BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE CONSENT AGREEMENT FOR

PATRICK KIN-YEE CHAU, M.D., APPLICANT

FILE No. 02-2020-0013

****

CONSENT AGREEMENT

****

COMES NOW the Iowa Board of Medicine ("Board") and Patrick Kin-Yee Chau, M.D. ("Applicant") on February 13, 2020, and enter into this Consent Agreement for the issuance of a permanent Iowa medical license subject to the following conditions:

1. Applicant is hereby granted Iowa license no. MD-47041.

2. On July 23, 2019, Applicant submitted an application for a permanent Iowa medical license.

3. **2006 Washington Discipline:** Applicant was issued a license to practice medicine in the State of Washington in 1992. Between March 2004 and July 2005, the Washington Medical Quality Assurance Commission ("Washington Commission") received six complaints involving Respondent's treatment of eight patients relating to patient care and improper prescribing. On May 25, 2006, the Washington Commission summarily suspended Applicant's license pending further investigation on the grounds that Applicant inappropriately prescribed amphetamine and/or methamphetamine for weight loss and/or depression, failed to properly monitor patients while on these

medications, failed to maintain accurate medical records for these patients, and failed to conduct appropriate testing and evaluations, resulting in a substantial threat of harm to his patients. See Attachment A. On November 8, 2006, the Washington Commission reinstated Applicant's license, but placed Applicant on probation for a period of two years after finding that Applicant's treatment of the patients at issue in the complaints fell below the standard of care. See Attachment B.

4. **2009 Washington Discipline:** The Washington Commission received additional complaints about Applicant in 2008. On July 15, 2008, the Washington Commission found that an immediate danger to the public health, safety, or welfare existed if Applicant's medical license remained unrestricted, and entered a summary order restricting Applicant from prescribing any benzodiazepines, thyroid medications, or stimulants pending final resolution of those complaints. See Attachment C. On October 15, 2009, the Washington Commission found that Applicant engaged in unprofessional conduct and violated the terms of his probation by prescribing large doses and large amounts of addicting medication, failed to obtain necessary medical records for his patients, failed to document patient pain complaints, failed to appropriately monitor his patients, and failed to produce records in response to the Washington Commission's investigation. The Washington Commission again placed Applicant's license on probation indefinitely, until he completed the terms of his probation. See Attachment D.

5. **2012 Washington Discipline:** On November 15, 2012, the Washington Commission found that Applicant again engaged in unprofessional conduct and violated the terms of his probation by improperly prescribing medications and failing to record his treatment of two patients. The Washington Commission again placed Applicant's license

on probation. See Attachment E. On November 3, 2017, Applicant completed the terms of his probation. See Attachment F.

6. **California Discipline:** Applicant was issued a license to practice medicine in the State of California in 1990. On December 27, 2006, the Medical Board of California ("California Board") filed an accusation based on the 2006 action by the Washington Commission. See Attachment G. On January 30, 2007, Applicant and the California Board entered into a stipulated agreement whereby Applicant surrendered his California medical license, see Attachment H, which the Board accepted as final on March 1, 2007, see Attachment I.

7. **CITATION AND WARNING:** Applicant is hereby **CITED** for failing to meet the minimum standard of care with respect to the care of his patients in Washington, as described above in paragraphs 3–5, and for the resulting discipline against his Washington and California medical licenses, as described above in paragraphs 3–6. Applicant is hereby **WARNED** that engaging is such conduct again may result in further disciplinary action against Applicant's Iowa medical license.

8. Applicant voluntarily submits this Order to the Board for consideration.

9. Applicant agrees that the State's counsel may present this Order to the Board for consideration.

10. By entering into this Order, Applicant understands that he has the right to legal counsel in this matter and waives any objections to the terms of this Order.

11. Applicant shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Iowa.

15. The Board's approval of this Order shall constitute a **Final Order** of the Board.

Patrick K. Chau, MD
Patrick Kin-Yee Chau, M.D., Applicant

Subscribed and sworn to before me on February 11th, 2020.

Notary Public, State of Washington

RYAN HUGHES
Notary Public
State of Washington
Commission # 181928
My Comm. Expires Aug 19, 2023

Notary Signature

This Consent Agreement is approved by the Board on February 13, 2020.

K. Ulveling MD
Kyle G. Ulveling, M.D., Chair
Iowa Board of Medicine
400 S.W. 8th Street, Ste. C
Des Moines, IA 50309

Attachment A

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **PATRICK CHAU, M.D.,** License No. MD00030053 Respondent.	**Docket No. 06-04-A-1014MD** **STATEMENT OF CHARGES**

The Health Services Consultant, on designation by the Medical Quality Assurance Commission (Commission) makes the allegations below, which are supported by the evidence contained in program file numbers 2004-03-0048MD, 2004-03-0078MD, 2004-06-0035MD, 2004-08-0001MD, 2004-11-0026MD, and 2005-07-0030MD. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

Section 1: ALLEGED FACTS

1.1 Patrick Chau, M.D., Respondent, was issued a license to practice as a physician and surgeon by the state of Washington in 1992. Respondent's license is currently active. Respondent is board certified as a psychiatrist.

1.2 Six complaints involving Respondent's treatment of eight patients were filed between March 2004 and July 2005. Respondent diagnosed thyroid dysfunction and/or obesity for all eight patients.

1.3 All complaints also involve Respondents pattern of prescribing Armour Thyroid (desiccated thyroid), Adderall (amphetamine), and/or Desoxyn (methamphetamine) as therapy for hypothyroidism (hormonal deficiency) and or weight loss. It is not clear from some patient records whether Respondent prescribed desiccated thyroid for thyroid dysfunction or for weight loss, or for both. Further, it is not clear from some patient records whether Respondent prescribed amphetamine or methamphetamine for weight loss or for depression, or for both.

1.4 Respondent's patient records are disorganized, partially illegible, and incomplete for Patients A, D, E, F, and G. Respondent was unable to produce any records for Patients B and C, and two different sets of records exist for Patient D.

1.5 Armour Thyroid is the trade name of a prescription medication and is made from desiccated (dried) pork thyroid glands. Desiccated thyroid is prescribed to treat thyroid dysfunction known as hypothyroidism that occurs when there is a hormonal deficiency. There are two major thyroid hormones secreted from the thyroid gland: thyroxine (T_4) and L-triiodothyronine (T_3).

1.6 Adderall is the trade name of a prescription medication containing amphetamine and dextroamphetamine, which are stimulants. Adderall is prescribed to treat Attention Deficit Disorder with Hyperactivity (ADHD). Amphetamine is not an appropriate medication for weight loss, and may produce serious and life-threatening tachycardia or myocardial infarction, especially when prescribed in tandem with desiccated thyroid.

1.7 Desoxyn is the trade name of a prescription medication containing methamphetamine hydrochloride, which is a stimulant. Desoxyn is prescribed to treat Attention Deficit Disorder with Hyperactivity (ADHD). Desoxyn is not highly regarded as a treatment of obesity even as a short-term (i.e., a few weeks) adjunct in a regimen of weight loss based on caloric restriction. Neither is the use of Desoxyn highly regarded for patients in whom obesity is resistant to alternative therapy (e.g., repeated diets, group programs, and other drugs). Methamphetamine has never been shown to be an effective adjuvant for treatment of obesity resulting in sustained weight loss of more than six months duration. Methamphetamine, furthermore, has an unacceptable risk/benefit ratio since this drug may produce serious and life-threatening tachycardia or myocardial infarction, especially when prescribed in tandem with desiccated thyroid, without significant sustained benefit.

1.8 Well-established and reliable clinical testing is available to assess thyroid function. Treatment of patients with thyroid hormones requires the periodic assessment of thyroid status by means of appropriate laboratory tests besides the full clinical evaluation performed at the time of diagnosis.

1.9 Armour Thyroid therapy is usually instituted in low doses, with increments that depend on the cardiovascular status of the patient. The usual starting dose is 30 mg/day Armour Thyroid, with increments of 15 mg every two weeks. Most patients require 60 to 120 mg/day. Maintenance dosages of 60 to 120 mg/day usually result in normal serum T_4 and T_3 levels. Adequate therapy usually results in normal TSH and T_4 levels after 2 to 3 weeks of therapy.

1.10 Doses of Armour Thyroid within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic drugs such as those used for their anorectic effects. Amphetamine is a classic sympathomimetic drug. The use of thyroid hormones to effect weight loss in the therapy of obesity, alone or combined with other drugs, has been shown to be ineffective.

1.11 Patient A was treated by Respondent from on or about January 23 to March 3, 2004. Respondent's treatment records for Patient A are illegible, disorganized, and incomplete. Respondent diagnosed Patient A as "little low thyroid induced wt. and energy problem." Respondent based his diagnoses on physical observations and a patient interview, and he did not conduct laboratory testing or monitoring.

1.12 Respondent prescribed Desoxyn 10 mg twice daily to Patient A. Respondent also prescribed Armour Thyroid to Patient A. The initial dose of desiccated thyroid was 90 mg/day for two days, then increased to 180 mg/day for one week. After one week, the dosage was increased to 270 mg/day for one week, and then increased to 360 mg/day for two weeks. Patient A mistakenly increased her dosage to 720 mg/day. Respondent directed that Patient A could continue at that level on or about March 3, 2004.

1.13 On or about March 11, 2004, Patient A consulted with other providers regarding significant swelling in her ankles, a condition that had existed for three weeks. Patient A was tested and diagnosed with hyperthyroidism (excessive hormones) and congestive heart failure with tachycardia (mild left ventricular diastolic dysfunction)

caused by the high dosages of methamphetamine and desiccated thyroid prescribed by Respondent.

1.14 Patient B was treated by Respondent from about February through March 2004. Respondent searched for but could not locate treatment records for Patient B. Patient B reported to her primary care physician that Respondent prescribed desiccated thyroid to her without conducting laboratory testing. Respondent also prescribed Desoxyn to Patient B for weight loss. Patient B reported that she felt agitated and tremulous while taking desiccated thyroid and methamphetamine. One week later, Patient B reported that she had abandoned those medications and felt better.

1.15 Patient C was treated by Respondent from about February through March 2004. Respondent searched for but could not locate treatment records for Patient C. Patient C reported to his primary care physician that Respondent prescribed Desoxyn to him for weight loss. Patient B reported that he abandoned that medication after learning that Desoxyn was methamphetamine.

1.16 Patient D was treated by Respondent from on or about November 26, 2003 to February 11, 2004. Respondent's treatment records for Patient D are illegible, disorganized, and incomplete. One version of Respondent's treatment records for Patient D was produced by Respondent, and another version was produced by Patient D's primary care physician. Respondent based his diagnoses on physical observations and a patient interview, and he did not conduct laboratory testing or monitoring.

1.17 Respondent prescribed Armour Thyroid to Patient D on or about November 26, 2003. The initial dose of desiccated thyroid was 90 mg/day for two days, then increased to 180 mg/day. On or about December 16, 2003, Respondent increased Patient D's dosage of desiccated thyroid to 360 mg/day. On or about January 14, 2004, Respondent increased Patient D's dosage of desiccated thyroid to 450 mg/day for one week, then to 540 mg/day. Between November 2003 and February 2004, Patient D's weight dropped from 248 to 209 pounds.

1.18 Patient D developed symptoms consistent with hyperthyroidism, including agitation and lack of concentration. Patient D had normal thyroid functions prior to being treated by Respondent. On or about March 8, 2004, Patient D's primary care physician obtained a thyroid function test that was consistent with hyperthyroidism. On

or about April 27, 2004, Patient D's pulse rate was 104, consistent with hyperthyroidism.

1.19 Patient E was treated by Respondent from on or about March 26, 2004 to June 1, 2004. Respondent's treatment records for Patient E are illegible, disorganized, and incomplete. Respondent diagnosed Patient E as thyroid dysfunction and weight problem. Respondent based his diagnoses on physical observations and a patient interview, and he did not conduct laboratory testing or monitoring. Respondent instructed Patient E not to tell other health care providers about her treatment plan.

1.20 The initial dose of desiccated thyroid was 90 mg/day for two days, then increased to 180 mg/day for one week. After one week, the doseage was increased to 270 mg/day for one week, and then increased to 360 mg/day. On or about April 23, 2004, Respondent increased the dosage of desiccated thyroid to 450 mg/day for two weeks, then to 540 mg/day.

1.21 On or about May 28, 2004, Patient E consulted with another physician with complaints of tachycardia. The physician obtained laboratory test results consistent with hyperthyroidism and advised Patient E to stop taking desiccated thyroid.

1.22 On June 1, 2004, Patient E complained to respondent about her tachycardia attack and reported that she was still experiencing a fluttering heart rate. Respondent recommended that Patient E decrease her dosage from 540 mg/day to 450 mg/day, and if that doesn't resolve the tachycardia, then to 360 mg/day. When Patient E called Respondent back and informed him about her laboratory test results and the advice that she stop taking desiccated thyroid, Respondent told her that being overweight distorted the test results and to just decrease her dosage until she felt comfortable.

1.23 Patient F was treated by Respondent from on or about October 19, 2004 to December 3, 2004. Respondent's treatment records for Patient F are illegible, disorganized, and incomplete. Respondent diagnosed Patient F as hypothyroid and overweight. Respondent based his diagnoses on physical observations and a patient interview, and he did not conduct laboratory testing or monitoring.

1.24 Respondent prescribed Adderall XR 30 mg twice daily to Patient F to control her appetite. Respondent also prescribed Armour Thyroid to Patient F. The

Initial dose of desiccated thyroid was 90 mg/day for two days, then increased to 180 mg/day for one week. After one week, the dosage was increased to 270 mg/day. After another week, the dosage was increased to 360 mg/day. Between October 19 and December 3, 2004, Patient F lost 17 pounds. On or about December 3, 2004, Respondent decreased Patient F's Adderall dosage to 15 mg twice daily.

1.25 Patient G was treated by Respondent from on or about August 31, 2004 to December 3, 2004. Respondent's treatment records for Patient G are illegible, disorganized, and incomplete. Respondent diagnosed Patient G as hypothyroid and overweight. Respondent obtained laboratory test results that did not support a diagnosis of hypothyroidism, and Respondent disregarded the results as inconclusive. Respondent based his diagnoses on physical observations and a patient interview.

1.26 Respondent prescribed Armour Thyroid to Patient G on or about August 31, 2004. The initial dose of desiccated thyroid was 90 mg/day for two days, then increased to 180 mg/day. On or about September 8, 2004, the dosage of desiccated thyroid was increased to 270 mg/day. Respondent also added Adderall XR 30 mg once daily. On or about September 24, 2004, the dosage of desiccated thyroid was increased to 360 mg/day.

1.27 Patient G lost fourteen pounds between September 8 and October 15, 2004. However, she gained six pounds by November 12, 2004, and Respondent increased her dosage of Adderall 30 mg to twice daily. Patient G gained another seven pounds by December 3, 2004, and Respondent approved an increase in her dosage of Adderall 30 mg to three times daily.

1.28 Patient H consulted with Respondent on September 21, 2004. Respondent's treatment records for Patient H are illegible, disorganized, and incomplete. Respondent diagnosed Patient H as hypothyroid and overweight. Respondent based his diagnoses on physical observations and a patient interview.

1.29 Respondent prescribed Armour Thyroid to Patient A. The initial dose of desiccated thyroid was 90 mg/day for two days, then increased to 180 mg/day. Respondent also prescribed Adderall 30 mg twice daily to Patient H. Respondent instructed Patient H not to tell other health care providers about her treatment p

Patient H did not trust Respondent after her consultation, and she did not fill the prescriptions or revisit Respondent.

Section 2: ALLEGED VIOLATIONS

2.1 Based on the facts in Section 1, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4), which provides in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
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> * * *
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
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> * * *

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

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Section 3: NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Health Services Consultant of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline pursuant to RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

DATED: May 3, 2006.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Executive Director for
LISA NOONAN
HEALTH SERVICES CONSULTANT

SUSAN L. PIERINI, WSBA # 17714
ASSISTANT ATTORNEY GENERAL

FOR INTERNAL USE ONLY:	PROGRAM NOS. 2004-03-0048MD, 2004-03-0078MD, 2004-06-0035MD, 2004-08-0001MD, 2004-11-0026MD, 2005-07-0030MD

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named herein. RCW 42.17.310(1)(d)

Patient A

Patient B

Patient C

Patient D

Patient E

Patient F

Patient G

Patient H

5-25-06

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: PATRICK CHAU, M.D., License No. MD00030053, Respondent.	Docket No. 06-04-A-1014MD EX PARTE ORDER OF SUMMARY SUSPENSION

PRESIDING OFFICER: L. Farris, Senior Health Law Judge

BOARD/COMMISSION PANEL: Chelle Moat, M.D., Panel Chair
Hampton Irwin, M.D.
Cabell Tennis, J.D.

This matter came before the Presiding Officer, Senior Health Law Judge L. Farris, on delegation from the Medical Quality Assurance Commission (Commission), on May 24, 2006, on a Motion for Order of Summary Restriction brought by the disciplining authority (Medical Program) through the Office of the Attorney General. The Program issued a Statement of Charges alleging the Respondent violated RCW 18.130.180(4). The Commission, after reviewing the Statement of Charges, Motion and supporting evidence, grants the motion. LICENSE SUSPENSED pending further action.

I. FINDINGS OF FACT

1.1 Patrick Chau (Respondent) is a physician and surgeon, credentialed by the state of Washington at all times applicable to this matter.

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ORIGINAL

1.2 The Medical Program issued a Statement of Charges alleging the Respondent violated RCW 18.130.180(4). The Statement of Charges was accompanied by all other documents required by WAC 246-11-250.

1.3 As set forth in the allegations in the Statement of Charges, as well as the motion for summary action, the Respondent routinely diagnoses thyroid dysfunction without proper clinical and laboratory evaluations and monitoring. The Respondent prescribes inappropriate medication in excessive dosages for hypothyroidism and obesity. Well-established and reliable clinical testing is available to assess thyroid function. Treatment of patients with thyroid hormones requires the periodic assessment of thyroid status by means of appropriate laboratory tests besides the full clinical evaluation performed at the time of diagnosis. *See Lipkin Declaration, para. 8.* Desiccated thyroid therapy is usually instituted in low doses, with increments that depend on the cardiovascular status of the patient. The usual starting dose is 30 mg/day Armour Thyroid, with increments of 15 mg every two weeks. Most patients require 60 to 120 mg/day. *See Lipkin Declaration, para. 10.* The Respondent routinely prescribed a starting dose of 90 mg/day desiccated thyroid, increased to 180 mg/day after two days. Thereafter, the Respondent increased prescribed dosages of desiccated thyroid for six of his patients from 180 mg/day to between 360 and 540 mg/day. *See Lipkin Declaration, para. 13.* Failure to properly monitor the administration of desiccated thyroid and the administration of large doses may produce serious or even life-threatening manifestations of toxicity. *See Lipkin Declaration, para. 9-11.*

1.4 The Respondent is trained as a psychiatrist, and his letterhead describes his practice as "General and Child Psychiatry". Medical records on several patients

indicate primary diagnoses of psychiatric disorders and a history of and current use of psychiatric medications. See Exhibit 2 (E), Exhibit 2 (G) and Exhibit 2 (I). Patients seeing the Respondent for psychiatric advice are started on dessicated thyroid, with simultaneous discontinuation of or a rapid taper of psychiatric medications. The documentation shows no evidence of a comprehensive psychiatric evaluation, the use of standard DSM (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders) criteria to make a diagnosis, nor clinical justification or rationale for medication or diagnosis changes.

1.5 The Respondent also prescribed desiccated thyroid, amphetamine, and methamphetamine, often in combination, to effect weight loss in the therapy of obesity. *See Lipkin Declaration, para. 12 and 14.* The use of thyroid hormones to effect weight loss in the therapy of obesity, alone or combined with other drugs, is unjustified and has been shown to be ineffective. *See Lipkin Declaration, para. 11.* Amphetamine is not an appropriate medication for weight loss, and may produce serious and life-threatening tachycardia or myocardial infarction, especially when prescribed in tandem with desiccated thyroid. *See Lipkin Declaration, para. 5.* Methamphetamine has never been shown to be an effective adjuvant for treatment of obesity resulting in sustained weight loss of more than six months duration. Methamphetamine, furthermore, has an unacceptable risk/benefit ratio since this drug may produce serious and life-threatening tachycardia or myocardial infarction, especially when prescribed in tandem with desiccated thyroid, without significant sustained benefit. *See Lipkin Declaration, para. 6.*

1.6 The serious risks inherent in the Respondent's substandard diagnostic and prescribing practice have manifested itself in the care of his patients. One of the

Respondent's patients developed serious complications, including hyperthyroidism and congestive heart failure with tachycardia, caused by the Respondent's regime of excessive and medically unjustifiable prescribing of desiccated thyroid and methamphetamine.

