STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Evelyn M. Hanshew, MD
Docket No.: 02-09-A-1035MD
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:

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 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: EVELYN M. HANSHEW, MD License No. MD00026630 Respondent.	)	**Docket No. 02-09-A-1035MD** STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER

The Medical Quality Assurance Commission (Commission), by and through Michael L. Farrell, Department of Health Staff Attorney, and Evelyn M. Hanshew, MD, Respondent, represented by John Schedler, attorney at law, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

1.1 Evelyn M. Hanshew, MD, Respondent, was issued a license to practice as a physician by the state of Washington in August 1989.

1.2 In September 2002, the Commission issued a Statement of Charges against Respondent.

1.3 The Statement of Charges alleges that Respondent violated RCW 18.130.180(1), (4), (6), (7), (9), (10), (13), (14), (20) and (22).

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

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

1.6 Respondent understands that, should the State prove at a hearing the allegations in the Statement of Charges, the Commission has the power and authority to impose sanctions, pursuant to RCW 18.130.160.

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

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

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

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

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

Section 2: STIPULATED FACTS

Respondent denies misconduct. For purposes of resolving this matter, however, Respondent stipulates that the state has sufficient substantial evidence to establish the following facts by clear and convincing evidence:

2.1 Respondent's license is currently subject to a Findings of Fact, Conclusions of Law and Final Order, issued July 15, 1999. The Order suspended Respondent's license to practice medicine in the state of Washington for a period of at least 60 months, but stayed the suspension upon Respondent's compliance with certain terms and conditions.

2.2 The July 15, 1999, Order prohibited Respondent from prescribing, administering or dispensing controlled substances or legend drugs. The Order also required Respondent to, among other things, undergo a psychological and psychiatric evaluation, obtain an assessment of her professional skills at the Colorado Personalized Education for Physicians Program (CPEPP), submit a plan of remedial education to the Commission's Medical Consultant, keep her medical records in a certain format and containing certain information, submit to practice reviews, and appear before the Commission periodically for compliance reviews.

2.3 On September 3, 1999, the Commission issued an Order Granting Petition for Reconsideration in Part and Denying in Part. This Order modified the requirement that Respondent undergo a psychological and psychiatric evaluation to permit Respondent to obtain updated evaluations from the evaluators who evaluated her in 1997. The Commission denied Respondent's request for permission to prescribe controlled substances and legend drugs.

2.4 On August 28, 2000, the Commission issued an Order on Compliance Review and Request for Modification of Commission Order. This Order modified the July 15, 1999, Order to remove the prohibition against prescribing controlled substances and legend drugs, and adding a requirement that Respondent write all prescriptions for controlled substances or any legend drugs for thyroid replacement or anti-depressant treatment on triplicate sequentially numbered prescription pads. This Order also required Respondent to cause her preceptor/practice monitor required by the CPEPP education plan to provide quarterly reports to the Commission.

2.5 Paragraph 4.6c of the July 15 1999, Order requires, among other things, that Respondent dictate and transcribe or legibly handwrite progress notes and file them in the patient's chart within 48 hours of the patient visit or contact. Paragraph 4.6c also requires Respondent to keep detailed progress notes in a standard charting format such as the SOAP format.

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2.6 In May 2002, the Commission obtained copies of the progress notes for some of Respondent's patients. Many of Respondent's progress notes for Patients One through Twenty-Two were incomplete in violation of paragraph 4.6c.

2.7 In the spring of 2002, shortly before a Commission investigator was to visit Respondent's office to determine if Respondent was complying with the Commission orders, Respondent removed numerous patient charts with incomplete progress notes from the office and placed them in her car in order to work on the incomplete progress notes at home. Respondent also asked her employees to take patient charts home to complete missing entries in progress notes. Occasionally, a patient would come into the office for a scheduled appointment, but the chart would not be in the office.

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2.8 Paragraph 4.6f of the July 15, 1999, Order requires, among other things, that each patient chart contain a periodic evaluation of medications prescribed, performed no less than four times a year.

