

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION**

In the Matter of:

ZBIGNIEW M. GRUDZIEN,
License No. MD.MD.00039350,

Respondent.

Master Case No. M2010-844

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND FINAL ORDER

APPEARANCES:

Zbigniew M. Grudzien, Respondent, pro se

Department of Health Medical Program, by
Office of the Attorney General, per
Kristin G. Brewer, Assistant Attorney General

COMMISSION PANEL: Michelle Terry, M.D., Chair
Leslie Burger, M.D.
Linda Ruiz, J.D., Pro Tem Public Member

PRESIDING OFFICER: John Kuntz, Review Judge

A hearing was held in this matter on January 16, 2015, regarding allegations of unprofessional conduct. Five-year probation with conditions.

ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(1), (4), (13), and (16).

If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the testimony of Leslie Enzian, M.D., Clinical Associate Professor, Department of Medicine, University of Washington School

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND FINAL ORDER

Page 1 of 53

Master Case No. M2010-844

of Medicine. The Respondent testified on his own behalf and did not call any additional witnesses.

The Presiding Officer admitted the following Department exhibits:

- D-1: Credential View Screen.
- D-2: Report of Dr. LeslieENZIAN, dated September 27, 2013.
- D-3: Curriculum Vitae of Dr. LeslieENZIAN
- D-4:
 - "Evaluation of Cognitive Impairment and Dementia:-Shadlen, Up-to-Date, literature review through August 3, 2012.
 - "Overview of Homocysteine"-Rosenson, et al, Up-to-Date, literature review through November 29, 2011.
 - "Subacute and Chronic Low Back Pain:-Nonsurgical Interventional Treatment"-Chou, Up-to-Date, literature review through 2012.
 - "Treatment of the Adult with Iron Deficiency Anemia"-Schrier, Up-to-Date, literature review through 2012.
- D-5: Department's Letter of Cooperation sent to the Respondent on April 16, 2010.
- D-6: The Respondent's response to the Department's Letter of Cooperation, dated May 21, 2010.
- D-7: Patient A's treatment records provided by the Respondent.
- D-8: Patient B's treatment records provided by the Respondent.
- D-9: Patient C's treatment records provided by the Respondent.
- D-10: Patient D's treatment records provided by the Respondent.
- D-11: Patient E's treatment records provided by the Respondent.
- D-12: Patient F's treatment records provided by the Respondent.

D-13: Patient G's treatment records provided by the Respondent.

D-14: Patient H's treatment records provided by the Respondent.

D-15: Patient I's treatment records provided by the Respondent.

D-16: Patient J's treatment records provided by the Respondent.

D-17: Patient K's treatment records provided by the Respondent.

The Presiding Officer admitted the following Respondent exhibits:¹

R-1: Patient A treatment records.

R-2: Patient B treatment records.

R-3: Patient C treatment records.

R-4: Patient D treatment records.

R-5: Patient E treatment records.

R-6: Patient F treatment records.

R-7: Patient G treatment records.

R-8: Patient H treatment records.

R-9: Patient I treatment records.

R-10: Patient J treatment records.

R-11: Patient K treatment records.

CREDIBILITY FINDINGS

The Respondent denies the allegations set forth in the Statement of Charges regarding his treatment of Patients A through K.

¹ The Respondent offered Exhibits D-7 through D-17 as his own exhibits. Pursuant to Prehearing Order No. 3, only one set of medical records was produced at the hearing.

The Respondent believed that he was providing appropriate medical care to his patients.

The Department presented expert testimony by LeslieENZIAN, M.D., in its case in chief. The Commission finds Dr. ENZIAN's testimony to be more credible and persuasive than that of the Respondent, on what constitutes the standard of care in Washington for medical treatment and the medical record keeping requirements.

Based on the exhibits and testimony presented, the Commission enters the following:

I. FINDINGS OF FACT

1.1 The Respondent was granted a license to practice as a physician and surgeon in the state of Washington on December 14, 2000.

1.2 The Respondent is the physician and manager for Hope Medical Holistic Services, PLLC, in Vancouver, Washington. The Respondent's practice includes an immigrant patient population (Russian, Ukrainian, and other Eastern European individuals), the majority of whom (95-98 percent) receive treatment under the Medicare/Medicaid programs. During the September 2006 through March 2010 period, the Respondent provided medical services to Patients A through K.² Each of these patients suffered from a variety of serious and chronic medical conditions that required the Respondent to treat and constantly monitor these medical conditions for the well-being of each patient.

² The identity of the patients is contained in a confidential schedule attached to the Statement of Charges and the identity of the patient or patients may not be disclosed without the patient's permission. See RCW 42.56.240(1) and chapter 70.02 RCW.

1.3 The Respondent's treatment of Patients A through K reveals several major areas of concern. These areas of concern include: the Respondent's management of: the patients' cardiac conditions; the patients' neuropsychiatric conditions; the Respondent's frequent intravenous (IV) infusions of vitamins and minerals to his patients without any objective clinical basis for doing so; the Respondent's management of the patients' diabetic conditions; the Respondent's frequent use of laboratory tests with his patients without clinical justification for the tests; the Respondent's failure to correctly chart the care provided to the patients; and the Respondent's billing of treatment without medical justification.

Charting of Patient Information in Electronic Medical Records

1.4 The Respondent's electronic medical record contained a number of errors. The errors included: (1) repeating information contained in prior treatment visits, which creates confusion regarding the patient medical condition or complaint being treated by the Respondent during any given patient's treatment visit; (2) repetitive phrases that are not related to the patient's identified concerns; (3) contradictory information (for example, record entries stating the patient reported being short of breath and also stating the patient did not); and (4) patient's medications changes (new medication or discontinuing medication) that were not reflected in the treatment visit notes for the same date. The standard of care in Washington for medical records requires clear, accurate, legible and understandable medical treatment entries. It is especially important where, as with Patients A through K, the patients are diagnosed with a number of serious and chronic medical conditions. The Respondent's records

consistently do not meet the required standards for clarity and accuracy.

1.5 The Respondent acknowledges that his record keeping system was less than perfect. He explains that the repetition in his electronic medical record is a function of the electronic medical record software he uses. It also reflects his use of a drop-down menu in creating the records, which creates repeated entries or which repopulated the same information for subsequent treatment dates. While he identified the issue, the Respondent did not take appropriate steps to correct it. At hearing, the Respondent explained that he could create a more concise report when other physicians requested patient records. This shows the Respondent could correct the problem but failed to do so.

1.6 The Commission recognizes that the prior treatment records and medical history for some of his patients was unavailable, given: (1) the age of the records; (2) the fact that the records were not located in the United States; and (3) the lack of patient cooperation. In those circumstances, the Respondent should have noted the unavailability of prior treatment records in the current patient treatment records or the patient's lack of cooperation as appropriate. The Respondent's treatment records do not comply with this standard.

Intravenous Infusions of Vitamins and Minerals

1.7 The Respondent diagnosed vitamin and mineral deficiency in Patients A through F, and H through K and treated the patients using IV infusions treatments.³ Because of their Eastern European backgrounds and cultural experiences, the

³ The Respondent had ten IV stations for this purpose.

Respondent's patients were familiar with and came to expect such IV infusion treatments. While such IV treatment can be appropriate where clinically indicated, the Respondent's medical records for the patients contain no objective clinical indication of such deficiencies to support such treatment. The Respondent's care focused on providing the IV procedures rather than managing other more significant medical issues. In addition, the Respondent decided on an arbitrary number of IV infusion treatments for each patient. The Respondent's treatment records do not record the need for the IV treatment, the efficacy of the treatment, or even the actual number of IV infusion treatments he provided to his patients. He continually provided IV treatment even where it was not indicated or medically inappropriate. Doing so created harm or the risk of harm to his patients as discussed below.

1.8 The typical IV infusion treatment was three hours in length. Some patients received IV treatments on a weekly basis. However, there are negative consequences resulting from IV infusion treatment. These negative consequences can include bruising and infection. The Respondent was required to advise his patients of these potential negative consequences but did not. The Respondent also did not inform his patients of the option of oral vitamin and minerals supplements that would reduce or eliminate the possible negative consequences. The Respondent explained that many of his patients could not afford to purchase the oral vitamin and mineral supplements, which was his justification for the billing of the IV infusion treatments to Medicare and Medicaid.⁴ However, the IV infusion treatments were both ineffective and medically

unnecessary and the Respondent's practice allowed him to bill Medicare and Medicaid as a means of increasing his practice's income.

