STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Evelyn M. Hanshew
Docket No.: 97-06-A-1140MD
Document: Final Order

Regarding your request for information about the above-named practitioner, 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:

Adjudicative Clerk Office
P.O. Box 47879
Olympia, WA 98504-7879
Phone: (360) 236-4677
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to Nancy Ellison, Deputy Secretary, 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:	)	Docket No. 97-06-A-1140MD
EVELYN M. HANSHEW, M.D., License No. MD26630,	)	FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER
Respondent.	)	

A hearing was held before the Medical Quality Assurance Commission (the Commission) and Senior Health Law Judge Eric B. Schmidt, Presiding Officer for the Commission, on October 20 through 23, 1998, at the Cherberg Senate Office Building, Hearing Room 2, Olympia, Washington, and on May 6 and 7, 1999, at the West Coast Sea-Tac Hotel, Sea-Tac, Washington. Members of the Commission present and considering the matter were: M. Estelle Connolly, M.D., Panel Chair; Jan Polek, Public Member; and Marilyn Ward, Public Member. David M. Hankins, Assistant Attorney General, represented the Department of Health (the Department). Evelyn M. Hanshew, M.D. (the Respondent) was represented by Craig E. Kastner, Attorney at Law. The proceedings were recorded by Cynthia LaRose, Jean Ericksen and Robert Lewis, certified court reporters. Having considered the testimony and evidence presented, the Commission issues the following:

I. PROCEDURAL HISTORY

1.1 On January 24, 1997, the Commission issued a Statement of Charges alleging that the Respondent committed unprofessional conduct under

REDACTED

RCW 18.130.180(1), (4), (6), (7), (10) and (22).

1.2 On or about March 12, 1997, following the granting of an extension of time, the Respondent filed her Answer to Statement of Charges and requested an adjudicative proceeding. The Respondent was represented by Donna M. Moniz and Michael D. Handler, Attorneys at Law.

1.3 On March 28, 1997, the Commission issued a Scheduling Order/Notice of Hearing, which scheduled a prehearing conference for September 3, 1997, and a hearing for September 25 through 27, 1997.

1.4 On September 29, 1997, Health Law Judge Suzanne Johnson issued Prehearing Order No. 2: Order on Continuance, which continued the prehearing conference to November 25, 1997, and the hearing date to December 10, 1997, to allow additional time for settlement discussions.

1.5 On December 31, 1997, Judge Johnson issued Prehearing Order No. 3: Order on Continuance, which continued the prehearing conference to January 29, 1998, and the hearing dates to March 17 through 21, 1998, after an informal settlement agreement had been rejected by the Commission.

1.6 On January 28, 1998, Craig E. Kastner, Attorney at Law, was substituted as counsel for the Respondent.

1.7 On February 9, 1998, Judge Johnson issued Prehearing Order No. 4: Order on Continuance and Disclosure Dates, which continued the prehearing conference to March 2, 1998, and the hearing dates to May 13 through 17, 1998, to allow the Respondent's new counsel to become familiar with the case.

REDACTED

1.8 A prehearing conference was held on March 2, 1998. On March 27, 1998, Judge Johnson issued Prehearing Order No. 5: Order Defining Conduct of Hearing, which contained the results of the March 2, 1998, prehearing conference.

1.9 On April 30, 1998, Judge Johnson issued Prehearing Order No. 6: Order to Strike Hearing Date and Continue Status Conference, which struck the May 13 through 17, 1998, hearing dates and set a status conference for May 1, 1998, in order to allow the Respondent's new counsel more time to prepare and more time to negotiate a settlement.

1.10 On June 12, 1998, Judge Johnson issued Prehearing Order No. 7: Order Setting Prehearing Conference, Hearing and Discovery Cut-Off, which scheduled a second prehearing conference for July 15, 1998, and continued the hearing dates to October 19 through 22, 1998.

1.11 In July 1998, Judge Johnson left the Office of Professional Standards, and Senior Health Law Judge Eric B. Schmidt was assigned as Presiding Officer.

1.12 On July 15, 1998, the Presiding Officer conducted a second prehearing conference. On August 7, 1998, the Presiding Officer issued Prehearing Order No. 8: Order Further Defining Conduct of Hearing, which contained the results of the July 15, 1998, prehearing conference.

1.13 On September 25, 1998, the Presiding Officer issued Prehearing Order No. 9: Order on Motion to Continue Hearing One Day, which continued the hearing dates to October 20 through 23, 1998.

1.14 On October 8, 1998, the Adjudicative Clerk Office issued a Notice of

Hearing informing the parties of the time and place of the hearing.

1.15 On October 21, 1998, the Presiding Officer issued Prehearing Order No. 10: Order Adding Witness to Department's Witness List.

1.16 The hearing commenced on October 20, 1998, and continued on October 21, 22 and 23, 1998. However, the hearing was not completed at the end of October 23, 1998, and additional hearing days were scheduled.

1.17 On November 12, 1998, the Adjudicative Clerk Office issued a Notice of Hearing, which scheduled additional hearing days for December 10 and 11, 1998.

1.18 On November 24, 1998, the Presiding Officer issued Prehearing Order No. 11: Order on Motion to Continue Hearing, which continued the additional hearing dates to January 21 and 22, 1999, because of the death of the Respondent's counsel's daughter.

1.19 On January 6, 1999, the Presiding Officer issued Prehearing Order No. 12: Order on Respondent's Motion for Continuance, which continued the additional hearing dates to March 4 and 5, 1999, because the Respondent's counsel's continuing difficulties following the death of his daughter.

1.20 One of the Commission panel members was not available for the March 4 and 5, 1999, additional hearing dates, so on March 23, 1999, the Adjudicative Clerk Office issued a Notice of Hearing rescheduling the additional hearing dates to May 6 and 7, 1999. On April 20, 1999, the Adjudicative Clerk Office issued an Amended Notice of Hearing changing the location of the additional hearing dates of May 6 and 7, 1999.

REDACTED

1.21 In support of its case in chief, the Department called the following witnesses: Lynn Larson-LaVier, Roger Rosenblatt, M.D., Connie Felstad, Siva Goodman, Karen Smith, Debbie Mitchell-Byron, Karen Easterly-Behrins, Mark Lemaster, Darla Bacus, and Yvonne Romine.

1.22 In support of its case in chief, the Respondent called the following witnesses: Evelyn M. Hanshew, M.D., Roxanne Helling, Angela Hawk, Vern Cherewatenko, M.D., Tracy Rudge, Martin Dafforn, Jan Zemplenyi, M.D., Mary Jackson, Dana Shaw, M.D., and Elizabeth Peterson. Dr. Shaw began her testimony on October 23, 1998, but was not available on May 6 or 7, 1999, and was allowed by the Presiding Officer to complete her testimony by video perpetuation deposition. Dr. Shaw was not available for questions from the Commission.

