

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

FILED
MAR 18 2010
Adjudicative Clerk

In the Matter of

KENNETH M. JONES, MD
License No. MD00028268

Respondent

**No. M2007-58443
(Docket No. 07-10-A-1067MD)**

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

The Medical Quality Assurance Commission (Commission), through Michael L. Farrell, Department of Health Staff Attorney, and Respondent, represented by counsel, Shawn Newman and William J. Stilling, stipulate and agree to the following:

1. PROCEDURAL STIPULATIONS

1.1 On November 16, 2007, the Commission issued a Statement of Charges against Respondent. On July 16, 2009, the Commission issued a Third Amended Statement of Charges against Respondent.

1.2 In the Third Amended Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(1),(4), (6), (7), (10) and (14), 21 U.S.C. 333(e)(1), RCW 69.41.040 and RCW 69.41.320.

1.3 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent understands that if the allegations are proven at a hearing, the Commission has the authority to impose sanctions pursuant to RCW 18.130.160.

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

1.6 Respondent waives the opportunity for a hearing on the Statement of Charges provided that the Commission accepts this Stipulated Findings of Fact, Conclusions of Law and Agreed Order. (Agreed Order)

1.7 The parties agree to resolve this matter by means of this Agreed Order.

1.8 Respondent understands that this Agreed Order is not binding unless and until it is signed and accepted by the Commission.

1.9 If the Commission accepts this Agreed Order, it is subject to the federal reporting requirements pursuant to Section 1128E of the Social Security Act and 45 CFR

Part 61, RCW 18.130.110 and any other applicable interstate/national reporting requirements. It is a public document and will be available on the Department of Health web site.

1.10 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 and the Program stipulate to the following facts:

2.1 On February 24, 1991, the state of Washington issued Respondent a credential to practice as a physician and surgeon. Respondent's credential is currently active.

2.2 Respondent is a board-certified plastic surgeon. Respondent has an office-based plastic surgery practice located in Wenatchee, Washington.

2.3 Pacific Laser & Skin (Pacific) is a limited liability company registered in the state of Washington. Between at least 2004 and 2006, Pacific operated a facility in Seattle that provided a number of services to its clients, including mesotherapy, Restylane® and Botox™ injections. The owners of Pacific were not licensed health care providers in the state of Washington.

2.4 Botox™ is a trade name for botulinum toxin. It is injected into the muscle to remove wrinkles. Botox™ is a prescription medication.

2.5 Restylane® is a trade name for a specific formulation of non-animal sourced hyaluronic acid. Restylane® is injected into the face to remove wrinkles or to augment lips. Restylane® is a prescription medication.

2.6 Mesotherapy is a cosmetic procedure in which small quantities of a "mesotherapy cocktail" pharmaceutical medication, homeopathic medication, and other ingredients are injected into the subcutaneous fat to break down fat deposits. The mesotherapy cocktail provided to patients at Pacific consisted of 4cc lecithin, 4cc aminophylline, 2cc levocarnitine, and 2cc 2% lidocaine. Aminophylline, levocarnitine and lidocaine are prescription medications.

2.7 In 2004, Respondent entered into an agreement to serve as the medical director of Pacific. Respondent agreed to supervise the staff, either in person when he was

in Seattle or by phone if he was in Wenatchee. In return, the owners of Pacific agreed to promote Respondent's plastic surgery practice. Respondent served as the medical director until he resigned in April 2006.

2.8 In 2005, Respondent provided his DEA registration number to the staff at Pacific to order Botox™ and Restylane® for use in the facility. The staff at Pacific did not have the legal authority to order prescription medication.

2.9 Respondent was in Pacific's facility approximately five days in 2004 and approximately sixteen days in 2005. Respondent did not visit the facility in 2006.

2.10 During Respondent's tenure as medical director for Pacific, Respondent knew or should have known that staff members routinely evaluated patients, determined whether they were appropriate candidates for treatment, and injected Botox, Restylane and a mesotherapy cocktail into patients without an order from, and not in the presence of Respondent. By doing so, these staff members engaged in the unlicensed practice of medicine. Respondent aided and abetted this unlicensed practice of medicine.

2.11 Under the "corporate practice of medicine doctrine," a corporation, partnership, or similar entity generally may not practice medicine. No exception to the doctrine applies to this case.

