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
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** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through Teresa Landreau, Department of Health Staff Attorney, and Respondent, represented by Craig L. McIvor, stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On June 27, 2012, the Commission issued a Statement of Charges against Respondent.

1.2 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(4).

1.3 The Commission is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.5 The Commission has the authority to impose sanctions pursuant to RCW 18.130.160 if the allegations are proven at a hearing.

1.6 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order).

1.7 Respondent waives the opportunity for a hearing on the Statement of Charges if the Commission accepts this Agreed Order.

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

1.9 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Databank (HIPDB) (45 CFR Part 61), the Federation of State

Medical Boards' Physician Data Center and elsewhere as required by law. HIPDB will report this Agreed Order to the National Practitioner Data Bank (45 CFR Part 60).

1.10 This 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 Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2. FINDINGS OF FACT

Respondent acknowledges that evidence is sufficient to justify the following findings of fact, which the Commission hereby makes:

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 provide grounds for imposing sanctions under RCW 18.130.160.

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4. AGREED ORDER

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

4.1 **License Status: Probation.** The Commission places Respondent's license on **PROBATION**. Respondent's license will remain on probation for a minimum of five (5) years, or longer as may be required for successful completion of all requirements of this Agreed Order.

4.2 **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 (tradename Benicar), long term antibiotics and restrictions of: Vitamin D intake, corticosteroids, and exposure to light.

4.3 **Clinical Skills Evaluation.** Respondent must commence an evaluation of her internal medicine clinical skills with the Center for Personalized Education for Physicians in Denver, Colorado (CPEP) or at the Physician Assessment and Clinical Education Program offered at the University of California at San Diego School of Medicine (PACE), within ninety (90) days of the effective date of this Agreed Order, or as soon as possible after that date if CPEP/PACE is unable to accommodate the Respondent within that timeframe (CPEP and PACE are collectively referred to below as PROGRAM). The evaluation shall include: medical knowledge, patient care, clinical judgment, medical record keeping, reasoning ability, ethics and communication skills.

4.3.1 Respondent will fully cooperate with the evaluation process, and provide PROGRAM with any information, documents, or releases that are requested.

4.3.2 The PROGRAM will provide 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, educational intervention, or anything else affecting Respondent's practice of medicine.

Respondent must complete all of the recommendations to the satisfaction of PROGRAM and the Commission.

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

4.3.4 Respondent authorizes PROGRAM 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 PROGRAM or third party evaluators to the Commission.

4.3.5 The PROGRAM 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 PROGRAM or third-party evaluators fail to do so.

4.4 **Physician Education Course.** Respondent shall follow the recommendations and requirements of PROGRAM for an educational intervention, if any is recommended, and for any recommended revisions to the plan. Respondent shall successfully complete all aspects of PROGRAM's recommended Educational Interventional Plan.

4.5 **Ethics Course**. Respondent will attend a two-day ethics course approved by the Commission Medical Consultant. The ProBE course offered by the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado is pre-approved. Respondent will complete the course within six months of the effective date of this Agreed Order unless otherwise allowed in writing by the Commission Medical Consultant. Respondent will provide the course instructors with a copy of this Agreed Order prior to the course. Respondent will sign all necessary waivers to allow the Department staff to communicate with the course instructors as needed. Respondent will submit proof of the satisfactory completion of the course to the Commission. If the course requires Respondent to complete a written report, Respondent will assure that the Commission receives a copy of Respondent's written report. If the course instructors inform the

Commission that Respondent did not receive an "unconditional pass" or otherwise satisfactorily complete the course, the Commission may require Respondent to re-take the course.

4.6 **Preceptor Requirement.** Respondent shall not practice medicine in Washington State except under the active supervision of a preceptor physician in compliance with the following requirements:

4.6.1 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 Agreed Order. This preceptor program is in addition to the preceptor requirement that PROGRAM may recommend, except to the extent they may overlap. 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 PROGRAM or this order.

4.6.2 Respondent shall ensure that her preceptor has timely reviewed the following documents, as well as any other information the Preceptor requests:

4.6.2.1 This Agreed Order.

4.6.2.2 All written reports from Respondent's prior preceptors, if any.

4.6.2.3 The PROGRAM evaluation of Respondent, and all subsequent written PROGRAM progress reports for Respondent.

4.6.3 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. Geographic proximity shall be taken into account in determining whether a preceptor is appropriate. 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.

4.6.4 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. Adjustments to these preceptor requirements may be pre-approved by the Commission's Medical Consultant in writing.