1.23 The following exhibits were admitted by the Presiding Officer in Prehearing Order No's. 5 and 8, and were provided to the Commission members during the hearing:

Exhibit 1:	Medical records for Patients One through Twenty.
Exhibit 2:	Patient Sixteen's medical records from Dr. Krank, except page 7.
Exhibit 3:	Pharmacy printout from Bartell's Drug Store # 29 and Payless Drug Store #2558 for Patient Five.
Exhibit 4:	Pharmacy survey of Payless Drug Store #2560 (as redacted).
Exhibit 5:	Pharmacy survey of Look's Pharmacy (as redacted).
Exhibit 6:	Pharmacy survey of Medical Center Pharmacy (as redacted).
Exhibit 7:	Portions of Respondent's office manual.
Exhibit 8:	Original table of Controlled Substance Count and table of Controlled Substance Count.
Exhibit 9:	On Site Medication Count.

REDACTED

Exhibit 10: Inventory Count.

Exhibit 11: Respondent's Diagnostic Code Lists for 1994 and 1995.

Exhibit 12: Controlled Substances Log.

Exhibit 13: Quality Care Pharmaceutical Sheets.

Exhibit 14: Original QCP Sheets.

Exhibit 15: QCP Purchase List.

Exhibit 16: Demerol Receipts from the Respondent and from Medical Center Pharmacy

Exhibit 17: December 21, 1994, letter to Department of Health from Lyn Hanshew, M.D.

Exhibit A: Respondent's logs regarding Demerol and diazepam.

Exhibit B: Respondent's 1994 diagnostic code survey.

Exhibit C: Respondent's 1995 diagnostic code survey.

Exhibit D: Respondent's 1996 diagnostic code survey.

Exhibit E: Forty-one medical journal articles on obesity and weight loss, hypothyroidism, smoking, anxiety disorders, sinus disease, bipolar disorders, and drug abuse.

Exhibit F: Declarations of support from patients, including Gabrielle M. Sundsted, Lisa A. Raab (as redacted), Susan K. Laing, Kathy K. Shreve, Meredith C. Laing (with attached note), Tami J. Spore, Connie G. Ellis, Pamela Jones, Brock Lamoreaux, Susan C.Watkinson, Pamela C. Buenaventura and Steven D. Wangsness.

Exhibit G: Letter of support from University of Washington School of Nursing.

Exhibit H: Booklet, dated November 1995, on The Law Relating to Health Care Assistants.

Exhibit I: Letter of support from Lisa A. Raab, dated April 28, 1998, (admitted over relevance objection from the Department).

Exhibit J: [Excluded in Prehearing Order No. 8].

Exhibit K: [Excluded in Prehearing Order No. 8].

Exhibit L: [Excluded in Prehearing Order No. 8].

Exhibit M: [Excluded in Prehearing Order No. 8].

REDACTED

Exhibit N: [Excluded in Prehearing Order No. 8].

Exhibit O: Respondent's Medical Journal Subscription List.

Exhibit P: [Excluded in Prehearing Order No. 8].

Exhibit Q: Prescription profiles from other physicians (pages 1 through 4 only, page 5 excluded).

Exhibit R: [Not submitted at hearing].

Exhibit S: Letter and photographs regarding donation of medications to Mother Teresa's clinic (admitted over relevance objection from the Department).

Exhibit T: On-Site Survey by Office of Laboratory Quality Assurance.

Exhibit U: Respondent's examination forms.

Exhibit V: Respondent's protocols and policies.

Exhibit W: MQAC Guidelines for Management of Pain, approved April 18, 1996, (admitted only to show guidelines adopted after conduct alleged in Statement of Charges).

Exhibit X: MQAC Guidelines for Pharmacotherapy on Weight Loss, effective November 7, 1997, (admitted only to show guidelines adopted after conduct alleged in Statement of Charges).

Exhibit Y: [Not used].

Exhibit Z: [Not used].

Exhibit AA: [Not submitted at hearing].

Exhibit BB: [Not submitted at hearing].

Exhibit CC: [Not submitted at hearing].

Exhibit DD: [Not submitted at hearing].

Exhibit EE: Respondent's medical school transcript.

Exhibit FF: Respondent's curriculum vitae.

Exhibit GG: Respondent's CME logs.

Exhibit HH: [Duplicate of Exhibit A].

Exhibit II: [Not submitted at hearing].

Exhibit JJ: Respondent's X-ray logs.

Exhibit KK: Respondent's explanatory notes regarding Patients One through Twenty.

Exhibit LL: Respondent's nursing manual (as constituted on October 20, 1998).

Exhibit MM: Respondent's front office manual (as constituted on October 20, 1998).

II. FINDINGS OF FACT

2.1 At all times material to this action, Evelyn M. Hanshew, M.D. (the Respondent), has been licensed to practice as a physician and surgeon by the State of Washington.

2.2 In the care of Patients One, Two, Four, Five, Seven and Eight, as identified in the Confidential Schedule attached to the Statement of Charges, the Commission finds the Respondent's prescribing of prolonged courses of narcotics and/or benzodiazepines, without appropriate clinical indications of pathology, appropriate referrals or discernible treatment plans, was inappropriate and below the standard of care for reasonably prudent physicians in the state of Washington, and created an unreasonable risk that patients might be harmed, as addressed in more detail below.

2.2.1 Patient One presented to the Respondent with complaints of muscular injury, headache and stress. The Respondent diagnosed multiple contusions, fatigue and insomnia, discontinued Patient One's prescriptions for Tranzene and Fiorinal, and replaced them with prescriptions for Effexor, Halcion, Skelaxin and Vicodin. (Exhibit 1, p. 33). Three weeks later, Patient One reported to the Respondent that she had been taking Dilaudid that had been prescribed for her husband during his terminal illness. The Respondent noted Patient One refused to enter an addiction

REDACTED

center. The Respondent then undertook treatment of Patient One's narcotics dependence and added prescriptions for morphine sulfate and Buspar. (Exhibit 1, p. 31). The Respondent maintained Patient One on morphine sulfate through the end of her care of Patient One nine months later. (Exhibit 1, pp. 3-30). The issue of whether the Respondent acted inappropriately in attempting to detoxify Patient One from the Dilaudid is addressed below in Finding of Fact 2.11. However, the Commission finds the continued prescribing of morphine sulfate for Patient One was not supported by appropriate clinical indications of pathology. While Patient One refused the Respondent's initial suggestion of attending an addiction center, the patient charts do not indicate any further attempts by the Respondent to refer Patient One to others, such as addiction medicine specialists or pain clinics.