2.12 Between at least 2004 and 2006, Pacific, through its employees, provided medical care to patients in the state of Washington, and, thus, engaged in the unlicensed practice of medicine in the state of Washington. Respondent aided and abetted this unlicensed practice of medicine.

2.13 Allure Laser Center and Skin Restoration (Allure) is a limited liability company registered in the state of Washington. From 2005 to 2007, Allure operated a facility in Yakima that provided a number of services to its clients, including hair removal with a prescription laser device and a prescription intense pulsed light device. Allure advertises its facility as a "medical day spa."

2.14 The owners of Allure were Robyn Fiebelkorn and Adrienne Phillips. Ms. Fiebelkorn holds a credential to practice as a surgical technician in the state of Washington. Ms. Phillips does not hold a credential to practice a health care profession in the state of Washington.

2.15 In the summer of 2005, Respondent entered into an agreement with Allure to serve as the medical director of Allure facility in Yakima. As medical director, Respondent agreed to supervise Ms. Fiebelkorn and Ms. Phillips. In return, the owners of Allure agreed to promote Respondent's plastic surgery practice. Respondent knew he was the only physician working with the staff at Allure. Respondent served as the medical director until he resigned in April 2007.

2.16 During his tenure as medical director, Respondent helped Allure purchase a McCue intense pulsed light device by providing the owners' names to a distributor for the device, and by permitting the owners to use his name and medical license to enter into a lease-to-buy agreement with the distributor. A McCue intense pulsed light device is a prescription device that can be sold only to persons with prescriptive authority. Respondent aided and abetted unlicensed practice by assisting the owners of Allure to purchase or lease a device they had no legal authority to purchase or lease.

2.17 During Respondent's tenure as medical director of Allure, both Ms. Fiebelkorn and Ms. Phillips used prescription laser and prescription intense pulsed light devices to perform hair-removal procedures on numerous clients.

2.18 The use of a prescription device to perform hair-removal procedures is the practice of medicine. Ms. Fiebelkorn and Ms. Phillips engaged in the unlicensed practice of medicine each time they used a prescription device to remove hair from a client.

2.19 As medical director of Allure, Respondent aided and abetted the unlicensed practice of medicine each time a prescription device was used in the office.

2.20 On or about February 2, 2007, Ms. Fiebelkorn used an EpiLight intense pulsed light device to attempt to remove a tattoo from Client A's hand. The Federal Food and Drug Administration approved the use of this particular device for hair removal, not tattoo removal. The FDA designated this particular device as a prescription device. Following the procedure, Ms. Fiebelkorn gave no instructions to Client A, other than telling her not to get the area wet, and that Client A should return in one month. Ms. Fiebelkorn's treatment resulted in third-degree burns to the skin on Client A's hand. Client A's hand subsequently became infected and required treatment at a local hospital.

2.21 The use of a prescription device to remove a tattoo is the practice of medicine. Ms. Fiebelkorn engaged in the unlicensed practice of medicine by using a

prescription intense pulsed light device to attempt to remove a tattoo from Client A's hand. As medical director of Allure, Respondent aided and abetted the unlicensed practice of medicine.

2.22 Ms. Fiebelkorn inappropriately used a prescription device for an unapproved use, and injured a client. As medical director of Allure, Respondent failed to adequately supervise Ms. Fiebelkorn's treatment of Client A.

2.23 Under the "corporate practice of medicine doctrine," a corporation, partnership, or similar entity generally may not practice medicine. No exception to the doctrine applies to this case.

2.24 Between 2005 and 2007, Allure, through its employees, provided medical care to patients in the state of Washington, and, thus, engaged in the unlicensed practice of medicine in the state of Washington. By acting as the medical director for Allure, Respondent aided and abetted this unlicensed practice of medicine.

2.25 In 2007, Respondent began promoting an "age management" practice on a web site at www.agemanagementnorthwest.com. The web site stated that Respondent is certified by the Cenegenics Medical Institute. The site states:

Through nutrition, exercise and hormonal support, Age Management Northwest helps to regain and maintain youthful vigor. Our process results in a healthier and happier life. Will you live longer? Probably, but we haven't proven that – yet. As essential hormones diminish, insulin and cortisol increase, bringing some of the recognizable results of the aging process.