1.7 The allegations and evidence presented establish that there is a risk of immediate danger to the public health, safety, and welfare. The Respondent's pattern of making diagnoses without ordering laboratory tests and his prescriptive practice are below standard. Patients diagnosed with thyroid dysfunction and/or obesity are at risk for serious health complications caused by inappropriate and excessive prescription medications. The Respondent's practice creates a risk of life-threatening toxicity.

1.8 In the Ex Parte Motion for Summary Action, the Department requested that the Commission restrict the Respondent's practice from prescribing any medications for treating thyroid dysfunction, thyroid preparation and/or stimulants for weight loss, believing that to be the least restrictive agency action justified by the danger posed by the Respondent's continued practice as a physician. However, the Commission concludes that the evidence indicates that any practice as a physician by the Respondent at this time is an immediate danger to the public health, safety and welfare. The Commission concludes that a summary suspension of the Respondent license to practice as a physician in the state of Washington is the least restrictive agency action justified by the danger posed by the Respondent's continued practice as a physician and surgeon.

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II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent's credential to practice as a physician and surgeon. RCW 18.130.040.

2.2 The Commission has authority to take emergency adjudicative action to address an immediate danger to the public health, safety, or welfare. RCW 34.05.422(4); RCW 34.05.479; RCW 18.130.050(7); and WAC 246-11-300.

2.3 The Medical Quality Assurance Commission may use its own expertise in reviewing the testimony and materials before it. RCW 34.05.461(5). *Johnston v. Washington State Medical Disciplinary Board, 99 Wn.2d 466 (1983); Brown v. State Department of Health, Dental Disciplinary Board, 94 Wn. App. 7, review denied 138 Wn.2d 1010 (1999).*

2.4 The Findings of Fact establish the existence of an immediate danger to the public health, safety, or welfare if the Respondent continues to practice as a physician. The Findings of Fact establish that the requested summary suspension is necessary and adequately addresses the danger to the public health, safety, or welfare.

III. ORDER

Based on the Findings of Fact and Conclusions of Law, it is ORDERED that the Respondent's credential to practice as a physician and surgeon is SUMMARILY

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SUSPENDED pending further disciplinary proceedings by the Commission. The Respondent shall immediately deliver all licenses, including wall, display, and/or wallet, if any, to the Commission.

Dated this 25th day of May, 2006.

Chelle L. Moat M.D.
CHELLE MOAT, M.D., Panel Chair

[OPTIONAL USE ONLY: (Internal tracking numbers)
Reports Nos. 2004-03-0040, 2004-05-0078, 2004-06-0035, 2004-08-0001, 2004-11-0028, & 2005-07-0010]

Attachment B

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

APPLICATION ATTACHMENT

In the Matter of the License to Practice as a Physician and Surgeon of: PATRICK CHAU, M.D., License No. MD00030053, Respondent.	Docket No. 06-04-A-1014MD FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

APPEARANCES:

Respondent, Patrick Chau, M.D., by
Hoffman Hart Wagner LLP, per
Michael Hoffman, Attorney at Law

Department of Health Medical Program, by
Office of the Attorney General, per
Susan L. Pierini, Assistant Attorney General

PRESIDING OFFICER: Michael T. Concannon, Health Law Judge

COMMISSION PANEL: Judith Tobin, Public Member, Panel Chair
Everardo Espinosa, M.D.
William Gotthold, M.D.
Janice Paxton, PA-C

The Medical Quality Assurance Commission (the Commission) convened a hearing over a two-day period in SeaTac, Washington on September 29-30, 2006. The Department of Health (the Department) had issued a Statement of Charges alleging that the Respondent had violated the Uniform Disciplinary Act with respect to eight patients named in a confidential schedule (hereafter, Patients A, B, C . . . H), and the Respondent had been summarily suspended as of May 25, 2006, pending this hearing. The Commission finds unprofessional conduct with respect to several patients and

orders the imposition of PROBATIONARY CONDITIONS on the Respondent's license to practice medicine.

ISSUES

Whether any of the Respondent's treatment of eight patients constitutes unprofessional conduct within the meaning of RCW 18.130.180(4).

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

SUMMARY OF THE PROCEEDING

The Department presented testimony from the following three witnesses:

1. The Respondent.
2. Dr. Edward Lipkin (Expert.)
3. Dr. Joseph Bloom (Expert) – video perpetuation deposition.

Department's Exhibits. The following numbered exhibits by the Department were admitted to become part of the record at the hearing:

D-1. Medical Records – Patient A.

D-2. Medical Records – Patient B.

D-3. Medical Records – Patient C.

D-4. Medical Records – Patient D.

D-5. Medical Records – Patient E.

D-6. Medical Records – Patient F.

D-7. Medical Records – Patient G.

D-8. Medical Records – Patient H.

D-9. Medical Records - Patient H (exhibit numbered pgs. 7 – 13 only).

D-10. Assessment of Dr. Edward Lipkin, dated October 21, 2005.

D-11. Assessment of Dr. Edward Lipkin, dated March 1, 2006.

D-12. Additional Medical Records – Patient B, received on July 7, 2006.

D-13. Additional Medical Records – Patient C, received on July 7, 2006.

The Respondent presented testimony from the following 4 witnesses:

1. The Respondent.
2. Paul Leung, M.D. (Expert) – video perpetuation deposition*.
3. Abraham Perlstein, M.D. (Expert) – video perpetuation deposition*.
4. Lance Brigman, M.D. – perpetuation deposition – transcript read into the record.

Respondent's Exhibits. The following numbered exhibits by the Respondent were admitted to become part of the record at the hearing:

R-1. Medical Records – Patients A through H (one exhibit).

R-2. Journal Article-Gaby, Alan, *Alternative Medicine Review*, Vol. 9, No. 2, pgs. 157-179 on Hypothyroidism.

R-3. Letter from Dr. Abraham Perlstein.

R-4. Letter from Dr. David Lee.

R-5. Letter from Dr. Daniel Moynihan.

R-6. Letter from Dr. Lance Brigman.

R-7. Letter from Dr. Blaine Tolby.

R-8. Letter from Warren Cowell.

R-9. Letter from Brenda Nilson.

* The video, and the written transcript of the deposition, are part of the record in this proceeding

R-10. Letter from Charles Mason.

R-11. Letter from Rhonda Hanson.

R-12. Letter from Jamie Huff.

R-13. Letter from Sherry McDonald.

R-14. Letter from L.C. Perry.

R-15. Letter from Pamela Graham.

R-16. Letter from Katherine Kiser.

R-17. Letter from Diane Howlett.

R-18. Letter from Kathi High.

R-19. Letter from Cheryl Royal.

R-20. Letter from Tom Bohna.

R-21. Letter from Evan Cummings.

R-22. Redacted email, dated May 25, 2006, from Mr. Berg to Dr. Bloom.

Based upon the evidence presented, the Commission makes the following findings by clear and convincing evidence.

I. FINDINGS OF FACT

1.1 The Respondent was issued a license to practice as a physician and surgeon by the State of Washington in 1992. His license is active, but has been subject to a summary suspension since May 25, 2006. The Respondent is board certified as a psychiatrist, and was most recently re-certified in September 2006.

1.2 The Respondent did his residency at the University of South Alabama Hospital in Mobile, Alabama in the late 1980's. The residency included a combined

program in general and adult psychiatry over a four year period, and he was the chief resident in child psychiatry. After various contract or other positions into the mid-1990's in the Vancouver/Portland/Longview area, mostly involving children and child psychiatry, the Respondent has had a full-time office practice as a psychiatrist since 1998. Presently, his main office is in Vancouver, Washington with a satellite office practice in Longview.

1.3 As a psychiatrist, the Respondent does not take patients that present with physical ailments only. His current patient population is approximately 50% children. All of the Respondent's patients have psychiatric or mood disorders, and his patient population consist of word-of-mouth referrals and (mostly) referrals by primary care physicians. In addition to the many difficult mental health symptoms presented by patients for his psychiatric treatment, many of the Respondent's patients also have pressing physical ailments. They are usually on medications prior to seeing the Respondent, and many have excessive weight or suffer from obesity.

1.4 The Respondent has adopted a sometimes unique, but generally accepted, alternative treatment regimen with some of his patients. With other practitioners, these patients may receive only the standard or "front-line" range of medications for depression. In the Respondent's practice, because of the difficulty of the cases he treats, he may be more likely to try alternatives if he concludes that standard anti-depressant treatment has not been totally able to reduce the patient's depressive symptoms. Most significant, for purposes of this disciplinary action, is the

Respondent's use of thyroid medications, including Armour Thyroid, and stimulants as an adjunct to his psychiatric treatment of particular patients.

1.5 The Commission does not find the Respondent to be a weight loss or "diet doctor"; rather, the Respondent is a practicing psychiatrist, and any weight loss "benefit" to a particular patient is incidental to the Respondent's primary treatment goal, i.e. the psychiatric well-being of the patient.

1.6 Armour Thyroid is the trade name of a prescription medication and is made from desiccated (dried) pork thyroid glands. Desiccated thyroid is prescribed to treat thyroid dysfunction known as hypothyroidism. Armour Thyroid therapy is usually instituted in low doses, with increments that depend on clinical evaluations, the cardiovascular status of the patient, and periodic laboratory testing. The usual maximum recommended dose of Armour Thyroid is 180 mg/day.

1.7 Adderall is the trade name of a prescription medication containing amphetamine, which is a stimulant. Amphetamine is not an appropriate medication for weight loss. It may produce serious and life-threatening cardiac effects. The usual maximum recommended dose of Adderall is 60 mg/day. If prescribed in conjunction with Armour Thyroid, the patient's progress and reaction to such a stimulant must be closely monitored.

1.8 Dysthymia is a long-term, chronic depression that is not disabling as an acute/major depression, but can result in a notable decrease of functional activity.

Patient A

1.9 Patient A was a 30 year old female, seen by the Respondent on three occasions over a five week period from January 23 to March 3, 2004. On her initial visit, the Respondent diagnosed Patient A as perhaps having "Dysthymia and a little low thyroid." The Respondent took a history from Patient A on the first visit and his diagnosis flows from his interview, symptoms, and his own analysis.

1.10 The Respondent prescribed Armour Thyroid to Patient A on January 23, 2004. The "trial" dose of Armour Thyroid was 90 mg/day for two days and, if the patient felt "OK," then Patient A was directed to take 180 mg/day for one week. After one week, the dosage was to be increased to 270 mg/day with a return visit of Patient A scheduled for February 6, 2004. On February 6, 2004, the Respondent confirmed the 270 mg/day dosage for another week and, if "OK," to 360 mg/day. On February 6, 2004, the Respondent also prescribed Desoxyn 10 mg twice daily to Patient A. A return visit was scheduled for March 3, 2004.

1.11 As it turned out, Patient A mistakenly increased her dosage before the March 3, 2004 office visit to 720 mg/day of Armour Thyroid and reported that to the Respondent. The Respondent did not note any adverse effects from the 720 mg/day regimen Patient A had put herself on, and therefore the Respondent did not recommend a decrease in the dosage. In fact, since Patient A reported no desired increase in her energy level between the morning and 4 p.m., the Respondent contemplated whether another 90 mg/day of Armour Thyroid would further assist Patient A. The Respondent did not see Patient A again after the March 3, 2004 visit.

1.12 On or about March 11, 2004, Patient A consulted with her primary care physician, Dr. Susan Hughes, for her annual physical. Noting that Patient A was on an "extremely high dose of thyroid medication," Dr. Hughes ordered lab work, an immediate consult with a cardiologist, and further stated that Patient A was in "congestive heart failure with tachycardia and is at high risk for a myopathy as well as rhythm disturbance."

1.13 Based on the reports of the cardiologist (Dr. Shaun D. Harper), Dr. Hughes, and the dosage levels of Armour Thyroid approved by the Respondent for Patient A, the Commission finds the prescribing of Armour Thyroid far in excess of the maximum recommended daily dosage caused a hyperthyroid state in Patient A. The Respondent's Armour Thyroid regimen with Patient A placed her in great risk of harm. As such, the Respondent's treatment of Patient A falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient D

1.14 Patient D was a 22 year old male who presented to the Respondent on November 26, 2003, having had multiple hospitalizations for psychiatric treatment, recurrent depression, and suicidal ideation dating back to childhood. The Respondent, in his capacity as a child psychiatrist, had seen Patient D at some time in the past when Patient D was a child and the Respondent was at Columbia River Associates Clinic. His most recent hospitalization for depression was for a two week period that had ended in mid-November, 2003. On November 26, 2003, prior to any treatment by the Respondent, Patient D was taking Lamictal, Lexapro, and Ativan. Over the years, he

had been treated with Prozac, Paxil, Celexa, Lithium, Zyprexa, and other medications in an attempt to deal with his depression/psychiatric illness.

1.15 On November 26, 2003, the Respondent diagnosed Patient D as being bi-polar with depression and panic disorder. The Respondent altered some of Patient D's anti-depressant medications prescribed on his recent hospital discharge, substituted Xanax on a trial basis for the Ativan, and also prescribed 30 mg/day of Adderall. He also prescribed Seroquel (which is an atypical antipsychotic agent or mood stabilizer) for Patient D on November 26, 2003.

1.16 Further, in that initial November 26, 2003 visit, the Respondent prescribed Armour Thyroid to Patient D. The initial dose of Armour Thyroid was 90 mg/day for two days, and then to be increased to 180 mg/day. There were interim weekly office visits prior to December 16, 2003. On December 16, 2003, the Respondent increased Patient D's dosage of Armour Thyroid to 360 mg/day. There were several changes, substitutions and alterations to Patient D's anti-depressant medications in the weeks between November 26, 2003 and January 14, 2004.

1.17 On January 14, 2004, the Respondent increased Patient D's dosage of Armour Thyroid to 450 mg/day for one week, then to 540 mg/day. Patient D developed symptoms consistent with hyperthyroidism (excessive hormones), including agitation and lack of concentration. There are patient records indicating normal thyroid functions for Patient D in 1998. On March 8, 2004, Patient D's primary care provider, Physician Assistant Michael Pastick, obtained a TSH test (Exhibit D-4, p. 83) that was consistent with overdoses of thyroid hormone. A TSH test shows a pituitary hormone secreted to

stimulate thyroid function and is important for analyzing potential hyperthyroid condition because a low TSH indicates an excess of thyroid hormone in the system.

1.18 The dosage levels of Armour Thyroid approved by the Respondent for Patient D, beyond the 180mg/day recommended maximum, caused a hyperthyroid state (i.e. an excess of thyroid hormone) in Patient D. The Respondent's Armour Thyroid regimen with Patient D placed him at a significant risk of harm. The Respondent's treatment of Patient D falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient E

1.19 Patient E was a 48 year old female on her initial visit to the Respondent for treatment on March 26, 2004. The Respondent diagnosed Patient E with dysthymia (long-term, chronic depression), basing his diagnosis on physical observations, a patient interview, and a mental status exam. On the first visit, the Respondent started Patient E on Armour Thyroid at 90 mg/day for two days, with an anticipated increase to 180 mg/day for one week, then 270 mg/day for one week, and then 360 mg/day. One month later, after an April 23, 2004 office visit, the Respondent further increased the dosage of Armour Thyroid to 450 mg/day for two weeks, then to 540 mg/day.

1.20 On or about May 28, 2004, Patient E consulted with Dr. Mary Shepard at Kaiser Foundation Health Plan with a complaint of tachycardia (rapid heart beat). Dr. Shepard ordered laboratory tests that resulted in a report of TSH so low it is almost not detectable (i.e. Less than .01 with a normal range of .28 – 5.00). Such a lab result

is consistent with hyperthyroidism. Dr. Shepard advised Patient E to stop taking Armour Thyroid.

1.21 Three days later, on June 1, 2004, Patient E complained to the Respondent about her tachycardia attack and symptoms of hyperthyroid and reported that she was still experiencing a fluttering heart rate. The Respondent recommended that Patient E decrease her dosage from 540 mg/day to 450 mg/day, and if that doesn't resolve the tachycardia, then to 360 mg/day. Patient E again called the Respondent on June 1, 2004, to report the laboratory test results previously noted by Dr. Shepard. The Respondent "assured" Patient E that "the Armour Thyroid might have distorted the TSH results and for her to decrease the Armour Thyroid until comfortable" (Exhibit D-5, pg. 4).

1.22 The mega-dosage levels of Armour Thyroid approved by the Respondent for Patient E of 540 mg/day caused a hyperthyroid state in Patient E. Even with the report of the laboratory test, the Respondent failed to recognize the test's consistency with the clinical symptoms then present in Patient E. The Respondent's Armour Thyroid regimen with Patient E placed her at a significant risk of harm. Accordingly, the Respondent's treatment of Patient E falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient F

1.23 Patient F was a 46 year old female when presenting for treatment by the Respondent on October 19, 2004. Intake notes by the Respondent on the patient interview indicated a prior diagnosis of depression of "mild to moderate severity" in

years past, significant weight gain over the years, prior use of Prozac, Paxil, and Wellbutrin for depression without effective results, and a family history of obesity, diabetes, and hypothyroidism.

1.24. On October 19, 2004, the Respondent diagnosed Patient F with "dysthymia and ? borderline hypothyroid but has not been detected by current lab." There is no record of the Respondent ordering any laboratory tests to assist in a hypothyroid diagnosis of Patient F.

1.25 The Respondent kept Patient F on Wellbutrin and Zoloft, which are anti-depressants. He then prescribed Adderall XR 30 mg twice daily to control Patient F's appetite. The Respondent also prescribed Armour Thyroid to Patient F on October 19, 2004. The initial dose of Armour Thyroid was 90 mg/day for two days, then increased to 180 mg/day for one week, then 270 mg/day for another week, and then to 360 mg/day.

1.26 As opined by an expert (Dr. Leung) for the Respondent, Patient F was a "difficult patient" given her twelve year history of depression, various medications that had not been effective, sleep deprivation, etc. The Respondent is attempting in his analysis and prescribing, in the opinion of Dr. Leung, "to do something" to help Patient F. Although there is no indication of actual harm to Patient F from the Armour Thyroid dosage, the excess Armour Thyroid placed Patient F at a risk of harm. As such, the Respondent's treatment of Patient F falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient G

1.27 Patient G was a 23 year old female when treated by the Respondent beginning August 31, 2004. The Respondent diagnosed Patient G with "mood disorder, non-specific, maybe from sub-clinical hypothyroid." The Respondent ordered laboratory tests that indicated normal thyroid function and commented they were not conclusive. He determined that Patient G should be treated based on his clinical observations and patient interview.

1.28 The Respondent prescribed Armour Thyroid to Patient G on August 31, 2004. The initial dose of Armour Thyroid was 90 mg/day for two days, and then increased to 180 mg/day. One week later, on September 8, 2004, the Armour Thyroid dosage was increased to 270 mg/day. The Respondent noted on September 8, 2004, that Patient G had only then been on Armour Thyroid for 4 days as the pharmacy had to order it but there had been no adverse effects. Also on September 8, 2004, the Respondent added Adderall XR 30 mg once daily.

1.29 On September 24, 2004, the dosage of Armour Thyroid was increased to 360 mg/day. On November 12, 2004, the Respondent increased Patient G's dosage of Adderall 30 mg to twice daily, and then on December 3, 2004, the Respondent approved an increase in her dosage of Adderall 30 mg to three times daily, perhaps as a result of weight gain by Patient G.

1.30 With respect to the last dosage recommended for Adderall, the usual maximum recommended dose of Adderall is 60 mg/day, and by December 3, 2004 the Respondent was recommending up to 90 mg/day of Adderall. With such a dosage, the

patient is at risk for central nervous system over stimulation, tachycardia, and hypertension. The excess Adderall did place Patient G at a risk of harm. Similarly, the 360 mg/day dosage of Armour Thyroid placed Patient G at a risk of harm as it exceeds the recommended maximum of 180 mg/day. With respect to the Respondent's prescribing regimen for both of these medications, his treatment of Patient G falls below the standard of care of a reasonably prudent physician practicing in Washington.

Other Findings

1.31 Although there can be difficulty in reading the Respondent's handwritten patient records in terms of legibility, the Commission does not find those records below the standard of care given the difficulty in deciphering many physicians' handwriting. The Commission also does not find the completeness or organization of the examined patient records in this matter to create a standard of care issue. Given its own experience and the testimony of the psychiatrist experts on the practice of psychiatrists in their record-keeping, especially in non-institutional settings such as the Respondent's, the Commission does not find their format or completeness fall below the standard of care.