2.2.2 Patient Two presented to the Respondent with a complaint of migraine headaches, for which she had been prescribed nortriptyline. The Respondent diagnosed migraine headaches, muscle tension headaches, insomnia and fatigue, discontinued the nortriptyline, and prescribed Imitrex, Torodol, Valium, Xanax and Halcion. (Exhibit 1, p. 71). The Respondent expanded Patient Two's diagnoses to include sinusitis and otitis media. (Exhibit 1, p. 72). Patient Two reported taking Vicodin, which had not been prescribed by the Respondent, but rather than investigate who else was prescribing for Patient Two, the Respondent added a prescription for Vicodin. (Exhibit 1, p. 74). The Respondent later added a prescription for Buspar. (Exhibit 1, p. 76). While the Respondent states she instructed Patient Two to taper the Xanax (Exhibit KK, Patient Two, p. 3), the progress notes do not contain that

REDACTED

information. The Respondent continued prescribing Xanax and Vicodin for Patient Two, despite her instructions to Patient Two to taper both medications. (Exhibit 1, pp. 81-92). Other than a referral to Dr. Tepper for evaluation of migraines, Patient Two's chart does not indicate any referrals for evaluation of her other on-going pain or for evaluation of possible psychological causes for her pain, fatigue and stress. While the Respondent continued to diagnose Patient Two as having otitis media, sinusitis, fatigue and headache, the chart does not indicate a treatment plan for these diagnoses other than a series of different prescriptions. Dr. Rosenblatt opined the Respondent's prescribing for Patient Two, particularly the continued prescription of Vicodin despite instructions to taper and the prescription of multiple benzodiazepines (Xanax, Buspar and Halcion), without adequate consideration of the dependence these prescriptions could create, fell below the standard of care of reasonable prudent physicians in the state of Washington. The Commission finds Dr. Rosenblatt's opinion persuasive, and adopts it as its finding regarding the Respondent's prescribing for Patient Two.

2.2.3 Patient Four initially presented to the Respondent with complaints of rhinitis secondary to seasonal allergies. (Exhibit 1, p. 124). Patient Four reported his weight as about three hundred pounds. Patient Four later reported anxiety and fatigue, for which the Respondent prescribed Xanax (Exhibit 1, p.125). Despite continued reports of fatigue, the Respondent continued prescribing Xanax and phentermine, but undertook no other treatments or consultations, other than nutritional consultations, for eighteen months. (Exhibit 1, pp. 125-32). Patient Four was eventually diagnosed by Drs. Zemplenyi and Pascualy as suffering from sleep apnea, and once Patient Four's

REDACTED

sleep apnea was treated by nasal CPAP, his fatigue resolved and he discontinued the Xanax. Dr. Zemplenyi noted that benzodiazepines, such as Xanax, can contribute to sleep apnea. The Commission finds the Respondent's continued prescribing of Xanax for Patient Four, without earlier consultation or referral for sleep apnea or other obesity-related disorders, was below the standard of care for reasonably prudent physicians in the state of Washington.

2.2.4 Patient Five presented to the Respondent with complaints of dizziness, nervousness, anxiety and insomnia. The Respondent diagnosed sinusitis, anxiety and probable depression, and prescribed Xanax, Halcion and Paxil. (Exhibit 1, p. 140). Three days later, after Patient Five reported sedation and diarrhea, the Respondent discontinued the Paxil and prescribed Zoloft. The Respondent also referred Patient Five to a psychologist, but there is no evidence in the patient chart that Patient Five ever saw a psychologist. (Exhibit 1, p. 141). Two weeks later, Patient Five discontinued the Zoloft on her own, and reported she felt better. The Respondent added a prescription for Ambien for insomnia. (Exhibit 1, pp. 141-42). Patient Five returned ten days later and requested a prescription for Prozac. Without further evaluation, the Respondent diagnosed Patient Five with depression and prescribed Prozac. (Exhibit 1, p. 142). The Respondent continued prescribing Prozac and Xanax for Patient Five for ten months, although no additional referrals or other treatment for depression were noted. (Exhibit 1, pp. 142-49). Patient Five's then-husband called the Respondent to report that Patient Five had made a suicide gesture by taking pills. Patient Five reported she had taken four tablets of Halcion, to which she had had

REDACTED

adverse reactions, to "get back at her husband" for his harassment. The Respondent discontinued the prescriptions for Halcion and Prozac, and replaced them with prescriptions for Ambien and Effexor, without justification in the chart and without further evaluating Patient Five's suicide gesture or obtaining any psychiatric or psychological referral. (Exhibit 1, p. 150). Dr. Rosenblatt opined the Respondent's prescribing for Patient Five, particularly starting Patient Five on Xanax, Halcion and Paxil simultaneously, switching from Paxil to Zoloft after only three days, and then to Prozac one month later, and switching Patient Five from Prozac and Halcion to Effexor and Ambien in response to the suicide gesture without further evaluation, fell below the standard of care of reasonable prudent physicians in the state of Washington. The Commission finds

Dr. Rosenblatt's opinion persuasive, and adopts it as its finding regarding the Respondent's prescribing for Patient Five.

2.2.5 Patient Seven presented to the Respondent with complaints of increased stress and decreased sleep. The Respondent diagnosed fatigue and insomnia, discontinued the Prozac prescribed by a prior practitioner, and prescribed Effexor, Ambien and Xanax. (Exhibit 1, p. 278). Patient Seven returned eleven days later, noting her anxiety had improved but her sleep had not. The Respondent discontinued the Ambien, and added prescriptions for Restoril and Buspar. (Exhibit 1, p. 279). In subsequent follow-up visits, Patient Seven reported additional problems with anxiety, to which the Respondent responded by increasing the amounts of Xanax, Buspar and Restoril (which was later switched to Halcion). (Exhibit 1, pp. 280-293).

REDACTED

Other than noting the lack of suicidal ideation, the patient charts for Patient Seven do not indicate any referral for mental health evaluation or treatment. While the Respondent states Patient Seven was participating in counseling through her church (Exhibit KK, Patient Seven, pp. 1 and 5), the progress notes do not contain that information. Although the Respondent instructed Patient Seven to taper the Xanax ten months after the prescription began (Exhibit 1, p. 287), the Respondent continued prescribing Xanax in the same amounts for another nine months, when she again instructed Patient Seven to taper the Xanax. (Exhibit 1, p. 293). As discussed above, Dr. Rosenblatt opined the prescription of multiple benzodiazepines (Xanax, Buspar and Halcion), without adequate consideration of the dependence these prescriptions could create, and without adequate consideration of psychological issues that could be contributing to the patient's anxiety, fell below the standard of care of reasonable prudent physicians in the state of Washington. The Commission finds Dr. Rosenblatt's opinion persuasive, and adopts it as its finding regarding the Respondent's prescribing for Patient Seven.