2.26 In February 2007, Respondent was interviewed on Evening Magazine, a television news program on KING-TV in Seattle. Respondent told the reporter that he takes human growth hormone every morning and a steroid stimulator twice a week.

2.27 The standard of care for diagnosing adult growth hormone deficiency requires first, that the physician have a high index of suspicion that the patient has growth hormone deficiency (for example the patient discloses a history of having a profound head trauma or brain tumor with radiation). Second, the physician must obtain an IGF-1 (insulin like growth factor) level and then perform the provocative (or stimulation) test. The stimulation test is required unless the patient has deficiencies in at least three other hormone levels or the patient has a history of childhood growth hormone deficiency. Third, if growth hormone

deficiency is determined as outlined above, the physician must look for the underlying cause.

A clinical study of normally aging adults in a 2002 issue of the top-tier medical journal, the Journal of the American Medical Association, documented a high risk- to-benefit-ratio for the administration of growth hormone to these subjects with up to a 50% rate of adverse effects, including joint pains, swelling and, in 13%, diabetes. A 2007 article in the Annals of Internal Medicine, which assessed the results of 31 clinical studies where growth hormone was administered to healthy adults, again reasserted an unacceptably high-risk- to-benefit ratio. The authors of both publications and consensus statements from the two major Professional Endocrinology Associations state that growth hormone should not be provided for purposes other than those allowed by the FDA (the Secretary of Health and Human Services).

2.28 Respondent began seeing Patient B, a 45-year old male, in March 2007. One of Patient B's "healthcare goals" was to increase his lean muscle mass. Respondent diagnosed Patient B with GHD and prescribed human growth hormone to Patient B shortly thereafter. Patient B had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient B had an IGF-1 level of 130, which was within the laboratory's normal range of 86 to 220. Endocrinologists do not rely upon an IGF-1 level to make a correct diagnosis of GHD. There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD, as incorrectly diagnosed by the Respondent, and the Respondent's prescribing of human growth hormone to Patient B was below the standard of care and created a potential risk of harm to Patient B.

2.29 Respondent began seeing Patient C, a 68-year old male, in November 2006. One of Patient C's "healthcare goals" was to re-gain his muscle mass. Respondent diagnosed Patient C with GHD and prescribed human growth hormone. Patient C had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient C had an IGF-1 level of 126, which was within the laboratory's normal range of 75 to 225. Endocrinologists do not rely upon an IGF-1 level to make a

correct diagnosis of GHD. There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD and the prescribing of human growth hormone to Patient C was below the standard of care and created a potential risk of harm to Patient C.

2.30 In November of 2006 Respondent also diagnosed Patient C as having a low testosterone level of 649, based on his Quest Diagnostic lab results, and prescribed testosterone for Patient C. The Quest reference range for a normal testosterone level is 250 to 1100. Dr. Jones might have attempted to indicate that the patient's testosterone level was low by using the Cenegenics-supplied normal range for testosterone of 700 to 900. But according to what would be regarded as the standard of care, that is, using the laboratory range supplied by the lab that performed the test, Patient C's testosterone level was normal. Thus, prescribing testosterone to Patient C, without laboratory evidence of testosterone deficiency, was below the standard of care and created a risk of harm to Patient C.

2.31 Respondent began seeing Patient D, a 42-year old female, in March 2007. Respondent diagnosed Patient D with GHD and prescribed human growth hormone. Patient D had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient D had an IGF-1 level of 132, which was within the normal range of 88 to 249. Endocrinologists do not rely upon an IGF-1 level to make a correct diagnosis of GHD. There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD and prescribing of human growth hormone to Patient D was below the standard of care and created a potential risk of harm to Patient D.

2.32 Respondent began seeing Patient E, a 45-year old male, in January 2008. One of Patient E's "healthcare goals" was to have more energy and endurance. Respondent diagnosed Patient E with GHD and prescribed human growth hormone. Patient E had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient E had an IGF-1 level of 109, which was within the normal range of 86 to 220. Particularly when one notes that the blood was obtained in the

morning, when IGF-1 levels are usually low, the diagnosis of GHD is all the more unlikely (note that endocrinologists do not rely on an IGF-1 level to make a diagnosis of adult GHD). There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD and the prescribing of human growth hormone to Patient E was below the standard of care and created a potential risk of harm to Patient E.