4.7 **PROGRAM Re-Evaluation.** In the event Respondent completes the PROGRAM's Educational Intervention Plan, she shall then schedule within four (4) months a follow-up clinical assessment at PROGRAM to re-evaluate her medical knowledge, patient care, clinical judgment, medical record keeping, reasoning ability, ethics, and communication skills. Respondent's awareness of the larger context and system of health care and her ability to effectively call on system resources to provide optimum care shall also be addressed. Respondent shall fully cooperate with this re-evaluation, and shall provide PROGRAM with any charts, documents, and releases that PROGRAM requests for this reassessment. The Commission's Medical Consultant will provide PROGRAM with pertinent documents, including records relating to Respondent's compliance with Commission Orders. The Medical Consultant will notify Respondent of any additional materials provided to PROGRAM. Respondent may provide additional materials to PROGRAM, and will notify the Medical Consultant if she does so. By signing this Agreed Order, Respondent releases PROGRAM representatives to discuss with representatives of the Commission any matters relating to Respondent's evaluation and PROGRAM's

conclusions and recommendations. Respondent waives any privileges or privacy rights She might otherwise have regarding such matters under federal and state law. Respondent understands that PROGRAM will provide a copy of its re-evaluation to the Commission's representatives and will communicate with those representatives as needed.

4.8 **Modification Consideration after PROGRAM Re-Evaluation.** Respondent will appear before the Commission at the next regularly scheduled meeting after PROGRAM issues its re-evaluation report. The parties may continue the matter to the following meeting if the circumstances so warrant. The purpose of this appearance will be to consider modifications to Respondent's license status under paragraph 4.1 of this Agreed Order in light of PROGRAM's re-evaluation findings and any other relevant evidence. The Commission will have full discretion to modifying paragraph 4.1 with additional terms of probation, or suspension or revocation of licensure.

4.9 **Practice Reviews.** In order to monitor compliance with this Agreed Order, Respondent will submit to semi-annual practice reviews at Respondent's office for the duration of probation. The Commission's representative will inspect office records, review patient records, interview Respondent and interview any professional staff, partners, and employees and preceptors associated with Respondent's practice. The representative will contact Respondent's office to give advance notice before each practice review. In the discretion of the Medical Consultant for the Commission, practice reviews may be waived while the preceptor program of paragraph 4.6 is in place.

4.10 **Compliance appearances**. Respondent shall appear before the Commission on an annual basis and present proof of full compliance with this Agreed Order. Respondent shall continue to appear annually unless otherwise instructed in writing by the Commission or its representative.

4.11 **Fine**. Respondent will pay a fine to the Commission in the amount of three thousand dollars ($3,000.00). Respondent will pay the fine according to a minimum schedule of four (4) semi-annual installments of seven hundred fifty dollars ($750) each, beginning no later than 90 days from the effective date of this Agreed Order. Installments will be paid by certified or cashier's check or money order, made payable to the

Department of Health and mailed to the Department of Health, Medical Quality Assurance Commission, at P.O. Box 1099, Olympia, Washington 98507-1099.

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

4.13 **Modification.** Respondent may file a petition for modification of this Agreed Order after two (2) years if Respondent has been in full compliance during that period. Respondent shall appear in person 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, and/or to make modifications to the conditions of probation.

4.14 **Termination.** Respondent may file a petition for termination of this Agreed Order after five (5) years if Respondent has been in full compliance during that period. Respondent shall appear in person 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.

4.15 **Responsibility for costs of compliance.** Respondent is responsible for all costs incurred in the course of complying with this Agreed Order.

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

4.17 **Updated Address.** Respondent shall inform the Program 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 Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

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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 of several patients fit Tier B of this schedule, by causing moderate harm or risking moderate to severe harm in 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 five (5) years of probation with practice restriction, a preceptor program, evaluation and follow-up educational intervention with an approved agency, an ethics course, annual compliance appearances before the Commission, semi-annual practice reviews, a fine, and other terms designed to protect the public. A longer term of probation or even suspension or revocation of Respondent's license is contemplated in the event she is not amenable to or successful with educational intervention.

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 listed aggravating factors significantly outweighs the listed mitigating factor, requiring oversight at the high end of the range. The mitigating factor is a sufficient basis to avoid revocation of license at this time.

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

B. As a mitigating consideration, 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 Agreed Order. This 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 Agreed Order.

SUSAN J. SHLIFER, MD
RESPONDENT

1/31/2013
DATE

CRAIG L. MCIVOR, WSBA #12745
ATTORNEY FOR RESPONDENT

2/1/13
DATE

8. COMMISSION'S ACCEPTANCE AND ORDER

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

DATED: February 21, 2013

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Michael T. Corcoran
PANEL CHAIR

PRESENTED BY:

TERESA LANDREAU, WSBA #9591
DEPARTMENT OF HEALTH STAFF ATTORNEY

February 21, 2013
DATE