STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Susan J. Shlifer, MD
Master Case No.: M2012-269
Document: Agreed Order

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

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

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

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

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

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

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **SUSAN J. SHLIFER, MD** License No. MD00035541 Respondent.	**No. M2012-269** **AMENDED STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through Larry Berg, Staff Attorney, and Respondent, submit this Amended Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Amended Agreed Order) for acceptance.

1. PROCEDURAL STIPULATIONS

1.1 On June 27, 2012, the Commission issued a Statement of Charges against Respondent. The Statement of Charges alleged that Respondent violated RCW 18.130.180(4).

1.2 On February 21, 2013, the Commission entered Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order) signed by Respondent and her attorney resolving all issues.

1.3 Respondent was required to complete a clinical skills evaluation at the Center for Personalized Education for Physicians (CPEP) within ninety days pursuant to the Agreed Order, Paragraph 4.3. Respondent contacted CPEP on March 27, 2013, but was unable to complete the evaluation before July 22-23, 2013.

1.4 CPEP issued an Assessment Report for Respondent on September 24, 2013, and an Amended Report correcting errors issued on August 13, 2015 (CPEP Report) pursuant to the Agreed Order, Paragraph 4.3.2. Respondent cooperated with the evaluation process and appeared to be a caring physician. CPEP Report recommendations included: Respondent should establish a relationship with an experienced educational Preceptor in family medicine with experience and knowledge of chronic pain management; Continuing Medical Education (CME) and self-study in courses

related to the topics indicated in areas of demonstrated need; and completion of a course on medical record keeping that includes a follow-up component.

1.5 The Agreed Order, Paragraph 4.3.2, also states that Respondent must complete all of the CPEP Report recommendations to the satisfaction of CPEP and the Commission. Respondent encountered difficulty and delays in securing an Educational Preceptor, initiating the CPEP education plan, and securing a clinical preceptor pursuant to the Agreed Order, Paragraph 4.6.

1.6 The Findings of Fact and Conclusions of Law stated in the Agreed Order remain unchanged in this Amended Agreed Order for the sake of continuity and clarity.

1.7 This Amended Agreed Order supersedes the Agreed Order. The Amended Agreed Order incorporates the CPEP Report recommendations and updates sanctions stated in Section 4 to reflect Respondent's progress in completing requirements. Section 5 – Compliance with Sanction Rules – is updated to recognize changes to Section 4 – Agreed Order – in this Amended Agreed Order.

1.8 This Amended Agreed Order is not binding unless it is accepted and signed by the Commission. Once the Amended Agreed Order is accepted, the Statement of Charges in case M2014-1097 becomes moot.

1.9 If the Commission accepts this Agreed Order, it will be reported to the National Practitioner Data Bank (45 CFR Part 60), the Federation of State Medical Boards' Physician Data Center and elsewhere as required by law.

1.10 This Amended Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Amended Agreed Order, Respondent waives any objection to the participation at any related hearing of any Commission members who heard the Amended Agreed Order presentation.

2. FINDINGS OF FACT

Respondent and the Commission acknowledge that for the purpose of this proceeding the evidence is sufficient to justify the following findings, and the Commission makes the following findings of fact.

2.1 On September 30, 1997, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent was formerly board-certified in Family Medicine.

2.2 During all pertinent time frames, Respondent provided medical care for patients at her medical office known as Sound Health and Wellness Center, Inc., located in Poulsbo, Washington. The substandard care detailed below was determined from a review of seven patient charts brought to the attention of the Commission through complaints.

GENERAL PATTERN OF SUBSTANDARD CARE

2.3 Respondent's general approach to medical care for patients consistently fell below the standard of care in similar respects. The following patterns of Respondent's practice created unreasonable risks of harm to these patients.

2.3.1 Respondent did not conduct adequate physical examinations.

2.3.2 When Respondent obtained detailed histories and reports of symptoms from patients, she failed to use this information in the development of diagnoses and treatment plans that meet the standard of care. Based on patients' ongoing reported symptoms, the respondent did not adjust treatment in a manner consistent with standards of care.