2.9 Respondent's charts for Patients Eight through Sixteen, Eighteen through Twenty-six, and Twenty-Eight, do not contain an evaluation of medications prescribed, as required by paragraph 4.6f.

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2.10 In September 2001, Respondent arranged to have Alan Sussman, MD, serve as her preceptor, as required by the August 28, 2000, Commission Order. Respondent agreed to send Dr. Sussman some of her patient charts on a monthly basis. Dr. Sussman agreed to review Respondent's patient charts and submit a report every three months to George Heye, MD, Medical Consultant, for the Commission. One of the patient charts Respondent submitted to Dr. Sussman was the chart of Patient Twenty-One.

2.11 In 2001, Patient Twenty-One went to Respondent's office on numerous occasions for chelation therapy. Patient Twenty-One's last visit to Respondent's office was on January 7, 2002.

2.12 In late February 2002, Respondent created a progress note for a supposed visit with Patient Twenty-One on February 20, 2002, and submitted this progress note to Dr. Sussman. Patient Twenty-One did not visit Respondent's office on February 20, 2002. Respondent created the progress note to mislead Dr. Sussman into believing that Respondent provided care to Patient Twenty-One on February 20, 2002.

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2.13 In April and May 2002, Respondent permitted an employee to insert an intravenous infusion catheter on multiple patients for the purpose of infusion of intravenous chelation therapy. During this period of time, Respondent knew the employee was neither registered, certified, nor licensed, or certified under Title 18 RCW to perform this procedure. This employee became certified as a health care assistant on May 13, 2002. However, even certified health care assistants are not authorized to perform this procedure.

2.14 In July 2002, Respondent asked her receptionist to monitor patients receiving intravenous infusion of chelation therapy and to discontinue the therapy while Respondent was out of the office. The receptionist was not licensed or certified to monitor or discontinue intravenous infusion of chelation therapy.

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2.15 In April 2002, Respondent closed her office, which was located in Renton, Washington. Until June 3, 2002, Respondent did not notify patients of the closure of the office, and did not arrange for her patients to see other providers or arrange a place to treat patients on an emergent basis.

2.16 On June 3, 2002, after being requested to do so by a Department of Health physician assistant consultant, Respondent mailed a letter notifying patients that she had closed her Renton office, and would be opening on office in Bellevue on July 10, 2002, but that her practice would be limited to treating certain conditions. Respondent wrote than an advanced registered nurse practitioner would be taking over her old office, and also recommended that a patient could see Sigrid Barnickel, MD, for care. Respondent had not made any arrangements with Dr. Barnickel to accept Respondent's patients.

2.17 Approximately fifteen of Respondent's patients went to see Dr. Barnickel. Dr. Barnickel asked Respondent to send her copies of the medical records for these patients. Respondent sent only one or two patient records. Dr. Barnickel had to turn away a patient who came to her for a pre-operative EKG, because she did not have access to Respondent's records for the patient.

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2.18 Respondent kept drug samples in a closet in her office. Respondent told an investigator and a physician assistant consultant from the Department of Health that the only time that anyone would have access to the legend drugs was when Respondent would hand staff sample medication to deliver to a patient. Yet, on numerous occasions between 1996 and 2000, Respondent permitted Patient Twenty-Seven to go into the closet and take drug samples without accounting for the type of drug or how much was taken. Patient Twenty-Seven took samples for herself and for her daughter of the following drugs: Xanax,

Effexor, Allegra, Celebrex, Zyrtec, Vantin, Protonix, Prevacid, Claritin, Nasonex, Flonase, Prilosec, Nasacort, as well as birth control pills and antibiotics.

2.19 Respondent also had Patient Twenty-Seven do office work on occasion, including bookkeeping, filing, chart documentation, reviewing blood test results, and pulling patient charts. Respondent permitted Patient Twenty-Seven access to patient charts and told Patient Twenty-Seven confidential information about patients. Respondent had Patient Twenty-Seven fill out the triplicate prescription forms and rubber stamp Respondent's name for prescriptions Respondent had called in or faxed to a pharmacy.