The Respondent's Laboratory Testing and Billing Practice

1.9 A physician should only order laboratory tests that are clinically indicated to appropriately monitor a patient's condition or conditions. The Respondent's billing practice shows that he routinely ordered complete urinalysis testing and blood testing without any objective clinical indication and where patients had consistently normal values in prior testing. The Respondent also ordered other tests that were not clinically indicated or ordered in response to the patient's complaints during treatment visits. Ordering unnecessary laboratory tests enabled the Respondent to generate higher billing fees and reimbursement rates.

1.10 If blood tests are necessary, the standard of care is to order blood testing during the treatment visit. Blood tests are performed by clinical staff. The Respondent directed and scheduled blood draws as full clinical visits instead of venipuncture visits to obtain blood samples for laboratory testing. The blood samples were usually drawn by a health care assistant but the Respondent billed the visit as a physician visit. The Respondent also scheduled and billed for a blood draw visit adjacent to a scheduled office visit instead of obtaining the sample as part of the primary office visit. The Respondent's laboratory testing and billing practices were not within the standard of care.

Treatment Using Trigger Point Injections

⁴ The Respondent testified that he did not bill Medicare/Medicaid for the vitamins and minerals and that

1.11 The Respondent treated pain complaints for his patients using injections at trigger point sites. Trigger point sites are an area of tissue that is tender when compressed. These sites may also give rise to referred pain and tenderness. Dr. Enzian's review of the Respondent's records show that the Respondent performed a seemingly excessive number of trigger point injections for Patients A, B, D, and F. Medical literature shows the very limited benefit of these trigger point injections. See Exhibit D-2, page 3.⁵ The Respondent's excessive use of trigger point injections allowed him to add procedural costs to his patient visits and thus increasing his profit.

Patient A

1.12 Patient A presented in September 2007 as a 58 year old female with a complex medical history of multiple diseases and problematic surgeries. Patient A's history included coronary artery disease; cardiac arrhythmias (irregular heartbeat); type two non-insulin dependent diabetes; hypertension or high blood pressure; degenerative joint disease; chronic fatigue; irritable bowel syndrome; colon polyps; strabismus (an abnormal turning of the eyes) with right eye vision deficit; and goiter. Patient A's surgical history included hernia repair; ovarian surgery; appendectomy; and percutaneous transluminal coronary angioplasty (PTCA) to open up blocked coronary arteries. The Respondent treated patient A from September 2007 through January 2010.

Management of Patient A's Cardiac Conditions

1.13 The standard of care for treating patients with cardiac conditions is to

he paid for them out of pocket. Even if true, the procedures were billed to Medicare/Medicaid.

determine the patient's treatment history. The Respondent did not do so. Patient A had coronary artery disease and reported her chest pain symptoms increased following physical exertion. She also had an irregular heartbeat. Based on the patient's complaints, the standard of care required the Respondent to determine whether Patient A suffered from an inadequate oxygen supply. The Respondent did not do so. Neither did the Respondent determine what medications are appropriate for treating the patient's condition. The use of aspirin or nitroglycerin was appropriate treatment for Patient A's cardiac condition. However, the Respondent did not prescribe such medication until July 2009, or almost two years following the start of Patient A's treatment.

1.14 Patient A suffered from hypertension (high blood pressure) but the Respondent did not take steps to adequately control it. While he altered the patient's hypertension medication levels, the Respondent did not do so in a manner that would assertively address Patient A's high blood pressure. Even though he assessed Patient A to have hypertensive heart disease with heart failure, the Respondent did not initially conduct tests to confirm the patient's heart failure diagnosis. While he diagnosed Patient A as having congestive heart failure, the Respondent did not assess or treat the identified condition.

1.15 On October 25, 2007, Patient A reported heart palpitations and an electrocardiogram test result showed some disturbance in the patient's heart rhythm.

⁵ Dr. Enzian did not number the report pages. The information appears on the third page of the report.

The Respondent should have ordered further appropriate testing to evaluate the patient for possible serious cardiac arrhythmias. He did not do so.

1.16 The Respondent frequently ordered fasting lipid testing for low density lipoprotein levels in Patient A. The purpose of such testing is to determine whether the patient's cholesterol levels fall within the therapeutic range. The recommended cholesterol level in patients with coronary artery disease is 70. Patient A's cholesterol level tests showed abnormal values. The test result for Patient A's October 4, 2007, test was 129; for the February 13, 2008, test, Patient A's level was 161. After obtaining the test results, the Respondent did not respond to such test results by providing appropriate treatment such as statin therapy. This increased Patient A's risk for progressive atherosclerotic cardiovascular disease.

Management of Neuropsychiatric Conditions

1.17 On August 26, 2009, Patient A presented to the Respondent with confusion, disorientation, lack of enjoyment in previously pleasurable activities, disturbed sleep, anxiety, and strong mood changes. The Respondent did not respond to Patient A's continued reporting of these conditions until December 8, 2009, at which time the Respondent documented a cognitive assessment. The Respondent diagnosed Patient A with vascular dementia and generalized anxiety disorder. The vascular dementia diagnosis was not indicated based upon the available history, normal neurological examination and lack of any brain imaging showing cerebrovascular disease. The Respondent noted that Patient A's speech was garbled. If this was a new

symptom, it was indicative of a recent cerebrovascular event, which required the Respondent to assess this symptom with imaging. He did not do so.

1.18 Patient A reported numerous symptoms of depression, including low energy, insomnia, anxiety, and irritability. The Respondent did not initiate treatment with Paxil (an antianxiety/antidepressant agent) for at least three months after Patient A reported these symptoms. Such treatment was clearly indicated at a much earlier stage, given the consistent reporting of the symptoms by Patient A.

Intravenous Infusions

1.19 The Respondent initiated IV vitamin and mineral infusions for Patient A on May 28, 2008. He recommended that Patient A receive 15 infusion treatments. However, the Respondent did not track the number of treatments, as Patient A actually received 22 infusion treatments. Patient A was diagnosed with coronary artery disease and hypertensive heart disease with heart failure, and she had poorly controlled blood pressure. The Respondent's treatment of Patient A with serial IV fluid infusions therefore placed Patient A at risk of fluid overload and congestive heart failure.

Management of Diabetes Condition

1.20 The Respondent did not manage Patient A's diabetic conditions consistent with the standard of care in Washington. The Respondent should have provided Patient A with standard health care maintenance such as yearly urine microalbumin screening to determine whether the patient had diabetic kidney disease and yearly monofilament examination to screen for diabetic neuropathy (the use of a strand of

nylon to assess the sensation or lack of sensation in peripheral nerves especially in the feet). He did not do so.

1.21 In addition to the above testing, the standard of care required the Respondent screen diabetic patients like Patient A for diabetic retinopathy (possible damage to the blood vessels in the patient's retina) that could lead to blindness. The Respondent did not refer Patient A to a yearly eye screening examination with an ophthalmologist. The failure to do so is below the standard of care.

Management of Epigastric Pain

1.22 Patient A reported she had a history of ovarian cancer. The standard of care in Washington required the Respondent to clarify or obtain the relevant patient information so that he could follow up or assess the patient's reported condition. Having this information was necessary to the assessment and care of the epigastric pain describe below.

1.23 On July 9, 2009, Patient A reported tenderness in her left and central upper abdomen. The Respondent did not ask follow up questions or inquire about blood in Patient A's stool to determine if the patient had gastritis (an acute or chronic inflammation of the stomach lining) or peptic ulcer disease. The Respondent initiated medication to inhibit acid production in Patient A's stomach. However, the patient's symptoms continued to persist for two years. The Respondent should have referred Patient A for an upper endoscopy to determine the possible source of the patient's complaints and to determine if the patient had gastritis or a peptic ulcer. He failed to do so. What the Respondent did recommend was Patient A take Advil or aspirin dialed for

pain control. Such non-steroidal anti-inflammatory medication was both contraindicated and may have contributed to the patient's gastric pain.