1.32 Based on the testimony of the Respondent, the expert witnesses, and the record, the Commission recognizes and finds that there may be appropriate circumstances to use stimulants and thyroid medication in a treatment regimen incorporated by psychiatrists, especially in those circumstances where the traditional, "front-line," drugs have been tried and not been successful with long-term, chronically depressed patients. Clearly, the Respondent is a believer in such alternative

approaches for some of his patients. But thyroid medication and stimulants can not be used without the necessary foundation and monitoring for the effects that can occur, such as cardiomyopathy, cardiac rhythm disturbances, tremors, and hypertension. The use of these medications requires a more careful and vigorous approach, and laboratory testing, than what occurred in the Respondent's care of the patients noted in these findings. While thyroid supplementation to antidepressant medication is a recognized treatment, the doses of thyroid medication used by the Respondent were greatly in excess of what is usually considered safe.

II. CONCLUSIONS OF LAW

2.1 At all times material to the Statement of Charges, the Respondent has been licensed to practice medicine in the state of Washington. The Commission has jurisdiction to hear this matter, pursuant to Chapter 18.71 RCW - Physicians, and Chapter 18.130 RCW - the Uniform Disciplinary Act.

2.2 The Washington Supreme Court has held that the standard of proof in disciplinary proceedings against physicians before the Commission is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534, *cert. denied*, 535 U.S. 904 (2002). In all findings forming the basis of this order, the Commission has applied the clear and convincing standard.

2.3 The Commission reviewed the admitted exhibits and considered the testimony, including the demeanor of all witnesses. Further, the Commission used its experience, competency, and specialized knowledge to evaluate the evidence presented in this case. RCW 34.05.461(5). There was substantial expert testimony on

this matter from both the Respondent and the Department. Expert testimony is sometimes helpful, but not essential, for the Commission in considering a case and in determining the standard of care. *Johnston v. Washington State Medical Disciplinary Board*, 99 Wn.2d 466 (1983); *Brown v. State Department of Health, Medical Disciplinary Board*, 94 Wn. App. 7, *review denied* 138 Wn.2d 1010 (1999).

2.4 The Uniform Disciplinary Act (the UDA) defines what conduct, acts, or conditions constitute unprofessional conduct. With respect to his care of each of the eight patients noted in the Statement of Charges, the Respondent has been charged with violating RCW 18.130.180(4). Any such violation constitutes unprofessional conduct under the UDA. RCW 18.130.180(4) provides as follows:

> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

2.5 Based on Finding of Fact 1.32 which is generally applicable to the Respondent's practice, and Findings of Fact: (i) Paragraphs 1.9 through 1.13 for Patient A; (ii) Paragraphs 1.14 through 1.18 for Patient D; (iii) Paragraphs 1.19 through 1.22 for Patient E; (iv) Paragraphs 1.23 through 1.26 for Patient F; and (v) Paragraphs 1.27 through 1.30 for Patient G, the Department proved by clear and convincing evidence that the Respondent's conduct constitutes unprofessional conduct as defined in RCW 18.130.180(4). The Respondent's conduct in those cases, for the reasons stated, does not meet the standard of care of a reasonably prudent physician practicing in Washington State.

2.6 Upon a finding of unprofessional conduct, the Commission may issue an order providing for one or a combination of sanctions including, *inter alia*, revocation of the physician's license, suspension, probation, censure, and fines. *See generally* RCW 18.130.160.

> In determining what action is appropriate, the disciplinary authority must first consider what sanctions are necessary *to protect or compensate the public*. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder. *Id.* (emphasis added)

2.7 The Respondent requested the Commission not to find unprofessional conduct. After conceding on multiple occasions during the hearing the need for laboratory testing on a going-forward basis to assist in monitoring the potentially harmful effects (including a hyperthyroid state) of Armour Thyroid dosages, the Respondent desired to avoid the stigma and financial effect which could be imposed by third-party payers (managed care, insurance companies) on his practice in the event of a finding of unprofessional conduct and sanctions. The Respondent claims the Statement of Charges, the summary suspension imposed on his practice on May 25, 2006, and the Department's case at hearing are misguided (beyond the need for lab testing). In any event, the Respondent claims to have become more enlightened since the 2003-2004 patient care that was the subject of this proceeding, and he should be trusted without required sanction or monitoring at this stage. Given his dangerous use of Armour Thyroid, at times, the promise of the Respondent to do better in the future does not address the Commission's requirement to arrive at a sanction that can protect the public.

2.8 On the other hand, the Department requested one or more of a variety of possible sanctions, including a full assessment by the Center for Personalized Education for Physicians (CPEP) in Colorado, other intensive training, a "mentor" of the Respondent's practice for some period, fines, and prescriptive practice monitoring.

2.9 The Commission concludes a certain degree of monitoring by and reporting to the Commission during a probationary period, especially on the Respondent's prescriptive practices, is necessary to arrive at a just sanction that protects the public. However, the Commission does not believe a CPEP assessment or other intensive training is necessary to assure the Respondent's competency.

2.10 In addition, RCW 18.130.160(8) provides the Commission may levy a fine for each unprofessional conduct violation not to exceed $5,000 per violation, and this addresses what sanction is necessary to *compensate the public.* The Commission finds that a somewhat minimal fine against the Respondent of $2,500 is appropriate. Given the number of violations with respect to the noted patients, the law would permit a more substantial fine than the $2,500 imposed.

III. ORDERS

Based on the foregoing, the Commission hereby issues in this case the following ORDERS:

3.1 The license of the Respondent, Patrick Chau, to practice as a physician and surgeon is hereby REINSTATED FROM THE SUMMARY SUSPENSION, and is instead placed on PROBATION for two years subject to the following requirements:

(A) If not already in place, the Respondent must institute and continuously implement appropriate prescribing practices for his thyroid medications to include but not be limited to periodic laboratory testing to avoid hyperthyroidism and other harmful effects of such thyroid use;

(B) No less than three practice reviews shall be performed by the Commission or its designee on the Respondent's practice, with the first one to occur within six months of the date of this Order, and then at the twelve month and twenty-four month intervals dating from this Order. Each such review shall provide a general overview of the Respondent's practice, with special emphasis on the Respondent's prescription protocol for thyroid medications and stimulants, and the documentation of thyroid lab testing, in his psychiatric practice. Further, the Commission representative shall inspect office records, medication logs and medical records as needed, and interview the Respondent, any professional staff or partners, and office staff.

(C) Upon written request from the Commission, the Respondent shall appear before the Commission at six month intervals during the first year of this Order (after the required practice review(s) have been completed) to demonstrate his compliance with the terms of this Order, with the first compliance appearance in May 2007 or as soon thereafter as the Commission's schedule permits. At any time beginning after the second practice review required by this Order has occurred (i.e. after approximately 12 months from the date hereof), the Respondent may file a written petition to appear before the Commission to request a modification or termination of the probationary conditions of this Order. Any modification or early termination of this Order

shall occur at the Commission's sole discretion. The third practice review shall occur after the Respondent has been under probation for two years (if not earlier terminated).

3.2 The Respondent is hereby fined the amount of $ 2,500.00, payable on or before May 1, 2007. The fine shall 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, P.O. Box 1099, Olympia, Washington 98507-1099.

3.3 The charges in this matter with respect to Patients B, C, and H, as set forth in the Statement of Charges Paragraphs 1.14, 1.15, and 1.28-.29 (respectively), are hereby DISMISSED.

3.4 The Respondent shall be responsible and shall pay for any and all costs involved in his compliance with any and all conditions in this Order, and comply with all federal, state, and local laws, and all administrative rules governing the practice of the medical profession in Washington.

3.5 The Respondent shall inform the Commission, in writing, of any changes in his residential or professional practice(s) addresses within twenty (20) days of the change.

3.6 Periods of either residency (without a practice) or practicing outside the state of Washington shall not apply to the reduction of the two year period of probation contemplated by this Order.

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IV. 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 the Respondent fails to comply with the terms and conditions of this Order, the Commission may hold a hearing to require the 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, the Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 8 day of November, 2006.

Medical Quality Assurance Commission

JUDITH TOBIN, Public Member.
Panel Chair

FOR INTERNAL USE ONLY: (internal tracking numbers)
Program Nos. 2004-03-0048, 2004-03-0076, 2004-06-0035, 2004-08-0001, 2004-11-0028, & 2005-07-0030

CLERK'S SUMMARY

Charges	Action
RCW 18.130.180(4)	Violated

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/national reporting requirements. If adverse action 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 10 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:

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

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on 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, however, the 30-day period will begin to run upon the resolution of that petition. RCW 34.05.470(3).

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

Attachment C

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of	No. M2008-117887
PATRICK K. CHAU, MD Credential No. MD00030053 Respondent	STATEMENT OF CHARGES

The Health Services Consultant of the Medical Quality Assurance Commission (Commission), on designation by the Commission, makes the allegations below, which are supported by the evidence contained in program file number 2007-59025. The patient referred to in this Statement of Charges is identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On August 13, 1992, the state of Washington issued Respondent a credential to practice as a physician and surgeon. Respondent's credential is currently active.

1.2 Respondent is a board-certified psychiatrist who treated Patient A from April to July 2007. In treating Patient A, Respondent violated the standard of care in the following ways:

A. When he first saw Patient A on April 2, 2007, Respondent diagnosed her with a severe anxiety disorder, for which he prescribed Xanax, a benzodiazepine also known as alprazolam in its generic form. Respondent started the patient on six milligrams per day. This dose is well beyond the usual starting dose of alprazolam and is in itself a highly addictive dose of this medication, which is addictive at three milligrams. Respondent has also demonstrated a pattern of prescribing excessive, addictive amounts of benzodiazepines for other patients.

B. Respondent next saw Patient A on April 30, 2007. At that time, he diagnosed her with bipolar disorder and started her on Topamax for the purpose of mood stabilization. Topamax has no proven effects as a mood stabilizer. In

addition, Respondent noted that he was starting the patient on Armour Thyroid and Adderall as an alternative therapy for depression, stating that the patient had a failed history with standard antidepressants. Armour Thyroid and Adderall act as stimulants. Respondent started the patient on sixty milligrams per day of Adderall, an unduly high starting dose for that medication, and therefore below the standard of care. He also started her on 90 milligrams of Armour Thyroid, to be increased to 180 milligrams per day if "OK" after "2 or 5 days", which is a dosage that is extremely high, potentially toxic, and therefore below the standard of care. At the same visit, Respondent noted that Patient A had self-reduced the amount of Xanax she was taking, and he insisted that she take five milligrams a day, which is an addictive dose. Respondent has also demonstrated a pattern of prescribing excessive, dangerous amounts of stimulants and thyroid medication for other patients.

C. By July 2007, Patient A was experiencing some very concerning symptoms that were the result of hyperthyroidism, including a hand tremor, issues with speech, bugged out eyes, sweating, and nausea. According to Patient A, Respondent dismissed these symptoms and denied they could result from the medications he had prescribed her. Patient A reports certain symptomatic episodes, starting on July 12th, during which her symptoms of sweating, nausea, and vomiting worsened, and she experienced difficulty swallowing and breathing, felt her heart racing, and experienced confusion and disorientation. When she called Respondent with her concerns over these symptoms, Respondent reportedly discouraged Patient A from going to the emergency room, and he instead had her discontinue Topamax. When that alleviated some, but not all, of the symptoms, Respondent reportedly denied that the medications could be the cause, and he tried to get the patient to re-start Topamax. Within a few days, Patient A was in the emergency room, and she was ultimately diagnosed with hyperthyroidism, tachycardia, and possible thyroid toxicity. Respondent should have heeded the warning signs of hyperthyroidism and potential toxicity when his patient first reported her symptoms to him. Instead, he minimized her complaints

and discouraged her from going to the hospital. As a result, he placed Patient A at risk of severe harm and quite likely caused her permanent injury.

1.3 Respondent went to a hearing before the Commission in September 2006 based on allegations that he was prescribing high doses of Armour Thyroid without monitoring thyroid levels and was also prescribing high doses of stimulants. In its Findings of Fact, Conclusions of Law and Final Order of November 8, 2006 (2006 Order), the Commission determined that Respondent did not meet the standard of care of a reasonably prudent physician practicing in Washington State. The remedies included that Respondent was to "continuously implement appropriate prescribing practices for his thyroid medications". 2006 Order,

A. Respondent has violated that order by continuously prescribing high doses of thyroid medication.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4) and (9), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> ...
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
>
> ...
>
> (9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
>
> ...

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

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3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Health Services Consultant of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: July 8, 2008

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

Erin Obenland

ERIN OBENLAND
HEALTH SERVICES CONSULTANT

SUSAN L. PIERINI, WSBA # 17714
ASSISTANT ATTORNEY GENERAL

CONFIDENTIAL SCHEDULE

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

Patient A [redacted]

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of: PATRICK K. CHAU, M.D., Credential No. MD00030053, Respondent.	Master Case No. M2008-117887 EX PARTE ORDER OF SUMMARY RESTRICTION

PRESIDING OFFICER: Laura Farris, Senior Health Law Judge

COMMISSION PANEL: Richard Brantner, M.D., Panel Chair
Theresa Elders, Public Member
Hampton W. Irwin, M.D.

This matter came before the Medical Quality Assurance Commission (Commisson) on July 15, 2008, on a Motion for Order of Summary Restriction brought by the Medical Program of the Department of Health (Department) through the Office of the Attorney General. The Department issued a Statement of Charges alleging Respondent violated RCW 18.130.180(4) and (9). After reviewing the Statement of Charges, Motion, and supporting evidence, the Commission grants the motion. Respondent's credential to practice as a physician and surgeon is RESTRICTED pending further action.

I. FINDINGS OF FACT

1.1 Patrick K. Chau, M.D. (Respondent), is a physician, credentialed by the State of Washington at all times applicable to this matter.

1.2 The Department issued a Statement of Charges alleging Respondent violated RCW 18.130.180(4) and (9). The Statement of Charges was accompanied by all other documents required by WAC 246-11-250.

1.3 As set forth in the allegations in the Statement of Charges, as well as the motion for summary action, Respondent, a psychiatrist, treated Patient A from April 2007 through July 2007, for what he initially diagnosed as panic and anxiety disorder, subsequently adding a diagnosis of bipolar disorder. Exhibit A (Respondent's chart for Patient A). Respondent started the patient on a daily regimen of six milligrams of Xanax, a benzodiazepine also known by its generic name, alprazolam. He later adjusted the dosage to five milligrams. After he diagnosed the patient with bipolar disorder, Respondent started her on Topamax as a mood stabilizer. He also started her on a daily regimen of 60 milligrams of Adderall, an amphetamine, and 180 milligrams of Armour Thyroid, ostensibly to treat her depression. Exhibit A, progress note for April 2, and 30, 2007.

1.4 Benzodiapines such as Xanax are addictive in doses of three milligrams per day. By prescribing five or six milligrams per day to Patient A, Respondent placed her on a highly addictive dose. Declaration of David L. Dunner, ¶ 5(A-B). In addition, a pharmacy profile from 2007, reflects that Respondent often prescribes his patients benzodiazepines such as alprazolam, clonazepam, and lorazepam in highly addictive amounts, sometimes as high as eight or ten milligrams per day. Exhibit B (K-Mart pharmacy profile).

1.5 Respondent also prescribed Patient A an unduly high starting dose of Adderall, and a dose of Armour Thyroid that was "extremely high, potentially toxic, and therefore below the standard of care." Dunner declaration, ¶ 5(B). The K-Mart pharmacy profile reflects that this is also a pattern. Respondent frequently prescribes high doses of amphetamine and Armour Thyroid. *See* Exhibit B.

1.6 In June 2007, Patient A developed symptoms of hyperthyroidism, including a hand tremor and poor speech, and her eyes were "bugged out." Exhibit C (Patient A's complaint). Respondent dismissed these symptoms as unrelated to the medications he prescribed. *Id.*

1.7 By mid July, Patient A was suffering from severe symptoms of hyperthyroidism, including severe nausea, vomiting, confusion, difficulty swallowing, difficulty breathing, profuse sweating, dizziness, confusion, and disorientation, and a racing heart beat. Exhibit C. On or about July 16th, she called Respondent to tell him she was headed to the hospital due to these symptoms. Exhibit C; *see also*, Exhibit A, progress note for 7/16/07. Respondent told her not to go to the hospital, and he instructed her to discontinue Topamax to alleviate the symptoms. Exhibit C.

1.8 Although some of the symptoms subsided, they did not resolve. Respondent told Patient A that she could not have been suffering side effects from her medications. Exhibit C. Patient A subsequently experienced another exacerbation of her symptoms, and, on July 19th, she went to the emergency room, where she was tachycardic. *See*, Exhibit D (chart from Patient A's emergency room stay) at pages 4-8 of 34. In addition, her T4 level was high and her TSH level was abnormally low. Exhibit D, page 10 of 34. She was subsequently seen in The Vancouver Clinic, where she was diagnosed with hyperthyroidism and iatrogenic thyrotoxicosis. Exhibit E, (The Vancouver Clinic chart).

1.9 Respondent has failed and refused to acknowledge that Patient A suffered from hyperthyroidism or that Respondent's prescription for Armour Thyroid caused that condition. *See*, Exhibit H (Respondent's 10/15/07 letter to Department of Health

investigator). Together with Respondent's failure to appreciate the emergent situation when Patient A was exhibiting the signs of hyperthyroidism, Respondent's prescribing practices pose a considerable risk to the public. Exhibit C; Dunner declaration, ¶ 5(C).

1.10 Respondent's prescribing practices reflect a fundamental lack of understanding of appropriate polypsychopharmaceutical practices. In the case of Patient A, he prescribed high doses of stimulants (Armour Thyroid and Adderall), then tried to counterbalance the stimulating effect with Xanax and Topamax. As Dr. Dunner indicates, "This is a simplistic, inappropriate, and potentially dangerous way to prescribe multiple medications." Dunner declaration, ¶ 5(E).

1.11 In September 2006, Respondent went to hearing before the Commission on charges that he was excessively dosing patients with Armour Thyroid and Adderall. The Commission found that Respondent violated the standard of care in treating five patients, and ordered him, among other things, to "institute and continuously implement appropriate prescribing practices for his thyroid medications . . . ." Exhibit F (Findings of Fact, Conclusions of Law and Final Order, dated November 8, 2006), ¶ 3.1(A). In the case of Patient A, and with respect to other patients listed on the pharmacy profile, Respondent continues to prescribe large and inappropriate amounts of Armour Thyroid to mental health patients. Exhibits B and C; Dunner declaration, ¶ 5(D).

II. CONCLUSIONS OF LAW

2.1 The Commission, has jurisdiction over Respondent's credential to practice as a physician and surgeon. RCW 18.130.040.

2.2 The Commission has authority to take emergency adjudicative action to address an immediate danger to the public health, safety, or welfare. RCW 34.05.422(4); RCW 34.05.479; RCW 18.130.050(7); and WAC 246-11-300.

2.3 The Findings of Fact establish the existence of an immediate danger to the public health, safety, or welfare if Respondent has an unrestricted credential. The Findings of Fact establish that the requested summary action is necessary and adequately addresses the danger to the public health, safety, or welfare. As Dr. Dunner opines, "Respondent poses an imminent danger to the public and will continue to represent a threat to public safety unless he is precluded from prescribing any thyroid medications, stimulants of any kind, and benzodiazepines." Dunner declaration, ¶ 6.

III. ORDER

Based on the Findings of Fact and Conclusions of Law, it is ORDERED that Respondent's practice is RESTRICTED. Respondent may not prescribe any benzodiazepines, thyroid medications, or stimulants pending final resolution of this case.

Dated this 15th day of July, 2008.

Richard D Brantner MD

RICHARD BRANTNER, M.D.
Panel Chair

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

FILED
FEB 11 2009
Adjudicative Clerk

In the Matter of **PATRICK K. CHAU, MD** License No. MD00030053 Respondent	**No. M2008-117887** **AMENDED STATEMENT OF CHARGES**

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission), on designation by the Commission, makes the allegations below, which are supported by the evidence contained in program file numbers 2007-59025, 2007-59024, 2008-127206, 2008-128752, 2008-128936, 2008-128964 and 2008-131732. The patients referred to in this Amended Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On August 13, 1992, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently subject to a summary restriction.

1.2 Respondent is a board-certified psychiatrist who treated Patient A from April to July 2007. In treating Patient A, Respondent violated the standard of care in the following ways:

A. When he first saw Patient A on April 2, 2007, Respondent diagnosed her with a severe anxiety disorder, for which he prescribed Xanax, a benzodiazepine also known as alprazolam in its generic form. Respondent started the patient on six milligrams per day. This dose is well beyond the usual starting dose of alprazolam and is in itself a highly addictive dose of this medication, which is addictive at three milligrams. Respondent has also demonstrated a pattern of prescribing excessive, addictive amounts of benzodiazepines for other patients.