2.20 On more than one occasion, Respondent called Patient Twenty-Seven into an examination room and asked Patient Twenty-Seven, without obtaining any type of consent, to tell a patient about her experience with breast cancer and subsequent chelation treatment.

2.21 In early May 2002, Patient Twenty-Seven noticed that her patient chart was missing from the office. Patient Twenty-Seven also noticed that her son's chart was not updated with test results from a visit in March 2001, until sometime after the beginning of the year 2002.

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2.22 Respondent began seeing Patient Twenty-Eight, who had multiple sclerosis, in 1996.

2.23 On November 16, 1999, Patient Twenty-Eight saw Respondent complaining of severe headache in the back of her head and a noisy humming in her head that was louder than the television at times. Patient Twenty-Eight also complained of right leg tingling, weakness and trembling.

2.24 Patient Twenty-Eight saw Respondent ten times over the next 16 months. On most of the visits, Patient Twenty-Eight complained of constant headaches and ringing in the ears. On some of the visits, Patient Twenty-Eight complained of ear pain, eye pain, tingling and numbness in her right leg and arm.

2.25 Respondent attributed Patient Twenty-Eight symptoms and her multiple sclerosis to heavy metal toxicity. Respondent advised Patient Twenty-Eight to have her amalgams removed. Patient Twenty-Eight complied.

2.26 In January 2002, Respondent sent a sample of Patient Twenty-Eight urine to a lab for the "Texas Protocol." Respondent told her this would reveal whether she still suffered from heavy metal toxicity.

2.27 Between April 17 and 19, 2002, Patient Twenty-Eight had three separate episodes of a lapse of consciousness.

2.28 Shortly after the third episode, Patient Twenty-Eight telephoned Respondent's office and left a message on Respondent's answering machine asking Respondent to call her.

2.29 On April 25, 2002, having not received a return phone call from Respondent, Patient Twenty-Eight went to Respondent's office, but found it closed. Patient Twenty-Eight then telephoned Respondent's office. The office answering machine told her to contact Respondent on her cell phone. Patient Twenty-Eight contacted Respondent on her cell phone, described the episodes of lost consciousness, and told Respondent she was very concerned. Respondent told Patient Twenty-Eight that the episodes were more symptoms of heavy metal toxicity, that they will be taken care of by the Texas Protocol, and not to worry because she did not have a brain tumor. Patient Twenty-Eight reminded Respondent that she had taken the Texas Protocol in January, but had not received the results. Respondent blamed her incompetent staff and told Patient Twenty-Eight that she would do some research over the weekend and get back to her.

2.30 On Tuesday, April 30, 2002, having not received a call back from Respondent, Patient Twenty-Eight telephoned Respondent's office during office hours. Respondent's answering machine said the mailbox was full and provided no further information.

2.31 On Wednesday, May 1, 2002, Patient Twenty-Eight telephone Respondent's office during office hours. Respondent's answering machine said the mail box was full and provided no further information.

2.32 At no time during Respondent's treatment of Patient Twenty-Eight did Respondent refer the patient to a neurologist.

2.33 On May 2, 2002, Patient Twenty-Eight called the University of Washington and received a referral to another physician. Patient Twenty-Eight saw another physician

that same day. The physician examined the patient and ordered an MRI. The MRI showed Patient Twenty-Eight had a brain tumor. Patient Twenty-Eight subsequently underwent surgery to remove the brain tumor.

2.34 On June 24, 2002, a Department of Health investigator visited Respondent's office and obtained a copy of Patient Twenty-Eight's records from an employee of Respondent.

2.35 On July 19, 2002, the investigator sent Respondent a letter stating that the Department had received a complaint that Respondent failed to diagnose a brain tumor in Patient Twenty-Eight, and requesting that Respondent send him a statement explaining her treatment of Patient Twenty-Eight and copy of Patient Twenty-Eight's medical records.

2.36 In August 2002, the investigator received a copy of Respondent's medical records of Patient Twenty-Eight from Respondent.