2.3.3 Respondent labeled patients with invalid diagnoses, which she determined without sufficient physical examination, analysis of blood tests, or other documented explanation.

2.3.4 Respondent failed to address patients' complaints and symptoms with individualized, evidence based treatment plans. Respondent instead imposed cookie cutter treatment methods that were unproven and inefficacious to meet the patients' conditions. Respondent failed to document adequate treatment plans.

2.3.5 Respondent failed to list abnormalities detected in diagnostic testing of patients. Respondent failed to acknowledge or record concerns or

recommendations articulated by consultants. Respondent failed to develop appropriate action to be taken to respond to abnormal test results or to consultant's reports.

2.3.6 Respondent failed to articulate and balance known risks against potential benefits of her treatment approach, and failed to provide sufficient information to patients about the unproven nature and the risks of treatments provided to ensure their informed consent.

2.3.7 Respondent's record-keeping for these patients is generally insufficient and illegible.

SUBSTANDARD MANAGEMENT OF CHRONIC PAIN WITH OPIOIDS

2.4 Respondent's approach to the management of chronic pain with opioid therapy for patients was repeatedly substandard in the following areas.

2.4.1 Respondent did not sufficiently develop or respond to baseline patient risk assessments for use of opioid therapy. Respondent failed to adequately direct therapies to treating underlying medical problems presented.

2.4.2 Respondent did not conduct adequate ongoing assessments of patient risk, including urine drug testing; although toxicology screens are recommended on a more regular basis for such patients who are on high doses of prescribed opioids.

2.4.3 Respondent escalated opioid dosing without diagnosing and treating underlying psychiatric co-morbidities. Respondent overused opioids in treating non-malignant pain.

2.4.4 Respondent did not modify pain treatment plans when improvement in function and pain or other goals of therapy were not met.

2.4.5 Respondent did not avoid dose escalation of opioids when pain and functional outcomes failed to improve.

2.4.6 Respondent failed to demonstrate awareness of or assess the impact of opioids on obstructive sleep apnea, endocrine function, fatigue, sleepiness, and depression and failed to manage such problems when noted in patients.

2.4.7 Respondent failed to demonstrate awareness of the syndrome of Opioid Hyperalgesia, where increasing opioid doses leads to increased pain.

2.4.8 Respondent failed to follow recommendations of independent pain consultants to reduce opioid use in therapy.

SUBSTANDARD FIBROMYALGIA DIAGNOSES AND TREATMENT

2.5 Respondent's diagnoses and purported treatment of Fibromyalgia was substandard in the following areas.

2.5.1 Respondent diagnosed fibromyalgia without documentation of appropriate evidence or criteria. Respondent's physical exam failed to document commonly described features of fibromyalgia in these patients. Respondent did not document discussion of the symptom complex of fibromyalgia for these patients.

2.5.2 Respondent purported to treat fibromyalgia with an experimental therapy program called the "Marshall Protocol" which focuses on use of antibiotics and vitamin D modulation. There are no clinical trials to support such therapeutic program in the treatment of fibromyalgia. One component of the Marshall Protocol, to continue medications even if known side effects of a medication develop, creates an unreasonable risk for patients.

2.5.3 Respondent labeled a patient with fibromyalgia and implemented the Marshall Protocol without appropriately exploring diagnoses of medical conditions consistent with the presenting complaints, such as inflammatory arthritis and inflammatory bowel disease. Respondent did not meet the standard of care for evaluation of chronic diarrhea and chronic back pain.

SUBSTANDARD CHRONIC FATIGUE SYNDROME DIAGNOSES AND TREATMENT

2.6 Respondent's identification and purported treatment of Chronic Fatigue Syndrome was substandard and placed these patients at unreasonable risk. Chronic Fatigue Syndrome (CFS) is not a diagnosis, but is a constellation of symptoms and signs that meet certain criteria when no other condition is found to explain the symptoms. The criteria are that:

1. Patients must have clinically evaluated, unexplained, persistent or relapsing fatigue that is:

a. of new or definite onset,

b. is not alleviated by rest, and

c. results in substantial reduction in previous activity levels; plus

2. four or more specifically defined subsequent persistent or recurring associated symptoms.