B. Respondent next saw Patient A on April 30, 2007. At that time, he diagnosed her with bipolar disorder and started her on Topamax for the purpose of mood stabilization. Topamax has no proven effects as a mood stabilizer. In addition, Respondent noted that he was starting the patient on Armour Thyroid and

Adderall as an alternative therapy for depression, stating that the patient had a failed history with standard antidepressants. Armour Thyroid and Adderall act as stimulants. Respondent started the patient on sixty milligrams per day of Adderall, an unduly high starting dose for that medication, and therefore below the standard of care. He also started her on 90 milligrams of Armour Thyroid, to be increased to 180 milligrams per day if "OK" after "2 or 5 days", which is a dosage that is extremely high, potentially toxic, and therefore below the standard of care. At the same visit, Respondent noted that Patient A had self-reduced the amount of Xanax she was taking, and he insisted that she take five milligrams a day, which is an addictive dose. Respondent has also demonstrated a pattern of prescribing excessive, dangerous amounts of stimulants and thyroid medication for other patients.

C. By July 2007, Patient A was experiencing some very concerning symptoms that were the result of hyperthyroidism, including a hand tremor, issues with speech, bugged out eyes, sweating, and nausea. According to Patient A, Respondent dismissed these symptoms and denied they could result from the medications he had prescribed her. Patient A reports certain symptomatic episodes, starting on July 12th, during which her symptoms of sweating, nausea, and vomiting worsened, and she experienced difficulty swallowing and breathing, felt her heart racing, and experienced confusion and disorientation. When she called Respondent with her concerns over these symptoms, Respondent reportedly discouraged Patient A from going to the emergency room, and he instead had her discontinue Topamax. When that alleviated some, but not all, of the symptoms, Respondent reportedly denied that the medications could be the cause, and he tried to get the patient to re-start Topamax. Within a few days, Patient A was in the emergency room, and she was ultimately diagnosed with hyperthyroidism, tachycardia, and possible thyroid toxicity. Respondent should have heeded the warning signs of hyperthyroidism and potential toxicity when his patient first reported her symptoms to him. Instead, he minimized her complaints and discouraged her from going to the hospital. As a result, he placed Patient A at risk of severe harm and quite likely caused her permanent injury.

1.3 Respondent went to a hearing before the Commission in September 2006 based on allegations that he was prescribing high doses of Armour Thyroid without monitoring thyroid levels and was also prescribing high doses of stimulants. In its Findings of Fact, Conclusions of Law and Final Order of November 8, 2006 (2006 Order), the Commission determined that Respondent did not meet the standard of care of a reasonably prudent physician practicing in Washington State. The remedies included that Respondent was to "continuously implement appropriate prescribing practices for his thyroid medications". 2006 Order, ¶3.1(A). Respondent has violated that order by continuously prescribing high doses of thyroid medication.

1.4 Respondent started seeing Patient B in February 2002 for medication management and psychotherapy. Patient B suffers from panic and anxiety disorders. He was 49 when he started treatment with Respondent and had a history of alcohol dependency requiring detoxification. Patient B had been in treatment with another mental health provider, who had tried Patient B on a variety of psychotropic medications. When he started with Respondent, Patient B was taking a benzodiazepine, Klonopin (generic name clonazapam), for anxiety. Because the Klonopin gave Patient B severe headaches, he was also taking the opioid Norco (hydrocodone and acetaminophen).

1.5 In treating Patient B over the next several years, Respondent prescribed increasingly high doses of benzodiazepines and opioids. He replaced Patient B's Klonopin with Xanax (alprazolam) a few months after he started treatment, and he added a second hydrocodone-based opioid (at first Lortab, and later Viocoprofen) to the Norco the patient was already taking, concluding that the opioids helped control the patient's anxiety as well as his benzodiazepine-induced headaches. This was in addition to other medications Respondent had Patient B try without any success. By the time Respondent had to stop treating Patient B due to a summary suspension the Commission imposed in May 2006, he was prescribing daily doses of 28 milligrams of Xanax, twelve 10/325 milligram tablets of Norco (he had previously prescribed up to 15 Norco tablets per day), and nine to twelve 7.5/200 milligram tablets of Vicoprofen per day (up to 210 milligrams of Hydrocodone per day).

1.6 During the time Respondent's license was suspended (May through November, 2006), Patient B saw a different provider, who discontinued Norco and

reduced the Vicoprofen and Xanax prescriptions. Patient B returned to treatment with Respondent in March 2007, after the suspension was lifted. Respondent continued the patient on a daily dose of twelve tablets of Vicoprofen 7.5/200 and 24 milligrams of Xanax per day, and he added 0.9 milligrams of Catapres (clonidine) to the daily regimen.

1.7 In treating Patient B, Respondent violated the standard of care in the following ways:

A. Patient B was on addicting doses of benzodiazepines and opioids when he started seeing Respondent. At that point, Respondent should have had Patient B detoxified rather than continue to support his treatment and, over time, increase the prescribed amounts of addictive medications.

B. Respondent increased Patient B's already addictive and dangerous doses of opioids and benzodiazepines. In addition, there is no evidence of much, if any, resulting improvement to the patient's condition.

C. Respondent's prescriptions of large amounts of opioids likely caused Patient B to become addicted to narcotics. Respondent failed to consider and try Patient B on non-addictive alternatives to treat his headaches. Respondent also failed to pursue a recommendation that Patient B see a neurologist regarding his headaches.

1.8 As a result, Respondent harmed, or created an unreasonable risk of harm, to Patient B.

1.9 Respondent treated Patient C for depression from August 2005 through May 2006, when he stopped because the Commission suspended Respondent's license. Patient C returned to Respondent in May 2008 and continued in treatment through August 2008.

1.10 When he stopped treating Patient C in 2006, Respondent was prescribing a daily regimen of 60 to 90 milligrams of Adderall, and one to two milligrams of Niravam (quickly absorbed alprazolam). The patient transferred his care to another provider, who weaned him off of his medications, including Adderall although the physician soon returned the patient to a daily regimen of 30 milligrams of Adderall in addition to two anti-depressants.

1.11 When Patient C returned to Respondent's care in May 2008, Respondent changed the regimen by prescribing only Adderall and increasing the dose. By the end of the month, Patient C was taking 120 milligrams of Adderall per day.

1.12 On July 15, 2008, Patient C notified Respondent that he had undergone a spell of weeping and crying. Respondent called in a prescription for Prozac (fluoxetine) to improve the patient's mood. Patient C called again that day to report a "panic like episode", including numbness and tingling in his hands, and feelings of fear and nervousness. Respondent responded by calling in a prescription for Xanax.

1.13 On August 7, 2008, Respondent charted that the patient's Adderall prescription was excessive and that he needed to taper it down. Because Respondent was, at that time, subject to a summary restriction which prohibited him from prescribing such medications, he suggested Patient C seek the care of another provider for medication management. Patient C went to the emergency room on August 14, 2008, suffering from panic attacks which likely resulted from the large amount of amphetamine Respondent had prescribed.

1.14 Respondent violated the standard of care in treating Patient C. He failed to recognize that Patient C was clinically deteriorating due to the amount of amphetamine he was taking. In addition, Respondent failed to consider other treatments for the patient's resistant depression, such as the addition of atypical antipsychotics to the Prozac.

1.15 On August 28, 2008, the Commission's investigator requested that Respondent produce his complete medical chart for Patient C. Respondent failed to produce records from August 2005 through May 2006.

1.16 Respondent has engaged in a pattern of prescribing high doses and large amounts of addicting medications, particularly benzodiazepines, to new patients who claimed to need ongoing treatment at such doses, but who also provided rationales for transferring their care to Respondent, such as that they recently moved from another state or part of this state, or that they changed or lost their insurance. Specifically:

A. Respondent saw Patient D on July 11, 2008. Patient D reported that he suffered from anxiety, moved from another state three months before, and was stable on a daily regimen of ten milligrams of alprazolam that his previous provider prescribed. Respondent planned to prescribe at that dose for three

months before seeing the patient again. He did not obtain any records or otherwise verify Patient D's treatment history. Patient D did not return as requested.

B. Respondent first saw Patient E on March 21, 2008. Patient E reported that he suffered from anxiety, was stable on a daily regimen of up to eight milligrams of Xanax that a psychiatrist in another state prescribed, but that he needed to change psychiatrists due to a change in insurance coverage. Respondent gave Patient E a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient E's treatment history. On July 7, 2008, Respondent provided Patient E with three more one-month prescriptions for Xanax.

C. Respondent first saw Patient F on June 11, 2008. Patient F reported that he suffered from anxiety, had moved from another state the month before, and was stable on a daily regimen that his previous provider prescribed of up to ten milligrams of Xanax and up to 1,400 milligrams of Soma, the latter for muscle spasms and panic control. Respondent gave Patient F a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient F's treatment history. When Patient F returned in September 2008, Respondent prescribed Xanax and Soma for another three months, along with two other medications.

D. Respondent first saw Patient G on March 11, 2008. Patient G reported that she suffered from panic attacks, had recently moved from another state, and was stable on a daily regimen of eight milligrams of alprazolam that her previous provider prescribed. Respondent gave Patient G a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient G's treatment history. When Patient G returned that June, Respondent prescribed another three-month supply of Xanax.

E. Respondent first saw Patient H in early May 2007. Patient H reported that she suffered from panic, anxiety and depression, that she had recently moved from another area, and that her anxiety and panic symptoms were stable on a daily regimen of up to ten milligrams of Xanax that her previous provider

prescribed. She was also taking Soma for back pain and an anti-depressant, which she reported was not effective. Respondent gave Patient H a prescription for a four-month supply of Xanax and had her continue on Soma. He had her wean off of the anti-depressant, and he started her on a daily regimen of 180 milligrams of Armour Thyroid (after taking 90 milligrams per day for two days) and 60 milligrams of Adderall. Respondent did not obtain any records or otherwise verify Patient H's treatment history. He continued to see the patient and prescribe Xanax and Soma, among other medications.

F. Respondent first saw Patient I on May 28, 2008. Patient I reported that she suffered from depression and panic attacks, was referred to Respondent after her previous prescribing physician retired two months before, and was stable on a daily regimen of ten milligrams of Xanax that her previous provider prescribed. Respondent gave Patient I a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient I's prescription history. Respondent prescribed another three-month supply on August 28, 2008.

G. Respondent first saw Patient J on February 22, 2008. Patient J reported that she suffered from panic attacks, had been in treatment with another psychiatrist for the preceding eight years, which was intermittent due to the patient's limited ability to pay for treatment, and had been stable on a daily regimen of six milligrams of Xanax, plus up to an additional one and a half milligrams for breakthrough panic, that her previous provider prescribed. She also reported that Respondent treated and maintained her on Xanax the previous year, but Respondent was unable to locate her chart. Respondent gave Patient J a prescription for a three-month supply and asked her to return in three months. He did not obtain any records or otherwise verify Patient J's treatment history. Respondent continued to provide the patient with prescriptions every three months. He increased the daily dose of Xanax to ten milligrams at Patient J's second visit on May 23, 2008.

H. Respondent saw Patient K on August 20, 2008. Patient K reported that he suffered from panic symptoms, stopped seeing his previous provider two months before for insurance reasons, and had previously been stable on a daily

regimen of six milligrams of Xanax and six milligrams of Klonopin that his previous provider prescribed. The patient also reportedly ran out of his medications and had experienced withdrawal symptoms. Respondent gave Patient K prescriptions for three-month supplies of each benzodiazepine, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient K's treatment history.

I. Respondent first saw Patient L on June 12, 2008. The patient reported that she suffered from anxiety, panic attacks and depression, stopped seeing her previous provider three months before for insurance reasons, and had previously been stable on a daily regimen of six milligrams of Klonopin and up to four milligrams of Xanax for breakthrough panic, that her previous provider prescribed, although the Klonopin reportedly made her sleepy. She also reported having run out of her medications. Respondent gave Patient L prescriptions for three-month supplies of eight milligrams of Xanax per day and two milligrams of Klonopin at night, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient L's treatment history. He re-prescribed the same regimen on September 5, 2008.

J. Respondent first saw Patient M on February 22, 2008. Patient M reported that he suffered from Panic Disorder, had recently moved from another part of the state, and was stable on a daily regimen of eight milligrams of Xanax that his previous provider prescribed. Respondent wrote Patient M one prescription for a three-month supply of Xanax. He also wrote for a two-month supply of OxyContin, 80 milligrams twice a day, even though Respondent did not chart anything about pain in his intake note (the chart does contain evidence that the patient suffered from chronic pain as recently as September 2006). Respondent did not obtain any records or otherwise verify Patient M's prescription history. On February 26, 2008, Patient M returned, stating he had lost the prescriptions that Respondent wrote four days before, and indicating he needed another three-month supply because he worked on a fishing boat out of Alaska and was about to leave for three months. Respondent gave Patient M another three-month supply of Xanax. Respondent did not chart any other visits with

Patient M. Respondent continued to write prescriptions to Patient M for eight milligrams per day of Xanax. On May 6, 2008, Respondent wrote for another 90-day supply of Xanax, even though the prescription Respondent wrote on February 26th should have lasted through late May, and, according to the patient's statement, he should have been away at sea in early May. On May 30, 2008, Respondent gave Patient M a five-month supply of Xanax. In just over three months, Respondent wrote Patient M prescriptions for a one year and two month supply of Xanax.

K. Respondent first saw Patient N on July 2, 2008. Patient N reported that she suffered from panic symptoms, stopped seeing her previous provider two months before because she lost her insurance, and had been stable until her insurance lapsed on a daily regimen of eight milligrams of Xanax. Respondent gave Patient N a prescription for a one-month supply of Xanax, which he renewed monthly, and he asked her to return in three months. Respondent also started her on Norco 10/325, two tablets three times daily, even though the patient did not report pain symptoms and did indicate that she had previously obtained complete relief from her panic symptoms with Xanax. Respondent did not obtain any records or otherwise verify Patient N's treatment history. In October 2008, someone reported to Respondent that Patient N was selling her "pain killers" for profit and that her husband was a "meth".

L. Respondent saw Patient O on July 25, 2008. Patient O reported that she suffered from back pain and related anxiety, lost her health coverage and moved from a different state two months before, and that she had relief from pain with the narcotic Vicodin (hydrocodone and acetimenophen) 7.5/700 that her previous provider prescribed. Respondent prescribed a three-month supply of Vicodin 7.5/700, four times daily, and asked the patient to return in three months. Respondent did not obtain any records or otherwise verify Patient O's treatment history.

M. Respondent first saw Patient P on June 10, 2008. Patient P reported that she suffered from chronic pain and anxiety, discontinued treatment six months before when she lost her insurance, and had experienced relief with Xanax, five milligrams per day and hydrocodone/acetaminophen 10/325. Respondent wrote

prescriptions for a three-month supply of Xanax, five milligrams per day, and Norco 10/325, up to three per day as needed. Respondent did not obtain any records or otherwise verify Patient P's treatment history. In the ensuing months, through October 16, 2008, Respondent increased Patient P's Norco prescription to up to six tablets per day, although he refused her request to increase it further to eight tablets. He also decreased her Xanax to three milligrams per day as she was taking less than the prescribed amount. Respondent also accommodated Patient P on September 29, 2008, by authorizing an early refill of a 15-day prescription for Norco that had been filled on September 22nd based on the patient's representation that she had travel plans. He again accommodated her on October 2nd by writing another 15-day prescription for Norco after Patient P told him someone else had picked up the prescription that was filled on September 29th. On October 16, 2008, Respondent wrote a 15-day prescription for six tablets per day of Norco with four refills. He also wrote a 15-day prescription for 1,050 milligrams of Soma per day with four refills. Respondent never verified Patient P's treatment history.

N. Respondent first saw Patient Q on May 20, 2008. Patient Q represented that he suffered from Panic Disorder, had moved from another state two months before, and that his symptoms were stable on ten milligrams of Xanax per day that his previous provider prescribed. Respondent gave Patient Q a prescription for a three-month supply of Xanax and asked him to return in three months. Respondent did not obtain any records or otherwise verify Patient Q's treatment history. Patient Q did not return as requested.

O. Respondent first saw Patient R on September 23, 2006. Patient R reported that she suffered from anxiety, panic disorder, and obsessive compulsive disorder, that she had lost her insurance, and that although she generally did well on a daily regimen of 10 milligrams of Klonopin, eight milligrams of Xanax had not helped with breakthrough episodes of panic. Respondent prescribed a daily regimen of 10 milligrams of Klonopin and up to four milligrams of Niravam for panic breakthrough symptoms. Respondent did not obtain any records or otherwise verify Patient R's treatment history. He has continued to treat Patient R, changing the Niravam to Xanax, and adding Soma.

As of September 2008, Respondent was prescribing a daily regimen that included ten milligrams of Xanax, four milligrams of Klonopin, and 1,050 milligrams of Soma.

1.17 Respondent violated the standard of care with respect to Patients D through R by:

A. Failing to recognize that the patients were on addicting doses of medications and refer them to an appropriate detoxification facility.

B. Repeatedly providing new patients with three-month supplies of high doses of addictive medications without planning to see the patients for three months.

C. Ignoring possible drug-seeking and diversion behaviors, and not requesting medical records from other providers or otherwise substantiating the patients' reported treatment and prescription histories.

As a result, Respondent placed these patients at an unreasonable risk of harm.

1.18 Respondent also violated the standard of care in treating patients J, K, L, N, and R by prescribing high doses of benzodiazepines and other medications even though, by the patients' reports, they had been drug free, rather than starting them at a lower dose and titrating up if warranted. By restarting them at high doses, Respondent put them at risk for adverse effects, such as sedation.

1.19 In addition to the standard of care violations described in Paragraphs 1.16 and 1.17, Respondent violated the standard of care in treating Patient H by starting her on an unduly high starting dose of Adderall (60 milligrams per day) and an extremely high and potentially toxic dose of Armour Thyroid (180 milligrams per day after two days at 90 milligrams) in violation of the 2006 Order.

1.20 In addition to the standard of care violations described in Paragraphs 1.16 and 1.17, Respondent violated the standard of care in treating Patient K by prescribing two benzodiazepines, both at addicting doses.

1.21 In addition to the standard of care violations described in Paragraphs 1.16 and 1.17, Respondent violated the standard of care in prescribing OxyContin to Patient M and Norco to Patient N because he did not document that they suffered from current pain complaints.

1.22 Patient S first saw Respondent on January 23, 2008. Patient S reported that he suffered from Post Traumatic Stress Disorder and insomnia and that his symptoms improved when he tried two milligrams of Xanax supplied by "other people". Respondent prescribed a daily regimen of eight milligrams of Xanax, wrote for a three-month supply, and asked the patient to return in three months. The patient returned one month early, on March 25th, at which time Respondent increased the prescription to ten milligrams per day and again wrote for a three-month supply. On May 30, 2008, Patient S told Respondent that he was leaving the area for a summer job in Alaska and that he needed a 90-day supply of Xanax to last him for that period. Respondent provided the requested prescription.

1.23 Respondent violated the standard of care in treating Patient S. He started the patient on an unduly high and addictive dose of Xanax instead of starting at a safer, lower dose and titrating up if warranted. He also disregarded signs that the patient was drug-seeking and possibly diverting. In accepting the patient's claim that he needed a 90-day supply of Xanax because he was going to work in Alaska for the summer, Respondent accepted at face value a brief note to that effect that the patient provided. The note was purportedly written by another of Respondent's patients.

1.24 Respondent provided records indicating he resumed treatment of Patient T on December 29, 2006, after having previously treated her from March 2005 through May 2006. Despite the Commission's investigator's request, Respondent did not provide records from the earlier treatment period. Patient T complained of depression, fatigue, sluggishness, and poor attention and concentration. Respondent had previously treated her with a daily regimen of 180 milligrams of Armour Thyroid and 30 milligrams of Adderall. Respondent returned the patient to those medications at the previous doses, and he continued to treat her, eventually increasing her daily Adderall to 60 milligrams.

1.25 Respondent violated the standard of care in treating Patient T and placed her at an unreasonable risk of harm. Respondent reinstituted a high dose of thyroid medication without titration. He also has failed to clinically monitor her for symptoms of hyperthyroidism. Respondent's treatment of Patient T constitutes a violation of the 2006 Order.

1.26 Respondent first treated Patient U from January through May 2006. Patient U reported that she was depressed, tired, and lacked energy, was slow thinking, had thinning hair, brittle nails and puffy eyes, and she had a history of abnormal weight gain since childhood. She also reported a family history of borderline hypothyroidism. Respondent started Patient U on 90 milligrams of Armour Thyroid, to be increased to 180 milligrams after two days. Less than two weeks later, he increased the dosage to 270 milligrams. He also started the patient on 30 milligrams of Adderall. The patient stopped seeing Respondent while he was summarily suspended from practice in 2006. After the Commission entered the 2006 Order and Respondent returned to practice, Patient U returned to see Respondent in February 2007, and he re-started her on Armour Thyroid, this time on a daily regimen of 180 milligrams, as well as 30 milligrams of Adderall. Patient U then stopped seeing Respondent and discontinued medications until September 8, 2008, when she returned to Respondent's care. Respondent re-started her on 180 milligrams of Armour Thyroid and 30 milligrams of Adderall per day.