1.24 The Respondent diagnosed Patient A as having *Helicobacter Pylori* (or *H. Pylori*, a bacteria associated with gastritis and peptic ulcer disease) but did not immediately confirm his diagnosis with *H. Pylori* serum testing. When the Respondent eventually confirmed the diagnosis with serum testing on December 15, 2008, he provided long-term treatment with double antibiotics and a twice daily dosage of proton pump inhibitor. Such treatment should only be continued for 10-14 days. The Respondent continued to recommend such treatment long after the appropriate 10-14 day treatment period, or until January 28, 2009. At this point, the Respondent should have ordered stool antigen testing to confirm the resolution of the *H. Pylori* condition. He did not do so.

Patient B

1.25 Patient B initially presented to the Respondent in September 2007 as a 70 year old female patient with complaints of chest pressure that were worsened by exertion. She reported trouble breathing, palpitations, and fatigue. Patient B had the following medical problems: coronary artery disease (the narrowing of the coronary arteries), congestive heart failure, a history of a stroke in 2006 with resulting weakness on one side of her body (hemiparesis); Type 2 diabetes mellitus; arthritis; a history of depression; anxiety; an unspecified disorder of the thyroid; and neck pain with associated numbness in bilateral upper extremities. The Respondent treated Patient B during the period September 2007 to March 2010.

Management of Patient B's Cardiac Conditions

1.26 The Respondent documented Patient B's coronary artery disease but did not gather a patient history (for example, did Patient B suffer from a past heart attacks) to enable appropriate treatment. The Respondent did not determine if Patient B had a heart catheterization or heart stress test, and any record of any prior test results. The Respondent did not prescribe nitroglycerin for Patient B's coronary artery disease (the recommended treatment) nor did he instruct the patient to seek emergent care if chest pain was not relieved with three doses of nitroglycerin. Neither did the Respondent treat Patient B with angiotensin converting enzyme (ACE) inhibitors (therapeutic agents used to treat hypertension and heart failure and to protect Patient B's kidney function).

1.27 In October 2007, the Respondent discontinued the patient's aspirin and lovastatin (a statin drug that helps to lower blood-fat levels) treatment. Patient B's record does not explain why the Respondent discontinued the medication other than noting Patient B complained of "dizziness" in the patient's medication list. The dizziness is not otherwise charted or discussed in the patient's medical records. The Respondent did substitute an alternative antiplatelet medication for the aspirin, which placed Patient B at a higher risk for heart attack. Neither did he replace the lovastatin medication, which was prescribed by an earlier treatment provider to appropriately manage Patient B's hyperlipidemia (or excessive quantity of fat in the blood).

1.28 Starting March 20, 2008, the Respondent diagnosed Patient B as having congestive heart failure. The Respondent continued to note this diagnosis in many of

Patient B's subsequent treatment notes. The Respondent did not explore the cause for Patient B's congestive heart failure. He did not determine if it was ischemic in origin (that is, caused by an inadequate supply of blood and oxygen). The Respondent did not order an electrocardiogram to properly assess the condition or prescribe the standard medication for heart failure. More importantly, the Respondent did not consider whether the continued IV infusion treatments for Patient B were safe or appropriate.

Management of Patient B's Neuropsychiatric Condition

1.29 The Respondent prescribed paroxetine (an anti-depressant) to Patient B beginning on January 24, 2008. Patient B's patient history did not note any psychiatric symptoms and Patient B's psychiatric examination results were noted to be unchanged. There was no assessment of diagnostic criteria for either depression or anxiety, yet the Respondent prescribed paroxetine. Patient B's May 15, 2008, medication list showed the Respondent discontinued the paroxetine due to it being ineffective. Later treatment notes reveal the paroxetine being on the active and inactive medication lists. The Respondent's treatment notes do not discuss the patient's unresponsive psychiatric symptoms, any consideration regarding the adjustment of the paroxetine dosage or any consideration of an alternative anti-depressant medication.

Management of Patient B's Thyroid Disease

1.30 The Respondent diagnosed Patient B as having an unspecified disorder of the thyroid. He did not gather any information to clarify that entry. The Respondent's treatment records reflect that he discontinued Patient B's propylthiouracil medication for

hyperthyroidism at her initial visit on September 24, 2007. The Respondent's records do not note that Patient B's thyroid function was tested at this initial visit and there is no medical reason to believe that Patient B's hyperthyroidism has spontaneously resolved.

1.31 Three days after he discontinued the propylthiouracil medication the Respondent conducted a thyroid-stimulating hormone test which revealed Patient B had a normal thyroid function. Because response to the withdrawal of propylthiouracil would take place slowly, this "normal" test result was inaccurate. By discontinuing the medication without further testing, the Respondent created harm or an unreasonable risk of harm to Patient B.

IV Infusion Treatment to Patient B

1.32 Given Patient B's diagnosed heart disease and congestive heart failure, her body was unable to process large amounts of fluid. It was therefore important for the Respondent to monitor her heart conditions to avoid the fluid overload risk and would argue against provided Patient B with large amounts of fluids. Despite this concern, and without any objective clinical indication regarding the need for IV treatment, the Respondent diagnosed Patient B with a vitamin and mineral deficiency and recommended 12 sequential IV infusion treatments. Patient B was actually provided with a total of 56 IV infusion treatments. The Respondent's action in providing 56 IV infusion treatments placed Patient B at an unreasonable risk of fluid overload.

Treatment of Patient B's Diabetic Condition

1.33 The Respondent did not manage Patient B's diabetic conditions consistent with the standard of care in Washington. The Respondent did not provide Patient B

with standard health care maintenance such as yearly urine microalbumin screening to determine whether the patient had diabetic kidney disease and yearly monofilament examination to screen for diabetic neuropathy (The use of a strand of nylon to assess the sensation or lack of sensation in peripheral nerves especially in the feet).

1.34 Diabetic patients should have yearly eye examinations, so the Respondent should have ordered a yearly eye examination for Patient B (a diabetic patient) to ensure that she did not suffer from diabetic retinopathy (possible damage to the blood vessels in the patient's retina). Diabetic retinopathy can lead to blindness. The Respondent did not refer Patient B to a yearly eye screening examination with an ophthalmologist. The Respondent's failure to do so created a risk to Patient B.

Patient C

1.35 Patient C initially presented as a 65-year-old female in December 2008. Patient C presented with complaints of diabetes and hypertension, coronary heart disease, and morbid obesity. The Respondent provided treatment to Patient C during the period December 2008 to January 2010.

Treatment of Patient C's Cardiac Condition

1.36 Patient C's medical history revealed that she was hospitalized for 21 days in 1994 related to her coronary artery disease. The Respondent should have determined what occurred to Patient C during this stay by obtaining the hospitalization records. The Respondent did not do so. The Respondent did not explore the status of Patient C's coronary artery disease by obtaining her past stress test or cardiac

catheterization results. At a minimum, the Respondent should have treated Patient C with aspirin for the secondary prevention of the coronary artery disease or provide the patient with statin drugs for cholesterol management. The Respondent did not do so.

1.37 On September 18, 2009, Deborah Bryant, PA-C, treated Patient C, as Ms. Bryant was providing the majority of Patient C's care under the Respondent's supervision. Patient C complained of chest pain during this visit. Given the patient's history of coronary artery disease, hypertension, and diabetes, the Respondent (the supervising physician) should have assessed Patient C's complaints to determine whether she had an unstable angina. An unstable angina condition can indicate an impending myocardial infarction (heart attack) and the condition requires an urgent evaluation and treatment. The Respondent did not do so. Neither did the Respondent provide Patient C with nitroglycerin for the treatment of the possible angina. Finally, the Respondent should have instructed Patient C to contact emergent care if the chest pain did not relieve following three nitroglycerin tablets. He failed to advise Patient C of this information.

Treatment of Patient C's Neuropsychiatric Condition

1.38 Patient C reported numerous symptoms that can indicate the patient is depressed (insomnia, low energy, and poor concentration). While Patient C reported these symptoms, the Respondent did not evaluate Patient C for depression.

Treatment of Patient C with IV Infusion of Vitamins and Minerals

1.39 The Respondent recommended that Patient C be treated with IV infusions to address vitamin and mineral deficiencies. The Respondent's treatment records do

not reflect any objective clinical indication of vitamin and mineral deficiencies. Patient C received 30 IV infusion treatments. Patient C's diabetes condition was not improved following these infusion treatments. There is no indication that the IV treatment supported the Respondent's diagnosis of vitamin/mineral deficiencies or improved Patient C's diagnosed condition. Even if a vitamin/mineral deficiency existed, Patient C could take an oral supplement to address that issue. Doing so would be less costly to Patient C and have fewer adverse side effects. The Respondent did not advise Patient C of this option.