Respondent diagnosed patients with CFS based upon complaints of fatigue without discussion in the records establishing that these patients met the criteria for CFS. Respondent failed to consider associated symptoms, time course, and exclusions of other causes including rheumatologic disorders such as Sjogren's syndrome that can present with similar symptoms. Respondent treated the fatigue reported by patients with the "Marshall Protocol" without evidence of its appropriateness. Respondent failed to timely follow-through to determine if sleep apnea contributed to fatigue. Respondent attributed "active human herpes virus – 6 viremia" to a patient without basis and failed to rule out other factors that may have contributed to patients' fatigue.

SUBSTANDARD APPROACH TO VITAMIN D DEFICIENCY

2.7 Respondent failed to diagnose or treat patients with prolonged low levels of vitamin D, which may have contributed to their ongoing symptoms of pain, weakness, fatigue, and increased risk for infectious, neoplastic, allergic and immune disorders. Respondent failed to obtain parathyroid hormone levels, bone density measurements, or other assessments of bone and muscle function for these patients. Respondent failed to discuss orthodox medical literature's conclusions that low vitamin D can be associated with and weaken the immune system, and cause fatigue, pain and weakness disorders.

SUBSTANDARD DIAGNOSIS OF VITAMIN D ELEVATION

2.8 Respondent mis-diagnosed a vitamin D abnormality when laboratory test results showed normal vitamin D levels, both of the 25-hydroxy and the 1,25-hydroxy vitamin D. Respondent diagnosed elevated vitamin D levels before any clinical evaluation was obtained and without reference to standard diagnostic criteria.

SUBSTANDARD USE OF ANGIOTENSIN RECEPTOR BLOCKING THERAPY

2.9 Respondent treated with the angiotensin receptor blocking medication Benicar, the trade name for olmesartan medoxomil, at doses beyond commonly accepted standards. Respondent did not discuss the basis for this off-label use. Respondent failed

to document awareness of potential complications or rare adverse reactions or documentation of informed consent by the patients. Respondent failed to make appropriate recommendations to these patients to reduce this medication dosage during times potential toxicity was indicated by the patient's symptoms of dizziness, or laboratory evidence of renal insufficiency. Respondent continued to advance Benicar therapies for patients despite their failure to improve with that treatment.

SUBSTANDARD DIAGNOSES AND TREATMENT OF ANTI-PHOSPHOLIPID ANTIBODY SYNDROME

2.10 Respondent diagnosed patients with a "variant" anti-phospholipid antibody syndrome, although there is no such diagnosis currently accepted by mainstream medicine. Respondent placed patients at risk with heparin anticoagulation without justification based on history or laboratory evidence of clotting risks. Anti-phospholipid antibodies were not performed. Minor abnormalities of fibrinogen and two other experimental coagulation tests relied upon by Respondent do not provide a basis for an anti-phospholipid antibody syndrome diagnosis.

USE OF HIGH RISK AND INEFFICACIOUS MARSHALL PROTOCOL

2.11 The "Marshall Protocol" implemented by Respondent in her treatment of patients is not supported by placebo controlled clinical trials or animal experiments. Developed by a non-physician, this protocol is contrary to the standard of care for treatment of anti-inflammatory and autoimmune diseases in the following aspects.

2.11.1 Vitamin D is restricted, which is potentially harmful from the effects of vitamin D deficiency.

2.11.2 Patients are not allowed to take doses of corticosteroids.

2.11.3 Light is to be avoided.

2.11.4 There is no clear timeline or symptom response that can be evaluated in a reasonable time frame.

2.11.5 In emergency or critical care situation, oral olmesartan must be continued, even in the presence of hypotension.

2.11.6 The protocol says to continue medications even if side-effects are occurring, which is an unreasonable risk to patients.

