STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Stephen L. Smith, MD
Master Case No.: M2022-722
Document: Summary Action 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
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STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon: **STEPHEN L. SMITH, MD** License No. MD.MD.00019257 Respondent.	**Master Case No. M2022-722** **EX PARTE ORDER OF SUMMARY ACTION**

PRESIDING OFFICER: Jessica L. Blye, Review Judge

COMMISSION PANEL: Sarah Lyle, MD, Chair
Claire Trescott, MD
Diana Currie, MD
John Maldon, Public Member

This matter came before the Washington Medical Commission (Commission) on March 29, 2024, on an Ex Parte Motion for Summary Action (Ex Parte Motion) brought by the Office of the Attorney General. The Commission issued an Amended Statement of Charges alleging Respondent violated RCW 18.130.180(1), (4), (9), (13), and (21). After reviewing the Amended Statement of Charges, Ex Parte Motion, and supporting evidence, the Commission grants the motion. Respondent's license to practice as a physician and surgeon is SUSPENDED pending further action.

I. FINDINGS OF FACT

1.1 Stephen L. Smith (Respondent) is a physician and surgeon licensed by the state of Washington at all times applicable to this matter.

1.2 The Commission issued an Amended Statement of Charges alleging Respondent violated RCW 18.130.180(1), (4), (9), (13), and (21).

1.3 As set forth in the allegations in the Amended Statement of Charges, as well as the Ex Parte Motion, Respondent allegedly treated numerous close family

members without keeping adequate records, performing necessary evaluations, or documenting serious risks of treatment. He also allegedly misrepresented the amount of time he cared for family members. Additionally, Respondent allegedly prescribed testosterone and anastrozole to several patients, including women, without adequately evaluating their needs for these medications as well as documenting a discussion of risks associated with these medications with patients. Respondent also allegedly reinfused blood into two patients without evidence of proper training or sterile procedures and equipment, creating a risk of blood infections. Finally, Respondent allegedly continued to fail to comply with the 2020 Modified Agreed Order even after being put on notice of the Commission's concerns, by failing to document that patients had seen a primary care provider or subspecialist within 12 of months of his treatments, failing to provide a copy of his treatment records to those providers, and failing to document the use of gloves when administering any injections.

1.4 The above allegations, and the additional allegations described in the Amended Statement of Charges, and the Ex Parte Motion, supported by the Declaration of Bradley D. Anawalt, MD, FACP and the Declaration of Health Care Investigator in Support of Motion for Summary Action, together with the attached exhibits, justify the determination of immediate danger in this case and a decision to immediately suspend Respondent's license until a hearing on the matter is held.

II. CONCLUSIONS OF LAW

2.1 The Commission, has jurisdiction over Respondent's credential to practice as a physician and surgeon. RCW 18.130.040.

2.2 The Commission has authority to take emergency adjudicative action to address an immediate danger to the public health, safety, or welfare. RCW 34.05.422(4); RCW 34.05.479; RCW 18.130.050(8); and WAC 246-11-300.

2.3 The Findings of Fact establish the existence of an immediate danger to the public health and safety if Respondent has an unrestricted credential. The Findings of Fact establish that the requested summary action is necessary and adequately addresses the danger to the public health and safety.

III. ORDER

3.1 Based on the Findings of Fact and the Conclusions of Law, it is ORDERED that Respondent's license to practice as a physician and surgeon is SUMMARILY SUSPENDED pending further disciplinary proceedings by the Commission.

3.2 It is HEREBY ORDERED that a protective order in this case is GRANTED. RCW 34.05.446(1) and WAC 246-11-400(2) and (5). This Protective Order prohibits the release of health care information outside of these proceedings. Unless required by law, anyone involved in these proceedings must keep confidential and not disclose health care information obtained through these proceedings. Health care information includes information in any form "that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care." RCW 70.02.010(16). The parties may share the information with their attorney, if any.

Dated this 31st day of March, 2024.

Sarah Lyle MD

SARAH LYLE, MD
Panel Chair

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Stephen L. Smith, MD
Master Case No.: M2022-722
Document: Amended Statement of Charges

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The following information has been withheld:

> Investigative, law enforcement, and crime victim information is exempt from public inspection and copying pursuant to RCW 42.56.240(1).

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STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **STEPHEN L. SMITH, MD** License No. MD.MD.00019257 Respondent.	**No. M2022-722** **AMENDED STATEMENT OF CHARGES**

The Executive Director of the Washington Medical Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in Commission file numbers 2021-6892, 2022-10310 and 2022-10903. The patients referred to in this Amended Statement of Charges are identified in the attached Confidential Schedule. The Alleged Facts below involve Respondent violating a prior Commission Order, treating family members, substandard patient care, and willful misrepresentation of facts to the Commission. These alleged facts are supported by the medical records for patients A through LL, Respondent's statements to the Commission, and patient statements.

1. ALLEGED FACTS

1.1 On June 30, 1981, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active with restrictions.

1.2 On June 11, 2014, the Washington Medical Commission issued a Statement of Charges alleging Respondent violated RCW 18.130.180(4).

