STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Geoffrey S. Ames, MD
Master Case No.: M2014-525
Document: Default Order

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4700
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **GEOFFREY S. AMES, MD** License No. MD00026961 Respondent	**No. M2014-525** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER OF DEFAULT (Failure to Respond)**

This matter comes before the Commission for a final order of default. Based on the record, the Medical Quality Assurance Commission (Commission) now issues the following:

1. FINDINGS OF FACT

1.1 On December 27, 1989, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

PATIENT A

1.2 In the summer or early fall of 2009, a psychiatric nurse practitioner referred Patient A to Respondent for the management of specific medical issues. At the time of referral, Patient A was a 44-year-old married female, with a history that included depression, anxiety, panic, insomnia, and substance abuse, and the patient had requested a medical provider who specialized in a natural approach to her physical symptoms. Respondent did not provide the Commission with a copy of Patient A's medical chart as requested, so the details of Respondent's care for Patient A are largely unknown. Other sources establish that Respondent ordered laboratory studies, prescribed medications, and developed a personal and intimate relationship with Patient A.

Boundary Violations and Sexual Misconduct

1.3 During the course of Patient A's office visits with Respondent, Patient A discussed her marital problems. Respondent revealed to Patient A that he had similar problems in his marriage. Respondent and Patient A began to develop a romantic

relationship. Patient A told her psychiatric nurse practitioner that Respondent "swept me off my feet."

1.4 Beginning sometime in 2010, and ending in early 2012, Respondent engaged in a romantic and sexual relationship with Patient A. In order to accommodate a romantic and sexual relationship, Respondent sent a discharge letter to Patient A, dated December 9, 2010. Respondent ostensibly referred Patient A to another provider (who had already been providing medical care for Patient A) in an apparent transfer of Respondent's role in Patient A's medical care. However, the sexual misconduct rules and longstanding ethical principles prohibit a physician from discharging a vulnerable patient who has confided personal information for the purpose of beginning or continuing a romantic and sexual relationship.

1.5 While Respondent did not see Patient A in his office between December 2010 and the end of the romantic relationship in early 2012, Respondent remained significantly involved in Patient A's medical care. For example, during the portion of the romantic relationship that occurred after the discharge letter, Respondent prescribed for Patient A, interacted with Patient A's other medical providers, ordered and directed the ordering of lab work, and even examined Patient A.

1.6 Respondent also violated appropriate physician-patient boundaries by developing other, potentially conflicting, relationships with Patient A. While also treating her as a patient, Respondent employed Patient A and made business plans with Patient A. Respondent was, at times, simultaneously Patient A's physician, employer, prospective business partner, and romantic and sexual partner. Respondent's business relationships with Patient A contaminated or complicated the doctor-patient relationship by placing Patient A in a position that linked her financially to Respondent.

1.7 After the romantic relationship ended, Respondent began providing medical care for Patient A in his office again in the fall of 2012. Despite the discharge letter, Respondent remained Patient A's physician, in some capacity, from 2009 until Patient A's death in January 2013 and during the entirety of their romantic relationship.

Other Substandard Care

1.8 Respondent failed to appropriately treat Patient A's depression and anxiety, and impeded her opportunity to receive appropriate psychiatric care.

Respondent's affair with Patient A, a psychiatrically and emotionally unstable patient, likely caused further damage to her troubled marriage and child custody issues and exacerbated her psychiatric issues. After Respondent separated from his wife he expressed a desire that Patient A separate from her husband. In March of 2011, Patient A acknowledged to her husband that she was having an affair with Respondent and asked her husband for a divorce. After the romantic relationship with Respondent concluded, Patient A unsuccessfully sought to save her marriage and restore her family. Rather than helping this vulnerable and troubled patient, Respondent caused further damage to Patient A's already troubled marriage. Respondent's pursuit of his own personal interests regarding Patient A caused her unreasonable harm.

1.9 Respondent failed to coordinate care with other providers who were providing contemporaneous or continuing care for Patient A.