1.27 Respondent violated the standard of care in treating Patient U, and he placed her at an unreasonable risk of harm. Respondent started the patient at an unduly high dose of thyroid medication, and increased it to an even more dangerous level. Respondent never screened Patient U for a thyroid disorder, even though her symptoms were consistent with hypothyroidism and she reported a family history. He also failed to clinically monitor her for potential hyperthyroidism during the time he was treating her. Respondent further violated the standard of care by starting Patient U on high doses of Armour Thyroid when she returned to his practice in February 2007 and again in September 2008, after she had been drug free, without any attempt at titration, and without checking her baseline blood levels for possible thyroid dysfunction. Respondent also violated the 2006 Order by providing substandard care in prescribing Armour Thyroid to this patient.

1.28 Patient V first saw seen Respondent from 2005 to 2006, although Respondent did not produce any records from that period despite a request from the Commission's investigator. Patient V complained of depression, fatigue, lack of energy, poor attention and concentration, and reduced memory. She also reported that her primary care provider had checked her thyroid function and advised her that it was "borderline normal," and she had a family history of hypothyroidism. During the initial

period of treatment, Respondent prescribed Armour Thyroid and Adderall, 30 milligrams. Respondent did not order any labs to check her thyroid function. Patient V ran out of medication after she stopped seeing Respondent in 2006. When she returned on March 27, 2007, Respondent prescribed a daily regimen of 180 milligrams of Armour Thyroid and 60 milligrams of Adderall. He again did not first order blood work to check her thyroid function. Respondent did have the patient obtain lab work for thyroid function four months later, in July. Since then, Respondent has continued Patient V on high doses of thyroid medication, yet he has not clinically monitored her for possible hyperthyroidism. Respondent has continued to see Patient V, who increased her daily Adderall to 90 milligrams in May 2008 "to cover the awaking period of a day" during the summer.

1.29 Respondent violated the standard of care in treating Patient V, and he placed her at an unreasonable risk of harm. In March 2007, he started her on high, dangerous doses of Armour Thyroid and Adderall without any effort to start at a lower dose and titrate up if warranted. He failed to assess her thyroid function before starting her on high doses for thyroid medication, and he did not check her blood levels before starting her on thyroid medication despite the possibility that she suffered from hypothyroidism. He has not clinically monitored her for possible hyperthyroidism. Respondent's substandard practices in prescribing Armour Thyroid constitute a violation of the 2006 Order. In addition, he increased the patient's Adderall to an even more dangerous dose without a valid basis for doing so.

1.30 Respondent first saw Patient W on June 9, 2008. Patient W complained of panic attacks, depression, extreme fatigue, sluggishness and lack of energy. She also reported rapid weight gain and that her hair was "falling off fast." Respondent started Patient W on a daily regimen of 90 milligrams of Armour Thyroid, to be increased to 180 milligrams after three days if tolerated well, and 60 milligrams of Adderall. He also had the patient try Xanax, three to four milligrams per day. Respondent did not order lab work at that time to check Patient W's thyroid function. Respondent has continued to treat Patient W, decreasing her Xanax in October 2008.

1.31 Respondent violated the standard of care in treating Patient W, and he has placed her at an unreasonable risk of harm. Respondent started the patient on high and potentially dangerous doses of Armour Thyroid and Adderall without any effort

to try lower doses and titrate up if warranted. He did not check her thyroid function before starting her on thyroid medication even though she exhibited clinical signs of possible hypothyroidism. He has not clinically checked her for thyroid dysfunction on a regular basis. Respondent violated the 2006 Order by providing substandard care in prescribing thyroid medication to Patient W.

1.32 Respondent initially treated Patient X from March 2003 until Respondent's license was summarily suspended in May 2006. During that period, Respondent diagnosed Patient X with Attention Deficit Disorder, Mood Disorder, and Anxiety Disorders, and he prescribed a daily regimen of a benzodiazepine, Valium (diazepam) 50 milligrams, and 60 milligrams of Adderall, which Respondent later increased to 180 milligrams per day. Respondent did not produce records from this time period to the Commission's investigator when asked. Following the 2006 Order and Respondent's return to practice, Patient X returned to Respondent on December 7, 2006. Patient X had run out of his medications, and Respondent noted that he suffered from depression symptoms when not taking Adderall. Respondent restarted the patient on Adderall, 60 milligrams, and Valium, 30 milligrams, per day.

1.33 Respondent violated the standard of care in treating Patient X, and he placed him at an unreasonable risk of harm. During the initial phase of treatment, Respondent started Patient X at high and dangerous doses of Valium and Adderall, and he eventually increased the Adderall to an extremely dangerous dose of 180 milligrams per day. When Patient X returned to Respondent's care in December 2006, Respondent restarted him on a high daily regimen of Adderall, 60 milligram, without any effort to titrate from a lower, safer dose.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4), (8)(a), and (9), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> ...
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute

unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

...

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

...

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

... .

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

3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Disciplinary Manager of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: February 10, 2009

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

DANI NEWMAN
DISCIPLINARY MANAGER

SUSAN L. PIERINI, WSBA # 17714
ASSISTANT ATTORNEY GENERAL

CONFIDENTIAL SCHEDULE

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

Patient A [redacted]
Patient B
Patient C
Patient D
Patient E
Patient F
Patient G
Patient H
Patient I
Patient J
Patient K
Patient L

Patient M [redacted]
Patient N
Patient O
Patient P
Patient Q
Patient R
Patient S
Patient T
Patient U
Patient V
Patient W
Patient X

Attachment D

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of **PATRICK K. CHAU, MD** License No. MD00030053 Respondent	**No. M2008-117887** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through Peter J. Harris, Department of Health Staff Attorney, and Respondent, represented by counsel, Scott T. Schauermann, stipulate and agree to the following:

1. PROCEDURAL STIPULATIONS

1.1 On July 16, 2008, the Commission issued a Statement of Charges against Respondent, alleging that Respondent violated RCW 18.130.180(4) and (9).

1.2 The Commission filed the Statement of Charges with an Ex Parte Motion for Order of Summary Action. On July 15, 2008, the Commission granted the motion and restricted Respondent from prescribing benzodiazepines, thyroid medications, or stimulants pending final resolution of the case.

1.3 Following service of the Statement of Charges and the summary restriction order, Respondent requested a show cause hearing under RCW 18.130.135(1). On August 13, 2008, based on evidence presented at the show cause hearing, the Commission revised the summary restriction of Respondent's license to require: (a) Respondent, in treating patients with benzodiazepines, thyroid medication and stimulants, to prescribe the lowest medically effective doses; (b) Respondent to prescribe to only one pharmacy; (c) each patient receiving such medications to sign a contract with terms that the Commission specified; and (d) the Commission to perform an unannounced practice review within three months to assure compliance.

1.4 On February 10, 2009, the Commission issued an Amended Statement of Charges against Respondent, alleging that Respondent violated RCW 18.130.180(4), (8)(a) and (9).

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

1.6 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.

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

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

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

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

1.11 If the Commission accepts this Agreed Order, it will be reported to the Health Integrity and Protection Databank (45 CFR Part 61), and it may be reported to the National Practitioner Databank (45 CFR Part 60) and elsewhere as required by law. It is a public document and will be placed on the Department of Health's website and otherwise disseminated as required by the Public Records Act (Chapter 42.56 RCW) and the Uniform Disciplinary Act, RCW 18.130.110.

1.12 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

Although Respondent maintains that he would present evidence to refute some of the following facts at hearing, Respondent and the Program acknowledge that the evidence is sufficient to justify the following findings:

2.1 On August 13, 1992, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently subject to a summary restriction.

2.2 Respondent is a board-certified psychiatrist who treated Patient A from April to July 2007. In treating Patient A, Respondent violated the standard of care in the following ways:

2.2.1 When he first saw Patient A on April 2, 2007, Respondent diagnosed her with a severe anxiety disorder, for which he prescribed Xanax, a benzodiazepine also known as alprazolam in its generic form. Respondent started the patient on six milligrams per day. This dose is well beyond the usual starting dose of alprazolam and is in itself a highly addictive dose of this medication, which is addictive at three milligrams. Respondent has also demonstrated a pattern of prescribing excessive, addictive amounts of benzodiazepines for other patients.

2.2.2 Respondent next saw Patient A on April 30, 2007. At that time, he diagnosed her with bipolar disorder and started her on Topamax for the purpose of mood stabilization. Topamax has no proven effects as a mood stabilizer. In addition, Respondent noted that he was starting the patient on Armour Thyroid and Adderall as an alternative therapy for depression, stating that the patient had a failed history with standard antidepressants. Armour Thyroid and Adderall act as stimulants. Respondent started the patient on sixty milligrams per day of Adderall, an unduly high starting dose for that medication, and therefore below the standard of care. He also started her on 90 milligrams of Armour Thyroid, to be increased to 180 milligrams per day if "OK" after "2 or 5 days", which is a dosage that is extremely high, potentially toxic, and therefore below the standard of care. At the same visit, Respondent noted that Patient A had self-reduced the amount of Xanax she was taking, and he insisted that she take five milligrams a day, which is an addictive dose. Respondent has also demonstrated a pattern of prescribing excessive, dangerous amounts of stimulants and thyroid medication for other patients.

2.2.3 By July 2007, Patient A was experiencing some very concerning symptoms that were the result of hyperthyroidism, including a hand tremor, issues with speech, bugged out eyes, sweating, and nausea. According to Patient A, Respondent dismissed these symptoms and denied they could result from the medications he had prescribed her. Patient A reports certain symptomatic episodes, starting on July 12th, during which her symptoms of

sweating, nausea, and vomiting worsened, and she experienced difficulty swallowing and breathing, felt her heart racing, and experienced confusion and disorientation. When she called Respondent with her concerns over these symptoms, Respondent reportedly discouraged Patient A from going to the emergency room, and he instead had her discontinue Topamax. When that alleviated some, but not all of the symptoms, Respondent reportedly denied that the medications could be the cause, and he tried to get the patient to re-start Topamax. Within a few days, Patient A was in the emergency room, and she was ultimately diagnosed with hyperthyroidism, tachycardia, and possible thyroid toxicity. Respondent should have heeded the warning signs of hyperthyroidism and potential toxicity when his patient first reported her symptoms to him. Instead, he minimized her complaints and discouraged her from going to the hospital. As a result, he placed Patient A at risk of severe harm and quite likely caused her permanent injury.

2.3 Respondent went to a hearing before the Commission in September 2006 based on allegations that he was prescribing high doses of Armour Thyroid without monitoring thyroid levels and was also prescribing high doses of stimulants. In its Findings of Fact, Conclusions of Law and Final Order of November 8, 2006 (2006 Order), the Commission determined that Respondent *did not* meet the standard of care of a reasonably prudent physician practicing in Washington State. The remedies included that Respondent was to "continuously implement appropriate prescribing practices for his thyroid medications". 2006 Order, ¶3.1(A). Respondent has violated that order by continuously prescribing high doses of thyroid medication.

2.4 Respondent started seeing Patient B in February 2002 for medication management and psychotherapy. Patient B suffers from panic and anxiety disorders. He was 49 when he started treatment with Respondent and had a history of alcohol dependency requiring detoxification. Patient B had been in treatment with another mental health provider, who had tried Patient B on a variety of psychotropic medications. When he started with Respondent, Patient B was taking a benzodiazepine, Klonopin (generic

name clonazapam), for anxiety. Because the Klonopin gave Patient B severe headaches, he was also taking the opioid Norco (hydrocodone and acetaminophen).

2.5 In treating Patient B over the next several years, Respondent prescribed increasingly high doses of benzodiazepines and opioids. He replaced Patient B's Klonopin with Xanax (alprazolam) a few months after he started treatment, and he added a second hydrocodone-based opioid (at first Lortab, and later Vicoprofen) to the Norco the patient was already taking, concluding that the opioids helped control the patient's anxiety as well as his benzodiazepine-induced headaches. This was in addition to other medications Respondent had Patient B try without any success. By the time Respondent had to stop treating Patient B due to a summary suspension the Commission imposed in May 2006, he was prescribing daily doses of 28 milligrams of Xanax, twelve 10/325 milligram tablets of Norco (he had previously prescribed up to 15 Norco tablets per day), and nine to twelve 7.5/200 milligram tablets of Vicoprofen per day (up to 210 milligrams of Hydrocodone per day).

2.6 During the time Respondent's license was suspended (May through November, 2006), Patient B saw a different provider, who discontinued Norco and reduced the Vicoprofen and Xanax prescriptions. Patient B returned to treatment with Respondent in March 2007, after the suspension was lifted. Respondent continued the patient on a daily dose of twelve tablets of Vicoprofen 7.5/200 and 24 milligrams of Xanax per day, and he added 0.9 milligrams of Catapres (clonidine) to the daily regimen.

2.7 In treating Patient B, Respondent violated the standard of care in the following ways:

2.7.1 Patient B was on addicting doses of benzodiazepines and opioids when he started seeing Respondent. At that point, Respondent should have had Patient B detoxified rather than continue to support his treatment and, over time, increase the prescribed amounts of addictive medications.

2.7.2 Respondent increased Patient B's already addictive and dangerous doses of opioids and benzodiazepines. In addition, there is no evidence of much, if any, resulting improvement to the patient's condition.

2.7.3 Respondent's prescriptions of large amounts of opioids likely caused Patient B to become addicted to narcotics. Respondent failed to consider

and try Patient B on non-addictive alternatives to treat his headaches. Respondent also failed to pursue a recommendation that Patient B see a neurologist regarding his headaches.

2.8 As a result, Respondent harmed, or created an unreasonable risk of harm, to Patient B.

2.9 Respondent treated Patient C for depression from August 2005 through May 2006, when he stopped because the Commission suspended Respondent's license. Patient C returned to Respondent in May 2008 and continued in treatment through August 2008.

2.10 When he stopped treating Patient C in 2006, Respondent was prescribing a daily regimen of 60 to 90 milligrams of Adderall, and one to two milligrams of Niravam (quickly absorbed alprazolam). The patient transferred his care to another provider, who weaned him off of his medications, including Adderall although the physician soon returned the patient to a daily regimen of 30 milligrams of Adderall in addition to two anti-depressants.

2.11 When Patient C returned to Respondent's care in May 2008, Respondent changed the regimen by prescribing only Adderall and increasing the dose. By the end of the month, Patient C was taking 120 milligrams of Adderall per day.

2.12 On July 15, 2008, Patient C notified Respondent that he had undergone a spell of weeping and crying. Respondent called in a prescription for Prozac (fluoxetine) to improve the patient's mood. Patient C called again that day to report a "panic like episode", including numbness and tingling in his hands, and feelings of fear and nervousness. Respondent responded by calling in a prescription for Xanax.

2.13 On August 7, 2008, Respondent charted that the patient's Adderall prescription was excessive and that he needed to taper it down. Because Respondent was, at that time, subject to a summary restriction which prohibited him from prescribing such medications, he suggested Patient C seek the care of another provider for medication management. Patient C went to the emergency room on August 14, 2008, suffering from panic attacks which likely resulted from the large amount of amphetamine Respondent had prescribed.

2.14 Respondent violated the standard of care in treating Patient C. He failed to recognize that Patient C was clinically deteriorating due to the amount of amphetamine he was taking. In addition, Respondent failed to consider other treatments for the patient's resistant depression, such as the addition of atypical antipsychotics to the Prozac.

2.15 On August 28, 2008, the Commission's investigator requested that Respondent produce his complete medical chart for Patient C. Respondent failed to produce records from August 2005 through May 2006.

2.16 Respondent has engaged in a pattern of prescribing high doses and large amounts of addicting medications, particularly benzodiazepines, to new patients who claimed to need ongoing treatment at such doses, but who also provided rationales for transferring their care to Respondent, such as that they recently moved from another state or part of this state, or that they changed or lost their insurance. Specifically:

2.16.1 Respondent saw Patient D on July 11, 2008. Patient D reported that he suffered from anxiety, moved from another state three months before, and was stable on a daily regimen of ten milligrams of alprazolam that his previous provider prescribed. Respondent planned to prescribe at that dose for three months before seeing the patient again. He did not obtain any records or otherwise verify Patient D's treatment history. Patient D did not return as requested.

2.16.2 Respondent first saw Patient E on March 21, 2008. Patient E reported that he suffered from anxiety, was stable on a daily regimen of up to eight milligrams of Xanax that a psychiatrist in another state prescribed, but that he needed to change psychiatrists due to a change in insurance coverage. Respondent gave Patient E a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient E's treatment history. On July 7, 2008, Respondent provided Patient E with three more one-month prescriptions for Xanax.

2.16.3 Respondent first saw Patient F on June 11, 2008. Patient F reported that he suffered from anxiety, had moved from another state the

month before, and was stable on a daily regimen that his previous provider prescribed of up to ten milligrams of Xanax and up to 1,400 milligrams of Soma, the latter for muscle spasms and panic control. Respondent gave Patient F a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient F's treatment history. When Patient F returned in September 2008, Respondent prescribed Xanax and Soma for another three months, along with two other medications.

2.16.4 Respondent first saw Patient G on March 11, 2008. Patient G reported that she suffered from panic attacks, had recently moved from another state, and was stable on a daily regimen of eight milligrams of alprazolam that her previous provider prescribed. Respondent gave Patient G a prescription for a three-month supply, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient G's treatment history. When Patient G returned that June, Respondent prescribed another three-month supply of Xanax.

2.16.5 Respondent first saw Patient H in early May 2007. Patient H reported that she suffered from panic, anxiety and depression, that she had recently moved from another area, and that her anxiety and panic symptoms were stable on a daily regimen of up to ten milligrams of Xanax that her previous provider prescribed. She was also taking Soma for back pain and an anti-depressant, which she reported was not effective. Respondent gave Patient H a prescription for a four-month supply of Xanax and had her continue on Soma. He had her wean off of the anti-depressant, and he started her on a daily regimen of 180 milligrams of Armour Thyroid (after taking 90 milligrams per day for two days) and 60 milligrams of Adderall. Respondent did not obtain any records or otherwise verify Patient H's treatment history. He continued to see the patient and prescribe Xanax and Soma, among other medications.

2.16.6 Respondent first saw Patient I on May 28, 2008. Patient I reported that she suffered from depression and panic attacks, was referred to

Respondent after her previous prescribing physician retired two months before, and was stable on a daily regimen of ten milligrams of Xanax that her previous provider prescribed. Respondent gave Patient I a prescription for a three-month supply, and he asked the patient to return in three months. .He did not obtain any records or otherwise verify Patient I's prescription history. Respondent prescribed another three-month supply on August 28, 2008.

2.16.7 Respondent first saw Patient J on February 22, 2008. Patient J reported that she suffered from panic attacks, had been in treatment with another psychiatrist for the preceding eight years, which was intermittent due to the patient's limited ability to pay for treatment, and had been stable on a daily regimen of six milligrams of Xanax, plus up to an additional one and a half milligrams for breakthrough panic that her previous provider prescribed. She also reported that Respondent treated and maintained her on Xanax the previous year, but Respondent was unable to locate her chart. Respondent gave Patient J a prescription for a three-month supply and asked her to return in three months. He did not obtain any records or otherwise verify Patient J's treatment history. Respondent continued to provide the patient with prescriptions every three months. He increased the daily dose of Xanax to ten milligrams at Patient J's second visit on May 23, 2008.

2.16.8 Respondent saw Patient K on August 20, 2008. Patient K reported that he suffered from panic symptoms, stopped seeing his previous provider two months before for insurance reasons, and had previously been stable on a daily regimen of six milligrams of Xanax and six milligrams of Klonopin that his previous provider prescribed. The patient also reportedly ran out of his medications and had experienced withdrawal symptoms. Respondent gave Patient K prescriptions for three-month supplies of each benzodiazepine, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient K's treatment history.

2.16.9 Respondent first saw Patient L on June 12, 2008. The patient reported that she suffered from anxiety, panic attacks and depression, stopped seeing her previous provider three months before for insurance reasons, and had previously been stable on a daily regimen of six milligrams of Klonopin and up to four milligrams of Xanax for breakthrough panic, that her previous provider prescribed, although the Klonopin reportedly made her sleepy. She also reported having run out of her medications. Respondent gave Patient L prescriptions for three-month supplies of eight milligrams of Xanax per day and two milligrams of Klonopin at night, and he asked the patient to return in three months. He did not obtain any records or otherwise verify Patient L's treatment history. He re-prescribed the same regimen on September 5, 2008.