2.2.6 Patient Eight presented to the Respondent with complaints of headaches and stress. The Respondent diagnosed migraine headaches, fatigue and insomnia, discontinued the Prozac prescribed by a prior practitioner, and prescribed Effexor and Skelaxin. (Exhibit 1, p. 297). In a follow-up visit one month later, Patient Eight reported needing to take Xanax and Ambien "to stop quivering" although the Respondent did not prescribe either of those medications. Rather than investigate who else was prescribing for Patient Eight, the Respondent began prescribing Xanax and

REDACTED

Ambien, and added a prescription for Buspar. (Exhibit 1, p. 298). The Respondent maintained Patient Eight on Effexor (later switched to Zoloft), Buspar, Skelaxin, Xanax and Ambien. (Exhibit 1, pp. 299-301). In response to renewed complaints of headaches, the Respondent prescribed Imitrex, then Percocet, then Demerol, and finally morphine sulfate. (Exhibit 1, pp. 301-307). The patient charts indicate the Respondent tapered Patient Eight off of the narcotics (Exhibit 1, p. 308), but five days later, Patient Eight presented at the Swedish Hospital emergency room with complaints of migraine headaches and requested narcotics. The emergency room staff contacted the Respondent, who agreed Patient Eight should not be prescribed narcotics. (Exhibit 1, p. 309). Yet, after this event and after Patient Eight had been referred to and seen Dr. Tepper, a neurologist specializing in migraine headaches, the Respondent restarted the prescription for Percocet. (Exhibit 1, p. 310). Further, Mark Lemaster, a pharmacist in Issaquah at the time, called and then wrote the Respondent with concerns about the amount and frequency of Percocet and other medications that Patient Eight was receiving. The issue of whether the Respondent acted inappropriately in attempting to detoxify Patient Eight from the narcotics is addressed below in Finding of Fact 2.11. However, as discussed above, the Commission finds the Respondent's prescribing of multiple benzodiazepines and narcotics for Patient Eight, without adequate consideration of the dependence these prescriptions could create, fell below the standard of care of reasonable prudent physicians in the state of Washington.

2.3 In the care of Patients Nine through Twenty, as identified in the

Confidential Schedule attached to the Statement of Charges, the Commission finds the Respondent's prescribing of prolonged courses of anorexic medications, often in combination, without a clearly charted plan emphasizing exercise, emphasizing proper nutrition, and addressing any underlying psychological conditions, was inappropriate and below the standard of care for reasonably prudent physicians in the state of Washington. Other than obtaining "nutritional consultations" performed by Elizabeth Peterson, who is a diet technician but not a registered dietitian or nutritionist, the charts show no evidence of a treatment plan and show no evidence of addressing possible underlying psychological conditions. The Respondent's treatment of the patients' weight gain, according to the charts, was focused on the use of anorexic medications, particularly levothyroxine and phentermine together, and the occasional use of body composition analysis. The Commission finds this approach to treatment of weight gain inadequate, and created an unreasonable risk that patients might be harmed.

2.4 In the care of Patients Nine, Eleven through Seventeen, Nineteen and Twenty, as identified in the Confidential Schedule attached to the Statement of Charges, the Commission finds the Respondent's patient charts indicate that the Respondent prescribed or dispensed prolonged courses of levothyroxine without clinical justification, as discussed in more detail below.

2.4.1 The Respondent testified she prescribed levothyroxine to treat "subclinical hypothyroidism," which she described as a condition in which patients have some symptoms of hypothyroidism, such decreased mood, fatigue and weight gain, but whose thyroid function tests are within the normal ranges. The Respondent presented

opinion testimony from Dr. Cherewatenko and Dr. Shaw that the use of levothyroxine for subclinical hypothyroidism is recognized, albeit off-label. The Department presented opinion testimony from Dr. Rosenblatt that he was not sure that subclinical hypothyroidism exists, and that he believes it is only appropriate to prescribe levothyroxine for hypothyroidism confirmed by laboratory tests. The Commission finds Dr. Rosenblatt's opinion more persuasive than those of the Respondent, Dr. Cherewatenko and Dr. Shaw.

2.4.2 The article upon which the Respondent principally relies, Ridha Arem, M.D., and David Escalante, M.D., "Subclinical Hypothyroidism: Epidemiology, Diagnosis and Significance," *Advances in Internal Medicine*, Volume 41, pp. 213-50 (Exhibit E, article 15), was actually published in 1996, after the prescribing and dispensing at issue in this case. Further, Drs. Arem and Escalante define subclinical hypothyroidism as "a state of mild thyroid hormone deficiency characterized by normal thyroid hormone levels and slightly elevated levels of thyroid-stimulating hormone (TSH) or an exaggerated TSH response to thyrotropin releasing hormone (TRH) in patients with normal baseline TSH levels." *Id.* at p. 213. This definition is somewhat different than that presented by the Respondent in that, although thyroid hormone levels are normal, the TSH levels are above normal. Drs. Arem and Escalante note "there remains controversy as to whether asymptomatic patients should be treated with thyroid hormone." *Id.* at p. 214. They recommend that "patients with one or several symptoms of thyroid hormone deficiency, namely dry skin, fatigability and cold intolerance . . . should be screened with TSH measurement . . . Although screening of

subclinical hypothyroidism relies on TSH measurement alone, a free thyroxine index (FTI) should be obtained if TSH levels are found to be elevated." *Id.* at p. 233. Once a diagnosis of subclinical hypothyroidism is made, Drs. Arum and Escalante recommend the use of levothyroxine, but starting with a small dose "for the first 2 to 3 months until a repeat TSH measurement is obtained", and they note that "patients with subclinical hypothyroidism should be followed on a regular basis with TSH measurement." *Id.* at p. 236.