1.10 Though Respondent had been prescribing psychotropic medications and acting as her de facto mental health provider, Respondent failed to respond with appropriate urgency to a psychiatric crisis that Patient A communicated to Respondent. On January 10, 2013, Patient A sent a text message to Respondent indicating that she was experiencing "acute depression," and that she was "so tired of this ride." In his reply later that day, Respondent asked: "Are you less depressed now?" Patient A's response was: "No, still very depressed. Not sure what the [g]enesis of this one is." At 11:25 a.m., the following morning, January 11, 2013, Patient A texted Respondent the following: "Hi Naten, heal all those waiting to see you. Nef." Respondent and Patient A used the pet names Naten and Nef in some of their communications. Respondent was obligated to respond more actively, to clinically intervene and obtain appropriate and safe treatment options for Patient A. Later that afternoon, Patient A fatally shot herself in the chest while sitting in her parked car.

1.11 Respondent failed to maintain and secure medical records for Patient A, a patient experiencing severe psychological issues and risk factors, and a patient with whom Respondent had a romantic relationship.

Failure to Cooperate/Failure to Maintain a Patient Record

1.12 In a letter dated June 11, 2013, the Commission investigator requested that Respondent send a complete copy of his office record for Patient A within 14 days. Respondent failed to provide a copy of his medical record for Patient A.

1.13 In a letter dated July 18, 2013, the Commission investigator requested that Respondent provide a response to the complaint in this case. The investigator provided Respondent with citations to the Commission's legal authority, including the requirement under RCW 18.130.180(8) that Respondent provide the Commission with a complete explanation covering the matter under investigation. Having asked Respondent to respond concerning his relationship with Patient A, the investigator specifically requested that Respondent address his "medical treatment of [Patient A] to include beginning and ending dates of treatment, diagnosis, and treatment rationale." The investigator also requested a copy of Patient A's chart, in the event that Respondent had located the chart. Respondent failed to provide a copy of Patient A's chart as requested, and failed to provide a complete explanation addressing the complaint as sought by the Commission's investigator.

Interference With Investigation By Misrepresentation

1.14 On June 23, 2013, Respondent wrote to the Department of Health and the Commission investigator. In this letter, Respondent asserted that he did not have sex with Patient A, and that she was his "friend and employee only." Respondent's express denial of a sexual relationship with Patient A, and his assertion to the Commission, during the course of the investigation, that Patient A was his "friend and employee only," were willful misrepresentations.

PATIENT B

Substandard Care

1.15 *Improper diagnosis of hypothyroidism.* Patient B began treating with Respondent in August of 2013. Respondent diagnosed her with hypothyroidism, despite having normal thyroid laboratory studies (T4 and T3) and negative thyroid antibodies. He then treated her for hypothyroidism, a condition that she did not have.

1.16 Hypothyroidism is diagnosed (for patients without a pituitary issue) with symptoms and a thyroid stimulating hormone (TSH) above the reference range. There is no record of Respondent having ordered a TSH, nor clear documentation from his visit of the signs and symptoms consistent with hypothyroidism.

1.17 *Improper dosing of thyroid medication.* Respondent's unnecessary treatment, due to his misdiagnosis, caused significant harm to Patient B. Respondent's dosing of thyroid medication for Patient B demonstrates his lack of understanding of proper dosing of thyroid medication. Levothyroxine is one of the most commonly prescribed medications in the United States, and Respondent formerly noted on his website that four out of ten of his patients had hypothyroidism. Despite this, his prescribing of thyroid medications shows he lacks a basic grasp of its pharmacology and half-life elimination: Euthyroid: 6 to 8 days; Hypothyroid: 9 to 10 days. Despite this, Respondent treated Patient B with dosing of levothyroxine as frequently as three times daily. He also used liothyronine – again, without evidence of hypothyroidism – at a dosing interval of up to five times daily.