2.37 The records received from Respondent in August 2002 differed significantly from the records received in June 2002. These differences indicate that just prior to sending the records of Patient Twenty-Eight to the investigator, Respondent made numerous additional entries into the existing progress notes in order to mislead the Commission into believing that she provided more comprehensive care, including physical examinations on each visit, than the initial set of records show. Respondent also removed records of progress notes from 1997 that show Patient Twenty-Eight complained of headaches on several occasions in 1997.

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2.38 On August 29, 2000, Patient Twenty-Nine saw Respondent complaining of blood in her stool, among other things. Upon examination, Respondent found a small external hemorrhoid. A guaiac test was negative.

2.39 On April 10, 2001, Patient Twenty-Nine saw Respondent complaining of fatigue and insomnia. Respondent performed a physical examination of Patient Twenty-Nine and noted that a rectal examination and guaiac were within normal limits. Respondent also ordered lab tests.

2.40 On September 13, 2001, Patient Twenty-Nine saw Respondent complaining of fatigue, painful forearms, and bloody stools. Respondent reviewed the lab results and

told Patient Twenty-Nine that she had a thyroid problem and prescribed Cytomel, DHEA and Ambien. Respondent asked Patient Twenty-Nine if the blood in her stool was bright red or dark red. When Patient Twenty-Nine said the blood was bright red, Respondent told her she probably had hemorrhoids and did not perform a rectal examination. Respondent gave Patient Twenty-Nine a stool test kit to take home and told her to mail the stool samples directly to a lab. Patient Twenty-Nine did not take a stool sample and send it to the lab.

2.41 On October 2, 2001, Patient Twenty-Nine saw Respondent complaining of fatigue, insomnia and stomach pain. Respondent diagnosed a hemorrhage of a left ovarian cyst.

2.42 In November 2001, Patient Twenty-Nine saw blood in her stool more frequently and took a stool sample and sent it to the lab as Respondent has instructed.

2.43 In December 2001, Patient Twenty-Nine began calling Respondent's office to find out the results of the stool sample test. Someone in Respondent's office told Patient Twenty-Nine that Respondent would return her call. Patient Twenty-Nine called three more times that month and left messages for Respondent to call her. Respondent did not return the phone calls.

2.44 On February 7, 2002, Patient Twenty-Nine saw Respondent complaining of lack of energy, insomnia, continued bloody stools and frequent bowel movements. Respondent asked Patient Twenty-Nine if she was still taking the Cytomel and DHEA. Patient Twenty-Nine said she was not aware she should still be on those medications because she had taken the prescribed amount. Respondent told Patient Twenty-Nine she needed to take these medications for the rest of her life, wrote a prescription for the medications, and told her that her lack of energy was due to not taking the medications.

2.45 During the February 7, 2002, visit, Patient Twenty-Nine asked Respondent about the lab results. Respondent asked a staff person to call the lab for the results. Respondent later told Patient Twenty-Nine that the lab said that the samples Patient Twenty-Nine submitted were not testable.

2.46 During the February 7, 2002, visit, Patient Twenty-Nine told Respondent that she still had blood in her stool and was having five to six bowel movements a day. Respondent asked what color the blood was; Patient Twenty-Nine told her it was bright red.

Respondent told Patient Twenty-Nine that she probably had hemorrhoids and that the frequent bowel movements were the likely cause of blood in her stool. Respondent gave Patient Twenty-Nine another stool test kit to take home with instructions to mail it directly to the lab. Respondent did not perform a physical examination or order additional tests, such as a sigmoidoscopy or colonoscopy.

2.47 Patient Twenty-Nine took a stool sample and mailed it to the lab as instructed by Respondent. Information provided with the stool test kit stated it would take four to six weeks for the results to become available. In the meantime, Patient Twenty-Nine used over-the-counter hemorrhoid medication.

2.48 Four weeks later, Patient Twenty-Nine called Respondent's office to find out the test results. A person in Respondent's office told Patient Twenty-Nine that Respondent would call her back. Patient Twenty-Nine continued to call Respondent's office approximately twice a week for four weeks leaving messages for Respondent to call her.