2.4.3 Thus, assuming that the Respondent was treating Patients Nine, Eleven through Seventeen, Nineteen and Twenty for subclinical hypothyroidism, the Commission finds her prescribing or dispensing of levothyroxine for them was inappropriate and below the standard of care for reasonably prudent physicians in the state of Washington, and created an unreasonable risk that patients might be harmed. Except for Patients Ten and Eighteen, who were prescribed levothyroxine for clinical hypothyroidism (Patient Ten, Exhibit 1, p. 383, and Patient Eighteen, Exhibit 1, pp. 587-91), the Respondent prescribed levothyroxine in response to symptoms alone, such as fatigue, decreased mood and weight gain, and did not obtain the necessary TSH laboratory testing necessary to make the diagnosis of subclinical hypothyroidism. The patients had either normal TSH levels (Patient Nine, Exhibit 1, p. 357; Patient Eleven, Exhibit 1, p. 431; Patient Twelve, Exhibit 1, pp. 458 and 461; Patient Thirteen, Exhibit 1, p. 475; Patient Fourteen, Exhibit 1, pp. 489-90; Patient Fifteen, Exhibit 1, p. 499; Patient Sixteen, Exhibit 1, p. 517; Patient Seventeen, Exhibit 1, p. 545; and Patient Twenty, Exhibit 1, P. 620) or did not have their TSH measured (Patient Nineteen,

Exhibit 1, p. 605). Further, the Respondent did not properly follow the purported diagnosis of subclinical hypothyroidism of any of these patients with regular, on-going TSH measurements, as suggested by Drs. Arum and Escalante.

2.5 In the care of Patients Nine through Twenty, as identified in the Confidential Schedule attached to the Statement of Charges, the Commission finds the Respondent's prescribing or dispensing of levothyroxine and phentermine together, for the purposes of weight reduction, was inappropriate and below the standard of care for reasonably prudent physicians in the state of Washington, and created an unreasonable risk that patients might be harmed. Other than the testimony of Dr. Cherewatenko, whose testimony the Commission does not find persuasive, the Respondent presented no evidence to support the use of levothyroxine and phentermine together for purposes of weight reduction. Accordingly, the Commission finds the prescribing was without medical justification.

2.6 In the care of Patients One through Twenty, as identified in the Confidential Schedule attached to the Statement of Charges, the Commission finds the Respondent's patient charts indicate that the Respondent frequently prescribed medications such as diuretics, anti-depressants and antibiotics in an episodic, inconsistent manner. The patient charts further reveal this prescribing was done without a reasonable basis for diagnosis, and that the Respondent frequently used symptoms in place of diagnoses. The patient charts do not describe any discernible treatment rationale or plan, based on laboratory testing or clinical indications of pathology. Finally, the patient charts do not demonstrate that the Respondent

considered the side effects of the multiple medications she often prescribed, administered or dispensed to Patients One through Twenty. The Commission is particularly concerned about the Respondent's prescription of an anti-depressant, Effexor, for an eleven-year-old patient, Patient Eleven, for the treatment of decreased mood, decreased energy, fatigue and weight stabilization without any psychiatric or psychological consultation. (Exhibit 1, pp. 393-431). The Commission finds the Respondent's approach to prescribing was both inappropriate and below the standard of care for reasonably prudent physicians in the state of Washington, and created an unreasonable risk that patients might be harmed.

2.7 In the care of Patients One through Twenty, as identified in the Confidential Schedule attached to the Statement of Charges, the Commission finds the Respondent's patient charts reveal a lack of historical information on each patient, limited documentation of objective evidence of pathology, a lack of corollary diagnostic imaging or laboratory information, infrequent consultation with experts, and the use of multiple, powerful and potentially dangerous medications not justified by the patients' complaints or the physical findings. The Respondent testified she had additional documentation that was not included in Exhibit 1, which she sent to the Department investigator. The Department investigator testified she asked the Respondent to provide any documentation she thought necessary, and denied having received any additional documentation beyond that provided by the Respondent and admitted as Exhibit 1. The Commission finds the Respondent had multiple opportunities to offer her versions of the charts into evidence, but did not do so, and according to her

REDACTED

testimony, did not notice any difference between her versions of the charts and Exhibit 1 until the hearing was reconvened in May 1999. Therefore, the Commission makes its findings in this matter on the charts as they are contained in Exhibit 1. The Commission finds the Respondent's record keeping was below the standard of care for reasonably prudent physicians in the state of Washington, and created an unreasonable risk that patients might be harmed.

2.8 After an inspection by the Radiation Protection Division of the Department of Health, the Respondent was informed she was out of compliance with the regulations regarding x-ray machine operation because Connie Felstad, who is not licensed, registered or certified to take x-rays, was performing that function. The Respondent sent a letter to the Department on December 21, 1994, stating she was unaware of the requirement for licensure, certification or registration to take x-rays, and further stating "we have since hired an R.N. that is now taking all x-rays and Connie Felstad is no longer operating the x-ray equipment." (Exhibit 17). However, Ms. Felstad testified the Respondent instructed her to keep taking x-rays after the letter was sent to the Department until the registered nurse had been trained to operate the x-ray equipment, and testified she took between three and ten x-rays after the letter was sent, including an x-ray of her daughter's wrist. The Respondent testified the x-ray of her daughter's wrist was the only x-ray Ms. Felstad took after the letter was sent to the Department, and that she had instructed Ms. Felstad to register as a radiological technician, but that Ms. Felstad had failed to do so. The Commission finds Ms. Felstad's testimony on this issue was more credible than that of the Respondent, and accordingly finds the

Respondent aided and abetted Ms. Felstad in the operation of x-ray equipment when Ms. Felstad was not licensed, registered or certified to do so.

2.9 The Department alleges the Respondent failed to keep complete records of controlled substances she administered and dispensed, and failed to properly secure all controlled substances in the office. The Respondent responds she did keep complete records of controlled substances in the patients' charts, but concedes she did not maintain a narcotics log and did not secure controlled substances in a locked cabinet. The Respondent testified she was unaware of the narcotic log and locked cabinet requirement, and complied as soon as the Department investigator brought the matters to her attention. The Respondent further testified she no longer administers or dispenses controlled substances in her office. The Commission finds the Respondent failed to comply with the requirements of maintaining a narcotics log and of securing controlled substances in a locked cabinet during the relevant period.

2.10 The Department alleges the Respondent falsely represented to a Department investigator, Ms. Larson-LaVier, that the Respondent did not permit any non-physician employee to administer, prescribe or dispense medications. The Respondent testified she told Ms. Larson-LaVier she permitted licensed staff to administer or dispense medications, so long as such administration or dispensing was within the scope of that person's license, but did not permit any staff to prescribe medications. Ms. Felstad, Karen Smith and Debbie Mitchell-Byron, former employees of the Respondent, testified the Respondent's patients were given the Respondent's cellular telephone number for night and weekend contact, and when the Respondent