SUBSTANDARD TREATMENT WITH SYNTHROID

2.12 Respondent persistently treated patients with Synthroid despite recurrently elevated free T-3 and T-4 levels. Thyroid supplementation can lead to osteoporosis. While supplemental thyroid can be responsibly recommended in patients with resistant depression without reference to thyroid levels, the elevated levels should be charted. Heart rate, weight, bowel symptoms and bone density results should be recorded. Respondent did not chart these items.

SUBSTANDARD DIAGNOSES OF IRRITABLE BOWEL SYNDROME

2.13 Respondent charted diagnoses of Irritable Bowel without documented supporting symptoms.

3. CONCLUSIONS OF LAW

The Commission 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 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4).

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

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order.

4.1 **Probation.** Respondent's license status is placed on **PROBATION.**

4.2 **Modification of Probation.** Respondent may petition to modify the term for Probation no less than two (2) years from the effective date of this Amended Agreed Order if Respondent has been in full compliance during that period. Respondent must appear at a hearing on the petition. At the hearing, evidence in opposition may be considered by the Commission. After considering the petition and the evidence presented, the Commission will

have sole discretion to grant or deny Respondent's petition, or to make modifications to the conditions of probation.

4.3 **Practice Restriction.** Respondent is permanently restricted from use of the treatment modality known as "The Marshall Protocol." Prohibited Marshal Protocol treatment components include off-label dosing of olmesartan medoxomil (trade name Benicar), long term antibiotics and restrictions of: Vitamin D intake, corticosteroids, and exposure to light.

4.4 **Clinical Skills Evaluation.** Respondent has completed an evaluation of her family medicine clinical skills with the Center for Personalized Education for Physicians in Denver, Colorado. The evaluation included: medical knowledge, patient care, clinical judgment, medical record keeping, reasoning ability, ethics and communication skills.

4.4.1 Respondent fully cooperated with the evaluation process, and provided CPEP with information, documents, and releases that were requested.

4.4.2 CPEP provided a written report to the Commission regarding the evaluation, including whether or not Respondent is able to practice medicine with reasonable skill and safety, areas needing improvement, and recommendations for the scope and length of any additional evaluation or clinical training, treatment for any medical or psychological conditions, and educational intervention. Respondent must complete all recommendations to the satisfaction of CPEP and the Commission.

4.4.3 Respondent will provide CPEP with a copy of this Amended Agreed Order. The Commission may provide CPEP with documents and records from its investigative files.

4.4.4 Respondent authorizes CPEP to discuss with the Commission any matters relating to Respondent's evaluation and compliance with recommendations. Respondent waives any privileges or privacy rights under federal and state law regarding disclosures by CPEP or third party evaluators to the Commission.

4.4.5 CPEP and third-party evaluators shall provide a copy of its evaluations and written reports to the Commission and shall communicate as necessary to keep the Commission informed of Respondent's progress. Respondent will provide the Commission with copies of evaluations if CPEP or third-party evaluators fail to do so.

4.5 **Educational Preceptor.** Respondent must follow the CPEP recommendation and requirements for an educational plan and preceptor, and for any revisions to the educational plan recommended by CPEP while the plan is in progress. Respondent must successfully complete all aspects of the CPEP educational plan. Dr. Donna Moore has been approved by CPEP to serve as educational preceptor. Respondent must immediately notify the Commission if Dr. Moore ceases to serve as her educational preceptor.

4.6 **Ethics Course.** In August 2013, the Commission approved that Respondent may complete a two-day course entitled Medical Ethics, Boundaries, and Professionalism offered by Case Western Reserve University, Cleveland, Ohio. In April 2014, Respondent reported that she completed that course. Respondent must submit proof of the satisfactory completion of the course to the Commission. If the course required that Respondent complete a written report, Respondent must also provide the Commission with a copy of her written report. If Respondent did not receive an "unconditional pass" or otherwise satisfactorily complete the course, the Commission may require Respondent to re-take the course.

