiazepines to address Patient C's anxiety. AR 10189. Rather than improving functionality in chronic pain patients, however, benzodiazepines frequently result in patients becoming isolated and withdrawn. AR 10190.

After the death of Patient A, Patient C's son, Dr. Alsager failed to provide Patient C with any grief counseling. AR 10191. Dr. Alsager instead continued Patient C on the same regime of medications without any type of coordinated care plan. AR 10191. Patient C's drug regime – including opioids and benzodiazepines – mimicked that of her husband and sons. AR 10191.

Dr. Alsager's habit of prescribing short-acting opiates for Patient C's long term pain created a high risk of overdose. AR 10193. Rather than attempt to discover the underlying cause of Patient C's anxiety or pain through non-opioid treatment options, Dr. Alsager continued to prescribe large doses of opioids. AR 10194. Dr. Alsager made no outside referrals for Patient C to try alternative care. AR 10194.

Dr. Alsager also injected Patient C with B12 and folate on a regular basis. AR 10191. As with Patient B, Dr. Alsager performed no testing to determine Patient C's levels of B12 or folate before

administering the injections. AR 10192. Nor did Dr. Alsager document the efficacy of the treatment. AR 10192.

4. Patient D

Patient D, a 28-year-old woman, presented to Dr. Alsager's office with shoulder pain. AR 10197. Despite Patient D's relatively young age, Dr. Alsager diagnosed her with shoulder pain without investigating the underlying cause. AR 10197. Dr. Alsager neither performed nor referred Patient D to an outside specialist for an orthopedic or physical therapy evaluation. AR 10197. To treat Patient D's pain, Dr. Alsager administered multiple shoulder joint injections. AR 10198. Current orthopedic and rheumatology literature states that multiple shoulder joint injections are contraindicated because the shoulder cartilage and tendons are degraded by the repeated steroid exposure. AR 10199. When Dr. Alsager's treatment plan failed to produce any improvement, he still failed to refer Patient D for specialist care. AR 10199.

Dr. Alsager prescribed Soma for Patient D's muscle spasms. AR 10200. Soma is sedating, habit forming, and ineffective for muscle relaxation. AR 10200. Dr. Alsager also prescribed benzodiazepines, which are also habit forming and problematic. AR 10200.

In June 2004, Patient D was arrested for prescription drug forgery. AR 10201. After learning of Patient D's alteration of his prescription,

Dr. Alsager failed to adjust Patient D's medications and continued to authorize refills. AR 10201. Dr. Alsager justified Patient D's forgery as "amateurish" and rationalized it as a sign of under-treatment of pain. AR 10789-90. Patient D again altered a prescription three months later. AR 10201. Dr. Alsager again failed to modify Patient D's medication regime in any way. AR 10201. Additionally, despite evidence that Patient D was not in compliance with her long-term benzodiazepine therapy, Dr. Alsager neglected to refer her to any sort of drug addiction treatment. AR 10202.

On or about April 30, 2005, Patient D reported to Dr. Alsager that her husband, Patient E, assaulted her. AR 10203. Even though Dr. Alsager prescribed medication for both Patient D and Patient E, he made no alterations to either patient's prescriptions upon learning of the abuse. AR 10203.

5. Patient E

Dr. Alsager treated Patient E for chronic pain. AR 10205. Although Patient E presented with an extensive history of chronic pain, his complaints were inconsistent with regards to location of pain and need for pain medication. AR 10205. In 2001, Patient E's employer called Dr. Alsager to report that Patient E appeared drugged at work. AR 10206. Dr. Alsager also noted in Patient E's record that Patient E had a personal and family history of alcoholism. AR 10207. And, Dr. Alsager knew of

reports that Patient E abused his wife. AR 10207. Despite ample evidence that Patient E needed close scrutiny and regulation of his medication, Dr. Alsager continued to increase Patient E's opioid levels. AR 10207.

During his treatment of Patient E, Dr. Alsager diagnosed Patient E with rheumatoid arthritis. AR 10208. Dr. Alsager's diagnosis, however, lacked any medical justification. AR 10209. Patient E's rheumatoid factor test was negative. AR 10208. He failed to demonstrate the requisite symptoms under either the new or old rheumatoid arthritis classification trees. AR 10208-09. Furthermore, Patient E's reported areas of pain – back, hips, and shoulders – were not areas associated with rheumatoid arthritis. AR 10209. Without referring Patient E to a rheumatologist, Dr. Alsager gave Patient E multiple intravenous injections of high potency immunosuppressants. AR 10209-10. Dr. Alsager failed to document any efficacy of the medications, and he failed to perform any follow-up testing. AR 10211. Instead, Dr. Alsager used this diagnosis to justify prescribing Patient E's high doses of opioid medications. AR 10208.

As with other patients, Dr. Alsager administered B12 and folate injections to Patient E without first checking Patient E's existing levels or establishing a diagnosis necessitating the injections. AR 10211.

Dr. Alsager also failed to utilize referrals to help Patient E move away from opioid dependence. AR 10212. Dr. Alsager's treatment of Patient E amounted to symptom suppression without relief or functional improvement. AR 10215.

6. Patient F

Patient F came to Dr. Alsager for treatment of chronic pain. AR 10215. Throughout the course of Dr. Alsager's treatment, Patient F displayed a number of signs indicating that she was out of compliance with her pain medication regimen. AR 10218. On numerous occasions, Patient F tested positive for cannabinoids in urine drug screens. AR 10218. In addition, her drug screens also tested negative for her prescribed opiates, indicating that she was not taking her medication as prescribed. AR 10218-19. Dr. Alsager failed to document any action taken in response to the positive/negative drug screens. AR 10220. Dr. Alsager did refer Patient F for one pain management consultation, but the records he provided to the reviewing doctor were incomplete – they lacked any information about Patient F's previous noncompliance. AR 10218.

Dr. Alsager relied on Patient F's self-reported diagnosis of rheumatoid arthritis to justify Patient F's long-term use of opioids. AR 10228. The diagnosis, however, lacked any substantiation. AR 10227.

Patient F failed to demonstrate the requisite criteria under both the new and old rheumatoid arthritis classification trees. AR 10228. Dr. Alsager's reliance on this misdiagnosis to prescribe increasing doses of opioids to Patient F left Patient F in more pain rather than less: the prescribed pain drugs resulted in the suppression of Patient F's natural ability to deal with pain, rendering Patient F unable to cope with day-to-day discomfort. AR 10228-29.

Dr. Alsager performed numerous steroid injections on Patient F. AR 10225. These injections included a number of joint and spinal injections given while Patient F was taking antibiotics for other ailments. AR 10225. Current medical literature contraindicates steroidal injections when a potential infection source exists. AR 10225. Dr. Alsager's administration of injections despite Patient F's infection put Patient F at increased risk of developing septic joints. AR 10226. Dr. Alsager also failed to establish any efficacy of his treatment protocol. AR 10227.

7. Patient G

Dr. Alsager treated patient G for chronic pain. AR 10233-34. Despite indications that Patient G was out of compliance with his prescribed drug regimen, Dr. Alsager failed to take any corrective action. AR 10230-31. After noting that Patient G's urinalysis showed positive for marijuana, Dr. Alsager neglected to discuss the dangers of marijuana use

with Patient F. AR 10230-31. And, after noting on multiple occasions that Patient G's urinalysis showed negative for his prescribed opioids, Dr. Alsager neglected to determine why Patient G was not taking his medications as directed. AR 10231.

During the course of Dr. Alsager's treatment of Patient G, Patient G was admitted to Harborview due to benzodiazepine-withdrawal seizures. AR 10232. Patient G returned to Dr. Alsager's care upon his release. AR 10232. Although Dr. Alsager noted in Patient G's file that he reviewed the Harborview records, Dr. Alsager failed to perform any follow-up care or provide any counseling. AR 10232. Instead, Dr. Alsager immediately started Patient G back on benzodiazepines. AR 10232.

Dr. Alsager's records indicate that most of Patient G's pain complaints stemmed from his previously fractured wrist. AR 10233-34. The contemporaneous records maintained by Patient G's orthopedist, however, consistently state that Patient G had little or no pain as a result of the fracture and subsequent surgery. AR 10234. Despite the dichotomy in Patient G's pain complaints, and without conferring with Patient G's orthopedist, Dr. Alsager administered multiple intra-articular joint injections to Patient G's wrist. AR 10234-35. Dr. Alsager's injections were neither beneficial nor effective. AR 10235. The injections also

created a risk of destruction of the cartilage and soft tissue surrounding the injection sites. AR 10235.

C. The Adjudicative Hearing

On August 1, 2006, the Department of Health, on behalf of the Board, issued a Statement of Charges against Dr. Alsager. AR 4-10. The Statement of Charges alleged that Dr. Alsager committed unprofessional conduct under RCW 18.130.180(4) and (7). AR 7-8. The specific charges against Dr. Alsager included allegations that he provided treatment below the standard of care to the seven chronic pain patients, that he improperly diagnosed and treated patients for rheumatoid arthritis, that he failed to make necessary referrals, and that he gave numerous contraindicated injections. AR 4-7.

On August 8, 2006, the Board determined that Dr. Alsager's "ability to practice osteopathic medicine and surgery represented an immediate danger to the public health, safety, and welfare" and that Dr. Alsager's "pattern of substandard practice demonstrates an immediate danger to current and potential patients." AR 16. Based on this determination, the Board summarily restricted Dr. Alsager's license and prohibited him from prescribing Schedule II and Schedule III controlled substances. AR 17.

The administrative hearing commenced April 21, 2008, and

ultimately lasted five days. AR 4957. During the administrative hearing, a panel of three Board members heard the evidence and made the decision in the case. AR 4956. Each of the panel members were osteopathic physicians. *Id.* At the hearing, Dr. Alsager testified, as did Patients B and C, the parents of Patient A. AR 10377-402; 10564-758; 10764-959; AR 10345-62; AR 10329-45. The Department's witnesses included Dr. John Lacy, M.D., the medical examiner who conducted Patient A's autopsy, Dr. John Hillyer, M.D., the Department's expert witness, and Dr. James Song, Patient A's neurologist. AR 10117-43; AR 10146-250; AR 10432-49. Dr. Alsager submitted the testimony of Dr. Wayne Anderson, D.O. and Dr. Thomas Reay, M.D. specifically related to Patient A. AR 10251-319; AR 10518-42.