Violation of Prior Order

1.3 On November 20, 2014, Respondent and the Commission resolved the Statement of Charges with Stipulated Finding of Fact, Conclusions of Law, and Agreed Order (2014 Agreed Order). Under the Agreed Order, Respondent is restricted from treating a patient who is not currently under the care of either a primary care provider or a physician who is certified by the American Board of Internal Medicine in a sub-specialty of Internal medicine. Prior to treating a patient, Respondent must obtain documentation that the patient has seen the primary care provider or subspecialist within the past 12 months, and make it part of the patient's record. Within seven days of

seeing the patient, Respondent is required to send a copy of records to the patient's primary care provider, and place a copy of the cover letter in the patient's medical record.

1.4 Due to concerns regarding sterile procedures raised during Respondent's compliance with the 2014 Agreed Order, on April 17, 2020, the 2014 Agreed Order was modified by stipulation of the parties (Modified Agreed Order).The Modified Agreed Order continued the requirement that Respondent obtain documentation that patients had seen a primary care provider in the last twelve months and submit a copy of any consultation to the patient's primary care provider within seven days and document the communication in the patient's medical records. The Modified Agreed Order at paragraph 4.5 also required that Respondent wear gloves when administering all injections and document the same in the patient records each time an injection was administered.

1.5 On or about June 1, 2021, Patient A presented to Respondent's clinic for a consultation and evaluation. Patient A's records were obtained by the Commission during investigation of a complaint.

1.6 There is no documentation in Patient A's file confirming that the patient had been seen by a primary care specialist within the past 12 months, and no documentation in Patient A's treatment record indicating that her office visit record had been shared with a primary care provider. In a statement to the Commission dated December 8, 2021, Respondent stated that he sent Patient A's office visit record from her June 1, 2021, visit to Patient A's primary care provider. However, the fax cover sheet provided by Respondent shows that the record was not actually provided to Patient A's primary care provider until November 22, 2021, after he received the Commission's November 17, 2021, Letter of Cooperation.

1.7 On April 19, 2022, the Commission emailed Respondent requesting two complete patient encounters for Patients B-F, including documentation that the patients had seen a primary care provider or subspecialist within 12 months of the encounters, and a copy of the cover letter sent to PCP or specialist following the encounter. A review of the records received from Respondent revealed that Respondent was consistently failing to provide and/or document communications and transmittals of patient records to the patients' primary care providers in the time period required by the

Modified Agreed Order. The Commission also requested treatment records from the patients' primary care providers, to specifically include any records/communications provided by Respondent and/or Encore Kennewick, a clinic where Respondent formerly served as Medical Director and rented space from and/or NW Integrative Medicine, Respondent's current practice.

Patient B

1.8 Respondent provided records for Patient B for encounters occurring on August 25, 2021, and February 15, 2022. There is no documentation indicating that Respondent provided a copy of Patient B's August 25, 2021, treatment record to her primary care provider, or that Respondent confirmed that Patient B had seen a primary care provider or subspecialist within the last twelve months of that visit. On the patient demographic for is a notation, "Seen PCP 11/2022 PCP Benton City Clinic." Patient B's records do include a fax transmittal sheet dated February 16, 2022, that appears to show that 3 pages of chart notes for Patient B were sent to a Suzanne Staudinger, MD, at fax number (509) 588-4197; however, there is nothing indicating what chart notes were purportedly attached to this transmittal sheet (Respondent's chart notes for Patient consist of 2 pages), or why they were being provided.

1.9 Patient B's records obtained from their identified primary care provider, Benton City Clinic, contained chart notes for April 19, 2021, and March 14, 2022, which is inconsistent with the date noted in Respondent's note. There is no indication in Benton City Clinic's records that they received any communication or documentation from Respondent regarding his treatment of Patient B.

Patient C

1.10 Respondent provided records for Patient C for one encounter occurring on January 5, 2022. On the patient demographic form is a notation, "Seen PCP 01/2022," and also, "Notes sent to PCP 02/15/2022," and "Notes sent to DOL 02/15/22;" however, there is no documentation in the patient's file to confirm these notations. A fax transmittal sheet dated February 15, 2022, appears to show 3 pages of chart notes for Patient C were sent to Suzanne Staudinger, MD, at fax number (509) 588-4197, but there is nothing indicating what chart notes were purportedly attached to this transmittal sheet (Respondent's chart note for the one visit with Patient C consists of 1 page), or why they were being provided.

1.11 Records obtained from Patient C's identified primary care provider, Benton City Clinic, contained one visit encounter on March 21, 2021, which is inconsistent with the January 2022 date documented in Respondent's note. There is no indication in the Benton City Clinic's records that they received any communication or documentation from Respondent regarding his treatment of Patient C.

Patient D

1.12 Respondent provided records for Patient D for encounters occurring on November 23 and December 14, 2021. On the patient demographic form is a notation, "Seen PCP 02/23/22," and also, "Notes sent to PCP 12/25/21," however, there is no documentation in the patient's file to confirm either notation. There is no documentation indicating that Respondent provided a copy of Patient D's treatment records to his primary care provider, other than a fax transmittal sheet, or that Respondent confirmed that Patient D had seen a primary care provider or subspecialist within the last twelve months of his November and December 2021 visits. A fax transmittal sheet dated December 15, 2021, appears to show 5 pages of chart notes for Patient D were sent to a David Frugone at fax number (509) 505-6116; however, there is nothing on this fax transmittal sheet indicating what chart notes were purportedly attached to this transmittal sheet (Respondent's chart notes for this patient consist of 4 pages), or why they were being provided.