Treatment of Patient C's Diabetes

1.40 Diabetic patients need yearly reviews of other related medical issues, including eye examinations and neuropathy testing. The Respondent did not provide Patient C with standard health care maintenance treatment such as yearly urine microalbumin screening (testing for a protein in the patient's urine) to see whether the patient is suffering from any progressive renal disease. Neither did he provide yearly monofilament examination to screen for diabetic neuropathy (the use of a strand of nylon to assess the sensation or lack of sensation in peripheral nerves especially in the feet).

1.41 In addition to the above testing, the Respondent should have screened Patient C for diabetic retinopathy (possible damage to the blood vessels in the patient's retina) that could lead to blindness. The Respondent did not refer Patient C to a yearly eye screening examination with an ophthalmologist. Failing to do so could have put Patient C at risk for blindness.

Treatment of Patient C for Gastrointestinal Condition

1.42 On November 3, 2009, the Respondent completed a referral form requesting an evaluation of Patient C's upper gastrointestinal track for the patient's complaints of increased frequency of upper central abdominal pain and difficulty swallowing. The Respondent's treatment notes for Patient C should have mentioned the referral form. The records do not mention the referral. Additionally, the Respondent completed the referral form in November 2009, but he did not actually refer Patient C for the evaluation until January 28, 2010. The two month delay in referring Patient C was below the standard of care. If there was a reason for the delay, it should appear in Patient C's treatment records. Additionally, it is unclear why the Respondent was ordering the referral, given Patient C's records did not reflect any gastrointestinal symptoms, the Respondent's abdominal examination of Patient C was benign, and there was no assessment or treatment plan discussion of the need for the gastroscopy. Finally, Patient C complained that she was having difficulty swallowing. The Respondent did not address Patient C's complaints.

1.43 The Respondent treated Patient C with three ibuprofen tablets (an anti-inflammatory medication) daily. Anti-inflammatory medication can cause or exacerbate gastritis or peptic ulcer disease. The ibuprofen could have been the possible cause of Patient C's reported upper-central abdominal pain. Long term treatment with non-steroidal anti-inflammatory medication such as ibuprofen placed Patient C at risk for renal insufficiency. This is a particular concern for a diabetic patient

with a pre-existing risk for kidney disease. The Respondent should have considered this possibility but he did not do so.

Patient D

1.44 Patient D was a 78 year old male when he first presented to the Respondent in February 2007. Patient D presented with: diabetes; coronary artery disease; chronic combined systolic (left ventricle heart pumping capacity) and diastolic (heart ventricle filling capacity) congestive heart failure; hearing loss; benign enlarged prostate; symptoms of chronic fatigue; back pain; a history of heart arrhythmia; bladder cancer in 1988; and pleural effusion (a build-up of fluid between the layers of tissue that line the lungs and chest cavity). Patient D's family history included a brother with colon cancer. The Respondent did not inquire about the brother's age at the time he was diagnosed with colon cancer, which would assist the Respondent in determining whether Patient D had an increased risk for colon cancer. Neither did the Respondent discuss or provide colon cancer screening with Patient D. The Respondent treated Patient D during the period February 2007 to January 2010.

Treatment of Patient D's Cardiac Condition

1.45 The Respondent should have obtained details regarding Patient D's significant medical history of heart disease, prior hospitalizations, and heart arrhythmias. The Respondent noted he would obtain Patient D's prior records but he did not obtain a release so that he could do so and he ultimately did not obtain the records in question. Neither did he evaluate Patient D's congestive heart failure using any relevant testing such as a chest x-ray, echocardiogram, or brain-type natriuretic

peptide levels (a test to see if there was an increased concentration of hormone level secreted by the left or right ventricle of the heart. An increased concentration in the bloodstream reflects episodes of decompensated heart failure). The Respondent's records do not show if he was aware whether Patient D had undergone past cardiac procedures.

Treatment of Patient D's Neuropsychiatric Condition

1.46 On February 21, 2007, the Respondent noted that 78-year-old Patient D was: oriented to person, place and time; had intact recent and remote memory recall of three objects at five and 10 minutes, with good ability to repeat phrases and speak spontaneously with intact abstract thought, judgment and insight. On October 22, 2007, the Respondent reported that Patient D was experiencing confusion, forgetfulness and difficulty concentrating. The patient was suffering from poor attention span and concentration, and intellectual impairment. The Respondent diagnosed Patient D with chronic organic brain syndrome and cerebrovascular disease despite the fact that there were not any abnormalities on his neurological examination that supported the diagnosis. The Respondent failed to assess Patient D for possible reversible causes of cognitive decline for this dramatic change over the eight month period such as thyroid dysfunction, B12 deficiency or depression.

Treatment of Patient D Using IV Infusion Treatment

1.47 Starting in February 2007, Patient D complained of back pain. The Respondent treated Patient D's reported back pain using IV infusion treatments of vitamins and minerals. The Respondent did not perform any laboratory testing to show

that Patient D suffered from a vitamin/mineral deficiency. There is no objective clinical evidence that treating Patient D with IV treatment would improve or resolve the patient's back pain complaints. The Respondent recommended that Patient D receive 20 weekly IV infusions. The Respondent actually administered 50 IV infusion treatments to Patient D. The IV infusion treatments were clearly unnecessary treatment for Patient D's back pain and did nothing to resolve or improve the condition.

1.48 Given Patient D's diagnosed congestive heart failure, it was important to monitor the patient's fluid intake. The Respondent's introduction of the fluid from the 50 repeated IV infusions placed Patient D at risk of fluid overload and put Patient D at risk of unnecessary harm. Even after treating Patient D with 50 IV infusion treatments over a two-year period, the Respondent continued to note that Patient D had a vitamin and mineral deficiency. Even if such a "deficiency" existed, clearly the IV infusion treatment did not resolve or improve the vitamin/mineral "deficiency."

Patient E

1.49 Patient E (an 81-year-old female in March 2007) presented with a number of complaints, including: shortness of breath accompanied with edema; chest tightness almost daily; and dizziness and fatigue. Patient E had severe and chronic medical conditions, including: chronic high blood pressure; congestive heart failure; hypothyroidism; hyperlipidemia; colon cancer with tumor removed in 2007; gastro-esophageal reflux disease; a history of gastrointestinal track bleeding (with a hematocrit of 17.3); and a history of malaria. The Respondent treated Patient E during the period March 2007 to March 2010.

Treatment of Patient E's Cardiac Condition

1.50 The Respondent did not adequately monitor or treat Patient E's identified heart issues. Patient E consistently complained of chest tightness. The Respondent neither evaluated her complaints nor referred her out for testing. He did not prescribe medication to address or treat any potential angina condition. Based on Patient E's reported symptoms, the Respondent should have considered the possibility that the patient's coronary artery disease was the cause of the congestive heart failure. He did not do so. Neither did the Respondent prescribe medications for Patient E consistent with the standard of treatment for a patient with a congestive heart failure condition.

Treatment Using IV Infusions of Vitamins and Minerals

1.51 As with his other patients, the Respondent recommended that Patient E receive IV infusions of vitamins and minerals to treat vitamin/mineral deficiencies. He ordered ten IV infusion treatments for Patient E without any clinical indication for such treatments or any explanation why ten treatments were medically appropriate. The Respondent actually administered 42 IV infusions to Patient E. There was no objective clinical indication that Patient E benefitted from the IV infusion treatment. Given Patient E's age and known congestive heart failure condition, the administration of 42 IV infusion treatments placed Patient E at the risk of volume overload and taxed or worsened Patient E's congestive heart failure condition. The Respondent placed Patient E at risk of harm.