was out of town, the Respondent gave the cellular telephone to one of the staff members. They testified the Respondent instructed the staff that when answering the cellular telephone, emergencies should be referred to the hospital, but requests for medication refills could be called into the pharmacy without contacting the Respondent first. They further testified the Respondent prepared a list of medications to be called into the pharmacy if patients called in with certain symptoms. Ms. Felstad and Ms. Smith, who were not licensed to practice any health care profession, testified they were among the staff who were given the cellular telephone on occasions and who called prescriptions and refills into the pharmacy. Ms. Mitchell-Byron is licensed as a registered nurse, but is not certified as an advanced registered nurse practitioner. The Respondent agreed that she gave the cellular telephone to staff on occasions when she was out of town, but denied having instructed them to call in prescription refills without notifying her first, and denied having prepared a list of prescriptions to be called in based on specific symptoms. The Respondent further testified that Ms. Felstad, Ms. Smith and Ms. Mitchell-Byron had been terminated for failure to comply with office procedures. Ms. Helling and Ms. Hawk, who were employed by the Respondent before and after the periods of employment of Ms. Felstad, Ms. Smith and Ms. Mitchell-Byron, testified they were not given authorization to call in prescription refills, or to call in new prescriptions based on specific symptoms, based on calls to the cellular telephone. Having considered the testimony and demeanor of the witnesses, the Commission finds the testimony of Ms. Felstad, Ms. Smith and Ms. Mitchell-Byron to be more credible than the testimony of the Respondent. The Commission finds the Respondent did not

REDACTED

demonstrate that her termination of those staff members created sufficient bias in them to cause them to testify falsely. While Ms. Helling and Ms. Hawk testified they were not instructed in the way the other staff members described, they were not working for the Respondent at the time these actions occurred. Accordingly, the Commission finds the Respondent falsely represented to the Department investigator that she did not permit staff members to prescribe medications, when the testimony demonstrates the Respondent permitted Ms. Felstad, Ms. Smith and Ms. Mitchell-Byron, none of whom have prescribing authority, to call in medication refills and new prescriptions based on reports of specific symptoms. The Commission further finds the Respondent aided and abetted Ms. Felstad, Ms. Smith and Ms. Mitchell-Byron in refilling and prescribing medications, tasks for which those persons were not licensed.

2.11 The Department alleges the Respondent was not approved to prescribe, administer or dispense narcotics for detoxification treatment, but provided such detoxification treatment for Patients One and Eight. The Respondent denies her treatment was "detoxification" and contends she was only conducting a "narcotics taper." "Detoxification treatment" is defined as "dispensing of a narcotic drug in decreasing doses to an individual to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic-free state . . . ." 21 C.F.R. 291.505(a)(1).

2.11.1 The Commission finds the Respondent's treatment of Patients One and Eight falls within the definition of "detoxification treatment." Patient One reported

REDACTED

she had been taking Dilaudid that had been prescribed for her late husband for over one year. (Exhibit 1, p. 31). The Respondent did not obtain laboratory confirmation of Patient One's account, did not contact Patient One's other physicians, and did not take a thorough history and physical examination. The Respondent recorded Patient One's diagnoses as carpal tunnel syndrome, fatigue and narcotics dependence. The Respondent then prescribed morphine sulfate to Patient One, in decreasing amounts, to "taper" Patient One off the Dilaudid and, by the Respondent's account, Patient One reached a narcotic-free state. The Respondent also prescribed Vicodin and Buspar for Patient One. (Exhibit 1, pp. 1 through 30, and Exhibit KK, Patient 1, pp. 1 through 4).

2.11.2 Patient Eight had been prescribed Percocet and Demerol by the Respondent for migraine headaches. (Exhibit 1, pp. 295 through 306). The Respondent then began to "taper" Patient Eight off these narcotics, and prescribed morphine sulfate to Patient Eight, in decreasing amounts, to assist in that tapering. (Exhibit 1, pp. 306 through 316, and Exhibit KK, Patient 8, pp. 5 through 10).

2.11.3 The Respondent does not claim that she has the required approval to provide detoxification treatment required by 21 C.F.R. 291.505(b)(2)(iv) for the prescribing, administering or dispensing of narcotic drugs as part of such treatment. Accordingly, the Commission finds the Respondent was not approved to prescribe, administer or dispense narcotics for detoxification treatment, but provided such detoxification treatment for Patients One and Eight. The Commission further finds that the unapproved detoxification treatment provided by the Respondent for Patients One and Eight was below the standard of care expected of reasonably prudent physicians in

REDACTED

the state of Washington, and created an unreasonable risk that patients might be harmed.

2.12 The Commission finds the Department has not proved by a preponderance of the evidence that the Respondent committed unprofessional conduct in her care and treatment of Patients Three or Six.

2.13 The Commission finds the Department has not proved by a preponderance of the evidence the allegations contained in paragraphs 3.5, 3.12, 3.13, 3.14, and 3.15 of the Statement of Charges. Those allegations are therefore dismissed.

2.14 The Commission finds that the deficiencies in the Respondent's professional performance, as described above, require that the Respondent undergo an assessment of her professional skills at the Colorado Personalized Education for Physicians Program.

2.15 The Commission finds that the Respondent's conduct described above, and her subsequent reactions to the allegations made against her, require the Respondent to undergo psychiatric and psychological evaluations. The Respondent contends that Patients One through Twenty were among her most difficult patients, and were specifically selected by the Department. Yet the Respondent testified that she believed all of her care of these patients was correct and appropriate. In none of these cases did the Respondent acknowledge, or appear to recognize, that in hindsight some of her care of these patients could have been better. The Respondent heard the comments and criticisms made by Dr. Rosenblatt, the vice chair of the family medicine

department at the University of Washington, and then rejected those comments and criticisms out of hand. The Respondent appears to have learned nothing from this process. This evidence of an inability, or limitation in the ability, to respond to appropriate feedback, and the demonstration of the Respondent's discrepancy between her assessment of her performance and the assessments of others of her performance, causes the Commission to have sufficient concern about the Respondent's mental and physical health to require the Respondent to undergo psychiatric and psychological evaluations to determine whether the Respondent suffers from a psychiatric or psychological diagnosis that may affect her ability to practice medicine with reasonable skill and safety.

III. CONCLUSIONS OF LAW

3.1 At all times material to the Statement of Charges, the Respondent has been licensed to practice medicine and surgery by the state of Washington. The Commission has jurisdiction to hear this matter, pursuant to chapter 18.71 RCW, and the Uniform Disciplinary Act, chapter 18.130 RCW.

3.2 The Commission has used its experience, competency and specialized knowledge to evaluate the evidence presented in this case. RCW 34.05.461.

3.3 The Department has proved by a preponderance of the evidence that the Respondent committed acts in violation of the Uniform Disciplinary Act. WAC 246-11-520.