4.7 **Clinical Preceptor.** Respondent shall not practice medicine in Washington State except under the active supervision of a Commission approved preceptor physician. Dr. Donna Moore has been approved by the Commission to serve as clinical preceptor. Respondent must immediately notify the Commission if Dr. Moore ceases to serve as her clinical preceptor and cease practice until a successor is approved by the Commission.

4.7.1 Respondent shall arrange for a qualified preceptor who is pre-approved by the Commission to monitor Respondent's practice of medicine and to consult with Respondent for a period of at least two (2) years from the effective date of this Amended Agreed Order. This preceptor program is in addition to the preceptor requirement that CPEP recommended. The preceptor shall report in writing to the Commission's Medical Consultant every three months regarding Respondent's medical skills. The Preceptor shall immediately report to the Medical Consultant any concerns the preceptor has regarding Respondent's ability to practice with reasonable skill and safety, or if Respondent is not compliant with requirements of CPEP or this order.

4.7.2 The Commission's medical consultant will approve the preceptor, who must be board certified in an appropriate specialty, licensed to practice medicine for at least the last ten years, and in clinical practice for at least the last five years. The preceptor must have experience training and consulting with other physicians with respect to patient care. The preceptor must not have any prior significant personal or business relationship with Respondent before entering into the approved preceptor relationship.

4.7.3 The preceptor will provide oversight with respect to Respondent's treatment of patients and her prescribing practices, if any. The preceptor may randomly attend and observe Respondent's office visits with patients, and will review the charts regarding those patients and the progress note entries relating to those visits. The preceptor will review the charting for a random selection of five (5) of Respondent's patients per week. To facilitate this oversight, Respondent will provide the preceptor with a patient list at the beginning of every month along with a copy of Respondent's appointment schedule for that month. Respondent will notify the preceptor of any changes to the list and the schedule on a weekly basis. The preceptor will decide which office visits to attend and notify Respondent of the decision before each visit. Respondent will allow the preceptor full access to her charts to facilitate the required chart reviews and discretionary office visits. Respondent and the preceptor shall meet at least twice every month to discuss and consult on the cases which the preceptor observed and reviewed. Changes to these preceptor requirements must be pre-approved by the Commission in writing.

4.8 **CPEP Re-evaluation.** After completing the CPEP educational plan, Respondent must schedule a follow-up clinical assessment with CPEP within four (4) months to re-evaluate her medical knowledge, patient care, clinical judgment, medical record keeping, reasoning ability, ethics, and communication skills. Respondent's awareness of health care systems and her ability to utilize system resources to provide patient care should also be addressed. Respondent must fully cooperate with the re-evaluation and provide CPEP with any charts, documents, and releases that CPEP requests in order to perform the re-evaluation. Respondent waives any privileges or privacy rights that she may otherwise have regarding such matters under federal and state law.

Respondent will provide releases to CPEP representatives to discuss any matters relating to Respondent's re-evaluation with representatives of the Commission. The Commission may provide CPEP with pertinent documents, including records relating to Respondent's compliance with the Commission orders, and will provide Respondent with copies of any additional materials provided to CPEP. Respondent must provide the Commission with copies of any additional materials that she provides to CPEP. Respondent and the Commission requests that CPEP produce a written re-evaluation report and provide a copy to the Commission. Respondent must complete all re-evaluation recommendations to the satisfaction of CPEP and the Commission.

4.9 **Practice Reviews.** Respondent agrees that a Commission representative may make pre-announced semi-annual visits to Respondent's practice to review her compliance with all requirements of this Amended Agreed Order. The Commission's representative may inspect office records, review patient records, interview Respondent and interview any professional staff, partners, and employees and preceptors associated with Respondent's practice. The Commission may waive practice reviews while the clinical preceptor program is in effect.

4.10 **Personal Appearances.** Respondent must personally appear before the Commission in approximately three (3) months, or as soon thereafter as the Commission's schedule permits pursuant to written notice from the Commission. The purpose of appearances is to provide meaningful oversight of Respondent consistent with the terms of this Order. Respondent will present information and answer questions posed by Commission members. Thereafter, Respondent must make appearances on an annual basis pursuant to written notice from the Commission, or as frequently as the Commission requires until this Amended Agreed Order is terminated. The Commission may waive the need for an appearance.