Treatment of Patient E's Thyroid Condition

1.52 Patient E suffered from an under-active thyroid gland (hypothyroidism). Despite this condition, the Respondent discontinued the patient's levothyroxine medication (that is, the medication used to treat Patient E's hypothyroidism) on August 27, 2007. He took this action without initially performing a thyroid function test to assess the patient's current thyroid function level at the time he discontinued the levothyroxine medication. The Respondent did not check Patient E's thyroid function level until November 19, 2007. The result of this check indicated a severely underactive thyroid function. Despite this test result, the Respondent did not prescribe or reinstitute Patient E's levothyroxine medication until January 2008. Patient E's thyroid condition was therefore untreated for six months. The Respondent's failure to treat Patient E's thyroid condition for six months was below the standard of care.

1.53 Once he reinstituted Patient E's levothyroxine medication in January 2008, the Respondent did test Patient E's medication levels to ensure they were within the appropriate range for the medication. The Respondent's testing during January-June 2008 indicated Patient E was taking too much levothyroxine. By June 11, 2008, Patient E's thyroid hormone levels still indicated she was taking excessive levothyroxine medication. Despite the test results, the Respondent did not adjust Patient E's levothyroxine dosage until February 17, 2009.

1.54 On September 10, 2009, the Respondent decreased Patient E's levothyroxine dosage again in response to the patient's thyroid hormone levels and her loss of weight. Although clinically indicated, the Respondent did not lower the dosage

again until January 5, 2010. The Respondent charted that Patient E's condition was chronic and progressive, but there was no identified progressive disease process to support that conclusion. There was only medication-induced hyperthyroidism. The Respondent did not properly manage Patient E's medication to prevent this result.

Management of Patient E's Colon Cancer

1.55 In managing Patient E's colon cancer, the Respondent did not initially request information in 2007 related to the stage of her cancer. He did not determine whether the tumor extended beyond the colon or what follow-up surveillance and treatment was indicated for the patient. The Respondent's records did not identify what provider was managing the patient's colon cancer. Neither did he coordinate care with Patient E's colon cancer provider as required by the standard of care in Washington.

1.56 On September 10, 2009, the Respondent determined that Patient E had an abnormal loss of weight and was failing to thrive. He properly referred Patient E for gastroscopy and colonoscopy tests but the Respondent failed to obtain copies of the procedure reports. The Respondent further failed to identify the cause of Patient E's reported weakness and fatigue. He attributed Patient E's weakness and fatigue to vitamin and mineral deficiencies, but there was no objective clinical evidence for the Respondent's conclusion. The Respondent needed to rule out Patient E's under-active and then over-active thyroid function, colon cancer, or congestive heart failure conditions, which could have contributed to the fatigue. He did not do so. The Respondent's actions harmed Patient E.

Patient F

1.57 Patient F was a 78 year old female in July 2008, and she had a number of severe and chronic medical conditions, including: congestive heart systolic and diastolic heart failure; hypertrophic cardiomyopathy; aortic stenosis, recurring reports of palpitations; a history of transient ischemic attack; hypertension; senile dementia with depressive features, a history of depression and reported depression in review of systems; a history of kidney stones; osteoarthritis; metabolic syndrome; myalgia; hearing loss; cataract; and glaucoma. The Respondent treated Patient F during the period July 2008 to January 2010.

Management of Patient F's Cardiac Condition

1.58 The Respondent documented Patient F's congestive heart failure condition and Patient F's aortic stenosis (the narrowing of the heart's aortic valve through which blood flows from the heart to the body). He should have recorded the level or the severity of these conditions. The Respondent did not do so. While Patient F's medication list reflected the Respondent's treatment for coronary artery disease, the Respondent did not list that diagnosis among the patient's conditions. If Patient F had coronary artery disease as the Respondent noted in Patient F's medication list, the Respondent should have requested Patient F's records from other providers to determine the extent of the condition and what testing was done. He did not do so.

1.59 On September 15, 2008, Patient F presented for a blood draw. She reported chest pain at that time. The Respondent should have sent Patient F to the

hospital. He did not do so. The Respondent also failed to urgently treat Patient F with aspirin, oxygen, or nitrates to decrease the risk of permanent loss of heart muscle. Rather, the Respondent ordered a number of lab tests to determine whether the patient had intermediate coronary syndrome (an unstable angina, which may progress to a heart attack) and sent Patient F home. The Respondent's actions placed Patient F in risk of a myocardial infarction. In subsequent patient visits the Respondent did not list coronary artery disease as a diagnosis, pursue cardiac testing, or make a cardiology referral for Patient F.

1.60 On October 26, 2009, the Respondent prescribed nitroglycerin tablets (plus three refills) for Patient F. On January 28, 2010, Patient F's pharmacy contacted the Respondent for a nitroglycerine refill request. The timing of this request indicated that Patient F was using a high volume of nitroglycerin tablets and it further indicated that Patient F was either inappropriately using the nitroglycerine medication or that her high volume use showed she had poorly controlled angina. In either event, the Respondent needed to address this issue with Patient F. He did not do so.

1.61 During her December 3, 2008, visit, Patient F developed severe chest pain while being treated with an IV vitamin/mineral infusion treatment. This coincided with hypotension (low blood pressure). The Respondent diagnosed Patient F with an acute coronary insufficiency and ordered lab tests but not an electrocardiogram. He initiated IV fluid treatment to address the low blood pressure and administered three doses of nitroglycerin sublingually. Despite this treatment, Patient F continued to report severe chest pain. At this point the Respondent ordered a rush on the lab tests and

arranged for an ambulance to transport Patient F to the hospital. The Respondent's response was appropriate under the circumstances.

1.62 On December 17, 2008, Patient F returned for a patient visit with the Respondent to receive trigger point injections. The Respondent's records made no reference to Patient F's December 3, 2008 prior chest pain episode and did not reference what occurred during Patient F's hospital evaluation. The Respondent's records also did not include a coronary artery disease diagnosis. The records should have addressed both issues. The Respondent should have determined whether it was appropriate to institute trigger point injections for Patient F given her December 3, 2008, hypotension episode. He did not do so.

1.63 On March 12, 2009, Patient F again experienced a hypotension/low blood pressure episode that lasted for several hours. The Respondent determined that Patient F was experiencing a vasovagal collapse but he did not order an electrocardiogram or consider the possibility of an unstable angina or acute coronary syndrome. The Respondent released Patient F to go home with instructions to call the clinic or an ambulance should the condition worsen. The Respondent's records show that Patient F received IV infusion treatments on March 18, 2009, March 25, 2009, and April 1, 2009.

1.64 The Respondent's records show that Julie at Southwest Medical Center informed him that Patient F was admitted for "exacerbated congestive heart failure" on April 2, 2009, and was discharged on April 3, 2009. The Respondent did not request copies of Patient F's hospitalization records. This action was necessary to review the

patient's cardiac evaluation or determine what treatment Patient F received during the hospitalization. Even though he did not receive the hospitalization records, the Respondent performed trigger point injections to Patient F on April 14, 2009. The Respondent should have determined if trigger point injections were appropriate during this visit. The Respondent did not do so.

Management of Patient F's Neuropsychiatric Condition

1.65 The Respondent's initial examination of Patient F during her first visit in July 2008, did not record any notable cognitive deficits. Patient F was found to have intact orientation, short and long-term memory, spontaneous speech and normal insight and judgment. During the September 23, 2008 visit, the Respondent noted Patient F reported confusion, disorientation, short-term memory loss, apathy and sleeping difficulty. The Respondent diagnosed Patient F with senile dementia with depressive features. He failed to consider what factors contributed to the patient's rapid cognitive decline and the Respondent did not consider alternative diagnoses, such as a major depressive disorder or hypothyroidism. The Respondent did not provide treatment for these alternative diagnoses.

Management of Patient F's Thyroid Disease

1.66 Patient F suffered from hypothyroidism (the clinical consequence of inadequate levels of thyroid hormone in the body). Patient F's thyroid stimulating hormone level was noted to be high on numerous occasions. Patient F's symptoms of confusion, fatigue, and constipation could have been related to her hypothyroidism. The Respondent conducted several tests to determine Patient F's thyroid function.

These tests showed Patient F's thyroid stimulating hormone levels were low, which indicated hypothyroidism. Despite these test results, the Respondent did not treat Patient F's hypothyroidism condition. The Respondent should have done so and the failure to do so violated the standard of care.