1.18 *Excessively frequent and unguided adjustments.* Respondent frequently adjusted thyroid medication more frequently than is clinically indicated. In addition, his notes reflect changes in thyroid medication without any reference to labs – and, in assessment and plans, he does not give any description of the symptoms, signs, or laboratory values guiding his clinic decisions. The dosing frequency and lack of clear guidance to explain the decisions for this dosing fall below the standard of care.

1.19 *Unresponsiveness to laboratory studies showing iatrogenic hypothyroidism.* On February 4th, 2014, Respondent ordered laboratory studies that revealed a TSH of 0.015. This indicates significant over replacement. A TSH suppressed to that level is clearly associated with increased risk of palpitations, arrhythmias, anxiety, and a litany of other adverse clinical symptoms and signs. Respondent's records show no evidence that this abnormal laboratory value was assessed and/or acted upon.

1.20 *Excessive iatrogenic hyperthyroidism leading to ER visit and hospitalization.* On March 20, 2014, Patient B presented to the emergency room with a "fluttering" heartbeat. She had palpitations, lightheadedness, dizziness, fatigue and

near-syncope. As a result of this presentation, the patient incurred the cost and imaging exposure of an MRI and a CT scan. She had laboratory studies that showed a TSH < 0.01, highly suppressed, and an elevated free T4 of 2.0. These both demonstrate very significant iatrogenic hyperthyroidism. The following day, on March 21, 2014, Patient B was seen by a cardiologist who noted the palpitations and chest pain, diagnosed iatrogenic thyroid toxicity, and recommended that Patient B cut all thyroid doses in half. Patient B's workup continued, to include an exercise treadmill test and an echocardiogram. During her visit with Dr. Zuroske, cardiology, on March 31, 2014, it was noted that she had iatrogenic thyroid toxicity. On April 8, 2014, however, the notes from Respondent suggested that he wished her to return to the same toxic thyroid doses.

1.21 Had the laboratory study of February 4, 2014, been recognized and acted upon, and Patient B's thyroid medication dose significantly reduced, she would not have had the cardiac symptoms that brought her to the emergency room on March 20, 2014, nor would she have had the ensuing hospital admission from that visit.

1.22 Respondent's prescribing of excessive doses of thyroid medication, despite laboratory evidence of significant iatrogenic hyperthyroidism, led to the harm of the hospitalization of March 20-21, 2014, the extensive neuroimaging, and cardiac testing. He put her at risk of harm for atrial fibrillation and other adverse cardiac and neuropsychological effects from iatrogenic hyperthyroidism. Despite this sentinel event of a cardiac admission for iatrogenic hyperthyroidism, he promptly re-escalated her thyroid medication doses in April of 2014.

1.23 *Documentation of risks/benefits/alternatives.* Respondent's records demonstrate a pattern of very poor documentation of medical decision-making. The visits do not include assessments, and the plans are very skeletal – it is very hard to garner the clinical decision-making, the interpretation of symptoms, signs, and objective data, or the inclusion of the patient in the proposed benefits, risks, and alternatives of the treatments offered.

1.24 An independent medical examination of Patient B for short and long term disability and to determine medical necessity of treatment on December 14, 2014, also raised concerns regarding Respondent's negligent and incompetent practice in his

treatment of Patient B. The report documented Patient B's normal thyroid function and Respondent's misdiagnosis of hypothyroidism and improper treatment with escalating doses of hormone supplementation which caused palpitations requiring treatment through the hospital emergency department in March of 2014.

Failure to Cooperate

1.25 In a letter dated December 14, 2015, the Commission investigator requested that within 14 days, Respondent send a complete copy of his charts for five additional named patients for whom he had prescribed thyroid medication. Respondent failed to provide a copy of the requested charts.

1.26 On January 4, 2016, the Commission investigator followed up with a final request for records within three days. Respondent failed to provide a copy of the requested charts.