1.13 Records obtained from Patient D's identified primary care provider, Dr. David Frugone Larrea, at KC Senior Clinic, contained visit encounters on January 19 and July 19, 2021, which is inconsistent with the February 2022, date documented in Respondent's note. There is no indication in KC Senior Clinic's records that they received any communication or documentation from Respondent regarding his treatment of Patient D.

Patient E

1.14 Respondent provided records for Patient E for encounters occurring on April 13, 2021, and March 22, 2022. On the Patient Demographic form is a notation, "Sent notes to PCP. Sent to DOL. 03/31/2022; Patient last saw PCP January 2022," however, there is no documentation in the patient's file to confirm this notation. There is no documentation indicating that Respondent provided a copy of Patient E's treatment records to his primary care provider, other than a fax transmittal sheet dated March 31,

2022, or that Respondent confirmed that Patient E had seen a primary care provider or subspecialist within the last twelve months of his April 13, 2021, visit. The fax transmittal sheet dated March 31, 2022, appears to show that 6 pages, identified as chart notes from the March 22, 2022, were sent to Jennifer Smith, MD, at fax number (509) 221-6333; however, there is nothing on this fax transmittal sheet indicating what chart notes were attached to this transmittal sheet (the notes for the March 22, 2022, consist of 2 pages), or why they were being provided.

1.15 Records obtained from Patient D's identified primary care provider, Dr. Jennifer Smith, at Trios Care Center, contained visit encounters on September 16, and November 30, 2020, January 15, May 4, and August 2, 2021, and March 9, 2022, which is inconsistent with Respondent's note indicating that Patient E's last visit with her PCP was in January 2022. There is no indication in in the records received from Trios Care Center that they received any communication or documentation from Respondent regarding his treatment of Patient E.

Patient F

1.16 Respondent provided records for Patient F for encounters occurring on November 17, 2021, and February 15, 2022. The patient demographic form contains a notation, "Seen PCP 10/2021 Notes sent to PCP 02/19/2022." There is no other documentation in the patient's records to confirm that Respondent verified that Patient F had seen a PCP or subspecialist within the past twelve months of the November 17, 2021, or February 19, 2022, visits. There is also no documentation indicating that Respondent provided a copy of Patient F's treatment records to his primary care provider, other than a fax transmittal sheet dated February 19, 2022. The fax transmittal sheet appears to show that 5 pages, identified as chart notes from 02/155/2022, were transmitted to a Tina Branson at fax number (509) 942-2340. Respondent's chart note for this encounter consists of one page.

1.17 Records obtained from Patient F's identified primary care provider, Kadlec Women's Clinic, contained a visit encounter occurring on March 21, 2021, which is inconsistent with Respondent's note indicating that Patient F's last visit with her PCP was in October 2021. There is no indication in the records received from Kadlec Women's Clinic that they received any communication or documentation from Respondent regarding his treatment of Patient F.

1.18 Following receipt of the patient records provided by the primary care providers for Patients B-F, the Commission investigator reached out to each provider to verify that they had had no communication with or received any correspondence from Respondent or his clinic. All of the providers confirmed that they had not received any records from Respondent. The fax number on the fax transmittal sheet in Patient D's records is not the correct fax number for the Kadlec Sr Clinic. The fax number on the fax transmittal sheet in Patient E's records is also incorrect, as is the fax number on the fax transmittal sheet in Patient F's records. In addition, the office manager at Kadlec Clinic Associated Physicians for Women, the clinic identified as Patient F's primary care provider, explained that their clinic is a specialty clinic, and does not have PCPs. She also confirmed that there are no records or communications from Respondent or his office in their records for Patient F.

1.19 The use of fax transmittal sheets to represent that the patients' records had been sent to their primary care providers was a misrepresentation. Furthermore, providing those fax transmittal sheets to the Commission was a willful misrepresentation of facts to the Commission.

1.20 On February 16, 2023, the Commission requested Respondent's complete medical records for Patients H-N. On September 11, 2023, the Commission requested the complete medical records for Patients O-LL. Respondent states that his office switched over to a new EMR system in July 2019, and that he no longer had access to patient records prior to that switch.

1.21 Review of the records provided showed no documentation of a primary care provider for Patients H, I, K, L, M, P-T, V, W, X, Z-CC, EE, FF, HH, KK, or LL, or any evidence that Respondent provided any treatment records to any primary care providers for Patients H-LL.

1.22 Review of the records also showed that the use of gloves was not consistently documented when Respondent or his staff administered injections or provided IV therapy to Patients H, I, L, U, V, X, Y, EE, FF, II, JJ and KK.