2.16.10 Respondent first saw Patient M on February 22, 2008. Patient M reported that he suffered from Panic Disorder, had recently moved from another part of the state, and was stable on a daily regimen of eight milligrams of Xanax that his previous provider prescribed. Respondent wrote Patient M one prescription for a three-month supply of Xanax. He also wrote for a two-month supply of OxyContin, 80 milligrams twice a day, even though Respondent did not chart anything about pain in his intake note (the chart does contain evidence that the patient suffered from chronic pain as recently as September 2006). Respondent did not obtain any records or otherwise verify Patient M's prescription history. On February 26, 2008, Patient M returned, stating he had lost the prescriptions that Respondent wrote four days before, and indicating he needed another three-month supply because he worked on a fishing boat out of Alaska and was about to leave for three months. Respondent gave Patient M another three-month supply of Xanax. Respondent did not chart any other visits with Patient M. Respondent continued to write prescriptions to Patient M for eight milligrams per day of Xanax. On May 6, 2008, Respondent wrote for another 90-day supply of Xanax, even though the prescription Respondent wrote on February 26th should have lasted through late May, and, according

to the patient's statement, he should have been away at sea in early May. On May 30, 2008, Respondent gave Patient M a five-month supply of Xanax. In just over three months, Respondent wrote Patient M prescriptions for a one year and two month supply of Xanax.

2.16.11 Respondent first saw Patient N on July 2, 2008. Patient N reported that she suffered from panic symptoms, stopped seeing her previous provider two months before because she lost her insurance, and had been stable until her insurance lapsed on a daily regimen of eight milligrams of Xanax. Respondent gave Patient N a prescription for a one-month supply of Xanax, which he renewed monthly, and he asked her to return in three months. Respondent also started her on Norco 10/325, two tablets three times daily, even though the patient did not report pain symptoms and did indicate that she had previously obtained complete relief from her panic symptoms with Xanax. Respondent did not obtain any records or otherwise verify Patient N's treatment history. In October 2008, someone reported to Respondent that Patient N was selling her "pain killers" for profit and that her husband was a "meth".

2.16.12 Respondent saw Patient O on July 25, 2008. Patient O reported that she suffered from back pain and related anxiety, lost her health coverage and moved from a different state two months before, and that she had relief from pain with the narcotic Vicodin (hydrocodone and acetimenophen) 7.5/700 that her previous provider prescribed. Respondent prescribed a three-month supply of Vicodin 7.5/700, four times daily, and asked the patient to return in three months. Respondent did not obtain any records or otherwise verify Patient O's treatment history.

2.16.13 Respondent first saw Patient P on June 10, 2008. Patient P reported that she suffered from chronic pain and anxiety, discontinued treatment six months before when she lost her insurance, and had experienced relief with Xanax, five milligrams per day and hydrocodone/acetaminophen 10/325. Respondent wrote prescriptions for a three-month supply of Xanax, five milligrams per day, and Norco 10/325, up

to three per day as needed. Respondent did not obtain any records or otherwise verify Patient P's treatment history. In the ensuing months, through October 16, 2008, Respondent increased Patient P's Norco prescription to up to six tablets per day, although he refused her request to increase it further to eight tablets. He also decreased her Xanax to three milligrams per day as she was taking less than the prescribed amount. Respondent also accommodated Patient P on September 29, 2008, by authorizing an early refill of a 15-day prescription for Norco that had been filled on September 22nd based on the patient's representation that she had travel plans. He again accommodated her on October 2nd by writing another 15-day prescription for Norco after Patient P told him someone else had picked up the prescription that was filled on September 29th. On October 16, 2008, Respondent wrote a 15-day prescription for six tablets per day of Norco with four refills. He also wrote a 15-day prescription for 1,050 milligrams of Soma per day with four refills. Respondent never verified Patient P's treatment history.

2.16.14 Respondent first saw Patient Q on May 20, 2008. Patient Q represented that he suffered from Panic Disorder, had moved from another state two months before, and that his symptoms were stable on ten milligrams of Xanax per day that his previous provider prescribed. Respondent gave Patient Q a prescription for a three-month supply of Xanax and asked him to return in three months. Respondent did not obtain any records or otherwise verify Patient Q's treatment history. Patient Q did not return as requested.

2.16.15 Respondent first saw Patient R on September 23, 2006. Patient R reported that she suffered from anxiety, panic disorder, and obsessive compulsive disorder, that she had lost her insurance, and that although she generally did well on a daily regimen of 10 milligrams of Klonopin, eight milligrams of Xanax had not helped with breakthrough episodes of panic. Respondent prescribed a daily regimen of 10 milligrams of Klonopin and up to four milligrams of Niravam for panic breakthrough symptoms.

Respondent did not obtain any records or otherwise verify Patient R's treatment history. He has continued to treat Patient R, changing the Niravam to Xanax, and adding Soma. As of September 2008, Respondent was prescribing a daily regimen that included ten milligrams of Xanax, four milligrams of Klonopin, and 1,050 milligrams of Soma.

2.17 Respondent violated the standard of care with respect to Patients D through R by:

2.17.1 Failing to recognize that the patients were on addicting doses of medications and refer them to an appropriate detoxification facility.

2.17.2 Repeatedly providing new patients with three-month supplies of high doses of addictive medications without planning to see the patients for three months.

2.17.3 Ignoring possible drug-seeking and diversion behaviors, and not requesting medical records from other providers or otherwise substantiating the patients' reported treatment and prescription histories. As a result, Respondent placed these patients at an unreasonable risk of harm.

2.18 Respondent also violated the standard of care in treating patients J, K, L, N, and R by prescribing high doses of benzodiazepines and other medications even though, by the patients' reports, they had been drug free, rather than starting them at a lower dose and titrating up if warranted. By restarting them at high doses, Respondent put them at risk for adverse effects, such as sedation.

2.19 In addition to the standard of care violations described in Paragraphs 2.16 and 2.17, Respondent violated the standard of care in treating Patient H by starting her on an unduly high starting dose of Adderall (60 milligrams per day) and an extremely high and potentially toxic dose of Armour Thyroid (180 milligrams per day after two days at 90 milligrams) in violation of the 2006 Order.

2.20 In addition to the standard of care violations described in Paragraphs 2.16 and 2.17, Respondent violated the standard of care in treating Patient K by prescribing two benzodiazepines, both at addicting doses.

2.21 In addition to the standard of care violations described in Paragraphs 2.16 and 2.17, Respondent violated the standard of care in prescribing OxyContin to Patient M and Norco to Patient N because he did not document that they suffered from current pain complaints.

2.22 Patient S first saw Respondent on January 23, 2008. Patient S reported that he suffered from Post Traumatic Stress Disorder and insomnia and that his symptoms improved when he tried two milligrams of Xanax supplied by "other people". Respondent prescribed a daily regimen of eight milligrams of Xanax, wrote for a three-month supply, and asked the patient to return in three months. The patient returned one month early, on March 25th, at which time Respondent increased the prescription to ten milligrams per day and again wrote for a three-month supply. On May 30, 2008, Patient S told Respondent that he was leaving the area for a summer job in Alaska and that he needed a 90-day supply of Xanax to last him for that period. Respondent provided the requested prescription.

2.23 Respondent violated the standard of care in treating Patient S. He started the patient on an unduly high and addictive dose of Xanax instead of starting at a safer, lower dose and titrating up if warranted. He also disregarded signs that the patient was drug-seeking and possibly diverting. In accepting the patient's claim that he needed a 90-day supply of Xanax because he was going to work in Alaska for the summer, Respondent accepted at face value a brief note to that effect that the patient provided. The note was purportedly written by another of Respondent's patients.

2.24 Respondent provided records indicating he resumed treatment of Patient T on December 29, 2006, after having previously treated her from March 2005 through May 2006. Despite the Commission's investigator's request, Respondent did not provide records from the earlier treatment period. Patient T complained of depression, fatigue, sluggishness, and poor attention and concentration. Respondent had previously treated her with a daily regimen of 180 milligrams of Armour Thyroid and 30 milligrams of Adderall. Respondent returned the patient to those medications at the previous doses, and he continued to treat her, eventually increasing her daily Adderall to 60 milligrams.

2.25 Respondent violated the standard of care in treating Patient T and placed her at an unreasonable risk of harm. Respondent reinstituted a high dose of thyroid

medication without titration. He also has failed to clinically monitor her for symptoms of hyperthyroidism. Respondent's treatment of Patient T constitutes a violation of the 2006 Order.

2.26 Respondent first treated Patient U from January through May 2006. Patient U reported that she was depressed, tired, and lacked energy, was slow thinking, had thinning hair, brittle nails and puffy eyes, and she had a history of abnormal weight gain since childhood. She also reported a family history of borderline hypothyroidism. Respondent started Patient U on 90 milligrams of Armour Thyroid, to be increased to 180 milligrams after two days. Less than two weeks later, he increased the dosage to 270 milligrams. He also started the patient on 30 milligrams of Adderall. The patient stopped seeing Respondent while he was summarily suspended from practice in 2006. After the Commission entered the 2006 Order and Respondent returned to practice, Patient U returned to see Respondent in February 2007, and he re-started her on Armour Thyroid, this time on a daily regimen of 180 milligrams, as well as 30 milligrams of Adderall. Patient U then stopped seeing Respondent and discontinued medications until September 8, 2008, when she returned to Respondent's care. Respondent re-started her on 180 milligrams of Armour Thyroid and 30 milligrams of Adderall per day.

2.27 Respondent violated the standard of care in treating Patient U, and he placed her at an unreasonable risk of harm. Respondent started the patient at an unduly high dose of thyroid medication, and increased it to an even more dangerous level. Respondent never screened Patient U for a thyroid disorder, even though her symptoms were consistent with hypothyroidism and she reported a family history. He also failed to clinically monitor her for potential hyperthyroidism during the time he was treating her. Respondent further violated the standard of care by starting Patient U on high doses of Armour Thyroid when she returned to his practice in February 2007 and again in September 2008, after she had been drug free, without any attempt at titration, and without checking her baseline blood levels for possible thyroid dysfunction. Respondent also violated the 2006 Order by providing substandard care in prescribing Armour Thyroid to this patient.

2.28 Patient V first saw seen Respondent from 2005 to 2006, although Respondent did not produce any records from that period despite a request from the

Commission's investigator. Patient V complained of depression, fatigue, lack of energy, poor attention and concentration, and reduced memory. She also reported that her primary care provider had checked her thyroid function and advised her that it was "borderline normal," and she had a family history of hypothyroidism. During the initial period of treatment, Respondent prescribed Armour Thyroid and Adderall, 30 milligrams. Respondent did not order any labs to check her thyroid function. Patient V ran out of medication after she stopped seeing Respondent in 2006. When she returned on March 27, 2007, Respondent prescribed a daily regimen of 180 milligrams of Armour Thyroid and 60 milligrams of Adderall. He again did not first order blood work to check her thyroid function. Respondent did have the patient obtain lab work for thyroid function four months later, in July. Since then, Respondent has continued Patient V on high doses of thyroid medication, yet he has not clinically monitored her for possible hyperthyroidism. Respondent has continued to see Patient V, who increased her daily Adderall to 90 milligrams in May 2008 "to cover the awaking period of a day" during the summer.

2.29 Respondent violated the standard of care in treating Patient V, and he placed her at an unreasonable risk of harm. In March 2007, he started her on high, dangerous doses of Armour Thyroid and Adderall without any effort to start at a lower dose and titrate up if warranted. He failed to assess her thyroid function before starting her on high doses for thyroid medication, and he did not check her blood levels before starting her on thyroid medication despite the possibility that she suffered from hypothyroidism. He has not clinically monitored her for possible hyperthyroidism. Respondent's substandard practices in prescribing Armour Thyroid constitute a violation of the 2006 Order. In addition, he increased the patient's Adderall to an even more dangerous dose without a valid basis for doing so.

2.30 Respondent first saw Patient W on June 9, 2008. Patient W complained of panic attacks, depression, extreme fatigue, sluggishness and lack of energy. She also reported rapid weight gain and that her hair was "falling off fast." Respondent started Patient W on a daily regimen of 90 milligrams of Armour Thyroid, to be increased to 180 milligrams after three days if tolerated well, and 60 milligrams of Adderall. He also had the patient try Xanax, three to four milligrams per day. Respondent did not order lab work

at that time to check Patient W's thyroid function. Respondent has continued to treat Patient W, decreasing her Xanax in October 2008.

2.31 Respondent violated the standard of care in treating Patient W, and he has placed her at an unreasonable risk of harm. Respondent started the patient on high and potentially dangerous doses of Armour Thyroid and Adderall without any effort to try lower doses and titrate up if warranted. He did not check her thyroid function before starting her on thyroid medication even though she exhibited clinical signs of possible hypothyroidism. He has not clinically checked her for thyroid dysfunction on a regular basis. Respondent violated the 2006 Order by providing substandard care in prescribing thyroid medication to Patient W.

2.32 Respondent initially treated Patient X from March 2003 until Respondent's license was summarily suspended in May 2006. During that period, Respondent diagnosed Patient X with Attention Deficit Disorder, Mood Disorder, and Anxiety Disorders, and he prescribed a daily regimen of a benzodiazepine, Valium (diazepam) 50 milligrams, and 60 milligrams of Adderall, which Respondent later increased to 180 milligrams per day. Respondent did not produce records from this time period to the Commission's investigator when asked. Following the 2006 Order and Respondent's return to practice, Patient X returned to Respondent on December 7, 2006. Patient X had run out of his medications, and Respondent noted that he suffered from depression symptoms when not taking Adderall. Respondent restarted the patient on Adderall, 60 milligrams, and Valium, 30 milligrams, per day.

2.33 Respondent violated the standard of care in treating Patient X, and he placed him at an unreasonable risk of harm. During the initial phase of treatment, Respondent started Patient X at high and dangerous doses of Valium and Adderall, and he eventually increased the Adderall to an extremely dangerous dose of 180 milligrams per day. When Patient X returned to Respondent's care in December 2006, Respondent restarted him on a high daily regimen of Adderall, 60 milligram, without any effort to titrate from a lower, safer dose.

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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), (8)(a) and (9).

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 **Disposition of License.** The Commission places Respondent's license on **PROBATION.** Respondent's license will remain on probation until he successfully completes the term and conditions of this Agreed Order and any modifications resulting from the evaluation referenced in Paragraph 4.4, and the Commission enters an order releasing Respondent.

4.2 **Prescribing Restriction.** Starting 30 days after the effective date of this Agreed Order, Respondent shall not prescribe any controlled substances or thyroid medications (including Armour Thyroid) to anyone. The Commission will not lift this restriction unless the Center for Personalized Education for Physicians in Denver, Colorado (CPEP) determines that Respondent can prescribe safely and with reasonable skill and without posing an unreasonable risk of harm to the public.

4.3 **Respondent to Refer Patients to Other Providers.** Respondent will have 30 days from the effective date of this Agreed Order to suspend his prescribing practices pursuant to Paragraph 4.2 and refer patients as necessary to other practitioners so that Respondent can complete the evaluation process with CPEP.

4.4 **CPEP.** Respondent shall commence an evaluative process with CPEP on November 30, 2009, which Respondent has already reserved with CPEP for this purpose. If CPEP cannot proceed on that date, the evaluation will commence on the next available date. Respondent shall fully cooperate with the evaluation, including any follow-up

education and preceptor program that CPEP might recommend, and shall provide CPEP with any charts, documents, and releases that CPEP request. The Commission's Medical Consultant shall provide CPEP with excerpts from this file, including copies of the Amended Statement of Charges, this Agreed Order and any other materials that CPEP, in consultation with the Medical Consultant, requests in order to complete a thorough evaluation. The Medical Consultant will notify Respondent, through his counsel, of any additional materials he provides to CPEP. Respondent may provide additional materials to CPEP, and he will notify the Medical Consultant if he does so. By signing this Agreed Order, Respondent releases CPEP representatives to discuss with representatives of the Commission any matters relating to Respondent's evaluation and CPEP's conclusions and recommendations. Respondent waives any privileges or privacy rights he might otherwise have regarding such matters under federal and state law. Respondent understands that CPEP will provide a copy of its evaluation to the Commission's representatives and will communicate with those representatives as needed.

4.5 **Modification Following CPEP Evaluation.** Respondent will appear before the Commission at the next regularly scheduled meeting after CPEP issues its report. The parties may continue the matter to the following meeting if the circumstances so warrant. The purpose of the meeting will be to modify this Agreed Order based on CPEP's conclusions and recommendations. Respondent agrees to abide by CPEP's recommendations and understands that he will not be allowed to dispute the CPEP report. Respondent further understands that if CPEP concludes that Respondent cannot practice with reasonable skill and safety, and is not a viable candidate for remediation, the Commission may revoke his license. Respondent further understands that if CPEP concludes that he cannot prescribe with reasonable skill and safety, the Commission may make the restriction in this Agreed Order permanent. If CPEP determines that Respondent can safely prescribe controlled substances and thyroid, the Commission will lift the restriction subject to the terms of this Agreed Order, the 2006 Order, and any further terms CPEP might recommend.

4.6 **Preceptor Program.** If Respondent returns to practice following the CPEP evaluation, a qualified and approved preceptor shall monitor and consult with Respondent

for five years. This preceptor program is in addition to any preceptor requirement that CPEP might recommend except to the extent two such programs might overlap.

4.6.1 The Commission's medical consultant will choose the preceptor. The preceptor must be board certified in psychiatry, licensed to practice medicine for at least ten years, and actively licensed and in clinical practice in Washington for at least the past five years. The preceptor must have experience training and consulting with other psychiatrists with respect to patient care. The preceptor must not have any prior significant personal or business relationship with Respondent.

4.6.2 Respondent shall commence the five-year preceptor program upon returning to practice. Respondent will provide the preceptor with a copy of this Agreed Order and any other materials the preceptor requests. Respondent shall provide the preceptor with any other information the preceptor requests.

4.6.3 The preceptor will provide oversight with respect to Respondent's treatment of patients and, if the Commission lifts the prescribing restriction, his prescribing practices. The preceptor will randomly attend at least two of Respondent's office visits with patients per week, and will review the charts regarding those patients and the progress note entries relating to those visits. The preceptor will also review the charting for a random selection of ten percent of Respondent's patients per week. To facilitate this oversight, Respondent will provide the preceptor with a patient list at the beginning of every month along with a copy of Respondent's appointment schedule for that month. Respondent will notify the preceptor of any changes to the list and the schedule on a weekly basis. The preceptor will decide which office visits to attend and notify Respondent of the decision before each visit. Respondent will allow the preceptor full access to his charts to facilitate the required chart reviews. Respondent and the preceptor shall meet at least twice every month to discuss and consult on the cases which the preceptor observed and reviewed.

4.6.4 The preceptor shall report in writing to the Commission's Medical Consultant every three months regarding Respondent's medical skills. The first report will be due on the first day of the third month after the preceptor program starts. The Commission may consider any report that Respondent's skills are less than satisfactory to constitute a violation of this Agreed Order.

4.6.5 The preceptor shall immediately report to the Medical Consultant any concerns the preceptor might have regarding Respondent's ability to practice with reasonable skill and safety or if, in the preceptor's opinion, Respondent is not compliant with the program.

4.7 **Practice Audits.** If Respondent returns to practice, Respondent shall permit a Commission representative to audit patient records and review practices related to Respondent's assessment and treatment of patients two times per year for five years. The representative will contact Respondent's office to give advance notice before each audit. The practice audits will occur sufficiently in advance of each compliance appearance to allow for a review and evaluation of the audited records before the appearance.

4.8 **Compliance Appearances.** If Respondent is allowed to return to practice, until the Commission releases him from this Agreed Order, Respondent shall appear every six months before the Commission for five years and present proof that he is complying with its terms.

4.9 **Fine.** Respondent shall pay a fine of $10,000 by paying installments of $2,000 per year for five years. The first installment is due one year from the effective date of this Agreed Order. The fine shall 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, P.O. Box 1099, Olympia, WA 98507-1099.

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4.10 **Disposition of Pending Files that the Commission Has Investigated.** There are five files currently before the Commission that have been investigated but are not included in the Amended Statement of Charges because they were investigated after those charges were served. Because this Agreed Order resolves any legal issues that those files raise, the Commission has closed them without taking action. This paragraph refers to file numbers 2009-132467, 2009-133372, 2009-138070, 2009-138490, and 2009-138749.

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

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

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

4.14 **Change of Address.** Respondent shall inform the Program and the Adjudicative Service Unit, in writing, of changes in Respondent's residential and/or business address within 30 days of the change.