FAILURE TO RESPOND

1.27 On June 30, 2016, the Commission served Respondent with a copy of the following documents at Respondent's last known address:

A. Corrected Amended Statement of Charges;

B. Notice of Your Legal Rights and Request for Interpreter; and

C. Answer to Corrected Amended Statement of Charges form.

1.28 The Answer to the Corrected Amended Statement of Charges was due in the Adjudicative Clerk Office by July 20, 2016.

1.29 On July 11, 2016, the Department, through Assistant Attorney General Kristin Brewer, filed a Request for Status Conference.[1] On that same date, the Presiding Officer instructed legal staff to set up a status conference. Legal staff was unable to establish contact with Respondent in order to set up a status conference. (Prehearing

---

[1] A request for a status conference was needed because of the procedural developments in the case. A Statement of Charges was originally issued regarding Respondent's alleged misconduct involving Patient A on December 10, 2015. Respondent's answer was received, a scheduling order issued, a prehearing conference occurred on June 20, 2016, and an Order Defining Conduct issued in Prehearing Order No. 2. However, the Department served an Amended Statement of Charges on June 29, 2016, adding allegations related to a new patient, Patient B, derived from a more recent investigation (Case no. 2014-10671). A Corrected Amended Statement of Charges was served on June 30, 2016, correcting a medical reference in one of the paragraphs. A status conference was needed to discuss the procedural posture of the case.

Order No. 3: Order of Continuance.) The Presiding Officer struck the hearing dates of July 22 – July 23, 2016, and set a status conference for July 22, 2016 at 1:00 p.m. (Id.) A copy of the order of the Presiding Officer was mailed to Respondent at his address of record.

1.30 On July 22, 2016, Respondent failed to participate in the telephonic status conference.

1.31 In Prehearing Order No. 4: Order of Continuance, dated July 28, 2016, the Presiding Officer continued the due date for Respondent's answer to the Corrected Amended Statement of Charges to July 29, 2016.

1.32 On August 5, 2016, the Adjudicative Clerk's Office issued a Notice of Failure to Respond. To date, the Adjudicative Clerk Office has not received an answer to the Corrected Amended Statement of Charges.

1.33 The Commission has no reason to believe Respondent is now or was in active military service or a dependent of a person in active military service at the time the Corrected Amended Statement of Charges was served.

1.34 The Commission has filed the Declaration of Staff Attorney James McLaughlin regarding Respondent's failure to respond to the Corrected Amended Statement of Charges, and the Declaration of Investigator Patty Melody in support of the findings in this Findings of Fact, Conclusion of Law, and Final Order of Default (Failure to Respond).

2. CONCLUSIONS OF LAW

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

2.2 Respondent did not file a response to the Corrected Amended Statement of Charges within the time allowed. WAC 246-11-270(1)(a)(i) or WAC 246-11-270(3). Respondent is in default and the Commission may issue a final order based on the evidence presented, RCW 18.130.090(1) and RCW 34.05.440.

2.3 Based upon the Findings of Fact, Respondent has engaged in unprofessional conduct in violation of RCW 18.130.180(1), (4), (7), (8)(a) and (b), (22), and (24); and WAC 246-919-630(2)(a) and (d) and WAC 246-919-630(3).

2.4 Sufficient grounds exist to take disciplinary action against Respondent's license. RCW 18.130.160 and 18.130.180.

2.5 The Commission finds that Respondent can never be rehabilitated, as required for permanent revocation under RCW 18.130.160.

3. ORDER

The COMMISSION ORDERS:

3.1 Respondent's license to practice as a physician and surgeon in the state of Washington is PERMANENTLY REVOKED, with no right to reapply.

3.2 Respondent shall immediately return all licenses to the Commission within ten (10) days of receipt of this Order.

3.3 The effective date of this Order is that date the Adjudicative Clerk Office places the signed order into the U.S. mail. Respondent shall not submit any fees or compliance documents until after the effective date of this Order.