Treatment of Family Members

1.23 It is a breach of ethical care to provide long-term care, including mental health care and the prescription of controlled substances, to close family members due to issues including, but not limited to, inappropriate influence of subjective evaluation

and judgments, the compromise of professional objectivity, possible inclination to treat problems beyond the physician's expertise or training, concerns regarding patient autonomy and informed consent, and awkwardness in asking or answering difficult questions (e.g., queries about suicidal thoughts and intentions). Respondent provided such care to Patients G-N, as described below.

Patient G

1.24 Patient G is a close family member of Respondent. Patient G had a long history of substance abuse and mental health issues, and had reportedly been diagnosed with bi-polar disorder. According to the patient's spouse (Patient N), Respondent had been their primary care provider for several years.

1.25 Respondent claimed that he had not treated this close family member as an adult patient prior to July 2022, when, according to Respondent, he "acted in that capacity" for a few days, searching for treatment facilities for Patient G. Respondent stated that no other treatment was provided during those few days. Despite Respondent's representations that he hadn't treated Patient G prior to July 2022, Respondent's own Prescription Drug Summary shows prescriptions for Wellbutrin (3/31/19-2021), Lexapro (2014-2019 and 01/25/22), Ivermectin (3/23/21-8/11/21), Lithium Carbonate (05/28/22), sulfacetamine (07/01/21) and azithromycin (11/09/20).

1.26 Pharmacy records also show that Respondent prescribed escitalopram (Lexapro) 20 mg, on March 4, 2020, July 1, 2020, January 25, 2022, and February 3, 2022. Respondent also prescribed a 90 day supply of lithium carbonate, with three refills, on May 28, 2022, and a 100 day supply with one refill, on October 1, 2022. Respondent ordered multiple laboratory tests, such as cholesterol/lipid panel, an adrenal hormone panel, a comprehensive chemistry panel, complete blood count, and a test for diabetes for Patient G. These long-term prescriptions and various lab testing constitute a commitment to long-term care and monitoring. Specifically, the prescription of 90 days of lithium with 3 refills in May 2022, and an additional prescription of a 100 day supply with 1 refill in October 2022, suggests more than a parent filling the gap for a depressed child.

1.27 The records provided by Respondent for Patient G consist of twenty-nine pages of lab testing results. There is no charting, no documentation of essential, standard of care safety monitoring, no rationale for a years' worth of lithium, or a

monitoring plan for suicide risk and/or lithium toxicity. Respondent claimed that the October 2022 lithium prescription was written at the request of Patient G's current provider, due to insurance issues; however, there is no documentation of this in the patient's records.

1.28 Respondent's records for Patients H-N contain minimal documentation of care. There is no acknowledgment in the records that these patients are related to Respondent, and inadequate documentation of the benefits and risks of the potent medications prescribed by Respondent:

Patient H

1.29 Patient H is another close family member of Respondent's. Respondent reported that he had been treating Patient H on and off since 2008, because she prefers her privacy. Respondent noted that Patient H was under the care of a hematologist for thrombothenia, but did not have a primary care provider of which Respondent was aware.

1.30 Records provided by Respondent for Patient H consist of six pages of visit notes from February 5, 2019, through October 11, 2022, which record the insertion of testosterone pellets, "Vita-Pure" injections, and exosome treatment.[1] Records show Patient H was being treated for hormone replacement, polycythemia vera, hypertension, spinal stenosis, and thrombocytosis. Pharmacy records and Patient H's Prescription Monitoring Program (PMP) report show Respondent had been prescribing testosterone since at least December 2013, and more recently had prescribed Ivermectin (August 10, 2021), Azithromycin (May 23, 2022), and Paxlovid (06/09/22). There are no treatment records provided that correspond to these prescriptions. Respondent's documentation and treatment of Patient H is below the standard of care.

1.31 There is very minimal overall documentation regarding Respondent's treatment of Patient H. The only rationale for the insertion of testosterone pellets is, "She is having symptoms of low hormone levels. Decreased libido, dryness and irritation." Patient H is a postmenopausal woman who is apparently not receiving estrogen therapy. It is not the standard of care to prescribe testosterone without

[1] Exosome therapy involves using exosomes, small vesicles that are naturally produced by stem cells, to deliver therapeutic molecules to specific cells in the body.

estrogen to postmenopausal women without a diagnosis of hypoactive sexual arousal disorder. There is no documentation of a discussion about potential adverse effects, including acne, hair loss and increased risk of adverse cardiovascular events and breast cancer. Testosterone may also cause erythrocytosis, and according to the treatment records provided, Patient H had a diagnosis of polycythemia vera, which would be a contraindication to testosterone therapy. The patient's erythrocytosis could also have been due to testosterone therapy. There is no documentation of the hematocrit or hemoglobin[2] before or during testosterone therapy.

1.32 There are no notes associated with Respondent's January 2019 prescription of micronized testosterone for Patient H. It is unclear if these prescriptions overlapped with Respondent's insertion of testosterone pellets in early February 2019, which would have resulted in very high blood testosterone concentrations.