3.4 RCW 18.130.180(1) defines unprofessional conduct to include "the commission of any act involving moral turpitude, dishonesty, or corruption relating to the

REDACTED

practice of the person's profession, whether the act constitutes a crime or not." An act of moral turpitude is one, which violates commonly accepted standards of good morals, honesty, or justice. In Re Hopkins, 54 Wn. 569, 103 P.2d 805 (1909). To constitute unprofessional conduct as an act of moral turpitude, the conduct "must indicate unfitness to bear the responsibilities of, and enjoy the privileges of, the profession." Haley v. Medical Disciplinary Board, 117 Wn.2d 720, 731, 818 P.2d 1062 (1991). Based on Finding of Fact 2.10, the Commission concludes that the Respondent's false representation violated RCW 18.130.180(1). The Commission concludes this violation was moderate in nature.

3.5 RCW 18.130.180(4) defines unprofessional conduct to include "incompetence, 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) provides further that "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." Based on Findings 2.2 through 2.7, the Commission concludes the Respondent's actions violated RCW 18.130.180(4). Even if some of the Respondent's treatments were "nontraditional," they resulted in injury to her patients or created unreasonable risks that her patients might be harmed. The Commission concludes this violation is severe in nature.

3.6 RCW 18.130.180(6) defines unprofessional conduct to include "the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for therapeutic purposes . . . ." Based on Findings of Fact

REDACTED

2.2 through 2.6, the Commission concludes that the Respondent's actions violated RCW 18.130.180(6). The Commission concludes this violation was severe in nature.

3.7 RCW 18.130.180(7) defines unprofessional conduct to include "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." Based on Findings of Fact 2.8 through 2.11, the Commission concludes that the Respondent's actions violated RCW 18.130.180(7) in that they violated the following statutes or rules: RCW 18.84.030 (Finding of Fact 2.8); RCW 69.41.010 and .040 (Finding of Fact 2.10); RCW 69.50.306 (Finding of Fact 2.9); 21 C.F.R. 291.505(a)(1) and (b)(2)(iv) (Finding of Fact 2.11); 21 C.F.R. 1301.75(b) (Finding of Fact 2.9); 21 C.F.R. 1304.03(b) (Finding of Fact 2.9); 21 C.F.R. 1304.24 (Finding of Fact 2.9); and 21 C.F.R. 1306.03(a) (Finding of Fact 2.10). The Commission concludes this violation was severe in nature.

3.8 RCW 18.130.180(10) defines unprofessional conduct to include "aiding or abetting an unlicensed person to practice when a license is required." Based on Findings of Fact 2.8 and 2.10, the Commission concludes that the Respondent's actions violated RCW 18.130.180(10). The Commission concludes this violation was moderate in nature.

3.9 RCW 18.130.180(22) defines unprofessional conduct to include "interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative." Based on Finding of Fact 2.10, the Commission concludes that the Respondent's actions violated

REDACTED

RCW 18.130.180(22). The Commission concludes this violation was moderate in nature.

3.10 The Commission concludes the Department did not prove by a preponderance of the evidence the allegations that the Respondent's actions violated RCW 18.135.010, RCW 69.41.042 or RCW 69.41.050. Those allegations are therefore dismissed.

3.11 Upon a finding of unprofessional conduct, the Commission has the authority to order appropriate sanctions. RCW 18.130.160.

IV. ORDER

Based on the foregoing Procedural History, Findings of Fact, and Conclusions of Law, the Commission hereby issues the following ORDERS:

4.1 The license to practice medicine and surgery in the state of Washington held by the Respondent, Evelyn M. Hanshew, M.D., is SUSPENDED for a period of at least sixty (60) months from the date of service of this Order. The suspension of the Respondent's license is hereby STAYED upon the Respondent's compliance with the following terms and conditions.

4.2 Prohibition on Prescribing, Administering or Dispensing. Until the Commission has considered the evaluations ordered below and has issued a subsequent order, the Respondent is prohibited from prescribing, administering or dispensing controlled substances or legend drugs. The Respondent may have another physician prescribe, administer or dispense controlled substances and legend drugs to the Respondent's patients, but that physician shall be responsible for the legitimacy of

REDACTED

that prescribing, administration or dispensing.

4.3 Mental Health Evaluation. The Respondent shall obtain psychiatric and psychological evaluations. Within thirty (30) days of the effective date of this Order, the Respondent shall schedule the psychiatric and psychological evaluations, which shall be completed within ninety (90) days of the effective date of this Order. The psychiatric and psychological evaluations shall be obtained at the Commission's expense. The Respondent shall sign all necessary waivers to allow the Department staff and Commission staff to communicate with the evaluators as needed. Upon completion of each evaluation, the Respondent shall assure that the Commission receives complete evaluation reports from each evaluator within forty-five (45) days of the completion of the evaluation. The psychiatric and psychological evaluations and reports shall be accomplished through the Respondent's compliance with the following:

a. Within thirty (30) days of the effective date of this Order, the Respondent shall make appointments for complete psychiatric and psychological evaluations to be conducted and for complete reports to be generated, by a psychiatrist and a psychologist, both of whom must be approved in advance by the Commission medical consultant. Upon scheduling the evaluations, the Respondent shall notify the Commission medical consultant of the scheduled dates for the evaluations.

b. The Respondent shall provide the evaluators with a copy of this Order prior to the evaluation.

c. The evaluators shall conduct thorough psychiatric and psychological evaluations and shall prepare reports for the Commission, stating in detail

REDACTED

their findings and opinions, describing the basis for their opinions regarding the Respondent's history and current diagnosis, if any, and stating their opinions regarding the Respondent's prognosis and risk to the public.

d. The reports shall state whether or not the evaluators recommend a treatment or counseling plan and the necessary elements of the recommended plan.

e. The evaluators may make other recommendations they conclude are necessary to provide effective treatment or to protect the public health and welfare.

f. The Commission will consider the evaluation reports and the evaluators' recommendations in determining whether additional conditions are necessary to protect the public.

4.4 CPEPP Evaluation. The Respondent shall obtain an assessment of her professional skills at the Colorado Personalized Education for Physicians Program (CPEPP). Within thirty (30) days of the completion of the evaluations ordered in paragraph 4.3 above, the Respondent shall schedule the CPEPP evaluation, which shall be conducted as soon thereafter as feasible. The CPEPP evaluation shall be obtained at the Respondent's expense. The Respondent shall provide the CPEPP evaluators with a copy of this Order prior to the evaluation. The Respondent shall sign all necessary waivers to allow the Department staff and Commission staff to communicate with the CPEPP evaluators as needed. Upon completion of the evaluation, the Respondent shall assure that the Commission receives a complete evaluation report from CPEPP. Within thirty (30) days of CPEPP's issuance of its evaluation report, the Respondent shall submit to the Commission's medical consultant

REDACTED

for approval a program of remedial education related to the violations found in this Order and any findings in the CPEPP evaluation.