4. COMPLIANCE WITH SANCTION RULES

4.1 *The Commission applies WAC 246-16-800, et seq.,* to determine appropriate sanctions in final orders pursuant to RCW 18.130.110: Tier C of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices cause severe harm or death to a patient. Respondent's violation of the appropriate physician-patient boundary between himself and Patient A violated the standard of care, and caused severe harm to Patient A's marriage and to her hopes of reuniting her family one day. Patient A came to Respondent in a vulnerable state. She talked with Respondent regarding her marital difficulties and about her longstanding difficulties with depression and anxiety. Instead of helping Patient A, Respondent became romantically and sexually involved with her. Respondent's affair with Patient A further contributed to her marital issues, degraded her hopes of reuniting her family, and exacerbated her psychiatric conditions. Patient A took her own life. While it cannot be said that Respondent's conduct caused Patient A's death, it is clear that his substandard care caused severe harm to Patient A and deprived her of the opportunity to receive care that may have saved her life. Respondent's failure to

respond with appropriate urgency in response to Patient A's expressions of severe depression in her January of 2013 text messages deprived Patient A of the possibility, however remote, of a life-saving intervention. Tier C therefore applies to the substandard care Respondent provided to Patient A.

4.2 Respondent's romantic relationship and sexual contact with Patient A are also addressed in the "Sexual Misconduct or Contact" schedule, at WAC 246-16-820. Respondent's romantic and sexual relationship with Patient A caused Patient A the harm described above. Tier B of the Sexual Misconduct or Contact schedule therefore applies. However, under WAC 246-16-800(3)(a)(i), when unprofessional conduct falls into more than one schedule, the schedule with the greater sanction is applied. Tier C of the Standard of Care schedule has a range from three years of oversight to permanent revocation, while Tier B of the Sexual Misconduct or Contact schedule ranges from two to five years of oversight unless a revocation is imposed. Since Tier C of the Practice Below Standard of Care schedule has the greater sanction, and expressly provides for permanent revocation, that schedule applies to this case.

4.3 Respondent's substandard prescribing of thyroid medication for Patient B caused moderate harm in the form of iatrogenic hyperthyroidism that required treatment in the hospital. Tier B of the "Practice Below Standard of Care" schedule therefore applies to Respondent's substandard management of Patient B. Under WAC 246-16-800(3)(a)(ii), when different acts of unprofessional conduct fall within the same schedule, the greatest sanction is imposed and the other acts are considered aggravating factors. Respondent's substandard care for Patient A falls within Tier C and has a greater sanction than the Tier B classification of Respondent's substandard care for Patient B. The Tier C range therefore applies, and Respondent's substandard management of Patient B is an aggravating factor.

4.4 Tier C of the Practice Below Standard of Care schedule ranges from three years of oversight to permanent revocation. Under WAC 246-16-800(3)(d), the starting point for the duration of sanctions is the middle of the range. The Commission uses aggravating and mitigating factors to move towards the maximum or minimum ends of the range. The sanction is this case is at the permanent or maximum end of the range.

This position at the maximum end of the range is justified by the extreme volume and weight of the aggravating factors, without any mitigating factors.

Aggravating Factors .

A. The gravity of Respondent's unprofessional conduct. Respondent engaged in a romantic and sexual relationship with a patient who had longstanding anxiety and depression, and who had confided her marital difficulties to Respondent. Patient A ultimately committed suicide.

B. The vulnerability of Patient A. Patient A suffered from anxiety and depression, was experiencing marital and family turmoil, and presented as desperate and obsessive regarding her medical care and mental and physical well-being.

C. The number of acts of unprofessional conduct. Respondent provided substandard care to both Patient A and Patient B, engaged in sexual misconduct with Patient A, failed to fully cooperate with the Commission's investigation, and interfered with the Commission's investigation by willfully misrepresenting the nature of his relationship with Patient A.