On August 7, 2008, the Board, in a written order, found by clear and convincing evidence that Dr. Alsager committed unprofessional conduct as defined in RCW 18.130.180(4). AR 4979; *see generally* Final Order attached hereto as Appendix A. In their Corrected Final Order, the Board made findings consistent with the statement of facts above. AR 4956-83. The Board noted that while Dr. Alsager was not a pain management specialist, he treated Patients A – G for chronic pain. AR 4960. The Board also found that Dr. Alsager prescribed controlled substances to Patients A – G without objective medical findings and

without monitoring for possible misuse. AR 4961-62. The Board determined that by writing initial prescriptions for large quantities or high dosages of controlled substances, Dr. Alsager created a danger of drug overdose for his patients. AR 4962. Dr. Alsager compounded this risk by simultaneously writing his patients prescriptions for benzodiazepines. AR 4962-63.

In addition to noting his errant prescribing of controlled substances, the Board made a number of other determinations about Dr. Alsager's treatment of Patients A – G. The Board found that Dr. Alsager: performed improper joint injections; failed to refer patients for necessary consultations; improperly diagnosed and treated rheumatoid arthritis; administered B12 and folic acid injections without medical indication and failed to evaluate the efficacy of courses of treatment. AR 4964-65. Ultimately, the Board concluded that Dr. Alsager's treatment of Patients A through G constituted "[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed." AR 4980.

The Board sanctioned Dr. Alsager's license based on its findings and implemented restrictions and conditions. AR 4980-81. The Board: (1) prohibited Dr. Alsager from prescribing Schedule II and Schedule III controlled substances until he completed a board approved training

course or residency regarding pain management; (2) required him to demonstrate that his facility provides adequate shielding for his x-ray machines; (3) required a qualified radiologist to over-read all of his diagnostic scans; and (4) required Dr. Alsager to pay a \$20,000 administrative fine. *Id.*

D. Procedural History

On September 10, 2008, Dr. Alsager filed for judicial review of the Board's Final Order in Thurston County Superior Court. CP 3. After hearing oral argument and considering the briefing, the court affirmed the Board's Final Order. CP 84-85. Dr. Alsager timely filed a Notice of Appeal on May 28, 2009. CP 86.

IV. STANDARD OF REVIEW

The standard of review is highly deferential to the Board's authority to discipline Dr. Alsager for unprofessional conduct. Judicial review of an agency order is authorized under the Administrative Procedure Act (APA). RCW 34.05.510. Under the APA, a party challenging the validity of agency action bears the burden of demonstrating its invalidity. RCW 34.05.570(1)(a). Questions of law, including constitutional challenges, are reviewed *de novo*. *Ames v. State Med. Quality Assur. Comm'n*, 166 Wn.2d 255, 260, 208 P.3d 549 (2009); *State v. Mertens*, 148 Wn.2d 820, 826, 64 P.3d 633 (2003). However,

courts give substantial weight to an agency's interpretation of its own laws and regulations, especially when the agency applies its own specialized knowledge or expertise to evaluate the evidence. *Id.*; see also *Univ. of Wash. Med. Ctr. v. Dep't of Health*, 164 Wn.2d 95, 187 P.3d 243 (2008); and *State Med. Disciplinary Bd. v. Johnston*, 99 Wn.2d 466, 482, 663 P.2d 457 (1983).

The standard of review for an agency's factual findings is the "substantial evidence" test. See RCW 34.05.570(3)(e). Substantial evidence is evidence sufficient to persuade a fair-minded person of the truth of the finding. *Heinmiller*, 127 Wn.2d at 607. This test is highly deferential to the administrative fact-finder. *Motley-Motley, Inc. v. State*, 127 Wn. App. 62, 72, 110 P.3d 812 (2005). Reviewing courts will not overturn an agency decision even where the opposing party reasonably disputes the issues and evidence with equal dignity. *Ferry Cy. v. Concerned Friends of Ferry Cy.*, 121 Wn. App. 850, 856, 90 P.3d 698 (2004). When reviewing an agency's factual findings, the court does not reweigh the evidence; but instead is limited to assessing whether the evidence satisfies the applicable burden of proof. *Ancier v. Dep't of Health*, 140 Wn. App. 564, 574, 166 P.3d 829 (2007).

V. ARGUMENT

A. The Board Properly Accepted The Cause Of Death Listed On Patient A's Death Certificate As Patient A's Legal Cause Of Death.

Dr. Alsager asserts that the Board's reliance on Patient A's death certificate for the legal cause of his death, pursuant to RCW 70.58.180, created an impermissible conclusive presumption in violation of his due process rights. *See* Brief of Appellant ("Br. Appellant") at 30. "The standard of review in a case where the constitutionality of a statute is challenged is that a statute is presumed to be constitutional and the burden is on the party challenging the statute to prove its unconstitutionality beyond a reasonable doubt." *Island Cy. v. State*, 135 Wn.2d 141, 146, 955 P.2d 377 (1998) (*citing State v. Myles*, 127 Wn.2d 807, 812, 903 P.2d 979 (1995); *Aetna Life Ins. Co. v. Wash. Life & Disab. Ins. Guar. Ass'n*, 83 Wn.2d 523, 528, 520 P.2d 162 (1974)). Dr. Alsager cannot meet this high burden because his analysis of RCW 70.58.180 as it relates to a conclusive presumption is simply incorrect.

A statute creates a conclusive presumption in violation of the Constitution only if it creates a presumption that the contesting party is incapable of disputing. *Heiner v. Donnan*, 285 U.S. 312, 324-25, 52 S. Ct. 358, 76 L. Ed. 772 (1932); *see also Adams v. Hinkle*, 51 Wn.2d 763, 322 P.2d 844 (1958). In other words, an impermissible presumption is one

that “when fact B is proven, fact A must be taken as true, and the adversary is not allowed to dispute this at all.” *State v. Savage*, 94 Wn.2d 569, 573, 618 P.2d 82 (1980) (quoting *McCormick’s Handbook of the Law of Evidence* § 342, at 804 (2d ed. 1972)). However, a statute may create a rule of evidence so long as there is “a rational connection between the facts declared to constitute *prima facie* proof of the fact to be proved and the fact presumed.” *Adams*, 51 Wn.2d at 786.

RCW 70.58.180 is exactly the type of allowable evidentiary rule envisioned by the *Adams* court. RCW 70.58.180 states that the manner, mode and cause of death listed in a properly filed death certificate shall be the legally accepted manner, mode and cause of death of a deceased individual. RCW 70.58.180. There is clearly a rational connection between the Medical Examiner’s determination of a cause of death, as it appears on a death certificate, and a legal cause of death.

The statute does not create an impermissible presumption because proof of the legal cause of death (e.g., death by acute intoxication of drugs, fact B) does not necessitate that the proximate cause of the death (e.g., prescribing doctor caused death, fact A) must be taken as true. There still must be evidentiary proof connecting the two. Furthermore, while the statute indicates that the death certificate is *prima facie* evidence

of the cause of death, nothing in the statute prohibits a party from challenging the determination.⁴

By accepting the death certificate, the Board neither applied an impermissible presumption nor abrogated its duties as fact-finder. Dr. Alsager's assertion that the Board engaged in an impermissible conclusive presumption by accepting the cause of death as listed on Patient A's death certificate ignores the elements of a conclusive presumption. Although Dr. Alsager identifies that the Board accepted the medical examiner's cause of death as Patient A's legal cause of death (fact B), Dr. Alsager fails to identify any presumption (fact A) that arose from the Board's acceptance. Dr. Alsager simply cannot establish that the Board's reliance on the medical examiner's determination resulted in a conclusive presumption. As such, his constitutional challenge to RCW 70.58.180 must fail.

In addition, the Board properly fulfilled its duties as a fact finder at Dr. Alsager's hearing by considering and weighing the evidence before it. The death certificate was merely one piece of evidence that the Board considered in regards to the allegation that Dr. Alsager's treatment of

⁴ In fact, the medical examiner's certification of the cause of death is subject to judicial review. *See, e.g.,* RCW 68.50.015 (accuracy of medical examiner's determination of cause of death is subject to judicial review); *Vanderpool v. Rabideau*, 16 Wn. App. 496, 577 P.2d 21 (1976) (exercise of discretion in certifying cause of death is subject to review by courts). Dr. Alsager failed to challenge the medical examiner's certification of Patient A's cause of death through the available channels.

Patient A fell below the standard of care. *See, e.g.*, AR 10117-43 (Testimony of Dr. Lacy); AR 10146-250 (Testimony of Dr. Hillyer); AR 10432-49 (Testimony of Dr. Song); AR 212-335 (Patient A's Medical Records). Dr. Alsager had an opportunity to present evidence to the contrary and establish that the care he provided was proper. *See, e.g.*, AR 10251-319 (Testimony of Dr. Anderson); AR 10518-42 (Testimony of Dr. Reay). The fact that the Board found that Dr. Alsager provided treatment below the standard of care after reviewing all of the evidence presented at hearing, including Patient A's death certificate, does not mean that the Board abrogated its duties.

In fact, the Board had no reason or obligation to decide Patient A's specific cause of death. Instead, the Board's purpose was to determine whether Dr. Alsager's care of Patient A fell below the standard of care, and, therefore, caused Patient A harm or created an unreasonable risk of harm. AR 4, 7. After considering all of the evidence, testimony and expert opinions, the Board made findings of fact and concluded that Dr. Alsager's total treatment of Patient A did, in fact, fall below the standard of care for an osteopathic physician. AR 4966-69. Based on the evidence presented, such a determination was entirely appropriate. There is no reason to vacate the Board's findings.

B. The Board May Rely On The Standard Of Care As Understood By A Reasonably Prudent Physician In The State Of Washington.

1. The Board Adhered To Its Statutory And Legal Authority When It Applied The Standard Definition For Standard Of Care To Dr. Alsager's Practice.