4.5 Petition for Modification. Upon the completion of the evaluations ordered in paragraphs 4.3 and 4.4 of this Order, and the receipt of the evaluation reports by the Commission, the Respondent may file a written petition for modification of the terms of this Order, including the prohibition on prescribing, administering or dispensing controlled substances and legend drugs ordered in paragraph 4.2 of this Order. The Respondent shall appear personally before the Commission when her petition for modification is considered. The Commission panel considering the petition for modification shall include as many of the Commission panel members who heard this matter as is feasible. Following the consideration of the petition for modification, the Commission shall issue a subsequent order.

4.6 Record Keeping. Throughout the term of this Order, unless modified in a subsequent order, the Respondent shall follow the following record keeping standards:

a. The Respondent's health care records shall follow the SOAP (Subjective, Objective, Assessment and Plan) format, shall be legible and shall be dated.

b. The patient's initial evaluation shall have a full and complete medical history, records of a general physical examination, a working diagnosis, and a treatment plan. A health history questionnaire shall be completed by all new patients at the initial visit and all established patients at periodic intervals.

REDACTED

c. Each patient chart shall contain contemporaneous progress reports to assess the patient's progress and prognosis for change, including an evaluation of on-going treatment. Progress notes shall be dictated and transcribed or legibly handwritten, and shall be filed in the chart within forty-eight (48) hours of the patient visit or contact. Progress notes shall be documented using a standard charting format such as the SOAP format. Progress notes shall be adequately detailed. Progress notes shall be written each time the patient has an office visit. Progress notes shall document positive and negative findings essential to diagnosis and patient care. Progress notes shall contain a suggested return date for the patient.

d. Each patient chart shall be appropriately documented with verbal and written instructions given to patients. Complications, unusual occurrences, and noncompliance shall be objectively documented in the chart. Recommendations for follow-up or referrals shall be documented in the chart. Substantive clinical telephone contacts with or regarding patients shall be documented in the chart. There shall be a standard form or charting format used to document telephone calls both during and after hours.

e. All diagnostic study/consultant reports shall be initialed or otherwise noted by the Respondent prior to filing in the chart. All handwritten chart entries shall be dated and signed by the author. Addenda to the chart shall also be properly made. The patient's name or an identification number shall appear on all pages of the chart to ensure accurate filing in the correct chart.

REDACTED

f The patient health care records shall contain a periodic evaluation of medications prescribed, performed no less than four (4) times per year. Each patient chart shall contain medication flow sheets that are used to document all medications currently taken by or prescribed for the patient. All medication refills shall be documented on the flow sheet. Complete medication histories shall be obtained from new patients and shall be updated as necessary. Drug and food allergies shall be consistently and conspicuously posted on or in the chart. Patient instructions for drug regimens shall be charted. Medications administered in the office shall be properly documented in the chart and shall include the medication name, dose, route, injection site, and patient response. The rationale for prescribing drugs for unapproved indications shall be adequately documented in the chart. The potential for abuse, psychic, or physical dependence shall be discussed with the patient and shall be charted for all controlled substances or drugs with addiction potential.

4.7 Practice Reviews. In addition to any other inspections that the Department of Health may make, the Respondent shall permit an investigator of the Department of Health to audit the Respondent's records and review practice activities at the Respondent's place of employment or practice on an unannounced basis for a minimum of four times a year. At least one practice review will be completed no less than sixty (60) days before each compliance appearance, as required in paragraph 4.9 below This practice review requirement may be continued or modified by discretion of the Commission following the Respondent's appearance at a compliance hearing, pursuant to paragraph 4.9 below.

REDACTED

4.8 Fine. In recognition of the costs of compliance with this Order that the Respondent must assume, the Commission declines to impose a fine upon the Respondent.

4.9 Compliance. The Respondent shall appear personally before the Commission six (6) months from the date of service of this Order, or as soon thereafter as is consistent with the Commission's calendar. At this compliance appearance, the Respondent shall submit evidence of compliance with the terms and conditions of this Order. Unless this Order is modified, pursuant to paragraph 4.5 above, or terminated, pursuant to paragraph 4.15 below, the Respondent shall appear personally before the Commission every twelve (12) months thereafter and shall submit evidence of compliance with the terms and conditions of this Order.

4.10 Reporting Requirements. This Order will be subject to the reporting requirement of RCW 18.130.110.

4.11 Responsibility for Reports and Providing Current Address. The Respondent shall ensure that the Commission has her current practice and residence addresses and telephone numbers. The Respondent shall notify the Commission in writing of any address change within twenty (20) days after the change.

4.12 Costs. The Respondent shall be responsible and shall pay for any and all costs involved in his compliance with this Order, except as noted in paragraph 4.3 above.

4.13 Compliance with Laws and Rules. The Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine and surgery in

REDACTED

Washington.

4.14 Violation of Order. If the Respondent violates any provision of this Order, the Commission, after giving the Respondent notice and the opportunity to be heard, may impose any sanction as it finds appropriate under RCW 18.130.160, or may take emergency action ordering summary suspension restriction or limitation of the Respondent's practice as authorized by RCW 18.130.050.

4.15 Termination of Order. No sooner than sixty (60) months from the date of service of this Order, the Respondent may petition for termination of this Order, provided the Respondent has complied fully with the terms and conditions of this Order.

4.16 Protective Order. **Exhibits 1 through 6, 13, 14, and KK are made subject to a PROTECTIVE ORDER, and shall not be disclosed through public disclosure, except by order of a Department of Health presiding officer or of a court of competent jurisdiction.** WAC 246-11-400.

As provided in RCW 34.05.461(3), 34.05.470, and WAC 246-11-580, either party may file a petition for reconsideration. The petition must be filed within ten days of service of this Order with the Adjudicative Clerk Office, 1107 Eastside Street, PO Box 47879, Olympia, WA 98504-7879, and a copy sent to the Medical Quality Assurance Commission, 1300 SE Quince Street, PO 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 shall not stay the effectiveness of this Order. The petition for reconsideration is deemed to have been denied 20 days after the petition is filed if the Adjudicative Clerk Office has not acted on

REDACTED

the petition or served written notice of the date by which action will be taken on the petition.

"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(18).

Proceedings for judicial review may be instituted by filing a petition in superior court in accordance with the procedures specified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. The petition for judicial review must be filed within 30 days after service of this Order, as provided in RCW 34.05.542.

DATED THIS 15th DAY OF JULY, 1999.

M. Estelle Connolly

M. ESTELLE CONNOLLY, M.D.
Panel Chair

FOR INTERNAL USE ONLY: (Internal tracking numbers)
OPS No. 97-02-10-689MD
Program No. 95-05-0089MD & 95-08-009MD

REDACTED