2.33 Respondent's records for Patient E show that Patient E reported having high blood pressure and was diagnosed with sleep apnea about four months prior to his first meeting with Respondent. In spite of this, Respondent has no notes of performing a physical examination of Patient E or communicating with or requesting records from Patient E's primary care physician. Some reports indicate that human growth hormone supplementation can worsen high blood pressure and sleep apnea.

2.34 In July of 2008 Respondent also diagnosed Patient E as having clinically significant low testosterone production, despite a level of 487, which is normal according to the Qwest Laboratory normal reference range (250 to 1100). Dr. Jones might have attempted to indicate that the patient's testosterone level was low by using the Cenegenics-supplied normal range for testosterone of 700 to 900. But according to what would be regarded as the standard of care, that is, using the laboratory range supplied by the lab that performed the test, Patient E's testosterone level was normal. Because Patient E's testosterone level was normal, according to the Qwest laboratory's reference range, there would be no anticipated medical benefit to Patient E from testosterone. Dr. Jones' prescribing of it was below the standard of care and created a risk of harm to Patient E. Furthermore, this patient was noted to have high blood pressure and obstructive sleep apnea, both of which are relative contraindications for the administration of testosterone, since testosterone can cause or make these conditions worse.

2.35 Respondent began seeing Patient F, a 52-year old male, in March 2007. One of Patient F's "healthcare goals" was to feel more energetic and vital. Respondent diagnosed Patient F with GHD and prescribed human growth hormone. Patient F had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient F had an IGF-1 level of 158, within the normal range of 87 to

225. Endocrinologists do not rely upon an IGF-1 level to make a correct diagnosis of GHD. The diagnoses of GHD and the prescribing of human growth hormone to Patient F was below the standard of care and created a potential risk of harm to Patient F.

2.36 In January of 2009 Respondent also diagnosed Patient F as having a low testosterone level of 774 based on his Quest lab results and prescribed testosterone for Patient F. The Quest reference range for a normal testosterone level is 250 to 1100. Because Patient F's testosterone level was normal, even considering the Cenegenics' suggested normal range of 700-900, there is no laboratory evidence of clinically significant low testosterone production and, therefore, prescribing testosterone was below the standard of care.

2.37 Respondent's records for Patient F show that on March 27, 2008 Respondent agreed with Patient F's decision to stop his medications. Respondent has no other notes or lab results for Patient F between November 20, 2007, and January 20, 2009. Patient F's chart notes that Patient F has sleep apnea. In spite of this, Respondent has no physical exam notes and did not request records from Patient F's primary care physician. In light of the patient's diagnosis of obstructive sleep apnea, by prescribing testosterone to this patient, Dr. Jones placed the patient at increased risk of worsening his obstructive sleep apnea and placing him at risk of other known adverse events associated with testosterone supplementation, including high blood pressure.

2.38 Respondent began seeing Patient G, a 69-year old male, in August 2007. Patient G had been taking human growth hormone by virtue of another physician's order. Respondent diagnosed Patient G with GHD and prescribed human growth hormone. Patient G had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient G had a IGF-1 level of 240, above the normal range of 75 to 228. There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD and the prescribing of human growth hormone to Patient G was below the standard of care and created a potential risk to Patient G.

2.39 Respondent began seeing Patient H, a 57-year old male, in January 2008. Respondent diagnosed Patient H with GHD and prescribed human growth hormone.

Patient H had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient H had an IGF-1 level of 90, within the normal range of 87 to 225. Endocrinologists do not rely upon an IGF-1 level to make a correct diagnosis of GHD. There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD and the prescribing of human growth hormone to Patient H was below the standard of care and created a potential risk to Patient H.

2.40 In January of 2008 Respondent also diagnosed Patient H as having clinically significant low testosterone production despite a testosterone level of 403, which is normal according to the Qwest Laboratory normal reference range (250 to 1100). Dr. Jones might have attempted to indicate that the patient's testosterone level was low by using the Cenegenics-supplied normal range for testosterone of 700 to 900. But according to what would be regarded as the standard of care, that is, using the laboratory range supplied by the lab that performed the test, Patient H's testosterone level was normal. Because Patient H's testosterone level was normal according to the Qwest laboratory's reference range, there would be no anticipated medical benefit to Patient H from testosterone. Dr. Jones' prescribing and contributing to the distribution of testosterone without a substantiated medical reason falls below the acceptable standard of medical care and poses unnecessary medical risks for the patient (such as obstructive sleep apnea, hypertension, and elevated LDL cholesterol and low HDL cholesterol).