Treatment of Patient F with IV Infusion Treatment

1.67 Patient F suffered from congestive heart failure and aortic stenosis. These are serious medical conditions and require that Patient F's volume levels be carefully monitored to prevent taxing the patient's heart. Despite this, the Respondent treated Patient F with 30 IV infusions of vitamins and minerals. The Respondent's records for Patient F do not show any objective clinical indication that she suffered from a deficiency of vitamin and mineral and therefore no IV supplementation was required, much less 30 such IV treatments. Given the patient's age (78) and cardiac health, the extra volume from the infusions risked an increased cardiac workload and angina symptoms. If vitamin and mineral supplementation was required, oral replacement was a safer alternative for Patient F. More seriously, the Respondent continued to treat Patient F with IV infusion treatments shortly after she was discharged from the hospital for a worsening of her congestive heart failure condition. Such treatments were continued even when Patient F's weight increased notably (a possible indication of fluid retention). The Respondent's treatment of Patient F was both deficient and created an unreasonable risk of harm to the patient.

Management of Patient F's Glaucoma

1.68 Patient F suffered from glaucoma (a group of eye conditions characterized by increased inter-ocular pressure that can lead to optic nerve damage and blindness). The Respondent should have referred Patient F to an eye clinic or eye specialist for eye pressure measurements to properly monitor and treat the patient's condition but did not do so. The Respondent's action put Patient F at risk for optic nerve damage and blindness.

Patient G

1.69 Patient G was a 66-year-old female patient when she first presented to the Respondent on January 31, 2008.⁶ Patient G's medical conditions included: coronary artery disease; depression; hypertensive heart disease with heart failure; hyperlipidemia; gastro-esophageal reflux disease; osteoarthritis and chronic complaints of neck and head pain; fatigue; insomnia; nausea; diarrhea; and constipation. The Respondent treated Patient G during the period January 2008 through June 2009.

Management of Patient G's Cardiac Condition

1.70 Patient G was diagnosed with coronary artery disease. She regularly reported symptoms of retrosternal (behind the sternum) chest pressure, which was made worse by walking up a hill or up the stairs. The retrosternal chest pressure occurred on a daily basis. Such regular complaints likely represented angina. The standard treatment for chest pain is prescribing nitroglycerine as needed. Patient G had

⁶ The Respondent provided treatment to Patient G prior to January 2008, but this treatment was not relevant to the charges.

previously been prescribed beta-blocker anti-anginal treatment (a class of drugs used to treat hypertension and other cardiac conditions) for her coronary artery disease condition. On September 30, 2008, the Respondent stopped Patient G's beta-blocker medication without any objective clinical reason for doing so. The standard of practice required the Respondent to explain in Patient G's treatment record what his clinical reasons were for stopping Patient G's beta-blocking medication. The Respondent did not do so. Then Patient G's beta-blocker medication reappeared on her medication list in February 2009, but there was no record why. This violated the standard of care.

1.71 The Respondent did not treat Patient G with aspirin, a medication clearly indicated in Patient G's case to prevent a myocardial infarction. The Respondent's records do not include the necessary information about the diagnosis and extent of Patient G's coronary artery disease, whether her heart muscle was at risk for ischemic injury (an inadequate supply of blood and oxygen to meet the heart muscle's demands), or whether Patient G had a previous myocardial infarction or any compromise to her ejection fraction (the percentage of blood emptied from the ventricle during systole or contraction of the heart's chamber). Both the Respondent's treatment plan and treatment records are deficient for this reason.

1.72 Patient G's coronary artery disease required tight control of her cholesterol levels. The goal for Patient G's low density lipoprotein (cholesterol) level results on testing was less than 70. On June 4, 2008, Patient G's levels were at 205. In this situation, the Respondent should have increased the patient's cholesterol lowering statin medication and increased the frequency of monitoring Patient G's cholesterol levels.

The Respondent did not increase Patient G's statin medication in June 2008 and the Respondent discontinued Patient G's statin medication according to the medication list entry dated July 24, 2008. There is no objective clinical indication as to why the Respondent discontinued Patient G's statin medication. On June 8, 2009, Patient G's low density lipoprotein level was measured at 189, still way above the recommended 70 measurement. Despite this disparity, the Respondent did not alter Patient G's treatment regime.

1.73 Finally, the Respondent diagnosed Patient G with hypertensive heart disease with heart failure in Patient G's regular visit assessments. However, he did not note any symptoms or signs of heart failure in his treatment records. The standard practice required the Respondent to obtain an echocardiogram of Patient G to support the heart failure diagnosis. The Respondent did not order an echocardiogram to confirm his diagnosis.

Management of Patient G's Neuropsychiatric Condition

1.74 Patient G suffered from depression. The Respondent regularly listed this diagnosis among the ones listed in Patient G's patient assessments but he did not treat Patient G's depression symptoms. Patient G initially started taking Celexa (an antidepressant medication) on October 30, 2004, which was four years prior to his being treated by the Respondent beginning in 2008. The Respondent noted the Celexa on the January 31, 2008, medication list for the patient.⁷ The Respondent continued to

⁷ It is unclear whether a prior treating physician prescribed the Celexa or the Respondent prescribed it during a previous treatment period for Patient G in 2004. The standard of care for medical recordkeeping requires that the Respondent clearly explain such issues in the patient's record.

include Celexa as an "active" medication on Patient G's medication lists until October 7, 2008. In that entry the Respondent's medication list for Patient G shows Celexa was discontinued on October 30, 2007. The Respondent did not explain why Patient G's Celexa medication was discontinued or why it remained on the "active" medication list when it was, in fact, discontinued. Neither did the Respondent explain why he was not treating Patient G's depression with another antidepressant medication.

1.75 On May 28, 2009, the Respondent noted that Patient G was suffering from symptoms of confusion and disorientation. The Respondent diagnosed the patient with cerebral atherosclerosis, hypertensive encephalopathy, and vascular dementia with depressed moods. The Respondent's records neither detail any psychiatric and neurological examinations in support of those diagnoses nor do the records show that the Respondent conducted a cognitive assessment to support a dementia diagnosis. The Respondent did not reinstitute Patient G's antidepressant medication despite the noted depression symptoms. The Respondent did not perform a thyroid stimulation levels tests to rule out the possibility that Patient G had a thyroid condition that was contributing to the diagnosed dementia.

Patient H

1.76 Patient H was a 65-year-old male when he first presented to the Respondent on September 20, 2006. Patient H's medical problems included: insulin dependent diabetes mellitus; sleep apnea syndrome (which was addressed with a continuous airway pressure (CPAP) device); hypertension; hyperlipidemia; glaucoma;

depression; arthritis with back pain; and a possible history of bladder stones.

The Respondent treated Patient H during the period September 2006 to March 2010.

Management of Patient H's Neuropsychiatric Condition

1.77 Patient H presented with symptoms of depression. The Respondent did not inquire whether Patient H had suicidal thoughts. The Respondent continued to list depression in his assessment diagnosis for Patient H.⁸ If Patient H had worsening depression, the Respondent should have increased Patient H's sertraline (Zoloft). Instead, the Respondent discontinued Patient H's Zoloft on May 15, 2007. The Respondent did not explain why he discontinued Patient H's Zoloft, a medication that is effective in treating common symptoms of depression. Failing to treat Patient H's depression was harmful to the patient.

1.78 One possible reason the Respondent discontinued Patient H's Zoloft depression medication was that he attributed Patient H's symptoms of depression to a vitamin and mineral deficiency. The Respondent's records for Patient H did not contain any laboratory data that supported the vitamin/mineral deficiency theory. The Respondent continued to treat Patient H's depression with IV treatments even after a multitude of vitamin and mineral IV infusion treatments did not correct the patient's depression. The Respondent should have stopped providing Patient H with the IV infusion treatments because they did not work. Rather the Respondent should have adjusted the patient's Zoloft medication levels to assist Patient H.

Treatment of Patient H with IV Infusions of Vitamins and Minerals

1.79 The Respondent administered IV vitamin and mineral infusion treatments to treat Patient H absent any objective clinical indication to support the IV treatment. The Respondent initially recommended 12 weekly infusions for Patient H beginning on March 5, 2007. The Respondent's records show that he did not track the actual number of treatments provided to Patient H. During the March 5, 2007, to November 6, 2008, period, the Respondent actually provided Patient H with 68 infusions and provided Patient H with an additional 19 IV infusion treatments after the above period. Patient H received 87 IV infusions for over one and one half years without any benefit in terms of repletion of vitamins and minerals.