1.33 In addition to prescribing testosterone to Patient H, Respondent prescribed "exosome therapy" with no documentation of the rationale or the benefits or the risks of this therapy to Patient H. There is also no documentation of the site and depth of these injections, or confirmation of the use of sterile technique. This lack of documentation is dangerous and below the standard of care. If Patient H had been evaluated for worsening or a flare of back pain in follow-up by Respondent or another physician, the lack of documentation could result in a failure to detect an infection from the exosome injection site.

1.34 Respondent also prescribed and injected vitamins and ozone into Patient H's back to treat back pain. There is no documentation of any evaluation of the cause of the back pain, or whether Patient H was experiencing neurological deficits. Failure to perform an appropriate evaluation of back pain can result in missing a serious cause of the pain, such as cancer, and could result in several adverse neurological problems, such as paralysis.

Patient I

1.35 Patient I another close relative of Respondent's, who Respondent has treated "off and on for thirty years." Records provided by Respondent cover the time period of September 13, 2022, through March 28, 2023; the patient's medical history

[2] the tests used to determine if a patient has erythrocytosis due to testosterone or polycythemia vera

includes mixed hyperlipidemia, Barrett's esophagus, hypothyroidism, old myocardial infarction, testicular hypofunction, sleep apnea and atherosclerosis. Medications listed include anastrozole, azithromycin, ivermectin, levothyroxine sodium, Lisinopril, methyl B12 injections, tadalafil, tamsulosin, armour thyroid, testosterone cypionate and testosterone gel.

1.36 Patient I's PMP report shows prescriptions for testosterone prescribed by Respondent between July 2018 and January 31, 2023. Pharmacy records show that Patient I was also being prescribed atorvastatin, brilinta, Lisinopril and metoprolol by other providers, and was on low-dose aspirin therapy.

1.37 The overall care provided by Respondent to Patient I was below the standard of care with respect to evaluation of symptoms and the lack documentation of the discussion of benefits and risks of medical therapies.

1.38 Respondent did not meet the standard of care for the evaluation of male hypogonadism, prescription of testosterone therapy, safety monitoring, or discussion of the benefits and risks of testosterone therapy.

1.39 Respondent prescribed Patient I a dosage of testosterone that was up to twice the typical replacement dosage. There is no documentation that Patient I met the criteria for male hypogonadism, which includes symptoms of testosterone deficiency and consistently low serum testosterone concentrations. There is also no evaluation for a cause of hypogonadism, thus leaving Patient I at risk of an undiagnosed brain tumor. There is no documented discussion of the potential risks of testosterone therapy, including heart attacks, strokes, pulmonary emboli, and prostate cancer. Patient I was at high risk of cardiovascular disease, and was being treated by other providers for hypertension and hypercholesterolemia. There was no documented monitoring of blood count for erythrocytosis, or discussion about monitoring for prostate cancer.

1.40 Respondent prescribed anastrozole to Patient I on April 23, 2019, January 9, 2020, February 11, 2021, June 7, 2022, and October 5, 2022. Each prescription included 4 refills. Anastrozole blocks the conversion of testosterone to estradiol, and is known to increase body fat, and decrease bone mineral density in normal men. Patient I had no documented medical need for this medication, and it is not standard of care to prescribe it long-term to men.

1.41 Respondent prescribed animal thyroid extract (armour thyroid) to Patient I, which contains variable amounts of thyroid hormones. Respondent did not document monitoring for the risk of excessive dosages leading to hyperthyroidism, a condition that is more common with the prescription of animal thyroid extract. Hyperthyroidism is associated with atrial fibrillation (a cardiac arrhythmia associated with strokes). Respondent's prescription and monitoring of animal thyroid extract were below the standard of care for hypothyroidism.

1.42 Patient I's records also show IV chelation therapy, and prolozone injections administered by both Respondent and his staff. There is no documentation in the records regarding the rationale, benefits or risks of these treatments. When chelation therapy was administered by Respondent's staff, the use of gloves is not documented.

Patient J

1.43 Patient J is another relative of Respondent's. Respondent denied that Patient J was ever treated at his clinic, but stated that she had seen ARNP Jennifer Armstrong when they were sharing office space. Respondent provided copies of ARNP Armstrong's treatment records, but did not provide any records reflecting his treatment of this patient. Patient J weighed 340 pounds, and had a BMI of 51.7. ARNP Armstrong was treating her for "weight loss, hormones and emotion."

1.44 Patient J's prescription records show Respondent prescribed medications to Patient J on August 11, 2016, March 9, 2017, and December 23, 2019.

1.45 According to Patient J's PMP report, in June of 2020, Respondent prescribed alprazolam, a highly addictive benzodiazepine and controlled substance to Patient J. In August of 2020 he also prescribed tranexamic acid, a medication that may cause dangerous blood clots, particularly in obese patients such as Patient J. There was no documentation of the rationale for prescribing these medications, or an assessment for risk of serious adverse events with the prescription of these medications.

Patient K

1.46 Patient K is a close family member of Respondent's, who Respondent has treated "off and on" for approximately thirty years. Records provided by Respondent consist of six pages, documenting visits on March 26, 2019, and October 13, 2020. The

patient's medical history includes attention and concentration deficit and hypertension. Listed medications include amphetamine-dextroamphetamine (Adderall), atomoxetine HCl (straterra), ivermectin, and Lisinopril. Patient K's pharmacy records and PMP report show that Respondent had been regularly prescribing Adderall and Lisinopril to Patient K since at least March 2013.