4.15 **Effective Date.** The effective date of this Agreed Order is the date the Adjudicative Service Unit 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 RULES

The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Tier B of the "Practice Below Standard of Care schedule, WAC 246-16-810, applies to cases where a Respondent's conduct places patients at risk of severe harm. Although the extent to which Respondent may have in fact harmed his patients is not clear from the evidence, and the Commission therefore cannot conclude that he in fact caused severe harm under Tier C of the schedule, the evidence does support the conclusion that he placed his patients at risk of moderate to severe harm. Tier B therefore applies. Tier B requires the imposition of sanctions ranging from two to five

years of oversight, depending on the circumstances and any aggravating and mitigating factors. The aggravating factors in this case include the Commission's 2006 Order disciplining Respondent for substandard practices. They also include the number of instances of substandard care in this case and the fact that this represents a pattern of misconduct. There are no mitigating circumstances. The Commission is therefore imposing the maximum number of years of oversight in the Tier B range. The sanctions are appropriate. They include a thorough evaluation with CPEP that could result in a license revocation or permanent prescribing restrictions, depending on Respondent's ability to practice and prescribe with reasonable skill in safety. If Respondent returns to practice, he will be subject to five years of significant oversight, including a preceptor program, semiannual practice reviews, semiannual compliance appearances, and any other terms that the Commission might impose based on CPEP's recommendations.

6. FAILURE TO COMPLY

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

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7. RESPONDENT'S ACCEPTANCE

I, PATRICK K. CHAU, 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.

PATRICK K. CHAU, MD
RESPONDENT

10-1-09
DATE

SCOTT T. SCHAUERMANN, WSBA #26785
ATTORNEY FOR RESPONDENT

10-1-09
DATE

8. COMMISSION'S ACCEPTANCE AND ORDER

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

DATED: October 15, 2009.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

Susan M Harrigan MD
PANEL CHAIR

PRESENTED BY:

PETER J. HARRIS, WSBA #24631
DEPARTMENT OF HEALTH STAFF ATTORNEY

10-15-09
DATE

Attachment E

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **PATRICK CHAU, MD** License No. MD00030053 Respondent	**No. M2010-628** **STATEMENT OF CHARGES**

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in files numbered 2010-146643 and 2010-143333. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On August 13, 1992, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is on probation and his license is restricted under the Commission's order in case number M2008-117887 (2009 Order), effective October 15, 2009 as modified March 17, 2011. Respondent's board-certification in psychiatry lapsed in 2006 so he is not currently board-certified.

1.2 The 2009 Order required Respondent to suspend his prescribing practices for controlled substances within thirty (30) days of October 15, 2009, and to refer patients as necessary to other practitioners so that Respondent can complete the evaluation process with the Center for Personalized Education for Physicians in Denver, Colorado (CPEP). Respondent signed the proposed Agreed Order on October 1, 2009 and was aware of its terms. Respondent completed the CPEP evaluation process on June 30, 2011. He remains under restriction from prescribing controlled substances until he successfully completes all aspects of a CPEP Education Intervention plan and until CPEP determines he can prescribe safely and with reasonable skill and without posing an unreasonable risk of harm to the public.

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ORIGINAL

1.3 Respondent's psychiatrist-patient relationship with Patient A began on June 10, 2009. Respondent's treatment records for Patient A that month are limited to a treatment contract, a treatment agreement, and an intake note on June 10, 2009 detailing the patient's self-reported history of panic attacks which concludes that her mental status was normal and not remarkable. Respondent failed to record any details of a mental status exam. There is no medical record of physical examination, vital signs, lab tests, blood work, or request to contact collateral sources. Respondent did not review or request prior medical records, despite the patient's reported treatment for the condition beginning three years earlier, including medication regimens, which ceased one and one-half years later. Except for a cursory self-report by the patient on July 6, 2009 that she felt "normal" again and was functioning well; Respondent's only subsequent medical records for Patient A are the details of Xanax prescriptions Respondent issued to Patient A, and notes he made after her death. Xanax is a brand name for alprazolam, a benzodiazepine categorized as a Schedule IV controlled substance. The prescription records show the following were issued by Respondent to Patient A:

1.3.1 On June 10, 2009: 70 Xanax, 2mg, to be taken in quantities and frequencies that increased weekly for a thirty (30) day period.

1.3.2 On July 6, 2009: 120 tablets of Xanax, 2 mg, with two (2) refills for a ninety (90) day period.

1.3.3 On October 2, 2009: 120 tablets of Xanax, 2 mg, with two (2) refills.

1.3.4 On or about November 4, 2009: a "predated" prescription for Xanax for a time frame to begin January 1, 2010 and extend through March 2010.

1.4 Respondent signed the proposed 2009 Order on October 1, 2009 and was aware of the pending restriction on his prescribing of controlled substances and a thirty day window to refer patients to other practitioners. On October 2, 2009, Respondent issued a thirty day prescription for Xanax with 2 refills to Patient A, and offered Patient A the opportunity to come back and pick up a predated Xanax prescription (mentioned above at paragraph 1.3.4) to start in January 2010 with refills through March of 2010. On November 4, 2009 Respondent issued this predated prescription to Patient A,

without making any arrangements for future medical oversight. Patient A died of a methadone and alprazolam overdose on November 11, 2009.

1.5 Respondent 's psychiatrist-patient relationship with Patient B began on or about October 13, 2008, when Respondent issued alprazolam (a Schedule IV controlled substance) and promethazine (an unscheduled antihistamine legend drug) prescriptions to Patient B, which were filled on the following dates:

1.5.1 11/06/2008 Alprazolam 2 mg #45 for 45 days with 0 refills

1.5.2 11/07/2008 Promethazine 50 mg #90 for 30 days with 0 refills

1.5.3 11/22/2008 Alprazolam 2 mg #45 for 45 days with 1 refill

1.5.4 12/07/2008 Alprazolam 2 mg #45 for 15 days with 2 refills

1.5.5 12/09/2008 Promethazine 50 mg #14 for 4 days with 1 refill

1.5.6 12/24/2008 Alprazolam 2 mg #45 for 15 days with 3 refills

1.6 Respondent's treatment records for Patient B between October 13, 2008 and December 28, 2008 are limited to an initial treatment contract, a treatment agreement, and an intake note covering the patient's self-reported history which concludes that the patient's mental status was normal and not remarkable. The records fail to record any details of a mental status exam. There is no medical record of physical examination, vital signs, lab tests, or blood work. Respondent did not review or request prior medical records, although the patient described experiencing several intensive panic attacks that resulted in emergency room visits. Respondent did not attempt to interview collateral sources such as the mother and aunt who Patient B mentioned as having shared medications and urged him to get medical help to assist with his panic attacks. No follow up treatment or consultations between Respondent and Patient B were scheduled or conducted between October 13, 2008 and December 29, 2008. On or about December 29, 2008 Respondent discharged Patient B based upon a report from a detoxification center that the patient had sought methadone treatment for heroin abuse.

1.7 Respondent resumed prescribing for Patient B on or about April 27, 2009; based upon Patient B's representation that he was a different patient with no chemical dependence history, despite having the same name and date of birth. The patient claimed to have a twin brother. Again Patient B mentioned his mother had shared her

medications to calm him. Respondent failed to attempt to consult with collateral sources such as Patient B's mother, although she could have clarified her son had no twin brother and had admitted his heroin abuse. Respondent's treatment records for Patient B between April 27, 2009 and May 29, 2009 do not include any details of a mental status exam, physical examination, vital signs, lab tests, blood work, review or request for prior medical records, or request to contact collateral sources. Respondent resumed issuing prescriptions for promethazine and alprazolam to Patient B, which were filled the same day as written, as follows:

1.7.1 4/27/2009 Alprazolam 2 mg #70 for 30 days with 0 refills.

1.7.2 5/29/2009 Alprazolam 2 mg #120 for 30 days with 0 refills.

1.8 On or about June 3, 2009, Patient B committed suicide.

2. VIOLATIONS

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

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
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> . . .

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

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3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Disciplinary Manager of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: December 28, 2011.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

DANI NEWMAN
DISCIPLINARY MANAGER

KIM O'NEAL, WSBA # 12939
ASSISTANT ATTORNEY GENERAL

CONFIDENTIAL SCHEDULE

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

Patient A

Patient B

[redacted]

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **PATRICK K. CHAU, MD** License No. MD00030053 Respondent	**No. M2010-628** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER**

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

1. PROCEDURAL STIPULATIONS

1.1 On December 28, 2011, the Commission issued a Statement of Charges against Respondent.

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

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

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

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

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

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

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

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

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

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

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

2. FINDINGS OF FACT

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

2.1 On August 13, 1992, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is on probation and his license is restricted under the Commission's orders in case numbers M2006-61927 (2006 Order - 06-04-A-1014MD) and M2008-117887 (2009 Order) as modified March 17, 2011. Respondent's board-certification in psychiatry lapsed in 2006 so he is not currently board-certified. Respondent's Department of Justice Drug Enforcement Administration Certificate of Registration was revoked on June 5, 2012, effective July 16, 2012.

2.2 The 2009 Order required Respondent to suspend his prescribing practices for controlled substances within thirty (30) days of October 15, 2009, and to refer patients as necessary to other practitioners so that Respondent can complete the evaluation process with the Center for Personalized Education for Physicians in Denver, Colorado (CPEP). Respondent signed the proposed Agreed Order on October 1, 2009 and was aware of its terms. Respondent completed the CPEP evaluation process on June 30, 2011. He remains under restriction from prescribing controlled substances until he successfully completes all aspects of a CPEP Education Intervention plan and until CPEP determines he can prescribe safely and with reasonable skill and without posing an unreasonable risk of harm to the public.

2.3 Respondent's psychiatrist-patient relationship with Patient A began on June 10, 2009. Respondent's treatment records for Patient A that month are limited to a treatment contract, a treatment agreement, and an intake note on June 10, 2009 detailing the patient's self-reported history of panic attacks which concludes that her mental status was normal and not remarkable. Respondent failed to record any details of a mental status exam. There is no medical record of physical examination, vital signs, lab tests, blood work, or request to contact collateral sources. Respondent did not review or request prior medical records, despite the patient's reported treatment for the condition beginning three years earlier, including medication regimens, which ceased one and one-half years later. Except for a cursory self-report by the patient on July 6, 2009 that she felt "normal" again and was functioning well; Respondent's only subsequent medical records for Patient A are the details of Xanax prescriptions Respondent issued to Patient A, and notes he made after her death. Xanax is a brand name for alprazolam, a benzodiazepine categorized as a Schedule IV controlled substance. The prescription records show the following were issued by Respondent to Patient A:

2.3.1 On June 10, 2009: 70 Xanax, 2mg, to be taken in quantities and frequencies that increased weekly for a thirty (30) day period.

2.3.2 On July 6, 2009: 120 tablets of Xanax, 2 mg, with two (2) retills for a ninety (90) day period.

2.3.3 On October 2, 2009: 120 tablets of Xanax, 2 mg, with two (2) refills.

2.3.4 On or about November 4, 2009: a "predated" prescription for Xanax for a time frame to begin January 1, 2010 and extend through March 2010.

2.4 Respondent signed the proposed 2009 Order on October 1, 2009 and was aware of the pending restriction on his prescribing of controlled substances and a thirty day window to refer patients to other practitioners. On October 2, 2009, Respondent issued a thirty day prescription for Xanax with 2 refills to Patient A, and offered Patient A the opportunity to come back and pick up a predated Xanax prescription (mentioned above at paragraph 1.3.4) to start in January 2010 with refills through March of 2010. On November 4, 2009 Respondent issued this predated prescription to Patient A, without making any arrangements for future medical oversight. Patient A died of a methadone and alprazolam overdose on November 11, 2009.

2.5 Respondent 's psychiatrist-patient relationship with Patient B began on or about October 13, 2008, when Respondent issued alprazolam (a Schedule IV controlled substance) and promethazine (an unscheduled antihistamine legend drug) prescriptions to Patient B, which were filled on the following dates:

2.5.1 11/06/2008 Alprazolam 2 mg #45 for 45 days with 0 refills,

2.5.2 11/07/2008 Promethazine 50 mg #90 for 30 days with 0 retills,

2.5.3 11/22/2008 Alprazolam 2 mg #45 for 45 days with 1 refill,

2.5.4 12/07/2008 Alprazolam 2 mg #45 for 15 days with 2 refills,

2.5.5 12/09/2008 Promethazine 50 mg #14 for 4 days with 1 retill;

2.5.6 12/24/2008 Alprazolam 2 mg #45 for 15 days with 3 retills.

2.6 Respondent's treatment records for Patient B between October 13, 2008 and December 28, 2008 are limited to an initial treatment contract, a treatment agreement, and an intake note covering the patient's self-reported history which concludes that the patient's mental status was normal and not remarkable. The records fail to record any details of a mental status exam. There is no medical record of physical examination, vital signs, lab tests, or blood work. Respondent did not review or request prior medical records, although the patient described experiencing several intensive panic attacks that resulted in emergency room visits. Respondent did not attempt to interview collateral sources such as the mother and aunt who Patient B mentioned as having shared medications and urged him to get medical help to assist with his panic attacks. No follow up treatment or consultations between Respondent and Patient B were scheduled or conducted between October 13, 2008 and December 29, 2008. On or about December 29, 2008 Respondent discharged Patient B based upon a report from a detoxification center that the patient had sought methadone treatment for heroin abuse.

2.7 Respondent resumed prescribing for Patient B on or about April 27, 2009; based upon Patient B's representation that he was a different patient with no chemical dependence history, despite having the same name and date of birth. The patient claimed to have a twin brother. Again Patient B mentioned his mother had shared her medications to calm him. Respondent failed to attempt to consult with collateral sources such as

Patient B's mother, although she could have clarified her son had no twin brother and had admitted his heroin abuse. Respondent's treatment records for Patient B between April 27, 2009 and May 29, 2009 do not include any details of a mental status exam, physical examination, vital signs, lab tests, blood work, review or request for prior medical records, or request to contact collateral sources. Respondent resumed issuing prescriptions for promethazine and alprazolam to Patient B, which were filled the same day as written, as follows:

2.7.1 4/27/2009 Alprazolam 2 mg #70 for 30 days with 0 refills.

2.7.2 5/29/2009 Alprazolam 2 mg #120 for 30 days with 0 refills.

2.8 On or about June 3, 2009, Patient B committed suicide.

3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

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

3.3 The above 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 **License Status: Probation.** The Commission continues Respondent's license on **PROBATION**. Respondent's license will remain on probation until he successfully completes all requirements of this Agreed Order, successfully completes any modifications resulting from the evaluation referenced in Paragraph 4.7 below, and until the Commission enters an order in its discretion releasing Respondent from probation.

4.2 **Restrictions on Prescribing.** Respondent is absolutely restricted from prescribing any controlled substance or thyroid medication (including Armour Thyroid) to anyone.

4.3 **Practice Restriction.** Respondent shall not practice forensic medicine or provide evaluations for court-related proceedings.

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

4.4.1 Respondent shall arrange for a qualified preceptor who is pre-approved by the Commission to monitor Respondent's practice of medicine and to consult with Respondent for a period of at least tive (5) years from the effective date of this Agreed Order. This preceptor program is in addition to the preceptor requirement that the Center for Personalized Education for Physicians (CPEP) located in Denver, Colorado has recommended, or may recommend, except to the extent two such programs may overlap. The preceptor shall report in writing to the Commission's Medical Consultant every three months regarding Respondent's medical skills. The Preceptor shall immediately report to the Medical Consultant any concerns the preceptor has regarding Respondent's ability to practice with reasonable skill and safety, or if Respondent is not compliant with requirements of the CPEP program or this order.

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

4.4.2.1 Orders from the Commission to Respondent issued November 8, 2006; October 15, 2009; March 17, 2011, and this Agreed Order.

4.4.2.2 All written reports from Respondent's prior preceptors.

4.4.2.3 The March 2010 CPEP program evaluation of Respondent, and all subsequent written CPEP progress reports for Respondent.

4.4.3 The Commission's medical consultant will approve the preceptor, who must be board certified in psychiatry, licensed to practice medicine for at least ten years, and actively licensed and in clinical practice for at least the past five years. Geographic proximity shall be taken into account in determining whether a preceptor is appropriate. The preceptor must have experience training and consulting with other psychiatrists with respect to patient care. The preceptor must

not have any prior significant personal or business relationship with Respondent before entering into the approved preceptor relationship.

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

4.4.5 Respondent began a preceptor program approved by the Commission in July 2011, and is currently in compliance. The preceptor program now in place may be continued so long as requirements are met to the satisfaction of the Commission.

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

Respondent to complete a written report, Respondent will assure that the Commission receives a copy of Respondent's written report. If the course instructors inform the Commission that Respondent did not receive an "unconditional pass" or otherwise satisfactorily complete the course, the Commission may require Respondent to re-take the course.

4.6 **Physician Education Course.** Respondent is currently in compliance with a Center for Personalized Education for Physicians (CPEP) Educational Intervention Plan developed for Respondent in June 2011. Respondent shall follow the recommendations and requirements of CPEP for this plan and for any revisions to the plan. Respondent shall successfully complete all aspects of the June 2011 CPEP Educational Interventional Plan.

4.7 **CPEP Re-Evaluation.** In the event Respondent completes the CPEP Educational Intervention Plan, he shall then schedule within four (4) months a follow-up clinical assessment at CPEP to re-evaluate his medical knowledge, patient care, clinical judgment, medical record keeping, reasoning ability, and communication skills. Respondent's awareness of the larger context and system of health care and his ability to effectively call on system resources to provide optimum care shall also be addressed. Respondent shall fully cooperate with this re-evaluation, and shall provide CPEP with any charts, documents, and releases that CPEP requests for this reassessment. The Commission's Medical Consultant will provide CPEP with pertinent documents, including records relating to Respondent's compliance with Commission Orders. The Medical Consultant will notify Respondent of any additional materials provided to CPEP. Respondent may provide additional materials to CPEP, and will notify the Medical Consultant if he does so. By signing this Agreed Order, Respondent releases CPEP representatives to discuss with representatives of the Commission any matters relating to Respondent's evaluation and CPEP's conclusions and recommendations. Respondent waives any priviieges or privacy rights he might otherwise have regarding such matters under federal and state law. Respondent understands that CPEP will provide a copy of its re-evaluation to the Commission's representatives and will communicate with those representatives as needed.

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

4.9 **Practice Reviews.** In order to monitor compliance with this Agreed Order, Respondent will submit to semi-annual practice reviews at Respondent's office for the duration of probation. The Commission's representative will inspect office records, review patient records, interview Respondent and interview any professional staff, partners, and employees and preceptors associated with Respondent's practice. The representative will contact Respondent's office to give advance notice before each practice review.

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

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

4.12 **Termination.** Respondent may file a petition for termination of this Agreed Order after five (5) years if Respondent has been in full compliance during that period. Respondent shall appear in person at a hearing on the petition. At the hearing, evidence in opposition may be considered by the Commission. After considering the petition and the evidence presented, the Commission will have sole discretion to grant or deny Respondent's petition.

4.13 **Responsibility for costs of compliance.** Respondent is responsible for all costs he may incur in the course of complying with this Agreed Order.

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

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

4.16 **Sanctions Supercede Prior Sanction Orders**. The provisions of Section 4 of this Agreed Order shall replace and supercede the sanction provisions of prior orders.

4.17 **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 RULES

5.1 The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Tier B of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices caused moderate patient harm or risked moderate to severe patient harm. Although two unrelated patient deaths occurred in these cases, neither patient died directly from an overdose of medications prescribed by Respondent. Therefore, the evidence does not establish by clear and convincing evidence that Respondent's substandard practices actually caused either death. However, Respondent's care of each patient clearly risked moderate to severe patient harm, because Respondent limited treatment to prescribing of controlled substances, without providing meaningful psychiatric treatment of the patients. Schedule B therefore applies.

5.2 Tier B requires the imposition of sanctions ranging from two years of oversight to tive years of oversight, unless revocation. Under WAC 246-16-800(3)(d), the starting point for the duration of the sanctions is the middle of the range. The Commission uses aggravating and mitigating factors to move towards the maximum or minimum ends of the range.

5.3 The aggravating and mitigating factors in this case, listed below, justify moving to the maximum end of the range. In the judgment of the Commission, the serious nature and magnitude of Respondent's prior disciplinary history, together with the tragic outcomes for Patients A and B, substantially outweigh the mitigating factors. The

sanctions in this case include probation, prescribing restrictions, practice restrictions, a preceptor requirement, ethics course, physician education course, re-evaluation of Respondent's clinical skills after completion of the education courses, practice reviews, and compliance appearances. Respondent has been on probation since October 2009 under case M2008-117887. The behavior in this case occurred before the effective date of the M2008-117887 order, and Respondent is in substantial compliance with the sanctions in that order which also address the standard of care issues raised in this case.. While the license status of probation may be subject to modification in the future under paragraph 4.8, above, the oversight of the Commission and other provisions will not be subject to termination until five (5) years from the effective date of this Agreed Order under paragraph 4.12.

5.4 These sanctions are appropriate within the Tier B range given the facts of the case and the following aggravating and mitigating factors:

5.4.1. As an aggravating factor, Patient A died of a drug overdose during a time when she was relying on Respondent's inadequate psychiatric treatment.