2.41 Respondent began seeing Patient I, a 50-year old male, in September 2007. One of Patient I's "healthcare goals" was regaining vitality. Respondent diagnosed Patient I with GHD and prescribed human growth hormone. Patient I had no documented evidence of pituitary or hypothalamic disease, nor was there any documentation of a stimulation test having been performed to document abnormal anterior pituitary function. Patient I had an IGF-1 level of 160, within the normal range of 86 to 220. Endocrinologists do not rely upon an IGF-1 level to make a correct diagnosis of GHD. There was no evidence of any other pituitary hormonal deficiencies, such as low thyroid function tests or low serum testosterone. The diagnoses of GHD and the prescribing of

human growth hormone to Patient I was below the standard of care and created a potential risk to Patient I.

2.42 Patient I reported in his medical history to Respondent that he had a liver biopsy in 2004, and that he was cured of HCV (Hepatitis C virus). Patient I also stated that his mother had endocrine issues and that he was pre-diabetic. In spite of this, Respondent did not do an extensive physical examination on Patient I and did not request records from Patient I's primary care physician. Particularly in light of the patient's family history of diabetes, Dr. Jones placed patient I at even greater risk of developing diabetes by unnecessarily prescribing and contributing to the distribution of growth hormone to this patient.

2.43 In September of 2007 Respondent also diagnosed Patient I as having clinically significant low testosterone production despite a testosterone level of 717, which is normal based on the Qwest Laboratory normal reference range (250 to 1100). Dr. Jones might have attempted to indicate that the patient's testosterone level was low by using the Cenegenics-supplied normal range for testosterone of 700 to 900. Because Patient I's testosterone level was normal according to the Qwest laboratory's reference range (and even the Cenegenics' range), there would be no anticipated medical benefit to Patient I from human chorionic gonadotropin (HCG) which stimulates testosterone production. Dr. Jones' prescribing and contributing to the distribution of HCG without a substantiated medical reason falls below the acceptable standard of medical care. Furthermore, the medical standard of care would have required that the patient's lutenizing hormone level be checked, to determine the need for HCG.

3. CONCLUSIONS OF LAW

The State 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), (10) and (14).

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

4. AGREED ORDER

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

4.1 **Suspension of Respondent's License.** Respondent's license to practice as a physician and surgeon in the state of Washington is SUSPENDED for a period of thirty days beginning on March 6, 2010 and ending on April 5, 2010.

4.2 **Practice Plan.** Prior to resuming the practice of medicine, Respondent will provide to the Commission a list of all the offices or clinics in which he sees patients or otherwise practices medicine, state whether he has an ownership interest in the facility or not, and a describe his practice in each of these offices. Respondent will update this information as the information changes.

4.3 **Probation.** Following the 30-day period of suspension, and upon Respondent's satisfactory completion of the requirements of paragraph 4.2, the Commission will issue an Order stating that the suspension is lifted and Respondent's license is placed on probation for a period of at least five years.

4.4 **Ethics Course.** Respondent will attend and successfully complete a two-day ethics course approved in advance by the Commission or its designee. Respondent will complete the course within 180 days of the effective date of this Agreed Order. Respondent will provide the course instructors with a copy of this Agreed Order prior to taking 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 successful 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. The ProBE course offered by the Center for Personalized Education for Physicians is pre-approved.

4.5 **Practice Restriction.** Respondent is permanently prohibited from prescribing, administering, dispensing or otherwise providing thyroid hormones, human growth hormone, human chorionic gonadotropin, and testosterone or other anabolic steroids for and to patients. Respondent is prohibited from stating to a patient or to the public that he takes any of these substances, and from promoting the use of any of these

substances. If Respondent encounters a patient with a hormone deficiency or imbalance, Respondent will refer the patient to a board-certified endocrinologist licensed and practicing in the state of Washington.

Respondent may prescribe, administer, and dispense corticosteroids, including without limitation prednisone, dexamethasone, Kenalog, Medrol Packs, and creams such as temovate in his plastic surgery practice, so long as their use is within the standard of care and documented in the patient chart.