1.47 Respondent's long-term prescribing of Adderall and Lisinopril for Patient K suggests undocumented longitudinal care. Genomic testing was ordered for Patient K on March 26, 2019, with no documented rationale for this testing. There was also no documentation of taking a history related to cardiovascular risks or events. Lisinopril, used to treat hypertension, is known to cause acute kidney injury and life-threatening hyperkalemia; however, there is no documentation of a plan for monitoring for these adverse effects, including monitoring for sodium, potassium and creatinine. Amphetamines also acutely raise blood pressure, which could increase this patient's risk of a stroke or heart attack.

1.48 On October 13, 2020, Patient K presented for follow-up of severe hand pain. There is no documented history of Patient K's hand pain, and no recorded physical examination of the hand. Respondent failed to document evaluation for bilateral hand pain and tingling, which could be due to a neuropathy such as carpal tunnel syndrome or heavy metal poisoning, which could lead to the permanent loss of hand functioning. Instead, Respondent diagnosed arthritis caused by nitrates due to "eating a lot of eggplant and tomatoes", and recommended curcumin, which is the active ingredient in mustard.

Patient L

1.49 Patient L is a relative of Respondent's and Patient K's. Respondent stated he had been treating Patient L for six years, and that Patient L received his allergy shots in Respondent's clinic. The medical chart notes consist of ten pages, documenting eight visits between June 2021 and March 2023. The records list a history of tympanic membrane, asthma, chronic rhinitis, and ADHD.

1.50 Pharmacy records and the patient's PMP report show that Respondent prescribed for Patient L between at least June 2013, and February 2023. Medications prescribed included bronchodilators, valacyclovir and amphetamine-dextroamphetamine.

1.51 Respondent prescribed amphetamines (Adderall), a highly addictive controlled substance, to Patient L over many years without documentation of the rationale of this treatment, the basis of the diagnosis of ADHD, or any discussion of the risks and benefits of this treatment.

1.52 Respondent also prescribed low-dose antigen therapy on several occasions, which was administered by Respondent's medical assistant. There is no documentation of blood pressure, heart rate, lung examination or general appearance before, during or after these antigen treatments, which can cause death by anaphylaxis. The lack of adequate safety monitoring for anaphylaxis is well below the standard of care for a patient with asthma. The use of gloves during the administration of this treatment is not documented.

Patient M

1.53 Patient M is also a relative of Respondent, Patient K, and Patient L. The records provided by Respondent for this patient consist of seven pages, and includes visits on April 11, 2019, and September 28, 2021. Pharmacy records and Patient M's PMP report document the prescribing of amphetamine/dextroamphetamine (Adderall) on seven occasions between August 31, 2017, and October 28, 2020. Records also document a prescription for bupropion HCl prescribed on April 11, 2019, and Valacyclovir HCl prescribed at the patient's last documented visit on September 28, 2021.

1.54 Respondent's prescribing of Adderall did not meet the standard of care for this patient. The records provided contain no documentation of the rationale for this treatment, the basis of the diagnosis of ADHD, or any discussion of the risks and benefits of treatment with this highly addictive controlled substance.

1.55 On April 11, 2019, Respondent noted that Patient M would like to try an anti-depressant, as he was feeling a bit depressed and lacked motivation. Respondent prescribed bupropion HCl (Wellbutrin), starting at 150 mg, then 300 mg after two weeks, if the patient tolerated it. There is no documentation of any discussion with Patient M regarding the risks or benefits of this medication, no query about suicidal ideation or risk, no plan for follow-up, and no referral to a mental health provider.

1.56 On September 28, 2021, Patient M had a follow-up visit to review lab work. Respondent noted Patient M had no energy and was "not feeling good." Patient

M reported that he was having trouble getting up in the morning, that his stress was high, he was drinking, and his girlfriend was breaking up with him. Respondent also noted that Patient M was positive for Epstein Barr virus, IgG (low-grade gliomas) and positive human herpes virus 6; however, there is no lab work included in the records provided.

1.57 Respondent's care provided to Patient M was below the standard of care with respect to evaluation of symptoms, documentation of discussion of benefits and risks of medical therapies, and inadequate assessment and follow-up for major depression for which Respondent prescribed a potent anti-depressant.

Patient N

1.58 Patient N is a relative of Respondent's and was married to Patient G. In his April 6, 2023, written statement to the Commission, Respondent denied that Patient N was a patient, and did not provide any treatment records for her.

1.59 Pharmacy records show that Respondent prescribed Ivermectin for Patient N on March 24, 2021 (a 5 day supply with 5 refills), and August 11, 2021 (a 10 week supply), and prescribed Azithromycin on October 24, 2021.

1.60 There is no documentation of the rationale for prescription of high-dosage ivermectin to Patient N, a woman in her early 30s. Ivermectin is used in humans to treat parasitic worms. This medication is teratogenic in animal studies and is considered class C (insufficient evidence of safety) for pregnant women. There is no documentation that Respondent discussed this danger with Patient N who was of reproductive age. It is below the standard of care to prescribe high dosage ivermectin for a woman of reproductive age who has no evidence of serious parasitic disease. It is also below the standard of care to not counsel about potential teratogenic effect before any of the 3 course of ivermectin that Respondent prescribed.