Management and Treatment of Patient H's Other Medical Issues

1.80 The Respondent did not address or adequately address Patient H's other medical issues. For example the Respondent documented that Patient H suffered from high blood pressure throughout the patient's treatment records. With one exception, there is no indication in the Respondent's records that he treated Patient H using blood pressure medication to address this concern. The one exception appears to be the drug losartan (Cozaar), a blood pressure medication that is used to lower blood pressure and improve blood flow. The Respondent initially prescribed Cozaar to Patient H at his initial April 23, 2007, visit. The Respondent apparently discontinued the Cozaar medication at the patient's May 13, 2009, visit.

⁸ This constant repetition in the Respondent's records is an example of the Respondent's poor recordkeeping.

The Respondent did not explain in Patient H's record why he did so.

1.81 Patient H had an issue with his cholesterol levels, which increased the patient's risk of developing coronary heart disease. The Respondent frequently documented that he provided patient education to Patient H on this issue. The Respondent prescribed pravastatin (Pravachol) (a cholesterol-lowering medication) for Patient H on September 27, 2006. The Respondent should have monitored the efficacy of treating Patient H with the Pravachol to determine if it was controlling the patient's cholesterol levels. Yet the Respondent failed to assess the efficacy of the treatment until one year later. The Respondent should have monitored the Pravachol's efficacy approximately six weeks after initiating the treatment to determine whether the patient needed any treatment changes. The Respondent did not do so. The Respondent then discontinued Patient H's Pravachol on June 20, 2007, without any laboratory results or other indication or explanation in Patient H's chart. On August 12, 2008, the Respondent reinstated Patient H's Pravachol prescription but did not note why he changed the patient's treatment plan.

1.82 Repeated hematocrit test results revealed that Patient H suffered from anemia (a reduction in the mass of circulating red blood cells). The test results showed Patient H's hematocrit readings in the 35-36 level range as early as June 2007, and subsequent hematocrit lab tests on September 14, 2007, January 24, 2008, and October 23, 2008, showed lower level test results as well. The normal range for such hematocrit readings should be in the 40-50 range level. The Respondent failed to mention, assess, or conduct a medical workup regarding Patient H's anemia. In

addition to adequately monitoring Patient H's medication levels, the Respondent should have conducted a medical workup to look for evidence of occult gastrointestinal bleeding (small amounts of blood in the gastrointestinal track). The Respondent did not perform a medical work. He did not address Patient H's hematocrit level issued until August 2009 when the patient's hematocrit levels normalized.

1.83 Patient H suffered from glaucoma, an eye condition that can lead to damage to the optic nerve and blindness. The standard of care required the Respondent refer Patient H to an eye clinic at least annually for eye pressure measurements to properly monitor and treat the patient's condition. The Respondent failed to refer the patient for an eye examine in the three and one half years he provided treatment to Patient H.

Patient I

1.84 Patient I was a 31-year-old female when the Respondent began treating her on September 17, 2007. Patient I had a number of chronic list of conditions that included: hypertension; reactive airway disease or asthma; depression; bipolar affective disorder; left ovarian cancer (2003); cervical cancer (1994, 1997, and 2003); diabetes; tubal pregnancy; lupus with a past 21-day hospitalization; methamphetamine abuse; increased body mass index (a measurement used to estimate body fat and classify persons as being overweight, underweight, or normal) of 41; fatigue; three miscarriages; former tobacco dependence (the patient quit in August 2007); tubal ligation in 2003; a history of 13 motor vehicle accidents (without documentation of associated injuries); and

progressive poly-arthritis. The Respondent treated Patient I during the period September 2007 through November 2007.

Management of Patient I's Psychiatric Condition

1.85 The Respondent discontinued two of Patient I's previously prescribed psychiatric medications, clonazepam (an anticonvulsant) and quetiapine or Seroquel (an antipsychotic) on her first visit. However, the Respondent's records did not state why. Additionally, the Respondent doubled the patient's dosage for her prazosin medication (an antihypertensive for high blood pressure). Again, there was no record why the Respondent made these adjustments. The Respondent should have communicated with the physician who previously prescribed these medications and requested Patient I's previous treatment records prior to discontinuing any medication. He did not do so.

Management of Patient I's Thyroid Symptoms

1.86 On September 26, 2007, the Respondent diagnosed Patient I with a sudden toxic worsening of her hyperthyroid symptoms (a disease caused by excessive levels of the thyroid hormone in the body). The Respondent made this diagnosis despite the lack of an abnormal thyroid examination or available thyroid function test result for Patient I on September 26, 2007. The Respondent's records indicate that a thyroid function laboratory test was performed on October 2, 2007. The test results indicated Patient I had normal thyroid function. The normal test result did not support the Respondent's diagnosis of hyperthyroidism.

Management of Patient I's Ovarian and Cervical Cancer

1.87 As stated previously, Patient I had a history of ovarian cancer. Dr. Enzian (the Department's expert) identified this to be Patient I's most concerning diagnosis. Yet the Respondent did not address the patient's ovarian cancer history anywhere in his treatment records. Neither did he address Patient I's cervical cancer history. The Respondent did perform a pap smear for Patient I in July 2007, but he did not note the results of the test. The patient complained of symptoms of fatigue and malaise to the Respondent. Such symptoms might indicate a recurrence of the patient's cancer yet the Respondent did not appear to consider that possibility. Instead, the Respondent ordered 12 IV vitamin and mineral infusion treatments. The Respondent's records did not provide any objective clinical basis for the 12 treatments he ordered. Neither is there any indication that the IV infusion treatments would address either the ovarian cancer or cervical cancer. The IV infusion treatments were therefore unnecessary.

Management of Patient I's Lupus Condition

1.88 The Respondent documented Patient I's history of lupus (generally described as any chronic, progressive, usually ulcerating skin disease). Patient I was hospitalized for this condition for 21 days. In this situation, the Respondent should have requested the patient's prior records including rheumatologic recommendations to confirm this diagnosis or obtain information regarding the patient's prior workup for the condition. He did not do so.

Patient J

1.89 Patient J's primary care provider was Deborah Bryant, PA-C during this period. The Respondent was her supervising physician.⁹ Patient J, a 50 year old female, first appeared for treatment on December 23, 2009. Patient H's medical conditions included: Human T-cell lymphotropic virus (HTLV) type II (a retrovirus that can be associated with neurological disorders and chronic pulmonary infections) with associated neuromuscular deficits; diabetes; hypertension; chronic obstructive pulmonary disease; a history of depression; fibromyalgia; tobacco dependence; complaints of fatigue/malaise. The Respondent supervised Patient J's treatment from December 23, 2009, to March 31, 2010.

Management of Patient J's Neuropsychiatric Condition

1.90 Patient J regularly reported depression during her clinical visits and constantly reported exhaustion, fatigue and insomnia, all of which are symptoms of depression. The Respondent did not address any of Patient J's depression symptoms during the three months he co-treated Patient J with PA-C Bryant. The standard of care requires the Respondent to treat Patient J's medical complaints and conditions. The Respondent failed to do so.

Management of Patient J's HTLV-II Condition

1.91 HTLV-II is a retrovirus that can be associated with neurological disorders and chronic pulmonary infections. This infection often coexists with the human

⁹ Based on the digital signatures in the record, the Respondent saw or treated Patient J on December 24, 2009; January 8, 2010; January 15, 2010; January 20, 2010; February 4, 2010; February 17, 2010; March 4, 2010; March 18, 2010; and March 22, 2010.

immunodeficiency virus (HIV) infection [a retrovirus of the subfamily lentivirus (a group of retroviruses that cause slowly developing disease that cause the gradual killing of lymphoid cells) that causes acquired immunodeficiency syndrome]. Neither PA-C Bryant nor the Respondent tested Patient J for HIV. Patient J was on disability, in part, due to the neurologic manifestations of HTLV-II. Though she regularly noted symptoms of nerve discomfort, the Respondent did not address these symptoms. He did not refer the patient to a neurologist or infectious disease physician to further evaluate her neurologic symptoms and chronic HTLV-II infection.

1.92 Patient J also consistently reported a cough during her clinic visits. The Respondent did not entertain or evaluate any consideration of an HTLV-II related pulmonary infection relating to Patient J's cough. Dr. Enzien (the Department's expert) reports that Patient J's HTLV-II diagnosis was at the top of the list in the patient's visit assessments. Yet the Respondent never addressed the infection.