4.11 **Fine.** Respondent has previously paid a fine to the Commission in the amount of three thousand dollars ($3,000.00).

4.12 **Termination.** Respondent may petition the Commission in writing to terminate this Amended Agreed Order no sooner than five (5) years from the effective date of this Order. The Commission will issue a notice scheduling a date and time for Respondent to appear, unless the Commission waives the need for a personal appearance.

4.13 **Reports.** All reports required to be sent to the Commission pursuant to this Amended Agreed Order should be sent to: Compliance Officer, Medical Quality Assurance Commission, P.O. Box 47866, Olympia, Washington 98504-7866.

4.14 **Obey All Laws.** Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the medical profession in Washington.

4.15 **Compliance Costs.** Respondent is responsible for all costs of complying with this Amended Agreed Order.

4.16 **Violation of Order.** If Respondent violates any provision of this Amended Agreed Order in any respect, the Commission may initiate further action against Respondent's license.

4.17 **Change of Address.** Respondent shall inform the Commission and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

4.18 **Effective Date.** The effective date of this Amended Agreed Order is the date the Adjudicative Clerk Office places the signed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Order.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Tier B of the "Practice Below Standard of Care" schedule, WAC 246-16-810 applies to cases where substandard practice causes moderate harm or risked moderate to severe harm. Respondent's care for several patients falls within Tier B of this schedule by causing moderate harm or risking moderate to severe harm by failing to provide adequate treatment in wide ranging aspects of medicine, from inadequate work-ups through invalid diagnoses, inefficacious treatment methods, failure to respond to abnormalities, poor record keeping, and failure to ensure informed patient consent.

5.2 Tier B recommends the imposition of sanctions ranging from two to five years of oversight, unless revocation is imposed.

5.3 Under WAC 246-16-800(3)(d), the starting point for the duration of the sanctions is the middle of the range. There is no specific midrange in tier B, which ranges

from two years of oversight to revocation of license. The Commission uses aggravating and mitigating factors to move towards the maximum or minimum ends of the range.

5.4 The aggravating and mitigating factors in this case, listed below, justify a term of five (5) years, probation with practice restriction, a clinical preceptor program, clinical skills assessment and follow-up educational preceptor program with CPEP, an ethics course, annual compliance appearances before the Commission, semi-annual practice reviews, re-evaluation, a monetary fine, and other terms designed to protect the public. A longer term of probation or suspension/revocation of Respondent's license is contemplated in the event she is not amenable to or successful in her educational program. This Amended Agreed Order deviates from the sanction schedule to the extent that may extend beyond a five year term if the educational program is not timely completed.

5.5 These sanctions are appropriate within the Tier B ranges, given the facts of the case and the following aggravating and mitigating factors. The Commission finds the breadth and depth of the aggravating factors significantly outweigh the mitigating factors, requiring a duration at the high end of the range.

A. As aggravating factors, Respondent's substandard practices extended through a wide range of treatment modalities and affected numerous patients.

B. As a mitigating factor, Respondent has agreed to cooperate with a clinical skills evaluation and educational intervention program, and to cease use of any aspect of the so called "Marshall Protocol."

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. RESPONDENT'S ACCEPTANCE

I, Susan J. Shlifer, MD, Respondent, have read, understand and agree to this Amended Agreed Order. This Amended Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Amended Agreed Order.

SUSAN J. SHLIFER, MD
RESPONDENT

10/26/2015
DATE

, WSBA #
ATTORNEY FOR RESPONDENT

DATE

8. COMMISSION'S ACCEPTANCE AND ORDER

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

DATED: Nov 5, , 2015.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

Michael T. Cowan
PANEL CHAIR

PRESENTED BY:

LAWRENCE J. BERG, WSBA#22334
COMMISSION STAFF ATTORNEY