1.61 During an interview with the Commission Investigator, Patient N reported that Respondent was her primary care provider and Patient G's primary care provider.

Substandard Care of Patients O-LL

1.62 The overall pattern of Respondent's practice demonstrates continual breaches in the standards of care, including a general practice of inadequate documentation, substandard of care with respect to the prescription of testosterone to men and women (including his family members), substandard long-term prescription of

amphetamines for ADHD without documentation of the patients meeting the established diagnostic criteria, substandard thyroid hormone management and monitoring, prescription of expensive or non-evidence-based medical therapy without a strong rationale that would include documentation of a discussion of the potential benefits and risks with the patients, and general substandard documentation of the potential benefits and detriments of risky and/or expensive therapies.

1.63 Respondent did not meet the standard of care for the diagnosis, evaluation for cause, treatment, or safety monitoring of testosterone therapy for male hypogonadism (testosterone deficiency in men).

a) There is no documentation that Patients I, O, P, T, R, W, Z, BB or LL had two low blood testosterone concentrations measured in the early morning hours before the initiation of testosterone therapy.
b) There is no documentation of evaluation for the cause of male hypogonadism for Patients I, O, P, T, R, W, Z, BB or LL.
c) Respondent failed, or failed to document, fully informing Patients I, O, P, T, R, W, Z, BB and LL about the potential of serious adverse effects of testosterone therapy – particularly high-dosage testosterone – including stroke, heart attacks, life-threatening blood clots, and infertility.
d) Respondent did not follow standards of care for monitoring and managing erythrocytosis. Erythrocytosis is a common adverse effect of excessive testosterone dosages, and is hypothesized to be a cause of increased risk of strokes, heart attacks, and blood clots in men treated with testosterone. It is the standard of care to advise men of these risks, and to monitor serum hemoglobin and hematocrit 3-6 months after initiation of testosterone, and annually thereafter. Respondent failed, or failed to document, monitoring of hematocrit and hemoglobin after the initiation of testosterone for Patients I, O, P, T, R, W, Z, BB and LL. For Patient LL, who apparently did develop erythrocytosis, Respondent recommended donating blood to lower the hematocrit. The standard of care would have been to reduce the excessive dosage of testosterone.

e) Respondent prescribed at least twice the typical testosterone dosages for Patients I, O, P, T, R, W, Z, BB and LL.

f) The minimum standard of practice when providing testosterone therapy is to counsel men about the uncertainty of testosterone therapy and the risk of prostate cancer, the fact that testosterone therapy increases serum PSA, and to conduct shared decision-making about prostate cancer screening in middle-aged and older men on testosterone therapy. Respondent did not meet this standard of care for Patients I, O, P, T, R, W, Z, BB and LL.

g) Respondent prescribed anastrozole to Patients I, O, P, T, R, BB & LL, which blocks the conversion of testosterone to estradiol, and is known to increase body fat and decrease bone mineral density in normal men. Respondent did not document the rational for the prescription of anastrozole, or any discussion of its benefits and risks when prescribing this medication to these patients.

1.64 Respondent did not meet the standard of care for the prescription of testosterone therapy for women. It is not standard of care to prescribe testosterone therapy to women without proven hypoactive sexual arousal disorder, and natural or surgical menopause.

a) Respondent prescribed testosterone to Patients H, Q, S, U, V, X, JJ and KK, without establishing that these women met the criteria for hypoactive sexual arousal disorder. Respondent did not document any discussion with these women about potential adverse effects, including acne, hair loss, and potential increases in the risk of major adverse cardiovascular events (e.g., strokes and heart attacks.

b) Patients H, Q, S, U, V, X and KK were all over the age of 60, and were being prescribed estrogen. In addition, prescription of estrogen therapy to women over the age of 60 is associated with increased risk of strokes and heart attacks. Respondent failed to document any discussion of these risks with these patients.

1.65 Respondent prescribed growth hormone-releasing hormone therapy to Patient X without documented evidence that Patient X had growth hormone deficiency.

Excessive growth hormone therapy can cause or worsen diabetes mellitus and hypertension, and eventually result in a life-threatening disease called acromegaly. Monitoring of serum IFG-1 concentrations is necessary to avoid excessive dosages of growth hormone or growth hormone releasing hormone. Respondent failed to monitor serum IGF-1 in Patient X.

1.66 Respondent prescribed amphetamines, a highly addictive controlled substance, over many years to Patients K, L, M, X, Z and AA without documentation of the rationale or the basis of the diagnosis of attention deficit hyperactivity disorder (ADHD). The diagnosis of ADHD is a complex and challenging process that must be undertaken professionals who are trained in this diagnosis, and should include repeated observations and reports from teachers and other observers. There is no indication that Respondent conducted this extensive evaluation, or obtained records from other clinicians who performed this diagnostic evaluation.