Dr. Alsager contends that each and every standard of care for the practice of osteopathic medicine must be promulgated by formal rulemaking prior to the Board taking disciplinary action. As the disciplinary authority for osteopathic physicians, the Board may make rules and regulations to govern the profession. RCW 18.57.005. However, formal rulemaking for every standard of care situation is unnecessary because the UDA, RCW 18.130.180(4), provides the appropriate standard by which the Board must evaluate osteopathic physicians. The statute reads in pertinent part that it is unprofessional conduct to treat a patient with “[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.” RCW 18.130.180(4). The statute incorporates the generally accepted principle that the failure to exercise the minimal degree of skill, care, and learning expected of a reasonably prudent practitioner constitutes a breach of the standard of care, and is negligence or incompetence. *See Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001) (definition of standard of care); RCW 7.70.040

(definition of standard of care in civil cases for medical malpractice); *see also* 6 *Washington Practice: Washington Pattern Jury Instructions: Civil*, WPI 105.01, 105.02 (5th ed. 2002).

In addition to the definition, the Board must also consider “the purposes of professional discipline, considered in the context of a specific application, and supplemented by the shared knowledge and understanding of medical practitioners” when determining whether a practitioner satisfied the requisite standard of care. *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 743, 818 P.2d 1062 (1991). The Board does this by relying on expert testimony, as well as their own expertise and knowledge. *Johnston*, 99 Wn.2d at 482. Furthermore, as the regulatory and disciplinary body, the Board is permitted to draw its own conclusions as to the acceptable standard of care. *Ames*, 166 Wn.2d at 261-62.

In this case, the Board applied the correct standard: whether, based on the factual evidence before them, Dr. Alsager’s care of Patients A through G, clearly and convincingly fell below the standard of care and thus constituted unprofessional conduct under RCW 18.130.180(4). The fact that there is not a rule, promulgated by formal rulemaking procedures, that specifically delineates the appropriate standard of care for osteopathic physicians providing pain management treatment is irrelevant. RCW

18.130.180(4) sufficiently outlines the standards a physician must meet when practicing medicine.

2. Requiring the Board to promulgate the standard of care for osteopaths in Washington via formal rulemaking is impracticable.

Furthermore, Dr. Alsager's contention that each and every standard of care for the practice of osteopathic medicine must be promulgated by formal rulemaking is simply infeasible. Formal rulemaking is only necessary when the questioned agency action will affect the public in a general way and where notice to and comment by the affected public would be useful. *Allan v. Univ. of Washington*, 140 Wn.2d 323, 372, 997 P.2d 360 (2000) (quoting William R. Andersen, *The 1988 Washington Administrative Procedure Act: An Introduction*, 64 Wash. L. Rev. 781, 791 (1989)). Osteopathic physicians engage in countless actions when treating their patients for a wide range of ailments and complaints. Each case is unique and specific. Establishing a formal rule to address each and every interaction a physician has or may have with a patient would be an impossible undertaking, and as explained above, unnecessary when the appropriate standard is already established by law.

3. Dr. Alsager's Reliance On Out-Of-State Case Law Is Misplaced.

Dr. Alsager relies on two out-of-state cases to support his assertion that the Board must promulgate the standard of care through the formal

rulemaking process; his reliance is misplaced. Neither the Pennsylvania Supreme Court decision in *Pennsylvania State Board of Pharmacy v. Cohen*, nor the Oregon Supreme Court decision in *Megdal v. Oregon State Board of Dental Examiners*, are applicable to this case. *Cohen*, 448 Pa. 189, 292 A.2d 277 (1972); *Megdal*, 288 Or. 293, 605 P.2d 273 (1980). In both cases, the reviewing courts invalidated a disciplinary board's findings of professional misconduct when the boards had not found a violation of specific statute or rule. The Pennsylvania Supreme Court in *Cohen* determined that without violating any of the thirteen specific prohibitions constituting "grossly unprofessional conduct" under Pennsylvania law, a medical professional could not be disciplined for simply "grossly unprofessional conduct." *Cohen*, 448 Pa. at 195. Similarly, in *Megdal*, the Oregon Supreme Court determined that the term "unprofessional conduct" in absence of specific promulgated standards was insufficient to provide due process notice to dentists prior to professional discipline. *Megdal*, 288 Or. at 305. The Oregon Court noted, however, that if the term had referred to norms of conduct that are uniformly or widely recognized in a particular profession, then the application of unprofessional conduct would not depend on rulemaking but on finding what the existing standards in fact are. *Id.* at 304.

In the case at hand, the Board specifically found that Dr. Alsager

violated RCW 18.130.180(4). AR 4979-80. As described above, the application of this statute refers to norms of conduct that are widely recognized by the osteopathic profession. The Board heard and compared expert testimony regarding this standard and its application to Dr. Alsager's case. Using its experience and expertise, the Board concluded that Dr. Alsager's treatment violated the standard of care. Because the Board applied an accepted standard, and found that Dr. Alsager violated a specific subsection of an enumerated statute, Dr. Alsager's analogy to *Cohen* and *Medgal* fails.

C. The Board Properly Determined That Dr. Alsager's Care Of Patients A-G Fell Below The Standard Of Care, And Thus Constituted Unprofessional Conduct Under The Uniform Disciplinary Act.

1. The Board Did Not Find That Dr. Alsager's Conduct Satisfied All Rules And Statutes Governing The Osteopathic Profession.

Dr. Alsager states on numerous occasions throughout his brief that the Board found that none of Dr. Alsager's conduct violated any of the rules or statutes regulating his profession. *See, e.g.*, Br. Appellant at 1-2, 13, 20 n.26. This assertion is disingenuous and misleading. As further explained below, the Statement of Charges alleged two separate violations of law. Contrary to Dr. Alsager's assertions, dismissal of one of those violations did not mean that the Board found Dr. Alsager's care acceptable

or that he met the standards of the *Pain Management Guidelines*, adopted by the Board.

a. The Statement Of Charges Alleged Two Separate Violations Of Law: Standard Of Care And Violation Of Hospital Policy.

The Statement of Charges issued against Dr. Alsager presented two main allegations: (1) Dr. Alsager provided treatment below the standard of care to Patients A through G – a violation of RCW 18.130.180(4)⁵; and (2) Dr. Alsager violated a rule regulating his profession when he treated a patient at a hospital at which he did not maintain privileges – a violation of RCW 18.130.180(7)⁶. AR 4-10. The Statement of Charges clearly indicated that factual allegations 1.1 through 1.22 constituted violations of RCW 18.130.180(4) and that factual allegation 1.23 alone constituted a violation of RCW 18.130.180(7). AR 7-8.

During pre-hearing proceedings, Dr. Alsager’s counsel noted that Prehearing Order No. 8, Order Defining Conduct At Hearing, failed to

⁵ RCW 18.130.180(4) states that unprofessional conduct includes:

[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

⁶ RCW 18.130.180(7) states that it is professional misconduct for a health care professional to violate “any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.”

reference the Department's allegation that Dr. Alsager violated RCW 18.130.180(7). AR 10100. He also noted that the Statement of Charges did not refer to a specific rule or statute that Dr. Alsager had violated under RCW 18.130.180(7). *Id.* The transcript of the discussion between counsel and the presiding officer clearly reflects that all of the parties understood the nature of, and relationship between, the allegations in the Statement of Charges. AR 10099-103.

Dr. Alsager, through counsel, understood that the alleged violation of RCW 18.130.180(7) concerned *only* factual allegation 1.23 in the Statement of Charges – Dr. Alsager's treatment of a patient at a hospital at which he did not maintain privileges. Ultimately, the presiding officer dismissed the allegation that Dr. Alsager violated RCW 18.130.180(7) because the Department failed to identify the underlying rule or statute that Dr. Alsager had violated. AR 10099-103. From the outset of the hearing, therefore, the panel was asked to determine only whether Dr. Alsager violated RCW 18.130.180(4), and if so, what sanctions were appropriate under RCW 18.130.160. AR 10103. The Board could not, and did not, determine whether Dr. Alsager's conduct in totality violated RCW 18.130.180(7).

b. The Department Did Not Allege, And So Did Not Attempt To Prove, That Dr. Alsager Violated The *Guidelines For Pain Management* Adopted By The Board In 2002.

Contrary to Dr. Alsager's assertions, the Board was not required to compare his conduct to the *Guidelines for Pain Management* before determining whether he met the appropriate standard of care. *See Guidelines for Pain Management* ("Guidelines"), effective September 12, 2002, attached hereto as Appendix B. First, the Statement of Charges did *not* allege that Dr. Alsager violated the Guidelines, as later promulgated in WAC 246-853-520. *See* AR 4-10. The Guidelines were not promulgated as formal rules until June 11, 2007 – long after Dr. Alsager treated the seven patients at issue.⁷ The Department, therefore, did not, and could not, charge Dr. Alsager with violating a rule that did not exist at the time of his misconduct.

Second, as adopted by the Board, the Guidelines were just guidelines. State agencies are encouraged to advise the public of their "current opinions, approaches, and likely courses of action" through policy and interpretive statements. RCW 34.05.240. Unlike administrative rules, however, these internal policies and guidelines do not create law – they are merely advisory. *Wash. Educ. Ass'n v. Pub.*

⁷ The Department's expert witness, Dr. Hillyer, testified at hearing that the Guidelines were inapplicable in this case because they were formally adopted after Dr. Alsager provided the treatment in question. AR 10184.

Disclosure Comm'n, 150 Wn.2d 612, 80 P.3d 608 (2003); *see also Champagne v. Thurston Cy.*, 163 Wn.2d 69, 178 P.3d 936, 942 n.8 (2008).

In 2002, the Board adopted the Guidelines to “a) encourage appropriate treatment for pain management; b) reduce providers’ fear of injudicious discipline; and c) protect the public from inappropriate prescribing practices and diversion.” *See* Guidelines, Appendix B. The Board cautioned, however, that it was “not the intent of these guidelines to define complete standards or acceptable medical care in the treatment of pain patients.” *Id.* Because the Board adopted the Guidelines as an informal policy statement, the Guidelines served only as a useful, non-binding, reference tool for osteopathic physicians engaged in the practice of chronic pain management. As discussed previously, the Guidelines were not the standard by which the Board was to compare Dr. Alsager. Instead, the Board appropriately compared Dr. Alsager’s treatment to that of a reasonably prudent osteopathic physician under the same or similar circumstances, and determined that Dr. Alsager’s conduct fell below the standard of care.