Patient K

1.93 Patient K was a 50-year-old female when she was first treated by the Respondent on September 29, 2008. Patient K was diagnosed with type 2 diabetes mellitus in 2000. Patient K also suffered from: hypertension; heart problems resulting in a 2005 hospitalization; a history of motor vehicle accident; and a family history of heart disease. The Respondent provided treatment to Patient K during the period of September 2008 through June 2009.

Treatment of Patient K with IV Iron Transfusions

1.94 Patient K's blood cell count results revealed the presence of anemia. As a starting point, the Respondent should have conducted tests to confirm whether the patient had an iron deficiency anemia. He did not do so. Neither did the Respondent explore the source of the patient's anemia (ruling out such causes as gastrointestinal bleeding from a peptic ulcer or colon tumor). The Respondent treated Patient K's anemia through the use of IV iron infusions. The Respondent did not consider treating Patient K with an oral supplement, a much safer alternative. The Respondent did not determine whether Patient K: (1) had any malabsorption problem that would prevent her from the use of the oral iron supplement; or (2) suffered from other indicators (such as continuous gastrointestinal bleed, inflammatory bowel disease, hemodialysis, or failure to respond) that argued against the use of an oral iron supplement.

1.95 Having decided to treat the patient using an IV iron infusion, the Respondent chose to use the Dexferrum formula (high molecular weight iron dextran) to treat Patient K's anemia on October 21, 2008, October 28, 2008, and November 4, 2008. Dr. Enzian notes that red blood cell response to IV iron is slower than that of oral iron. See Exhibit D-2, pages 32-33. The Dexferrum formula has the highest incident of adverse reactions. Patient K suffered from adverse reactions (itching and hives) during her October 28, 2008 IV iron infusion treatment. Patient K suffered a more severe reaction—anaphylactic shock—(hypotension and unresponsiveness) during her November 4, 2008, IV iron infusion treatment by the Respondent. This was a potentially life-threatening reaction. The Respondent gave Patient K four doses of epinephrine (a treatment for allergic reaction) and 1500 mg of IV fluids to help her regain a stable

blood pressure. The Respondent's duty in such life-threatening reactions is to call 911 or otherwise arrange emergent care for the patient. The Respondent did not do so.

1.96 Following the life-threatening reaction with Patient K, the Respondent discontinued the patient's IV iron infusion and initiated oral supplements. The Respondent then treated Patient K with weekly IV vitamin and mineral infusion treatments for folate (folic acid), vitamin, and mineral deficiencies. There were no objective clinical indications such as lab tests that Patient K suffered from these deficiencies. Neither was there any indication that the Respondent's chosen treatment for Patient K was effective or necessary.

Management of Patient K's Diabetes Condition

1.97 The Respondent did not provide Patient K with standard health care maintenance treatment such as yearly urine microalbumin screening (testing for a protein in the patient's urine) to see whether the patient is suffering from any progressive renal disease. Neither did he conduct a yearly monofilament examination to screen for diabetic neuropathy (The use of a strand of nylon to assess the sensation or lack of sensation in peripheral nerves especially in the feet).

1.96 Potential eye diseases may arise as a complication of diabetes, including damage to the blood vessels in the retina (diabetic retinopathy) that can ultimately result in blindness. The standard of care required the Respondent to refer Patient K to an ophthalmologist for eye screening for diabetic retinopathy. He did not do so in his management of Patient K's diabetic condition. The Respondent did not manage Patient K's diabetic conditions consistent with the standard of care in Washington.

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.

2.2 The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), *cert. denied*, 535 U.S. 904 (2002).

2.3 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

2.4 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(1), which states:

The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.

2.5 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which states:

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 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.

2.6 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(13), which states:

Misrepresentation or fraud in any aspect of the conduct of the business or profession.

2.7 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(16), which states:

Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment procedure, or service.

2.8 The Department requested the Commission suspend the Respondent's license until he fixes the problems identified in the hearing, to include: (1) a prohibition against IV vitamin and mineral infusion treatments; (2) consistent cardiologist referrals where indicated; (3) the documentation of any referral to another physician in the patient's records; (4) a recordkeeping course and a requirement that the Respondent correct his electronic medical record software; and (5) a practice assessment and successful completion of a ProBE offered by the Center for Personalized Education for Physicians (CPEP) course. The Department further requests a five-year period of probation following the Respondent's successful completion of the suspension, with yearly appearances before the Commission. The Respondent agrees that he will stop

providing IV vitamin and mineral infusion treatments and will correct the electronic medical records software, but that his practice should not otherwise be limited.

2.9 In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160. The Commission concludes the Respondent's conduct falls in Tier B of the Practice Below the Standard of Care schedule. WAC 246-16-810. The Commission panel considered the following aggravating factors when determining the sanction in this matter: (1) age and vulnerability of the patients; (2) the Respondent's motivation in providing IV vitamin and mineral infusion treatment was for personal gain; and (3) the number and frequency of the acts of unprofessional conduct. The Commission panel considered the following mitigating factors when determining the sanction in this matter: (1) the lack of the Respondent's prior disciplinary history; and (2) the Respondent's admission that his recordkeeping was sub-standard.

III. ORDER

3.1 Probation. The Respondent's license to practice as a physician and surgeon in the state of Washington is placed on PROBATION for a period of five years. During the period of probation, the Respondent shall comply with the following terms and conditions.

3.2 Attendance at CPEP. The Respondent shall enroll in the Center for Personalized Education for Physicians in Denver, Colorado (CPEP) within 12 months of the effective date of this Order. The Respondent shall fully cooperate with a clinical skills assessment, including any recommendations for continuing education or preceptor

program, and will provide CPEP with any charts, documents, and releases that are requested. The Commission may provide to CPEP investigative materials, pleadings, or orders in this case. The Respondent shall release CPEP to discuss any matters relating to the Respondent's evaluation with the Commission. The Respondent waives any privileges or privacy rights he might have under federal and state law with regard to his CPEP participation.

3.3 Practice Review. The Respondent shall permit a representative of the Commission to audit the Respondent's records and review the Respondent's practice at least two times per year. The first practice review shall occur three months after the effective date of this Order, and every six months thereafter. The Respondent shall cooperate with the Commission's representative during the practice reviews and to permit the representative to review and copy patient records.

3.4 Continuing Medical Education. Within 12 months of the effective date of this Order, the Respondent must complete a continuing medical education course in the area of medical recordkeeping. The course must be approved in advance by the Commission or the Commission's designee. The Respondent will submit proof of the completion of the course within 12 months of the effective date of this Order to the following address:

Compliance Officer
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

3.5 Automatic Suspension of License. In the event the Respondent fails to fully comply with the terms and conditions in Paragraphs 3.2, 3.3, and 3.4 within

one year of the effective date of this Order, the Commission automatically SUSPENDS the Respondent's license to practice until such time as the Respondent fully complies.

3.6 Compliance Appearances. The Respondent shall appear before the Commission 12 months from the effective date of this Order and present proof that he is complying with the Order. After the first appearance, the Respondent shall continue to make compliance appearances every 12 months unless otherwise instructed in writing by the Commission or its representative, until the Commission releases the Respondent from the terms and conditions of the Order.

3.7 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in her residential and or business address within 30 days of such change.

3.8 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Order.

3.9 Failure to Comply. Protecting 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 and or revocation of the Respondent's license after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing. At that hearing, the Respondent must show cause why his license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

3.10 Modification of Order. The Respondent may not seek modification of this Order for five years from the date of this Order.

3.11 Effective Date of Order. The effective date of this Order is the date the Adjudicative Service Unit places the signed Order into the U.S. mail. The Respondent shall not submit any fees or compliance documents until after the effective date of this Order.

Dated this 17 day of March, 2015.

Medical Quality Assurance Commission


MICHELLE TERRY, M.D.
Panel Chair

CLERK'S SUMMARY

<u>Charge</u>	<u>Action</u>
RCW 18.130.180(1)	Violated
RCW 18.130.180(4)	Violated
RCW 18.130.180(13)	Violated
RCW 18.130.180(16)	Violated

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND FINAL ORDER

Page 52 of 53

Master Case No. M2010-844

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within ten days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Medical Program
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx>