STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Susan J. Shlifer, MD
Master Case No.: M2012-269
Document: Statement of Charges

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:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

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

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

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

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **SUSAN J. SHLIFER, MD** License No. MD00035541 Respondent	**No. M2012-269** **STATEMENT OF CHARGES**

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in file numbers 2005-53049, 2007-59335, 2008-59336, 2009-133591, and 2009-135896. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 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 is board-certified in Family Medicine.

1.2 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.

GENERAL PATTERN OF SUBSTANDARD CARE

1.3 Respondent's general approach to medical care for Patients A, B, C, D, E, F & G 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.

1.3.1 Respondent did not conduct adequate physical examinations.

1.3.2 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.

//

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

1.3.4 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.

1.3.5 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.

1.3.6 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.

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

SUBSTANDARD MANAGEMENT OF CHRONIC PAIN WITH OPIOIDS

1.4 Respondent's approach to the management of chronic pain with opioid therapy for Patients B, C, D, E & G was repeatedly substandard in the following areas.

1.4.1 Respondent did not develop or respond to baseline patient risk assessments for use of opioid therapy for Patient E & G. Therapies directed to treating the underlying medical problems were not referenced for Patient E & G.

1.4.2 Respondent did not conduct adequate ongoing assessments of patient risk, including urine drug testing, for Patients B, C, D, E, & G, although toxicology screens are recommended on a more regular basis for such patients who are on high doses of prescribed opioids.

1.4.3 Respondent escalated opioid dosing for Patients B, C, D & E without diagnosing and treating underlying psychiatric co-morbidities. Respondent overused opioids in treating non-malignant pain in patients.

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

1.4.5 Respondent did not avoid dose escalation of opioids for Patients B, C & D when pain and functional outcomes failed to improve.

1.4.6 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.

1.4.7 Respondent failed to demonstrate awareness of the syndrome of Opioid Hyperalgesia, where increasing opioid doses leads to increased pain, in her treatment of Patient C.

1.4.8 Respondent failed to follow recommendations of independent pain consultants to reduce opioid use in therapy for Patient C.

SUBSTANDARD FIBROMYALGIA DIAGNOSES AND TREATMENT

1.5 Respondent's diagnoses and purported treatment of Fibromyalgia in Patients A, B, C, D, F & G was substandard in the following areas.

1.5.1 Respondent diagnosed fibromyalgia in Patients A, B, C, D, F & G 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.

1.5.2 Respondent purported to treat fibromyalgia in Patients A, B, C, D, F with an experimental therapy program called the "Marshall Plan" 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 Plan protocol, to continue medications even if known side effects of a medication develop, creates an unreasonable risk for patients.

1.5.3 Respondent labeled Patient F with fibromyalgia and implemented the Marshall Protocol without appropriately exploring diagnoses of medical conditions consistent with Patient F's presenting complaints, such as inflammatory arthritis and inflammatory bowel disease. Respondent's evaluation

of Patient F did not meet the standard of care for evaluation of chronic diarrhea and chronic back pain.

SUBSTANDARD CHRONIC FATIGUE SYNDROME DIAGNOSES AND TREATMENT

1.6 Respondent's identification and purported treatment of Chronic Fatigue Syndrome in Patients A, B, C, D, E, F & G 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 A, B, C, D, E, F & G 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 A, F & G with the "Marshall Plan" without evidence of its appropriateness. Respondent failed to timely follow-through to determine if sleep apnea was causing Patient A's reported fatigue. Patient A did not have "active human herpes virus – 6 viremia", which was referenced by Respondent as a basis to diagnose CFS in this patient. Respondent failed to rule out other factors that may have contributed to patients' fatigue.

SUBSTANDARD APPROACH TO VITAMIN D DEFICIENCY

1.7 Respondent failed to diagnose or treat Patients B, C, D & G for their prolonged low levels of vitamin D, which may have contributed to their 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

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

SUBSTANDARD USE OF ANGIOTENSIN RECEPTOR BLOCKING THERAPY

1.9 Respondent treated Patients A & G with the angiostensin 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

1.10 Respondent diagnosed Patients A, D, E & G with a "variant" anti-phospholipid antibody syndrome, although there is no such diagnosis currently accepted by mainstream medicine. Respondent placed Patients A, B, C & D 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

1.11 The "Marshall Protocol" implemented by Respondent in her treatment of Patients A, F & G 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.

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

1.11.2 Patients are not allowed to take doses of corticosteroids.

1.11.3 Light is to be avoided.

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

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

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

SUBSTANDARD TREATMENT WITH SYNTHROID

1.12 Respondent persistently treated Patients B, C & D 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

1.13 Respondent charted a diagnosis of Irritable Bowel Syndrome for Patients A and G without documented supporting symptoms.

SUBSTANDARD MEDICAL CARE FOR PATIENT A

1.14 Respondent served as Patient A's physician beginning in approximately March or April 2003 through September 15, 2006. At the initial consultation, Patient A noted a history of depression, sleep disturbance, anxiety and inability to work. Patient A had been previously diagnosed with exertional chest pain, obesity, bilateral knee pain, manic depression, carpal tunnel syndrome, chronic pain, and health maintenance issues. Patient A filled out checklists for Respondent, but Respondent's charting doesn't

discuss or indicate any use of this history. Respondent failed to conduct a physical exam. There is no documented assessment of reports of laboratory test results. There is no clearly stated treatment plan. Respondent's handwritten notes are often illegible. Respondent failed to document any explanation to Patient A sufficient to obtain informed consent to the unproven Marshall Protocol which Respondent provided to Patient A.

1.15 Respondent provided substandard clinical diagnoses for Patient A in the following respects.

1.15.1 Respondent provided a diagnosis of fibromyalgia classification without any history or exam findings that fulfill the criteria for fibromyalgia classification.

1.15.2 Respondent provided a diagnosis of chronic fatigue syndrome although Patient A did not meet the criteria for this diagnosis, which specifically requires that other causes for chronic fatigue, including clinical depression, sleep apnea, and pain had been ruled out. Patient A experienced several conditions which provided alternative causes for chronic fatigue, including depression, obstructive sleep apnea, osteoarthritis and severe pain that limited his activities and contributed to fatigue.

1.15.3 Respondent provided a diagnosis of a variant of anti-phospholipid antibody syndrome without the requisite laboratory results to support this diagnosis.

1.15.4 Respondent provided a groundless diagnosis of vitamin D abnormality. Patient A's lab results in Respondent's records show normal levels both of the 25-hydroxy and the 1,25-hydroxy vitamin D.

1.15.5 Respondent noted a diagnosis of IBS, presumed to refer to irritable bowel syndrome with no indication of symptoms to support this diagnosis.

1.15.6 Respondent charted a diagnosis of coagulopathy without any indication of laboratory test results.

1.16 Respondent provided substandard clinical treatment for Patient A in the following respects.

1.16.1 Respondent subjected Patient A to the Marshall Protocol, even though Patient A did not meet even the Marshall Program's criteria for such

treatment. Patient A had no elevations in the routine inflammatory parameters of erythrocyte sedimentation (sed) rate test and C-Reactive Protein (CRP) test. He had normal vitamin D levels. He had no auto antibodies. All of his viral, mycoplasma, and Chlamydia antibodies were negative.

1.16.2 Respondent's treatment of Patient A with heparin was not clinically justified. Respondent used non-standard, non-specific lab studies not correlated with clinical clotting problems for which heparin is indicated. Patient A did not have active human herpes Virus (HHV-6) viremia, as was the case in patients with Chronic Fatigue Syndrome coagulation disorders in the paper provided by Respondent to support the theoretical possibility that patients with Chronic Fatigue Syndrome may have coagulation disorders.

1.16.3 Respondent failed to explain or discuss in the medical record Patient A's initiation of heparin and methadone in May, 2004.

1.16.4 Respondent provided olmesartan, trade name Benicar, to Patient A at an excess dosage. Patient A was dizzy and suffered very low blood pressure for the first one to two weeks of use of Benicar. There is no discussion in Respondent's chart notes regarding off-label use of these medications or of the side effects that did occur. Despite Patient A's failure to improve, Respondent continued to advance Benicar therapies for Patient A without obtaining new history or exam findings, even though the patient did not report significant improvement in sleepiness and fatigue in the standardized questionnaires.

1.16.5 During 2003, despite Patient A's continuing reports of increased pain, difficulties holding onto things, numbness, and tingling, there is no indication Respondent performed a joint exam, a neurological, or a musculoskeletal examination.