2. The Board’s Determination That Dr. Alsager Violated The Standard Of Care Is Supported By Substantial Evidence.

Dr. Alsager challenges many of the Board’s findings of fact on the basis that they were not supported by substantial evidence under the clear,

cogent and convincing standard of proof. *See* Br. Appellant at 47. However, Dr. Alsager's challenge is based on the premise that the Board must agree with his version of the facts and the standard of care. *See, e.g.*, Br. Appellant at 47-48. As discussed previously, the Board's findings of fact are reviewed for substantial evidence. When some expert testimony has been offered, and the Board issues findings of facts based on the expert testimony, the reviewing court will not inquire whether the testimony fits within some preconceived formulation. *Ames*, 166 Wn.2d at 262. Instead, the court will review the evidence on the record to determine whether a fair-minded person could have been persuaded of its truthfulness. *Id.* In ¶ this case, the combination of the expert and lay witness testimony, as well as the evidence submitted, clearly supports the Board's ultimate findings that Dr. Alsager's treatment of Patients A through G fell below the standard of care.

D. The Board Acted Within Its Authority When It Imposed Sanctions Against Dr. Alsager.

The UDA governs the imposition of sanctions against licensed health care professionals: RCW 18.130.160. If a disciplinary authority finds that a license holder committed professional misconduct, the disciplinary authority must issue an order prescribing sanctions. *Id.* When choosing sanctions, the disciplinary authority must consider what is

necessary to protect the public. *Lang v. Dep't of Health*, 138 Wn. App. 235, 255, 156 P.3d 919 (2007). The available sanctions are enumerated in RCW 18.130.160. The sanctions range from fines to revocation and may be imposed individually or in combination. RCW 18.130.160.

Courts accord an agency's determination of sanctions considerable judicial deference. *Brown v. Dep't of Health*, 94 Wn. App. 7, 16, 972 P.2d 101 (1999). A court may overturn a sanction order that is arbitrary and capricious, but "the scope of review of an order alleged to be arbitrary or capricious is narrow, and the challenger carries a heavy burden." *Keene v. Bd. of Accountancy*, 77 Wn. App. 849, 859, 894 P.2d 582, review denied, 127 Wn.2d 1020, 904 P.2d 300 (1995). A sanction order is arbitrary and capricious only if it is a "willful and unreasoning action, without consideration and in disregard of facts and circumstances." *Heinmiller*, 127 Wn.2d at 609. Harshness is not the appropriate determination of an arbitrary and capricious action. *Id.*

The sanctions imposed by the Board against Dr. Alsager fall within the authority of the Board and adequately reflect the severity of Dr. Alsager's misconduct. The Board imposed four main sanctions. Dr. Alsager challenges the sanctions levied against him on three grounds.⁸

⁸ Dr. Alsager may be asserting a fourth challenge in footnote 57 to his Brief. The footnote is remarkably unclear, however, as to whether it is an argument, an observation, or a musing. As to Dr. Alsager's probation argument, RCW 18.130.160(7)

Each challenge fails to meet the high burden necessary to overturn the Board's sanctioning decisions.

First, Dr. Alsager argues that the sanctions relating to his use of MRI, CT, and DEXA scans are outside of the Statement of Charges. Br. Appellant at 43. This is simply inaccurate. The Statement of Charges alleged that Dr. Alsager improperly diagnosed and treated rheumatoid arthritis. AR 6. During his testimony, Dr. Alsager stated that he uses these scans to diagnose and treat rheumatoid arthritis. AR 10810. The Board's imposition of restrictions relating to Dr. Alsager's use of his scanning equipment, then, adequately reflects the underlying charges, the found misconduct, and the Board's desire to protect the public from future harm.

Second, Dr. Alsager argues that RCW 18.130.160(8) limits any fine imposed against him to \$5,000. Br. Appellant at 44-45. Dr. Alsager reaches this conclusion by noting that RCW 18.130.160(8) limits fines to \$5,000 per violation and by noting that the Board found that he violated only RCW 18.130.180(4). Br. Appellant at 44-45. Dr. Alsager misconstrues both the statute and the Board's findings. The statute does

certainly contemplates practice restrictions without accompanying probation. With regards to Dr. Alsager's reference to the sanction guidelines, it is impossible to effectively respond without knowing whether Dr. Alsager is referring to RCW 18.130.160, RCW 18.130.390, or other guidelines. Regardless, Dr. Alsager has made no argument and cited to no legal authority to support his assertion that any such guidelines are arbitrary or capricious.

not say \$5,000 per provision violated; it says \$5,000 per violation. RCW 18.130.160(8). The Board specifically stated that Dr. Alsager violated the standard of care on no less than *ten* occasions. AR 4956-83. Under the direction of RCW 18.130.160(8), then, the Board could have imposed a fine in the amount of at least \$50,000. The \$20,000 fine actually imposed indicates discretion on the part of the Board.

Third, Dr. Alsager asserts that the \$20,000 fine is unconstitutionally excessive because it is grossly disproportionate to the gravity of the offense committed. Br. Appellant at 45. The Board found that Dr. Alsager practiced below the standard of care in relation to the treatment he provided for seven patients. AR 4979-80. Dr. Alsager's care caused harm or unreasonable risk of harm to each and every one. Dr. Alsager underestimates the gravity of his offenses.

E. The Board Appropriately Summarily Restricted Dr. Alsager's License To Practice As An Osteopathic Physician And Surgeon And Provided Dr. Alsager With Proper Due Process When So Doing.

Under the APA, an agency may use emergency adjudicative proceedings to address a situation involving an immediate danger to the public health, safety, or welfare. RCW 34.05.479(1). The UDA further allows disciplinary boards to summarily suspend or restrict a license holder's practice pending disciplinary proceedings. RCW 18.130.050(8).

To do so, the Board must make a finding that immediate action is required to protect the public health, safety, or welfare. RCW 34.05.422(4).

The summary restriction process satisfies the requisite elements of due process. Procedural due process is “a flexible concept, requiring such procedural protections as the particular situation demands.” *Sherman v. State*, 128 Wn.2d 164, 184, 905 P.2d 355 (1995). The fundamental requirements of due process are twofold: notice and the opportunity to be heard. *Id.* To prevail on a procedural error claim, a petitioner must establish that he suffered actual and “substantial prejudice” due to the Department’s error. *See Motley-Motley, Inc.* 127 Wn. App. at 81; *Lang*, 138 Wn. App. at 235; RCW 34.05.570(1)(d).

The Board acted appropriately when it summarily restricted Dr. Alsager’s license and precluded him from prescribing Schedule II and Schedule III controlled substances. The Ex Parte Order of Summary Restriction, dated August 8, 2006, included a finding that Dr. Alsager represented an immediate danger to the public health, safety, and welfare. AR 15-17. Specifically, the Board determined that the evidence presented indicated that Dr. Alsager’s prescription writing practices fell below the standard of care. AR 16. The charging packet served on Dr. Alsager – which included the Statement of Charges and Ex Parte Order of Summary Restriction, among other things – notified Dr. Alsager of the pending

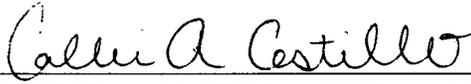
action and of his right to request a prompt hearing. Dr. Alsager failed to do so when he submitted his answer. AR 166-67. Dr. Alsager cannot now challenge an action that he neglected to challenge in a timely manner and that has subsequently been resolved by a Final Order.

VI. CONCLUSION

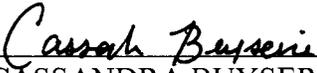
For the foregoing reasons, the Board's Final Order determining that Dr. Alsager's treatment and care of Patients A through G fell below the standard of care and constituted unprofessional conduct should be affirmed.

DATED this 8th day of September, 2009.

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

In the Matter of the License to Practice)
as a Osteopathic Physician and)
Surgeon of:)
)
DALE E. ALSAGER, D.O.,)
Credential No. OP00001485,)
)
Respondent.)

Docket No. 06-07-A-1024OP
Master Case No. M2006-11164

**CORRECTED FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND FINAL ORDER
(corrects word in introductory
paragraph only)**

APPEARANCES:

Respondent, Dale E. Alsager, D.O., by
Rhys A. Sterling, P.E., J.D., Attorney at Law

Department of Health Osteopathic Program, by
Office of the Attorney General, per
Kim O'Neal, Assistant Attorney General

BOARD PANEL: Thomas N. Shelton, D.O., Panel Chair
Thomas Bell, D.O.
Peter V. Kilburn, D.O.

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

A scrivener's error occurred in the original Findings of Fact, Conclusions of Law and Final Order in the introductory paragraph, wherein the Board's order regarding unprofessional conduct was inadvertently listed as suspension with restrictions. The error has been corrected to reflect that the Board had ordered restriction with conditions. For that reason, under the rationale of CR 60(a), the Corrected Order is entered and in bold face.

**CORRECTED FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND FINAL ORDER**

Docket No. 06-07-A-1024OP
Master Case No. M2006-11164

The Board of Osteopathic Medicine and Surgery (the Board) convened a hearing on April 21, 2008 – April 23, 2008, and May 19, 2008 – May 20, 2008. The Department of Health issued a Statement of Charges alleging the Respondent engaged in unprofessional conduct in violation of the Uniform Disciplinary Act, chapter 18.130 RCW. The Board finds unprofessional conduct, and orders **restriction** with conditions.

ISSUES

- A. Did the Respondent commit unprofessional conduct as define in RCW 18.130.180(4)?
- B. If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF THE PROCEEDINGS

At the hearing, the Department presented the testimony of John Matthew Lacy, M.D.; Mary Wilson; James Song, M.D.; Betty Lui; Rebecca McLemore; Trish Hoyle; Patient B; Patient C; and Jon F. Hillyer, M.D. (expert witness). The Respondent testified and presented the testimony of Wayne Anderson, M.D. (expert); David Buscher, M.D.; and Donald Reay, M.D.