2.49 On May 2, 2002, having received no return phone call from Respondent, and having continued bloody stools, increased fatigue and now stomach pain, Patient Twenty-Nine went to see another physician. This physician examined Patient Twenty-Nine and ordered a colonoscopy and stool tests. The colonoscopy showed that Patient Twenty-Nine had colon cancer. She subsequently learned that she had stage IV metastatic cancer involving her liver and lungs.

2.50 In late June, Patient Twenty-Nine, curious about her stool test results, called Respondent's office, but received a recording stating that Respondent was moving her office and giving Respondent's cell phone number. On July 5, 2002, Patient Twenty-Nine contacted Respondent on her cell phone. Respondent told Patient Twenty-Nine that she was in California and would be back in her office on July 8. Respondent promised Patient Twenty-Nine that she would call her then with the stool test results.

2.51 Having not received a phone call from Respondent as promised, Patient Twenty-Nine called Respondent's office several times and left messages for Respondent to call her. On July 19, 2002, a person in Respondent's office called Patient Twenty-Nine and said Respondent wanted to see her. Patient Twenty-Nine went to Respondent's office and

told Respondent that she had been diagnosed with colon cancer. Respondent asked Patient Twenty-Nine if she could examine the inside of her mouth. After she did so, Respondent told Patient Twenty-Nine that the cancer was caused by her mercury fillings.

Section 3: CONCLUSIONS OF LAW

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

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

3.2 The above facts constitute unprofessional conduct in violation of RCW 18.130.180(1), (4), (6), (7), (9), (10), (13), (14), (20) and (22) which provide in part:

> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under Chapter 9.96A RCW.
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.
>
> (6)... the violation of any drug law.

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The drug laws Respondent violated are RCW 69.50.308, 69.41.030, and 21 CFR § 1301.75(b) which provide in part:

> **69.50.308 Prescriptions.** (a) A controlled substance may be dispensed only as provided in this section.
> ...
> (d) Except when dispensed directly by a practitioner authorized to prescribe or administer a controlled substance, other than a pharmacy, to an ultimate user, a substance included in Schedule III or IV, which is a prescription drug as determined under RCW 69.04.560, may not be dispensed without a written or oral prescription of a practitioner.
>
> **69.41.030 Sale, delivery, or possession of legend drugs without prescription or order prohibited—Exceptions.** It shall be unlawful for any person to sell, deliver, or possess any legend drug except upon the order or prescription of a physician ....
>
> **§ 1301.75 Physical security controls for practitioners.**
> ...
> (b) Controlled substances listed in Schedules II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet.
>
> (7) 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.
>
> (9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority.
>
> (10) Aiding or abetting an unlicensed person to practice when a license is required.
>
> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession.
>
> (14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk.
>
> (20) The willful betrayal of a practitioner-patient privilege as recognized by law.

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative.

3.3 The above violations are grounds for the imposition of sanctions under RCW 18.130.160.

Section 4: AGREED ORDER

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

4.1 Respondent's license to practice medicine in the state of Washington is REVOKED, with no right to apply for reinstatement for a period of at least ten years from the effective date of this Agreed Order.

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

4.3 Respondent agrees to surrender her DEA license to the DEA, if she has not already done so, within ten (10) days from the date this Agreed Order is signed by the Commission.

4.4 This Agreed Order is not binding on Respondent or the Commission unless accepted by the Commission.

4.5 This Agreed Order shall become effective ten (10) days from the date the Order is signed by the Commission chair, or upon service of the Order on the Respondent, whichever date is sooner.

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I, Evelyn M. Hanshew, MD, Respondent, certify that I have read this Stipulated Findings of Fact, Conclusions of Law and Agreed Order in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Commission without my appearance. If the Commission accepts the Stipulated Findings of Fact, Conclusions of Law and Agreed Order, I understand that I will receive a signed copy.

Evelyn M. Hanshew, MD
Respondent

6/8/04
Date

Copy Received:

John W. Schedler WSBA # 8563
Counsel for Respondent

6/8/2004
Date

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Section 5: ORDER

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

DATED this 10th day of June, 2004.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

By _____

Panel Chair

Presented by:

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

June 10, 2004
Date

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