4.6 **Prohibition Against Supervising Persons not in Office.** Respondent will not supervise, employ or direct any individual who does not work in one of the offices on the list Respondent provides to the Commission pursuant to paragraph 4.2.

4.7 **Employee Scope of Practice.** Respondent will ensure that no employee in Respondent's office practices beyond the scope of his or her license, certificate, or registration.

4.8 **DEA Number.** Respondent will not provide his DEA number to another individual, or in any way facilitate the purchase of a prescription medication or a prescription device by another person.

4.9 **Fine.** Respondent will pay a fine to the Commission in the amount of ten thousand dollars (\$10,000.00) which must be received by the Commission within ninety (90) days of the effective date of this Agreed order. The fine 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.

4.10 **Obey all Laws.** Respondent will obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.11 **Practice Reviews.** In order to monitor compliance with the Order Respondent agrees that a representative of the Commission may make announced semi-annual visits to each of Respondent's offices to inspect the office, review medical records and interview Respondent's employees. The frequency of the visits may be modified at Respondent's first compliance appearance before the Commission.

4.12 **Compliance Appearances.** Respondent will appear before the Commission twelve (12) months from the date this Agreed Order is signed by the

Commission, or as soon thereafter as the Commission's schedule permits, and present proof that he is complying with this Order. After the first appearance, Respondent will continue to make compliance appearances every twelve(12) months unless otherwise instructed in writing by the Commission or its representative, until the Commission releases Respondent from the terms and conditions of this Order.

4.13 **Costs.** Respondent is responsible for all costs of complying with this Agreed Order.

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

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

4.16 **Petition to Modify Order.** Respondent may file a petition to modify this Agreed Order no sooner than two years from the effective date of this Agreed Order. When and if Respondent files a petition, the Commission will review Respondent's compliance and issue an order granting or denying Respondent's petition. The Commission may require Respondent to appear before it to answer questions concerning his compliance. The Commission has sole discretion to grant or deny Respondent's petition.

4.17 **Petition to Terminate Order.** Respondent may file a written petition to terminate the terms and conditions of this Agreed Order no sooner than five years after the effective date of this Agreed Order. When and if Respondent files a petition, the Commission will review Respondent's compliance and issue an order granting or denying Respondent's petition. The Commission may require Respondent to appear before it to answer questions concerning his compliance. The Commission has sole discretion to grant or deny Respondent's petition.

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.

5. COMPLIANCE WITH SANCTION SCHEDULE

5.1 RCW 18.130.390 and WAC 246-16-800, et. seq., require the Commission to impose sanctions that fall within one of the sanction schedules in WAC 246-16-800, et. seq., or to explain why the Commission is deviating from those sanction schedules.

5.2 The conduct described in the Findings of Fact is the type of conduct described in Tier B of the sanction schedule entitled "Practice Below Standard of Care" and is set forth in WAC 246-16-810. Tier B is the appropriate tier because Respondent's conduct either harmed or created a risk of moderate to severe harm to patients, but did not cause severe harm or death to a patient.

5.3 The range for Tier B is oversight for two to five years, unless revocation. The sanctions imposed in this Agreed Order are on the maximum end of the range set forth in Tier B because of the following aggravating and mitigating factors:

(a) Aggravating factors:

(i) Respondent has engaged in numerous acts of misconduct with numerous patients at three different clinics from 2004 to 2010.

(ii) Respondent has engaged in a variety of acts that constitute unprofessional conduct.

(iii) Respondent's conduct damages the standing of the medical profession.

(b) Mitigating factors:

(i) Respondent's current plastic surgery practice demonstrates he is competent to practice plastic surgery.

(ii) Respondent has practiced medicine for 28 years.

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 credential 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 credential 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. ACCEPTANCE

I, Kenneth M, Jones, 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.


KENNETH M. JONES, MD
RESPONDENT

4/5/10
DATE

SHAWN T. NEWMAN, WSBA#14193
ATTORNEY FOR RESPONDENT

DATE

WILLIAM J. STILLING
ATTORNEY FOR RESPONDENT

DATE

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8. ORDER

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

DATED: March 15, 2010.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

Frederick H. Gore MD
PANEL CHAIR

PRESENTED BY:

Jim McLaughlin, WSBA #27349, for
MICHAEL FARRELL, WSBA #16022
DEPARTMENT OF HEALTH STAFF ATTORNEY

March 15, 2010
DATE