The Presiding Officer admitted the following Department exhibits:

- Exhibit D-1: Assessment Systems, Inc. (ASI) Report.
- Exhibit D-2: Medical Records of Patient A.
- Exhibit D-3: Medical Records of Patient B.
- Exhibit D-4: Medical Records of Patient C.
- Exhibit D-5: Medical Records of Patient D.

**CORRECTED FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND FINAL ORDER**

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- Exhibit D-6: Medical Records of Patient E.
- Exhibit D-7: Medical Records of Patient F.
- Exhibit D-8: Medical Records of Patient G.
- Exhibit D-9: King County Medical Examiner Autopsy Report of Patient A.
- Exhibit D-10: Washington State Patrol Toxicology Report of Patient A.
- Exhibit D-11: Curriculum Vitae of Jon F. Hillyer, M.D.
- Exhibit D-12: The Respondent's appointment schedule, dated July 1, 2005 – November 30, 2005.
- Exhibit D-13: Expert Review of Jon Hillyer, M.D., dated June 15, 2006 (with August 1, 2006 Declaration).

The Presiding Officer admitted the following Respondent exhibits:

- Exhibit R-1: Alsager Chart: Patient A.
- Exhibit R-2: Alsager Chart: Patient B.
- Exhibit R-3: Alsager Chart: Patient C.
- Exhibit R-4: Alsager Chart: Patient D.
- Exhibit R-5: Alsager Chart: Patient E.
- Exhibit R-6: Alsager Chart: Patient F.
- Exhibit R-7: Alsager Chart: Patient G.
- Exhibit R-8: Potential Anatomical Diagrams.
- Exhibit R-9: Wayne E. Anderson, D.O., Curriculum Vitae.

Exhibit R-10: Dale E. Alsager, D.O., Curriculum Vitae, dated March 6, 2008.¹

Exhibit R-11: Donald T. Reay, M.D., Curriculum Vitae.

Exhibit R-12: June 21, 2007 Letter from Law Offices of Mark G. Olson, with attached pleading entitled "Pre-Filing Notice of Intent to Commence Action and Notice of Good Faith Request for Mediation."

Exhibit R-13: November 14, 2007 Letter to Patients B and C.

At the hearing, the Department moved to correct Paragraph 1.22 of the Statement of Charges to correct a typographical error. More specifically, the allegation was corrected to reflect Patient G, not Patient F. The Respondent waived any objection to the timing of the notice regarding the typographical error.

The Respondent moved to dismiss the allegation of unprofessional conduct under RCW 18.130.180(7).² More specifically, the Respondent contended the Department could not point to any statute or rule governing the factual allegation set forth in Paragraph 1.23 (regarding treatment provided to Patient B at Overlake Hospital Medical Center) of the Statement of Charges. In response to the motion, the Department did not cite to any statute or regulation in support of that allegation. For

¹ The version of Exhibit R-10 offered for admission contained sections previously highlighted by the Respondent. In response to questions regarding what the acronym FACOFP stood for, the Respondent could not clearly identify the organization in question, what criteria he was required to meet to belong to the organization, or whether his membership was current.

² Unprofessional conduct under RCW 18.130.180(7) includes the violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.

that reason, the Respondent's motion to dismiss the violation under RCW 18.130.180(7) was granted.³

I. FINDINGS OF FACT

1.1 The Respondent was granted a credential to practice as an osteopathic physician and surgeon in the state of Washington in August 1995.

1.2 The Respondent conducted a general osteopathic medical practice in Maple Valley, Washington. The Respondent is, by training, a family practitioner. The Respondent is not a pain management specialist, but was providing pain management treatment to his patients during the relevant time period. Pain management treatment includes the use of opioid medications in the treatment of acute⁴ pain and chronic⁵ pain. Chronic pain may not have a well-defined onset, and by definition does not respond to treatment directed at its causes.⁶

Treatment of Family Members

1.3 The Respondent provided chronic pain management services to seven patients: A, B, C, D, E, F, and G.⁷ Patients A, B, C, D, and E were related by blood or marriage. Patients F and G were boyfriend-girlfriend in a long standing relationship.

³ See Oral Ruling on Transcript.

⁴ "Acute" is defined as being sharp or severe, having rapid onset, severe symptoms, and a short course. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 31.

⁵ "Chronic" is defined as long draw out, of long duration, designating a disease showing little change or of slow progression and long continuance. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 289.

⁶ Washington Board of Osteopathic Medicine and Surgery Guidelines for Management of Pain, OP96.22 DOC, effective date September 13, 2002.

⁷ The identity of the seven patients is set forth in a Confidential Schedule attached to the Statement of Charges. The identity of the individuals is confidential and is not to be released without the consent of the individual or individuals. RCW 42.56.240(1).

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The standard of care in Washington does not prevent a practitioner from providing chronic pain management treatment to family members at the same time. Where a practitioner does provide chronic pain management treatment to several family members at the same time, the practitioner must remain vigilant to the possibility that family members will interfere with each others treatment plan. Such interference includes, but is not limited to, family members sharing pain medications.

1.4 When he provided chronic pain management services, the Respondent required his patients to complete pain management contracts. The contract required the patients to comply with specified requirements, such as using only one pharmacy and only obtaining pain medicine prescriptions from the Respondent. Patients A, B, C, D, E, F, and G entered into chronic pain management contract with the Respondent. Under the chronic pain management contract, the patient agreed to follow-up visits every two to four weeks. The Respondent used an electronic medical record system to keep track of the number of pain medications being prescribed to the various family members.

General Standard of Care Findings

1.5 A general review of the treatment provided to the above-identified patients reveals that the Respondent's treatment practices fall below the standard of care for the practice of osteopathic medicine in the state of Washington in several areas.

1.6 The Respondent prescribed controlled substances without sufficient objective medical findings to support such a prescription practice. A patient's pain

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complaints are subjective, not objective findings. The patient's pain complaints cannot support the types and level of controlled substance or opiate medication the Respondent prescribed to these patients. The Respondent continued to prescribe the controlled substances, or opiate medications without watching for or recording the risk factors or behavior that indicated the patient's possible misuse or diversion of the prescribed medication.

1.7 In addition to immediately prescribing controlled substances for the patients in question, the Respondent initially prescribed these controlled substances or opiate medications in large amounts and at high dosages or potency. The prescription of medication in large amounts or high dosage or potency in this manner creates several treatment problems. It creates a danger of drug overdose for the patient. Even where prescribing controlled substance or opiate medications at higher dosages or potency strength can be considered appropriate, doing so precludes the ability of the practitioner or subsequent practitioners from increasing the patient's dosage at a later point in the treatment of the patient, if such an increased dosage was medically appropriate or required.

1.8 In addition to his practice of prescribing controlled substances without objective medical findings, and the prescription of medication in amounts or at higher dosage than are medically appropriate, the Respondent often prescribed benzodiazepine medications for use in addition to the opiate medications. The benzodiazepine medications are known to have a synergistic effect with the opiate

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medication.⁸ More specifically, the benzodiazepines enhance or increase the effect and potency of the opiate medication being prescribed. There is no indication that the Respondent considered this synergistic effect when prescribing the strength or dosage of the opiate medication. It is not addressed in his treatment records for these patients.

1.9 In addition to the synergistic effect, benzodiazepine medications are rapidly habit forming, addictive, act with opiates as a respiratory depressant, and interfere with the patient's ability to obtain restful (that is, rapid eye movement or REM) sleep. It is for that reason that benzodiazepine medication is avoided in chronic pain management treatment. There is no indication that the Respondent considered these factors in his prescribing practices for these patients.

1.10 The use of large dosage or large amounts of opiate medication induces constipation in the patient. For that reason, the responsible practitioner records the patient's bowel movement history on every visit. Doing so ensures that patients receive stool softeners or other advice to deal with the opioid-induced constipation issue. A review of the Respondent's patient records do not show, or consistently show, that he addressed that issue.

1.11 Given the amount of medication prescribed to the patients, the patient records should reflect more patient complaints of constipation being reported by the patients. The lack of patient reports of constipation, or lack of recorded information on that complaint, might indicate that the patients were not actually taking the medication

⁸ "Synergism" is defined as the harmonious action of two agents, such as drugs or organs, producing an effect which neither could produce alone or an effect which is greater than the total effects of each agent operating by itself. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 1411.

being prescribed. This is a red flag for the prudent practitioner. It requires the prudent practitioner to follow up with the patient to ensure that the issue is addressed. Even though there was little or no record of complaints of constipation by his patients, this did not raise any red flags with the Respondent. It does not appear that the Respondent followed-up on this basic red flag indicator to confirm whether his patients were, in fact, taking the medication. Failing to do so is below the standard of care in Washington.

1.12 The Respondent repeatedly injected steroid medication into joint and tissue without apparent medical justification and despite the possibility of joint, tendon, and tissue damage that could be caused by this practice. The Respondent's explanation regarding this practice was that he only injected small amounts of steroid medication. The injection of steroid medication, even in small amounts, carries a cumulative risk, and is problematic for the long-term health of the patient.

1.13 The Respondent failed to obtain consulting opinions on a consistent basis with pain management specialists regarding his treatment plan for the chronic pain patients. In those instances where the Respondent did obtain consulting opinions, he often ignored the consulting opinion and continued with his previous treatment plan.

1.14 The Respondent diagnosed patients with rheumatoid arthritis in at least two of the patients being treated, but failed to obtain the required consulting opinions from a rheumatologist in support of his diagnosis. The diagnosis of rheumatoid arthritis is based on the presence of at least four of seven factors. These factors include, but are not limited to: arthritis in three or more skeletal joints; the symmetric involvement of

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skeletal joints; rheumatoid nodules over bony prominences; and positive serum rheumatoid factors.

1.15 The Respondent contends there are new criteria for the diagnosis of rheumatoid arthritis, including treatment based on x-ray and CT examinations. The Respondent's stated goal was to treat the arthritis at the earliest possible point using these new criteria. No matter what diagnostic criteria are used, the Respondent was not, and is not, a rheumatologist. Even where a diagnosis of rheumatoid arthritis is appropriate, the Respondent's failure to obtain a second opinion from a rheumatologist, at the earliest possible point, falls below the standard of care for an osteopathic physician in Washington

1.16 A general review of the treatment provided to these patients shows that once the Respondent determined a course of treatment, he did not deviate or attempt alternative therapies beyond continued medication in response to the pain complaints of the patients. The Respondent's continued use of a course of treatment should be based on the success of the treatment regime for the patient in question, including the increased social function of the patient. If, as here, he could not document the improvement of the patient's condition, then the Respondent should have referred the patient out to a pain management specialist. The Respondent's failure to do so falls below the standard of care for an osteopathic physician engaged in the chronic pain treatment of patients in Washington.

1.17 The Respondent gave injections of B-12 and folic acid to his patients without any medical indication that such injections were, in fact, required by the patient.

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After starting the B-12 and folic acid injections, the Respondent continued to provide injections without testing for the B-12 levels in the patient's system. B-12 and folic acid levels can be measured and, contrary to the Respondent's assertions at hearing, the cost of such testing is not prohibitive.

1.18 A review of the patient records show the Respondent does not consistently record vital signs for the patients. Respiratory examinations and blood pressure examinations are especially important when treating patients with pain complaints. The failure to consistently record such basic information as vital signs, blood pressure results, and respiration results at every visit falls below the standard of care for osteopathic physicians in Washington.

Specific Patient Treatment Findings

Patient A.

1.19 The Respondent treated Patient A during two separate time periods. The first treatment period occurred from October 2001 to February 2002. At the initial visit on October 11, 2001, the Respondent diagnosed Patient A with low back pain based on Patient A's report of a five year old football injury. Based on his physical examination and the patient's subjective pain report, the Respondent prescribed Percocet, a 50 microgram duragesic patch, and celebrex for Patient A's joint pain. There were no objective findings which would support starting the patient with such a high dosage of medication. Other than medication refills and some counseling, the Respondent did not create a functional plan for the treatment of Patient A. The Respondent's stated

treatment goal was the temporary control of Patient A's pain complaints until the Respondent could determine the actual cause of the patient's complaints.

1.20 In addition to the patient's back pain complaints, the Respondent also diagnosed Patient A as suffering from colitis, enteritis, and gastroenteritis.⁹ When treating a patient for colitis, it is mandatory for the practitioner to chart the patient's bowel movement history at each treatment visit. The Respondent did not do so. The Respondent's failure to consistently chart the bowel history for Patient A falls below the standard of care.

1.21 The Respondent then resumed treatment of Patient A in July 2005. Low back pain treatment was resumed, including the renewed prescription of opiate medication (Roxicodone), Xanax for the patient's irritable bowel/anxiety, Compazine for nausea, and Alprazolam for insomnia. As with his treatment approach in 2001, the Respondent prescribed these medications following a physical examine and based on Patient A's subjective pain complaints. In fact, the Respondent began the prescription of medications at the same levels prescribed in the 2001-2002 period, without any sufficient explanation or objective medical findings to support that treatment approach. There is no indication in the Respondent's treatment record that he attempted to obtain information regarding the medical or osteopathic treatment Patient A received during the intervening period, or any attempt to obtain any treatment records from the

⁹ "Colitis" is defined as the inflammation of the colon. "Enteritis" is defined as the inflammation of the intestines, more particularly, of the mucous and submucous tissues of the small intestines. "Gastroenteritis" is defined as the inflammation of the stomach and intestinal tract. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), pages, 308, 481, and 576.

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intervening period. There is no indication that the Respondent considered prescribing opiate medication at a lesser dose or lesser potency for the patient.

1.22 On August 2, 2005, Patient A had a motor vehicle accident where his truck went off the road and into a ditch. While awaiting discharge following treatment in the emergency room, Patient A was observed to have a seizure. Patient A was treated for his seizure condition by neurologist James Song M.D., and was prescribed Dilantin. This information was forwarded to the Respondent.

1.23 The Respondent saw Patient A on September 13, 2005, and provided him with a 100 microgram Fentanyl (duragesic) patch. Fentanyl is the highest potency opiate available for non-parenteral use.¹⁰ It is used only in opiate tolerant patients in a stepwise fashion.¹¹ The 100 microgram Fentanyl patch is the highest dose for such a duragesic. There is no indication that the Respondent prescribed a 75 microgram patch prior to prescribing the 100 microgram patch to Patient A. The Respondent had the 100 microgram patch in his medication safe and gave it to Patient A.

1.24 Patient A died the next day after receiving the Fentanyl patch from the Respondent. On December 21, 2005, Dr. J. Matthew Lacy of the King County Medical Examiner issued an Autopsy Report. Exhibit D-9. The pathological diagnoses found in that report was "[a]cute intoxication due to the combined effects of fentanyl, diazepam, oxycodone, and carbamazepine." The Respondent disputes the cause of death and

¹⁰ "Parenteral" denotes any route other than the alimentary canal such as intravenous, subcutaneous, intramuscular, or mucosal. The "alimentary canal" route refers to drugs taken orally, and absorbed in the stomach or intestines. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), pages 1048 and 53.

¹¹ Fentanyl duragesic patches are available in 12, 25, 50, 75, and 100 mcg strengths.

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presented expert testimony to suggest that Patient A's death was a sudden unexpected death from the seizure disorder (SUDEP) and not the acute intoxication due to the combined effects of the drugs he prescribed to Patient A.

1.25 The King County Medical Examiner's Office has established the cause of death for Patient A. This is the official cause of death recorded on the death certificate. For that reason, the Board has no need to choose between the alternative causes of death for Patient A (acute intoxication due to the combined effects of the drugs or death from seizure). The Board views its responsibility to determine whether the care the Respondent provided to Patient A was incompetence or negligence of the type that results in injury to Patient A or creates an unreasonable risk that Patient A may be harmed. In other words, did the Respondent's treatment of Patient A fall below the standard of care for an osteopathic physician in the state of Washington.

1.26 The Respondent's care of Patient A fell below the standard of care for an osteopathic physician in the state of Washington. In his initial treatment of Patient A in 2001, the Respondent prescribed a large amount of Schedule II controlled substances to treat the patient's pain complaints. The Respondent renewed the prescription of a large dosage of controlled substances, including the use of the highest potency Fentanyl patch, upon resuming treatment of Patient A in 2005. The Respondent also prescribed benzodiazepine medication to Patient A at the same time he prescribed the controlled substances. The Respondent did not record any objective medical basis for the amount and dosage of the medications being prescribed. The Respondent did not

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record whether he considered the synergistic effect of the opiate and benzodiazepine medication, or justify why he chose to prescribe the medications. By doing so, the Respondent's actions fell below the standard of care for an osteopathic physician in the state of Washington regarding Patient A.

1.27 A review of the patient treatment records reveals that the Respondent provided Patient A with B-12 and folic acid injections. Prior to injecting the patient, the Respondent did not check whether there was any objective medical indication that Patient A required such B-12 or folic acid injections. Nor did the Respondent perform any test to measure the patient's B-12 or folic acid levels prior to providing the injections.

Patient B.

1.28 The Respondent provided chronic pain management treatment to Patient B during the period 2005-2006. Patient B had lower back pain following several unsuccessful spinal surgeries. In addition, the patient had colon surgery in 1999 with a J pouch. Because of Patient B's failed back surgeries, it was within the standard of care for the Respondent to prescribe high dose opiate medication for chronic pain management. There were no other treatment modalities or surgery that would improve the patient's condition.

1.29 The use of large amounts of opiate medication for any patient raises the likelihood that the patient will become constipated. Because of that likelihood, standard of care required that the Respondent watch Patient B carefully for constipation to avoid

or significantly reduce the possibility of a bowel rupture, given the patient's colon surgery. The Respondent's treatment records for Patient B did not address the issue of constipation or record the patient's bowel movement history on every visit, consistent with the standard of care for the treatment of pain patients receiving large doses or large amounts of opiate medication. In fact, Patient B's colitis should not be treated with narcotics at all.

1.30 Because of his colon surgery, Patient B was experiencing explosive diarrhea. The Respondent recorded that some of the prescribed medication passed through the patient's system without being absorbed. There is at least one entry to this effect. However, the patient's explosive diarrhea condition, and episodes of failing to absorb medication, does not relieve the Respondent of the responsibility of recording the patient's bowel movement history on every visit.

1.31 While the prescription of high dose opiate medication or the use of large amount of medication might be considered appropriate in treating Patient B's chronic pain, the Respondent's records do not support the use of benzodiazepines. The benzodiazepine medication creates a synergistic effect, and this effect increases the potency of the opiate medication. The Respondent's prescription of benzodiazepines does not increase Patient B's ability to function, and there is no basis to support prescribing the medications in addition to the opiate medications used to relieve pain for Patient B. The Respondent's continued prescription of benzodiazepine medication in

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addition to opiate medication for Patient B was below the standard of care for this patient.

1.32 The Respondent provided B-12 and Folic acid injections to Patient B. There is no objective medical evidence in Patient B's medical records to support the B-12 and Folic acid injections. There is no entry in Patient B's treatment record that the Respondent tested the patient's levels prior to, or during the period of, providing the injections.

Patient C.

1.33 The Respondent provided chronic pain management treatment to Patient C during the period 2002-2006. Patient C, the mother of Patient A, was in her late 40's. She suffered a lower right leg fracture in March 2004, and had a total knee replacement in March 2005.

1.34 Similar to the Respondent's prescribing practice for Patients A and B, the Respondent prescribed Patient C with opiate medication and multiple benzodiazepine medications without any clear objective basis for such medications. There was no record that the Respondent considered the use of other, non-narcotic medications or other treatment strategies prior to starting the opiate medication treatment. As with the other patients, the Respondent prescribed large amounts of medication at a higher potency than was supportable in the absence of objective medical findings. Such prescription practices created the possibility of drug overdose. This prescription practice precluded the Respondent's ability to increase these medications for Patient C

if it were later determined to be medically appropriate or necessary. There was no documentation that the medication being prescribed by the Respondent was medically effective for this patient.

1.35 The Respondent provided treatment to Patient C following the death of her son, Patient A. The treatment records indicate that the Respondent provided counseling to Patient C, but those record entries do not describe what that counseling entailed. The Respondent did not refer Patient C out for specialized grief or mental health counseling, which would be appropriate under the circumstances.

1.36 The Respondent injected Patient C with B-12 and folic acid. The Respondent provided those injections without first testing for appropriate levels in the patient and without any medical necessity for such injections. The Respondent explained that such injections were useful in the overall treatment plan for Patient C, but providing such injections without appropriate testing is below the standard of care.

Patient D.

1.37 The Respondent provided chronic pain management treatment to Patient D during the period 2004-2006. Patient D was a 28 year old patient suffering from chronic right shoulder pain. The Respondent treated Patient D's shoulder condition with a series of at least 10 injections into the shoulder joint and tendon sheath. The repetitive injection treatment plan raises concerns of, or can contribute to, cartilage and tendon degradation. There is nothing in the Respondent's treatment records that reflects the consideration of this issue. There is nothing in the patient's treatment

records to show that the Respondent's course of treatment was effective or improving the patient's shoulder complaints.

1.38 Additionally, the standard of care for this type of treatment would require the practitioner to refer the patient out for an orthopedic consultation after the second set of injections. The Respondent did not refer this patient out for an orthopedic consultation, and his actions were below the standard of care for that reason.

1.39 Patient D altered or forged the opioid prescriptions prepared by the Respondent. The patient was arrested for this prescription forgery. Despite Patient D's forgery arrest, the Respondent continued to treat Patient D without any change in the patient's treatment plan or reduction in pain medication. At this point, the prudent practitioner would have referred Patient D out for a pain management, psychological, or substance abuse consultation or evaluation. The Respondent's failure to do so is below the standard of care for an osteopathic physician in Washington.

Patient E.

1.40 The Respondent provided chronic pain management treatment to Patient E during the period 2001-2006. Patient E was a thirty-three year old male with no surgical history. Despite that fact, the Respondent prescribed short-acting opiates to Patient E in response to his subjective pain complaints. A review of Patient E's subjective complaints shows inconsistencies in the location of the pain being complained of, which should raise a red flag for any physician providing pain management treatment. Inconsistent pain complaints suggest that the patient may be

engaging in drug seeking behaviors. There is no indication that the Respondent considered the potential of drug seeking by Patient E in managing his case.

1.41 In addition to the above subjective complaint issue, Patient E's employer notified the Respondent in December 2001 of the patient's apparent drugged behavior at work. The Respondent continued to provide Patient E with opioid medication after receiving the employer's notice for several additional years. A prudent practitioner would have referred the patient out for a pain management, substance abuse, or psychological evaluation or consultation. The Respondent's continued treatment of Patient E with opioid medications, without such referrals, is below the standard of care in Washington.

1.42 The Respondent diagnosed Patient E as having rheumatoid arthritis. There are no objective findings and no x-ray evidence that supports the Respondent's diagnosis of rheumatoid arthritis for this patient. Rheumatoid factor lab results were normal for this patient. There were no records that Patient E has at least four of the seven rheumatoid arthritis factors necessary to support such a diagnosis. The standard of practice requires that a diagnosis of rheumatoid arthritis be confirmed by a rheumatologist. The Respondent should have referred Patient E out to a rheumatologist for a second opinion regarding this diagnosis, but failed to do so. The Respondent's failure to obtain a second opinion by a rheumatologist falls below the standard of care for an osteopathic physician in Washington.

1.43 Despite the lack of objective findings for such a diagnosis or a second opinion, the Respondent injected Patient E with an arthritis medication (Remicade).

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The Respondent continued to provide Patient E with Remicade injections without any objective basis for the use of the drug, and even though the use of the Remicade medication did not appear to be an effective treatment.

1.44 The Respondent provided Patient E with injections of B-12 and folic acid. There is no documentation in the record that indicates the patient required injection of these substances, and the Respondent did not check the patient levels prior to giving the injections.

Patient F.

1.45 The Respondent provided chronic pain management therapy to Patient F during the period 2005-2006. Patient F, a woman in her late 20's, suffered from a number of medical conditions. Patient F had undergone two lumbar spine surgeries and had a history of lower back pain. The Respondent treated Patient F's low back pain condition with opioid medications and epidural steroid injections in the sacroiliac joint.

1.46 The Respondent's epidural injection treatments were provided on several dates while the patient was being treated with intravenous antibiotics for an infection. See Exhibit D-7, pages INV. 232, 248, 289, 299, and 308. Sacroiliac joints are prone to infection. Any infection would be a contraindication¹² to injection at that time. The use of steroid medications is additionally contraindicated because of the steroids immune suppressive properties, which increase the risk of the spread of infection. Despite these

¹² "Contraindication" is defined as any symptom or circumstance indicating the inappropriateness of a form of treatment otherwise advisable. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 330.

factors, the Respondent provided the injections and increased the risk of infection for Patient F.

1.47 The Respondent referred Patient F out for a pain clinic evaluation in January 2006. At least at the time of the pain clinic consult, the level of opioid medication being prescribed by the Respondent was viewed as appropriate. The epidural injections were viewed by the consulting physician assistant and contraindicated. A surgical referral was considered to determine if further surgery could provide relief.

1.48 The Respondent diagnosed Patient F with rheumatoid arthritis. There are no objective findings and no x-ray evidence to support that diagnosis. The patient's rheumatoid factor lab results were in the normal range. The standard of practice requires that a diagnosis of rheumatoid arthritis be confirmed by a rheumatologist.¹³ The Respondent should have referred Patient F out to a rheumatologist for confirmation and co-management of the patient, but he failed to do so. The Respondent's failure to do so falls below the standard of care in Washington.

1.49 Patient F's records contain multiple urine drug screens. While the patient was prescribed opiates, an insufficient amount of opiate residue appears in urine drug screen tests contained in the patient's records. One possibility, which explains the contrast between the opiates prescribed versus the amount of opiate residue which is actually reflected in the urine drug screens, is that the patient is not actually taking all of

¹³ The Respondent contended that rheumatologist Andrew Holman, M.D., previously diagnosed Patient F as having rheumatoid arthritis. That information was not reflected in the Respondent's treatment records for Patient F.

the prescribed medication. Additionally, the urine drug screen results were positive for or showed residue from marijuana use. A prudent practitioner would consider reducing the amount of medication being prescribed or investigating into whether the patient is giving or selling the drugs to others.

1.50 Despite the discrepancy between the opiates being prescribed versus the amount of opiate residue actually appearing in the urine drug screen tests, the Respondent continued to prescribe opiate medications at the same or similar levels until March 2006. See Exhibit F0477. It was at this point that the Respondent became alarmed at the patient's use of medication which the Respondent did not prescribe. The Respondent stopped providing pain management services to the patient. The Respondent re-referred Patient F to a pain management clinic for tapering off of opioid medication. See Exhibit F0474.

Patient G.

1.51 The Respondent provided chronic pain management treatment therapy to Patient G during the period of 2004-2006. Patient G, a 31 year old male, fractured his left wrist in 2004, which resulted in surgery.

1.52 Following his surgery, Patient G reported pain complaints regarding his left wrist. The Respondent treated Patient G's pain complaints by providing the patient with multiple joint injections of Lidocaine (an anesthetic), and Decadon and/or Celestone (which are corticosteroids).¹⁴ There is no indication that the Respondent

¹⁴ "Corticosteroid" is any of a number of hormonal steroid substances obtained from the cortex of the adrenal gland. Taber's Cyclopedic Dictionary, 14th Edition (1981), page 341.

advised the patient's primary treating orthopedic physician regarding this course of treatment. This course of injections raised the possibility of soft cartilage damage. There is nothing in the Respondent's records for Patient G to show that this possibility was considered or addressed.

1.53 In November 2005, Patient G suffered a benzodiazepine withdrawal seizure. See Exhibit D-8; INV. 04576-04579. The physician treating Patient G for that seizure episode recommended weaning the patient from benzodiazepine medication and initiating another anxiety medication. The Respondent chose to return Patient G to the benzodiazepine medication without discussion in the patient's records regarding that decision.

II. CONCLUSIONS OF LAW

2.1 The Board has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.180(4) and RCW 18.57.011.

2.2 The standard of proof in a professional disciplinary hearing is clear and convincing evidence. *Ongom v. Department of Health*, 159 Wn.2d 132 (2006), cert. denied 127 S. Ct. 2115 (2007).

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

2.4 The Department proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which states:

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Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

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

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

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

III. ORDER

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

ORDERED:

3.1 The Respondent's license to practice as an osteopathic physician and surgeon in the state of Washington is RESTRICTED. The Respondent is prohibited from prescribing Schedule II and Schedule III controlled substances. The restriction shall remain in effect until the Respondent completes a Board approved training course or residency regarding pain management. Any such training program must include at least a 6-month rotation in general medicine and a 6-month rotation in pain management.

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3.2 During the period the Respondent's license is restricted, the Respondent shall have any and all diagnostic MRI scan, CT scan, or Dexa scan taken by him over-read by a qualified radiologist. Prior to the Respondent taking any further diagnostic x-rays, MRI scan, CT scan, or Dexa scan, the Respondent shall schedule an inspection with the Department of Health Osteopathic Program, OSHA, or other appropriate governmental agencies to have the Respondent's office inspected to ensure that the Respondent's office facility has the appropriate shielding to protect the safety of any and all patients, treatment providers, and other office staff.

3.3 Fines. The Respondent shall pay a \$20,000.00 administrative fine, which can be paid in the amount of \$5,000.00 per year over a four-year period, beginning on the date of service of this order. The fine shall be paid by check made out to the State Treasurer, and mailed to P.O. Box 1099, Olympia, WA 98507-1099. Failure to remit the fine within the specified time period shall constitute a violation of this order.

3.4 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in the Respondent residential and/or business address within 30 days of such change.

3.5 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this order.

3.6 Failure to Comply. Protecting the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension and/or revocation of the Respondent's credential

**CORRECTED FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND FINAL ORDER**

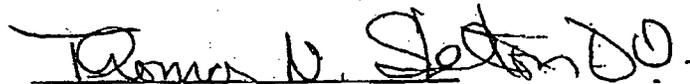
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after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this order, the Board may hold a hearing. At that hearing, the Respondent must show cause why the Respondent's osteopathic medicine credential should not be suspended. Alternatively, the Board may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 15 day of August, 2008.