D. The injury caused by the unprofessional conduct. The damage that Respondent's violation of the appropriate physician-patient boundary did to Patient A cannot be measured. It is clear, however, that keeping her family together was of extreme importance to Patient A, and that Respondent's affair with Patient A contributed to breaking her family apart. Respondent's substandard care also exacerbated Patient A's already vulnerable psychiatric condition. Patient A ultimately took her own life.

E. Abuse of trust. Respondent abused the trust of Patient A, who disclosed very personal information to Respondent, including information regarding her troubled marriage. Rather than obtain appropriate help for Patient A, Respondent engaged in a romantic and sexual relationship with Patient A while she was still married.

F. Past disciplinary record. Respondent was previously subject to discipline in a Final Order entered by the Commission on May 30, 2004, in Docket No. 02-05-A-1012MD. In that final order the Commission found, following

a hearing, that Respondent provided substandard care and inefficacious treatment.

G. Lack of Cooperation. Respondent was not cooperative with the investigation. He failed to provide the medical records of Patient A, provided a terse statement that failed to respond fully to the investigator's questions, and obstructed the investigation and resolution of this matter by misrepresenting the nature of his relationship with Patient A.

H. Remorse or awareness. Respondent did not demonstrate any remorse regarding his misconduct, or any awareness of his possible role in Patient A's deterioration.

I. Ill repute upon the profession. Respondent's misconduct lowers the standing of the profession in the eyes of the public.

J. Potential for successful rehabilitation. As discussed further below, Respondent's continuing pursuit of self-interest contrary to the welfare of his patients combined with his lack of response to non-permanent action and his repeatedly expressed and exhibited contempt for the disciplining authority (the Commission), demonstrate that he is not amenable to rehabilitation.

4.5 The Commission is required to enter a suspension or revocation when a licensee cannot practice with reasonable skill and safety. WAC 246-16-800(2)(b)(i). Considering the gravity of the factual findings above, Respondent's pattern of substandard care, lack of recognition of his wrongs despite the stark nature of his misconduct and substandard care, and his lack of response to lesser measures in a previous order, the Commission concludes that Respondent is unable to practice with reasonable skill and safety. These findings require the Commission to impose a revocation or suspension.

4.6 Under WAC 246-16-800(2)(b)(ii), permanent revocation may be imposed when the Commission finds that a licensee can never be rehabilitated. Respondent's continuing pursuit of self-interest contrary to the welfare of his patients, combined with his lack of response to non-permanent action and his repeatedly expressed and exhibited contempt for the disciplining authority (the Commission) demonstrate that he

is not amenable to rehabilitation. Rehabilitation requires Respondent's participation. Respondent has consistently communicated by action and inaction that he is not interested in efforts by the Commission to rehabilitate him, nor does he acknowledge the need. It is the Commission's conclusion that Respondent can never be rehabilitated and that permanent revocation is a necessary and appropriate resolution to this case.

5. NOTICE TO PARTIES

This Order will be reported to the National Practitioner Data Bank (45 CFR Part 60), the Federation of State Medical Board's Physician Data Center and elsewhere as required by law. This Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's listserv, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

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

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

and a copy must be sent to:

State of Washington
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

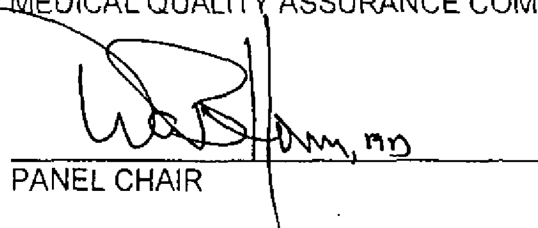
The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied twenty (20) days after the petition is filed if the Adjudicative Clerk Office has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within thirty (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, however, the thirty (30) day period will begin to run upon the resolution of that petition, RCW 34.05.470(3).

The Order remains in effect even if a petition for reconsideration or petition for review is filed. "Filing" means actual receipt of the document by the Adjudicative Clerk Office, RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail, RCW 34.05.010(19).

DATED: September 23, 2016.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION



PANEL CHAIR