1.67 Respondent did not meet the standard of care for the diagnosis and treatment of hypothyroidism for Patients H, Q or W, R, S, X and GG.

a) Respondent inappropriately diagnosed hypothyroidism in Patient GG, citing a low serum thyroid stimulating hormone (TSH) as evidence of hypothyroidism. Hypothyroidism is almost always diagnosed based on a high TSH. The diagnosis of hypothyroidism with a low TSH occurs only in the rare patient with pituitary disease, which Patient GG was not documented to have.

b) Respondent treated Patients H, I, Q, R, S, X and GG with animal thyroid extract (Armour). Because animal thyroid extract has a variable amount of thyroid hormone, there is a higher risk of causing hyperthyroidism with animal thyroid extract. Also, when prescribing thyroid hormone – particularly animal thyroid extract – it is essential to monitor thyroid hormone. There is no documentation in the records of these patients that Respondent performed this monitoring.

1.68 Respondent's documentation is often dangerously inadequate. For example, Respondent injected prolozone, vitamin B12 and alpha lipoic acid into the back of Patient CC to treat his back pain. There is no documentation of an evaluation of the cause of the back pain, or how the injection was done. If Patient CC should present

with recurrent severe back pain or fever, another clinician would not know whether to consider a deep infection of the spine.

1.69 On May 18, 2022, Respondent also notes in Patient CC's records, "froze wart on left forehead." There is no description of this lesion, or whether it is actually a wart. Standard practice would be to describe the "wart" to distinguish it from other non-cancerous causes (e.g., a seborrheic keratosis) or a skin cancer. The lack of a description could lead to the delay in the identification and treatment of skin cancer.

1.70 Respondent performed phlebotomy on Patients R and X. He centrifuged and extracted fluid twice from the blood sample obtained from Patient R, then injected the blood product back into the patient. He removed a large volume of blood from Patient X, irradiated the blood, "treated it with ozone" then reinfused the blood back into Patient X. Extracting blood, processing it and reinfusing it back into a patient requires meticulous laboratory equipment and trained personnel. In the absence of strict sterile techniques, patients are exposed to the risk of life-threatening blood infections. There is no evidence that Respondent had either the necessary equipment or trained personnel to safely perform this procedure in his office.

1.71 Respondent diagnosed "slow mitochondrial function or disfunction in several patient, including but not limited to Patients H, W. X, HH, W, JJ, and EE, based on non-evidence based blood test panels to justify IV infusions of glutathione, vitamin C, and/or exosomes. Intravenous infusions are associated with a risk of blood clots, phlebitis, and serious blood infections.

1.72 Respondent, or his staff, also administered various vitamin solution injections and prolozone injections or infusions, which can cause skin and blood stream infections, with no documentation of discussion of the risks of these injections, and no evidence-based rationale of the need or effectiveness of these treatments.

Willful Misrepresentation of Facts

1.73 In his statement to the Commission dated January 26, 2023, Respondent denies treating Patient G as an adult patient until July of 2022. However, as demonstrated by Respondent's own Prescription Drug Summary, Patient G's PMP and other prescription records, Respondent had been prescribing for Patient G since at least 2014 through at least October 2022. Respondent also ordered multiple laboratory testing for Patient G, and Respondent was recorded as Patient G's primary care

provider in outside provider records. Finally, Patient G's wife, Patient N, identified Respondent as the primary care provider for both herself and her husband.

1.74 It is apparent from review of the prescription records, and Respondent's own Prescription Drug Summary provided to the Commission, that Respondent misrepresented both the scope and longevity of his care of Patient G. Respondent's willful misrepresentation of his treatment of Patient G constitutes interference with an investigation of a disciplinary proceeding.

1.75 In his statement to the Commission dated April 6, 2023, Respondent denied that Patients J and M were his patients, and provided no treatment records for either patient. However, pharmacy records show multiple prescriptions written for both Patient J and Patient M by Respondent. The act of prescribing for these patients created a physician-patient relationship, and Respondent's denial that Patients J and M were patients is a willful misrepresentation of the facts, and constitutes interference with an investigation of a disciplinary proceeding.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), (9), (13), and (21), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> (1) The Commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession...
> ...
> (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;
> ... .
> (9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
> ...
> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
> ...
> (21) Interference with an investigation of disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorize

representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

. . . .

2.2 The above violation provides grounds for imposing sanctions under RCW 18.130.160.

3. NOTICE TO RESPONDENT

The charges in this document affect the public health and safety. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: March 26, 2024.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

KYLE S. KARINEN
EXECUTIVE DIRECTOR

KRISTIN G. BREWER, WSBA #38494
ASSISTANT ATTORNEY GENERAL
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)

Patient A [redacted]

Patient B

Patient C

Patient D

Patient E

Patient F

Patient G

Patient H

Patient I

Patient J

Patient K

Patient L

Patient M

Patient N

Patient O

Patient P

Patient Q

Patient R

Patient S

Patient T

Patient U

Patient V [redacted]

Patient W

Patient X

Patient Y

Patient Z

Patient AA

Patient BB

Patient CC

Patient DD

Patient EE

Patient FF

Patient GG

Patient HH

Patient II

Patient JJ

Patient KK

Patient LL