 THOMAS N. SHELTON, D.O.
 Panel Chair

CLERK'S SUMMARY

<u>Charge</u>	<u>Action</u>
RCW 18.130.180(4)	Violated
RCW 18.130.180(7)	Dismissed

NOTICE TO PARTIES

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

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

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

**CORRECTED FINDINGS OF FACT,
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and a copy must be sent to:

Board of Osteopathic Medicine and Surgery
P.O. Box 47866
Olympia, WA 98504-7866

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

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

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

For more information, visit our website at <http://www.doh.wa.gov/hearings>.

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Department Of Health
 Health Professions Quality Assurance Division
 Washington Board Of Osteopathic Medicine And Surgery
 Policy/Procedure

Title:	Guidelines for Management of Pain	OP96.22 DOC
Reference:	Board minutes: May 3, 1996; September 20, 1996, November 1, 1996, January 31, 1997, May 2, 1997, April 12, 2002, September 13, 2002	
Contact:	Program Manager	
Effective Date:	September 13, 2002	
Supersedes:	May 2, 1997	
Approved:	Board	
Signature:	Mark Hunt, DO	

INTRODUCTION

There are widespread concerns among patients throughout the state about access to appropriate medical treatment, including opioid therapy, for addressing chronic intractable pain. Similarly, providers express apprehensions about challenges by state disciplinary authorities when prescribing opioid analgesics for indicated medical treatment when serving the legitimate medical needs of pain patients. The under treatment of chronic pain due to concerns about addiction and drug diversion affect the public health, safety, and welfare. There is a need for guidance which would: a) encourage appropriate treatment for pain management; b) reduce providers' fear of injudicious discipline; and c) protect the public from inappropriate prescribing practices and diversion.

PURPOSE STATEMENT

The Secretary of the Department of Health recommends the uniform adoption, by appropriate state regulatory authorities, of the following guidelines when managing pain. It is not the intent of these guidelines to define complete standards or acceptable medical care in the treatment of pain patients. These guidelines are not intended to direct clinical practice parameters. It is the intent that providers will have confidence that these guidelines are the standard by which opioid usage is evaluated.

GUIDELINES FOR OPIOID USAGE

Acute Pain

Opioids are useful for patients with acute pain such as surgery, burn, or trauma. The goal of such treatment is to provide adequate and timely pain management to the patient. Side effects of opioids that are difficult to treat may occur and must

be balanced against the benefits of pain relief. The provider should, for any patient who has a history of alcoholism or other drug addictions, carefully monitor medications and when available seek appropriate consultation.

Chronic Pain Associated with Cancer

Chronic pain associated with cancer may often be successfully managed with opioids. If use of opioids is the primary analgesic strategy, adequate doses should be given frequently enough to keep the patient continuously comfortable. Addiction is rare in patients with cancer pain; tolerance and physical dependency are often unavoidable and should not interfere with opioid prescribing. Not all pain in patients with cancer is responsive to opioids; alternative strategies for managing the pain should also be made available.

Other Chronic Pain Conditions

Opioid analgesics can be useful in the treatment of patients with intractable non-cancer pain especially, where efforts to remove the cause of pain or to treat it with other modalities have failed or were not fully successful. The pain of such patients may have a number of different etiologies and may require several modalities. In addition, the extent to which pain is associated with psychological, physical, and social impairment varies greatly. Therefore, the selection for a trial of opioid therapy should be based on a careful assessment of the pain as well as the impairment experienced by the patient. Continuation of opioid therapy should be based on the provider's evaluation of the results of treatment, including the degree of pain relief, changes in psychological, physical, and social functioning, and appropriate utilization of health services. Providers are encouraged to obtain consultation from providers who are knowledgeable in pain management.

DEFINITIONS

1. **Addiction** - A disease process involving use of psychoactive substances wherein there is loss of control, compulsive use, and continued use despite adverse social, physical, psychological, or spiritual consequences.
2. **Physical Dependence** - A physiologic state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is a normal physiological consequence of habitual use of many substances, not just opiates. It does not equate to substance abuse or addiction, but will be seen with addiction.
3. **Psychological Dependence** - A subjective sense of need for a specific substance, either for its positive effects or to avoid negative effects associated with its abstinence.

4. **Tolerance** - State in which an increased dosage of a psychoactive substance is needed to produce a desired effect.
5. **Withdrawal Syndrome** - The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a substance.
6. **Acute Pain** - An essential biologic signal of the potential for or the extent of injury. It is usually short-lived and is associated with hyperactivity of the sympathetic nervous system; e.g. tachycardia, increased respiratory rate and blood pressure, diaphoresis, and papillary dilation. The concurrent affect is anxiety.
7. **Chronic Pain** - Pain persistent beyond expected healing time often cannot be ascribed to a specific injury. Chronic pain may not have a well-defined onset and by definition does not respond to treatment directed at its causes.
8. **Intractable Pain in a Non-Cancer Patient** - Pain in which the cause cannot be removed or otherwise treated and no relief or cure has been found after reasonable efforts.

GUIDELINES FOR ASSESSMENT AND DOCUMENTATION IN NON-CANCER PAIN

Alternative strategies for managing pain must be explored. If alternative strategies for managing the pain are unsuccessful, long term opioid therapy can be added. The goal is not merely to treat the symptoms of pain, but to devise pain management strategies which deal effectively with all aspects of the patient's pain syndrome, including psychological, physical, social, and work-related factors. Documentation in the patient's medical record should include:

1. **History and medical examination** - A complete physical examination and comprehensive medical history should be part of the active treatment record including, but not limited to, a review of past pain treatment outcomes and any history of addiction risks to establish a diagnosis and treatment plan.
2. **Diagnosis and medical indication** - A working diagnosis must be delineated, which includes the presence of a recognized medical indication for the use of any treatment or medication.
3. **Written treatment plan with recorded measurable objectives** - The plan should have clearly stated, measurable objectives, indication of further planned diagnostic evaluation, and alternative treatments.

4. **Informed consent** - Discussions of risks and benefits should be noted in some format in the patient's record. The use of a patient contract and informed consent is encouraged.
5. **Periodic reviews and modifications indicated** - At these periodic reviews, the provider should reassess the treatment plan, the patient's clinical course, and outcome goals with particular attention paid to disease progression, side effect and emergence of new conditions.
6. **Consultation** - The treating provider should be knowledgeable and competent in referring patients to the appropriate specialist if needed and noting in the patient's record the treating provider's interpretation of the consultation reports. Additionally, a new patient with evidence of at-risk patterns of opioid usage should be evaluated by a knowledgeable specialist.
7. **Records** - The provider should keep accurate and complete records documenting the dates and clinical findings for all evaluations, consultations, treatments, medications and patient instructions.
8. **Assessment and monitoring** - Some patients with chronic pain not associated with cancer may be at risk of developing increasing opioid consumption without objective improvement in functional status. Subjective reports by the patient should be supported by objective observations. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, patient consumption of health care resources, positive answers to specific questions about the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient as observed by the physician.

Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a disease with behavior characterized by psychological dependence and aberrant drug related behaviors. Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts merely because they are being treated with opioids.

The physician is responsible for monitoring the dosage of the opioid. Monitoring includes ongoing assessment of patient compliance with drug prescriptions and related treatment plans. Communication between health care providers is essential. The patient should receive long term analgesic medications from one physician and where possible one pharmacy. All

providers should exercise appropriate caution for any patient with a history of alcoholism or other drug addiction when prescribing long term opioids. Consults with additional physician(s) appropriate to management and treatment of the patient's pain and addiction are recommended.

PATIENT RESPONSIBILITIES

1. It is the patient's responsibility to candidly provide the treatment provider with a complete and accurate treatment history, including past medical records, past pain treatment and alcohol and other drug addiction history.
2. The patient should participate as fully as possible in all treatment decisions.
3. The patient and family members, if available, should inform the prescriber of all drug side effects and concerns regarding prescription drugs.
4. The patient should not use other psychoactive agents, including alcohol, naturopathic products or over-the-counter drugs without agreement of the prescriber.
5. The patient should use the same name when receiving medical care to assure completeness of the medical record.
6. The patient should demand respect and expect to be believed.
7. The patient should keep an open mind and be willing to work with the treatment provider, including:
 - a. negotiate with the provider to arrive at an acceptable plan of treatment;
 - b. be open in trying alternative treatment strategies; and
 - c. follow the treatment provider's instructions precisely.
8. The patient should, where possible, get all central nervous system medications from one provider. If this is not possible, the patient should inform each provider of all medications he/she is receiving.
9. The patient should, where possible, have all prescriptions filled at a single pharmacy.
10. The patient should not hoard, share, or sell medications.
11. The patient should be aware that providers may, by law, share information with other providers about the patient's care.

FILED
COURT OF APPEALS
DIVISION II

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STATE OF WASHINGTON

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

BY _____
DEPUTY

DALE E. ALSAGER, D.O.,

Appellant,

v.

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

Respondent.

DECLARATION OF
SERVICE

I, Laurie L. Carley, make the following declaration:

1. I am over the age of 18, a resident of Thurston County, and not a party to the above action.
2. On September 8, 2009, I deposited via U.S. mail, postage prepaid, the original and one true and correct copy of the Brief of Respondent and this Declaration of Service to:

David C. Ponzoha, Court Clerk
Court of Appeals, Division II
950 Broadway, Suite 300
Tacoma, WA 98402-4454.

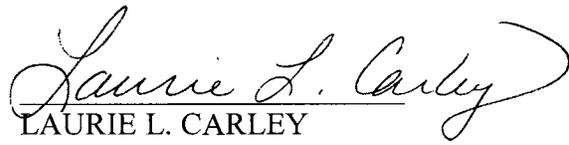
3. On September 8, 2009, I deposited via U.S. mail, postage prepaid, a true and correct copy of the Brief of Respondent and this Declaration of Service to:

Rhys Alden Sterling
Attorney at Law
P.O. Box 218
Hobart, WA 98025-0218

(Attorney for Appellant.)

I declare, under penalty of perjury under the laws of the State of
Washington, that the foregoing is true and correct.

DATED this 8th day of September, 2009.


LAURIE L. CARLEY
Legal Assistant