1.16.6 On February 26, 2004 Patient A reported his back was acting up more and his feet were numb and tingly. He circled complaints about emotions, concentration, activity, fatigue, and relationship issues on the checklist form. He noted no pain relief and activities day-to-day were hard to do. His symptoms worsened after arthroscopic surgery. Subsequent encounters indicated problems of metabolic syndrome and possible diabetes. No physical examination was documented by Respondent and no laboratory results were recorded.

1.16.7 Respondent continued to advance antibiotic therapy for Patient A despite that patient's failure to respond or improve with that treatment.

1.17 Respondent provided substandard documentation of her medical services to Patient A. Handwritten notes are illegible. There was never a documented physical exam to support clinical diagnoses. Respondent utilized checklists to gather information from patients, but failed to discuss or clarify the information provided. There is no documented assessment of findings, assessment of reports of lab results, nor is there a clearly stated plan of care.

SUBSTANDARD MEDICAL CARE FOR PATIENT B

1.18 Respondent served as Patient B's physician beginning in approximately March 1998 through May 3, 2007. Pharmacy records document on April 5, 2007 Respondent's initial prescribing for Patient B of Cytomel, the brand name for the thyroid hormone l-thyroxine. However the visit note for April 5, 2007 provides no clinical history other than standard questionnaires, recording the Epworth sleepiness scale at 10 and the Fatigue Severity Scale at 60. There is no discussion of the initiation of thyroid treatment or of clinical improvements in Patient B's May 3, 2007 chart. Patient B was prescribed hydrocodone and oxycodone from other providers between January 2006 and February 2007. As of February 20, 2007, Respondent notes indicate Patient B was on 6 Vicodin per day, with no significant impact on pain. Pain medication ordering was transferred to Respondent, who ordered Kadian, baclofen, diazepam and 220 of hydrocodone 10 mg tablets for Patient B in March 2007. At the following visit, Respondent provided no discussion of Patient B's response to the opioids. The patient reported ongoing sleepiness and fatigue. Subsequent office notes by Respondent were cryptic with few comments about the patient's response to therapy, no additional examination findings, and no discussion of clinical decision-making or overall treatment program rationale or plans.

SUBSTANDARD MEDICAL CARE FOR PATIENT C

1.19 Respondent served as Patient C's physician from March 15, 2001 up to at least October 12, 2010. Patient C was seen by a variety of pain consultants and other consultants between 2005 and 2007. In 2005 she was assessed to have a major depressive disorder, borderline personality disorder, and multiple chronic pain problems. In October 2005, a pain clinic consultant noted Patient C reported using 800

mcg, a high dosage, of fentanyl and yet reporting pain of 9 on a scale of 10. The consultant pointed out Patient C's pain regimen was not working and should be reconsidered, explaining "She may be an individual who simply does not respond to opiates". Respondent failed to acknowledge the consultants' concerns or respond to their recommendations. Respondent provided exceptionally high doses of opioids to Patient C thereafter. In January, 2006, Patient C was given 146 OxyContin 80 mg and 120 oxycodone 15 mg. This adds up to an average of 450 mg per day of oxycodone. By May 2006, Patient C's prescription for oxycodone 15 mg was #300, and the OxyContin 80 mg was #720. This added up to an average daily dose of 2070 mg. During an office visit in May 2006, Patient C provided patient questionnaires rating fatigue and sleepiness at the maximum possible. She described a fall while carrying groceries up stairs, chest tightness and a cough. She was tearful and frustrated and was referred to a pain clinic. Patient C's questionnaires in September 22, 2006 documented increasing distress, functional limitations and multi-system complaints, but Respondent did not alter the medication program, which included: soma, Singulair, Klonopin, Prilosec, Flonase, Cytomel, Lovenox (heparin), Prozac, Restoril, MS Contin, dextroamphetamine, Seconal and oxycodone. On October 30, 2006 and the following visit the patient sought to increase pain medications, checking psychiatric symptoms she was experiencing, including feeling that "she would be better off dead" and "considering suicide". These psychiatric symptoms identify individuals at high risk for opioid drug complications, misuse, diversion, overdose and suicide. Respondent did not further evaluate or discuss these symptoms in the medical record, and did not adjust the treatment program in response. It was not until June of 2009 that the first urinary drug screen of Patient C was obtained to eliminate the possibility of other drugs of abuse or the possibility of diversion.

1.20 Respondent diagnosed Patient C with fibromyalgia without supporting examination findings.

1.21 Respondent labeled Patient C with Chronic Fatigue Syndrome inappropriately, given this patient's psychiatric history and other co-morbidities that cause fatigue, including years of excessive opioid use.

1.22 Patient C's 25-hydroxy vitamin D level tested at 4 in February, 2007, which is a very low level. It was again measured as significantly low twice in 2008.

However, Respondent's written assessments state Patient C's vitamin D level was "too high".

SUBSTANDARD MEDICAL CARE FOR PATIENT D

1.23 Respondent served as Patient D's physician from January 25, 2005 up to April 27, 2010. Respondent provided diagnoses for Patient D, including fibromyalgia, chronic fatigue syndrome, and anti-phospholipid antibody syndrome without regard to appropriate criteria. Respondent gathered information from Patient D at her office visits with standard questionnaires, but failed to adequately discuss and respond to this information. Respondent's hand written notes are often minimal or when more extensive, are difficult to read.

1.24 Respondent did not recognize Patient D's vitamin D deficiency syndrome and did not discuss the orthodox medical literature's conclusions that low vitamin D can be associated with and cause immune system, pain, fatigue, and weakness disorders.

1.25 Respondent persistently provided Synthroid medication to Patient D despite recurrently elevated free-T3 and T4 levels. While such thyroid supplementation risks development of osteoporosis, it can be recommended in patients with resistant depression. However, Respondent failed to meet the standard of care with Patient D's thyroid supplement regimen because she failed to note elevated thyroid levels, heart rate, weight, bowel symptoms and bone density in Patient D's chart.

1.26 Patient D received a sleep evaluation assessment in March 2007 that noted a significant number of respiratory-related arousals disrupting her sleep. The sleep study report noted that "Aggressive treatment of contributing upper airway diseases such as nasal congestion and aggressive weight modification efforts would be very appropriate." There is no documentation that Respondent discussed this with Patient D or made appropriate recommendations based upon the results of that consultation.

1.27 In January 2009, a consult for Patient D noted a problem of progressive parotid enlargement. This is a classic finding in Sjorgren's Syndrome, a well known rheumatology disorder which presents with pain, fatigue and multiple other symptoms, which Patient D was experiencing. In August 2009, Patient D was assessed with "hand swelling, pain, stiffness, elevated C-reactive protein, likely due to an inflammatory process. No significant changes on radiographs to discern osteoarthritis from

rheumatoid-like process. Triggering of her thumb and finger continues." There is no evidence that Respondent assessed Patient D for underlying inflammatory disorders or obtained for Patient D rheumatology blood tests for antinuclear antibody, repeat C-reactive protein, rheumatoid factor, or cyclic citrullinated peptide antibody.

SUBSTANDARD MEDICAL CARE FOR PATIENT E

1.28 Respondent served as Patient E's physician from May 21, 2007 through approximately January 2008. Respondent initially failed to record a complete physical examination and under musculoskeletal only the box "gait" was checked. Respondent did not provide a comprehensive plan of assessment for Patient E based on the differential diagnosis list formulated in the initial patient history, exam and record review. Respondent failed to adequately evaluate Patient E's back and pelvic area symptoms. Respondent provided diagnoses for Patient E before conducting a clinical evaluation and without reference to standard diagnostic criteria. These diagnoses included variant anti-phospholipid antibody syndrome, chronic fatigue syndrome, and elevated vitamin D.

1.29 Several appointments later, on June 26, 2007, Patient E presented with new shoulder complaints and continuing back pain. Respondent noted a plan for an increased Norco prescription and to hold the Valium prescription. Respondent did not obtain more detailed laboratory or diagnostic assessments. When urinalysis on December 9, 2007 suggested infection, there is no antibiotic prescription charted. There is no assessment of inflammatory parameters or x-ray reports evaluating the chronic back and pelvic pain for underlying inflammatory or degenerative back problems. Respondent's charts are handwritten and difficult to read. In the remainder of the records, Respondent provides little discussion of evaluation or treatment of underlying medical problems. A number of visit notes include no new written history or assessment. Respondent treated Patient E with increasing levels of opioids without documented discussion of risk factors for abuse or diversion, without evidence of satisfactory evaluation of or therapy directed to the Patient's underlying medical problems. Patient E's opioid prescriptions were escalated by Respondent without sufficient monitoring of the patient's psychiatric or drug-seeking behaviors.

SUBSTANDARD MEDICAL CARE FOR PATIENT F

1.30 Respondent served as physician for Patient F from November 2, 2006 through approximately October 2010. Patient F presented initially with a history of chronic pain and chronic diarrhea, which could have been due to a spondylitis syndrome associated with an undiagnosed inflammatory bowel disease such as Crohn's Disease. Respondent failed to appropriately explore diagnoses of inflammatory arthritis and inflammatory bowel disease. Instead, Respondent simply labeled the patient with fibromyalgia and implemented the Marshall Protocol. This approach did not meet the standard of care for evaluation of chronic diarrhea, assessment of chronic back pain, assessment of underlying factors contributing to fibromyalgia, or for the exclusion of conditions necessary to diagnose chronic fatigue syndrome.

SUBSTANDARD MEDICAL CARE FOR PATIENT G

1.31 Respondent served as Patient G's physician from November 2006 through approximately March 2010. Respondent failed to meet the standard of care in her diagnosis, therapy and documentation for Patient G.

1.31.1 Respondent failed to adequately assess Patient G's symptoms. Respondent did not utilize physical examination and lab studies sufficiently. Respondent appears to have applied a standard set of diagnoses and lab tests to Patient G regardless of her individual issues.

1.31.2 Respondent failed to meet the standard of care for treating Patient G's very low 25-hydroxy vitamin D on at least three occasions. Such low 25 OH vitamin D levels correlate with and may cause significant pain, neuromuscular and inflammatory clinical problems.

1.31.3 Respondent failed to consider and discuss the possible etiologies of Patient G's renal failure, including the increased dosage of Benicar, over-sedation-caused muscle necrosis, or Benicar associated rhadomyoloysis. Respondent failed to check Patient G's myoglobin level during the renal failure episode.

1.31.4 Respondent failed to assess or address Patient's G's hematocrit drop to 24.

1.31.5 Respondent's attribution of chronic fatigue syndrome to Patient G fell below the standard of care because Respondent failed to rule out other conditions contributory to fatigue. Patient G experienced symptoms indicative of

depression, obstructive sleep apnea, and an inflammatory condition. Patient G had an unexplained elevation in her erythrocyte sedimentation rate of 60 that was not evaluated.

1.31.6 Respondent improperly diagnosed fibromyalgia in Patient G without documenting the requisite tender point or musculoskeletal examination.

1.31.7 Respondent improperly diagnosed Patient G with a variant anti-phospholipid antibody syndrome without measuring anti-phospholipid antibodies.

1.31.8 Respondent overused opioids in her treatment of Patient G's non-cancer pain. Respondent failed to address Patient G's high risk for misuse of opioids based upon a history of legal problems, illicit drug use, addiction, severe depression and suicidal ideation. Respondent failed to account for Patient G's symptoms of severe fatigue and sleepiness in prescribing high doses of opioid medication to this patient. Respondent failed to discuss the potential worsening effects of opioids on Patient G's sleep apnea. Respondent failed to conduct routine drug screen monitoring of Patient G.

1.31.9 Respondent subjected Patient G to the Marshall Protocol with its nonstandard, high-dose use of Benicar without adequately explaining the lack of scientific evidence for its efficacy, or the risks of this approach sufficiently to obtain Patient G's informed consent.

1.31.10 Respondent's medical documentation of Patient G's treatment was substandard. Handwritten notes are mostly illegible, and there are very few typewritten notes. Respondent never recorded a comprehensive discussion of Patient G's medical problems. Respondent failed to document a comprehensive assessment of Patient G's clinical issues. Respondent never documented a comprehensive treatment plan other than "opioid management" and "Marshall Protocol".

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4) which provides in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

. . .

(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;

. . .

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, safety and welfare. The Disciplinary Manager 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: June 27, 2012.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

DANI NEWMAN
DISCIPLINARY MANAGER

KRISTIN BREWER, WSBA # 38494
ASSISTANT ATTORNEY GENERAL

CONFIDENTIAL SCHEDULE

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

Patient A

Patient B

Patient C

Patient D

Patient E

Patient F

Patient G