5.4.2 As an aggravating factor, Patient B initiated a violent confrontation with police officers, resulting in his death, during a time when he was relying on Respondent's inadequate psychiatric treatment.

5.4.3 As an aggravating factor, Respondent has a significant history of prior disciplinary actions, described in paragraph 2.1.

5.4.4 As a mitigating factor, Respondent is in substantial compliance with the CPEP educational intervention program, and has received satisfactory reports from his preceptors.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under

RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. RESPONDENT'S ACCEPTANCE

I, Patrick K. Chau, 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.

P.K. Chau MD — Oct. 17th 2012

PATRICK K. CHAU, MD
RESPONDENT

DATE

_____, WSBA# _____
ATTORNEY FOR RESPONDENT

DATE

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8. COMMISSION'S ACCEPTANCE AND ORDER

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

DATED: Nov 15, 2012.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Linda A. Ruiz
PANEL CHAIR

PRESENTED BY:

TERESA LANDREAU, WSBA#9591
DEPARTMENT OF HEALTH STAFF ATTORNEY

November 15, 2012
DATE

Attachment F

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **PATRICK K. CHAU, MD** License No. MD00030053 Respondent.	**No. M2010-628** **ORDER OF TERMINATION**

This matter comes before the Medical Quality Assurance Commission (Commission), on the petition of Patrick K. Chau, MD, Respondent, to terminate the Stipulated Findings of Fact, Conclusions of Law, and Modified Agreed Order (Modified Agreed Order) in this case.

1. PROCEDURAL HISTORY

1.1 On August 13, 1992, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

1.2 On December 28, 2010, the Commission offered a Stipulation to Informal Discipline to Respondent. Respondent failed to sign the Stipulation.

1.3 On January 3, 2012, the Commission served a Statement of Charges to Respondent's last known address on file. On or about November 20, 2012, the Commission entered the Stipulated Findings of Fact, Conclusions of Law, and Agreed Order in this case. On September 8, 2015 the Commission entered the Modified Agreed Order in this case.

1.4 On or about, October 27, 2017, the Commission received Respondent's written petition to terminate the Modified Agreed Order. Respondent has complied with all the terms and conditions of the Modified Agreed Order.

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

1.6 This Order of Termination is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's listserv, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56

ORIGINAL

RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

2. FINDINGS OF FACT

The Commission makes the following Findings of Fact:

2.1 On August 13, 1992, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

2.2 On December 28, 2010, the Commission offered a Stipulation to Respondent. Respondent failed to sign the Stipulation.

2.3 On January 3, 2012, the Commission issued a Statement of Charges against Respondent. The Statement of Charges was resolved by Stipulated Findings of Fact, Conclusions of Law and Agreed Order entered on November 20, 2012. A Modified Agreed Order was entered on September 8, 2015.

2.4 The Modified Agreed Order placed Respondent on probation for 5 years, imposed prescribing and practice restrictions, required an ethics course and continued enrollment in a CPEP course, practice reviews and a practice plan.

2.5 The Modified Agreed Order also provided that Respondent could petition the Commission to terminate the Modified Agreed Order after all conditions were met and five (5) years had passed from the date of the original Agreed Order.

2.6 The Commission has reviewed all relevant materials and finds that Respondent has fully complied with all conditions in the Modified Agreed Order and that the five (5) year period will end on November 20, 2017.

3. CONCLUSIONS OF LAW

The Commission makes the following Conclusions of Law based on the Findings of Fact.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent's petition to terminate the Modified Agreed Order is properly before the Commission.

3.3 Respondent has fully complied with all conditions in the Modified Agreed Order.

3.4 Respondent's request to terminate the Modified Agreed Order should be granted and take effect on November 20, 2017.

4. ORDER

Based on the Findings of Fact and Conclusions of Law, the Commission ORDERS:

4.1 Respondent's request to terminate the Modified Agreed Order is GRANTED. This Order is to take effect on November 20, 2017.

DATED: 11/3, 2017.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

PANEL CHAIR

PRESENTED BY:

GORDON WRIGHT, WSBA#32907
COMMISSION STAFF ATTORNEY

Attachment G

APPLICATION ATTACHMENT

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 27, 20 0
BY Valerie Melo ANAL

12-27-06

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: PATRICK KIN-YEE CHAU, M.D. 5501 NE 109th Court, Suite L-1 Vancouver, WA 98662 Physician's and Surgeon's Certificate No. G 68517 Respondent.	Case No. 16-2006-175852 **FIRST AMENDED ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant David T. Thornton is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this First Amended Accusation solely in his official capacity.

2. On or about May 7, 1990, Physician and Surgeon's Certificate No. G 68517 was issued by the Board to Patrick Kin-Yee Chau, M.D. (hereinafter "respondent"). This certificate expires on July 31, 2007. On July 12, 2006, pursuant to Section 2310(a) of the Business and Professions Code, a full out of state suspension order of no practice was issued by the Board. On December 8, 2006, respondent's license to practice was fully restored.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period of not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring if probation is imposed.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

"(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein."

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

4. Respondent is subject to discipline within the meaning of section 2305 and/or section 141 of the Code as more particularly set forth herein below.

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

5. On May 25, 2006, the Washington Department of Health Medical Quality Assurance Commission (hereinafter "Commission") issued a summary suspension of respondent's medical license. After a hearing, which convened on or about September 29-30, 2006, the Commission issued an order dated November 8, 2006, which reinstated respondent's license to practice medicine, and placed his license on probation for two years including, but not limited to, the following conditions: Respondent must implement appropriate prescribing practices for his thyroid medications to include, but not be limited to, periodic laboratory testing to avoid hyperthyroidism; respondent's practice is subject to periodic reviews and inspection by the Commission or its designee, and respondent must pay a $2,500.00 fine. The basis for this action was respondent's inappropriate care and treatment of 5 patients who he diagnosed with thyroid dysfunction. The respondent treated these five patients by prescribing Amour Thyroid (desiccated thyroid), and for one patient, in addition to the Amour Thyroid, he prescribed Adderall (amphetamine), as therapy for hypothyroidism. Respondent's prescribing practices with respect to these five patients placed them at a significant risk of harm.

6. Attached hereto as Exhibit A, and made a part hereof, is a certified copy of the Commission's Findings of Fact, Conclusions of Law, and Final Order.

7. The action by the Commission regarding respondent's license to practice medicine, as set forth above, constitutes unprofessional conduct and/or grounds for disciplinary action within the meaning of section 2305 of the Code and/or section 141(a) of the Code. Therefore, cause for discipline exists.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged and that following the hearing the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G 68517 heretofore issued to respondent;

2. Ordering respondent to pay the Division the costs of probation monitoring upon

order of the Division; and,

3. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants; and,

4. Taking such other and further action as the Division deems necessary and proper.

DATED: December 27, 2006.

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

Chau.1st Amended Acc

EXHIBIT A

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: PATRICK CHAU, M.D., License No. MD00030053, Respondent.	Docket No. 06-04-A-1014MD FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

APPEARANCES:

Respondent, Patrick Chau, M.D., by
Hoffman Hart Wagner LLP, per
Michael Hoffman, Attorney at Law

Department of Health Medical Program, by
Office of the Attorney General, per
Susan L. Pierini, Assistant Attorney General

PRESIDING OFFICER: Michael T. Concannon, Health Law Judge

COMMISSION PANEL: Judith Tobin, Public Member, Panel Chair
Everardo Espinosa, M.D.
William Gotthold, M.D.
Janice Paxton, PA-C

The Medical Quality Assurance Commission (the Commission) convened a hearing over a two-day period in SeaTac, Washington on September 29-30, 2006. The Department of Health (the Department) had issued a Statement of Charges alleging that the Respondent had violated the Uniform Disciplinary Act with respect to eight patients named in a confidential schedule (hereafter, Patients A, B, C . . . H), and the Respondent had been summarily suspended as of May 25, 2006, pending this hearing. The Commission finds unprofessional conduct with respect to several patients and

orders the imposition of PROBATIONARY CONDITIONS on the Respondent's license to practice medicine.

ISSUES

Whether any of the Respondent's treatment of eight patients constitutes unprofessional conduct within the meaning of RCW 18.130.180(4).

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

SUMMARY OF THE PROCEEDING

The Department presented testimony from the following three witnesses:

1. The Respondent.
2. Dr. Edward Lipkin (Expert.)
3. Dr. Joseph Bloom (Expert) – video perpetuation deposition.

Department's Exhibits. The following numbered exhibits by the Department were admitted to become part of the record at the hearing:

D-1. Medical Records – Patient A.

D-2. Medical Records – Patient B.

D-3. Medical Records – Patient C.

D-4. Medical Records – Patient D.

D-5. Medical Records – Patient E.

D-6. Medical Records – Patient F.

D-7. Medical Records – Patient G.

D-8. Medical Records – Patient H.

D-9. Medical Records - Patient H (exhibit numbered pgs. 7 – 13 only).

D-10. Assessment of Dr. Edward Lipkin, dated October 21, 2005.

D-11. Assessment of Dr. Edward Lipkin, dated March 1, 2006.

D-12. Additional Medical Records – Patient B, received on July 7, 2006.

D-13. Additional Medical Records – Patient C, received on July 7, 2006.

The Respondent presented testimony from the following 4 witnesses:

1. The Respondent.
2. Paul Leung, M.D. (Expert) – video perpetuation deposition*.
3. Abraham Perlstein, M.D. (Expert) – video perpetuation deposition*.
4. Lance Brigman, M.D. – perpetuation deposition – transcript read into the record.

Respondent's Exhibits. The following numbered exhibits by the Respondent were admitted to become part of the record at the hearing:

R-1. Medical Records – Patients A through H (one exhibit).

R-2. Journal Article-Gaby, Alan, *Alternative Medicine Review*, Vol. 9, No. 2, pgs. 157-179 on Hypothyroidism.

R-3. Letter from Dr. Abraham Perlstein.

R-4. Letter from Dr. David Lee.

R-5. Letter from Dr. Daniel Moynihan.

R-6. Letter from Dr. Lance Brigman.

R-7. Letter from Dr. Blaine Tolby.

R-8. Letter from Warren Cowell.

R-9. Letter from Brenda Nilson.

* The video, and the written transcript of the deposition, are part of the record in this proceeding

R-10. Letter from Charles Mason.

R-11. Letter from Rhonda Hanson.

R-12. Letter from Jamie Huff.

R-13. Letter from Sherry McDonald.

R-14. Letter from L.C. Perry.

R-15. Letter from Pamela Graham.

R-16. Letter from Katherine Kiser.

R-17. Letter from Diane Howlett.

R-18. Letter from Kathi High.

R-19. Letter from Cheryl Royal.

R-20. Letter from Tom Bohna.

R-21. Letter from Evan Cummings.

R-22. Redacted email, dated May 25, 2006, from Mr. Berg to Dr. Bloom.

Based upon the evidence presented, the Commission makes the following findings by clear and convincing evidence.

I. FINDINGS OF FACT

1.1 The Respondent was issued a license to practice as a physician and surgeon by the State of Washington in 1992. His license is active, but has been subject to a summary suspension since May 25, 2006. The Respondent is board certified as a psychiatrist, and was most recently re-certified in September 2006.

1.2 The Respondent did his residency at the University of South Alabama Hospital in Mobile, Alabama in the late 1980's. The residency included a combined

program in general and adult psychiatry over a four year period, and he was the chief resident in child psychiatry. After various contract or other positions into the mid-1990's in the Vancouver/Portland/Longview area, mostly involving children and child psychiatry, the Respondent has had a full-time office practice as a psychiatrist since 1998. Presently, his main office is in Vancouver, Washington with a satellite office practice in Longview.

1.3 As a psychiatrist, the Respondent does not take patients that present with physical ailments only. His current patient population is approximately 50% children. All of the Respondent's patients have psychiatric or mood disorders, and his patient population consist of word-of-mouth referrals and (mostly) referrals by primary care physicians. In addition to the many difficult mental health symptoms presented by patients for his psychiatric treatment, many of the Respondent's patients also have pressing physical ailments. They are usually on medications prior to seeing the Respondent, and many have excessive weight or suffer from obesity.

1.4 The Respondent has adopted a sometimes unique, but generally accepted, alternative treatment regimen with some of his patients. With other practitioners, these patients may receive only the standard or "front-line" range of medications for depression. In the Respondent's practice, because of the difficulty of the cases he treats, he may be more likely to try alternatives if he concludes that standard anti-depressant treatment has not been totally able to reduce the patient's depressive symptoms. Most significant, for purposes of this disciplinary action, is the

Respondent's use of thyroid medications, including Armour Thyroid, and stimulants as an adjunct to his psychiatric treatment of particular patients.

1.5 The Commission does not find the Respondent to be a weight loss or "diet doctor"; rather, the Respondent is a practicing psychiatrist, and any weight loss "benefit" to a particular patient is incidental to the Respondent's primary treatment goal, i.e. the psychiatric well-being of the patient.

1.6 Armour Thyroid is the trade name of a prescription medication and is made from desiccated (dried) pork thyroid glands. Desiccated thyroid is prescribed to treat thyroid dysfunction known as hypothyroidism. Armour Thyroid therapy is usually instituted in low doses, with increments that depend on clinical evaluations, the cardiovascular status of the patient, and periodic laboratory testing. The usual maximum recommended dose of Armour Thyroid is 180 mg/day.

1.7 Adderall is the trade name of a prescription medication containing amphetamine, which is a stimulant. Amphetamine is not an appropriate medication for weight loss. It may produce serious and life-threatening cardiac effects. The usual maximum recommended dose of Adderall is 60 mg/day. If prescribed in conjunction with Armour Thyroid, the patient's progress and reaction to such a stimulant must be closely monitored.

1.8 Dysthymia is a long-term, chronic depression that is not disabling as an acute/major depression, but can result in a notable decrease of functional activity.

Patient A

1.9 Patient A was a 30 year old female, seen by the Respondent on three occasions over a five week period from January 23 to March 3, 2004. On her initial visit, the Respondent diagnosed Patient A as perhaps having "Dysthymia and a little low thyroid." The Respondent took a history from Patient A on the first visit and his diagnosis flows from his interview, symptoms, and his own analysis.

1.10 The Respondent prescribed Armour Thyroid to Patient A on January 23, 2004. The "trial" dose of Armour Thyroid was 90 mg/day for two days and, if the patient felt "OK," then Patient A was directed to take 180 mg/day for one week. After one week, the dosage was to be increased to 270 mg/day with a return visit of Patient A scheduled for February 6, 2004. On February 6, 2004, the Respondent confirmed the 270 mg/day dosage for another week and, if "OK," to 360 mg/day. On February 6, 2004, the Respondent also prescribed Desoxyn 10 mg twice daily to Patient A. A return visit was scheduled for March 3, 2004.

1.11 As it turned out, Patient A mistakenly increased her dosage before the March 3, 2004 office visit to 720 mg/day of Armour Thyroid and reported that to the Respondent. The Respondent did not note any adverse effects from the 720 mg/day regimen Patient A had put herself on, and therefore the Respondent did not recommend a decrease in the dosage. In fact, since Patient A reported no desired increase in her energy level between the morning and 4 p.m., the Respondent contemplated whether another 90 mg/day of Armour Thyroid would further assist Patient A. The Respondent did not see Patient A again after the March 3, 2004 visit.

1.12 On or about March 11, 2004, Patient A consulted with her primary care physician, Dr. Susan Hughes, for her annual physical. Noting that Patient A was on an "extremely high dose of thyroid medication," Dr. Hughes ordered lab work, an immediate consult with a cardiologist, and further stated that Patient A was in "congestive heart failure with tachycardia and is at high risk for a myopathy as well as rhythm disturbance."

1.13 Based on the reports of the cardiologist (Dr. Shaun D. Harper), Dr. Hughes, and the dosage levels of Armour Thyroid approved by the Respondent for Patient A, the Commission finds the prescribing of Armour Thyroid far in excess of the maximum recommended daily dosage caused a hyperthyroid state in Patient A. The Respondent's Armour Thyroid regimen with Patient A placed her in great risk of harm. As such, the Respondent's treatment of Patient A falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient D

1.14 Patient D was a 22 year old male who presented to the Respondent on November 26, 2003, having had multiple hospitalizations for psychiatric treatment, recurrent depression, and suicidal ideation dating back to childhood. The Respondent, in his capacity as a child psychiatrist, had seen Patient D at some time in the past when Patient D was a child and the Respondent was at Columbia River Associates Clinic. His most recent hospitalization for depression was for a two week period that had ended in mid-November, 2003. On November 26, 2003, prior to any treatment by the Respondent, Patient D was taking Lamictal, Lexapro, and Ativan. Over the years, he

had been treated with Prozac, Paxil, Celexa, Lithium, Zyprexa, and other medications in an attempt to deal with his depression/psychiatric illness.

1.15 On November 26, 2003, the Respondent diagnosed Patient D as being bi-polar with depression and panic disorder. The Respondent altered some of Patient D's anti-depressant medications prescribed on his recent hospital discharge, substituted Xanax on a trial basis for the Ativan, and also prescribed 30 mg/day of Adderall. He also prescribed Seroquel (which is an atypical antipsychotic agent or mood stabilizer) for Patient D on November 26, 2003.

1.16 Further, in that initial November 26, 2003 visit, the Respondent prescribed Armour Thyroid to Patient D. The initial dose of Armour Thyroid was 90 mg/day for two days, and then to be increased to 180 mg/day. There were interim weekly office visits prior to December 16, 2003. On December 16, 2003, the Respondent increased Patient D's dosage of Armour Thyroid to 360 mg/day. There were several changes, substitutions and alterations to Patient D's anti-depressant medications in the weeks between November 26, 2003 and January 14, 2004.

1.17 On January 14, 2004, the Respondent increased Patient D's dosage of Armour Thyroid to 450 mg/day for one week, then to 540 mg/day. Patient D developed symptoms consistent with hyperthyroidism (excessive hormones), including agitation and lack of concentration. There are patient records indicating normal thyroid functions for Patient D in 1998. On March 8, 2004, Patient D's primary care provider, Physician Assistant Michael Pastick, obtained a TSH test (Exhibit D-4, p. 83) that was consistent with overdoses of thyroid hormone. A TSH test shows a pituitary hormone secreted to

stimulate thyroid function and is important for analyzing potential hyperthyroid condition because a low TSH indicates an excess of thyroid hormone in the system.

1.18 The dosage levels of Armour Thyroid approved by the Respondent for Patient D, beyond the 180mg/day recommended maximum, caused a hyperthyroid state (i.e. an excess of thyroid hormone) in Patient D. The Respondent's Armour Thyroid regimen with Patient D placed him at a significant risk of harm. The Respondent's treatment of Patient D falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient E

1.19 Patient E was a 48 year old female on her initial visit to the Respondent for treatment on March 26, 2004. The Respondent diagnosed Patient E with dysthymia (long-term, chronic depression), basing his diagnosis on physical observations, a patient interview, and a mental status exam. On the first visit, the Respondent started Patient E on Armour Thyroid at 90 mg/day for two days, with an anticipated increase to 180 mg/day for one week, then 270 mg/day for one week, and then 360 mg/day. One month later, after an April 23, 2004 office visit, the Respondent further increased the dosage of Armour Thyroid to 450 mg/day for two weeks, then to 540 mg/day.

1.20 On or about May 28, 2004, Patient E consulted with Dr. Mary Shepard at Kaiser Foundation Health Plan with a complaint of tachycardia (rapid heart beat). Dr. Shepard ordered laboratory tests that resulted in a report of TSH so low it is almost not detectable (i.e. Less than .01 with a normal range of .28 – 5.00). Such a lab result

is consistent with hyperthyroidism. Dr. Shepard advised Patient E to stop taking Armour Thyroid.

1.21 Three days later, on June 1, 2004, Patient E complained to the Respondent about her tachycardia attack and symptoms of hyperthyroid and reported that she was still experiencing a fluttering heart rate. The Respondent recommended that Patient E decrease her dosage from 540 mg/day to 450 mg/day, and if that doesn't resolve the tachycardia, then to 360 mg/day. Patient E again called the Respondent on June 1, 2004, to report the laboratory test results previously noted by Dr. Shepard. The Respondent "assured" Patient E that "the Armour Thyroid might have distorted the TSH results and for her to decrease the Armour Thyroid until comfortable" (Exhibit D-5, pg. 4).

1.22 The mega-dosage levels of Armour Thyroid approved by the Respondent for Patient E of 540 mg/day caused a hyperthyroid state in Patient E. Even with the report of the laboratory test, the Respondent failed to recognize the test's consistency with the clinical symptoms then present in Patient E. The Respondent's Armour Thyroid regimen with Patient E placed her at a significant risk of harm. Accordingly, the Respondent's treatment of Patient E falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient F

1.23 Patient F was a 46 year old female when presenting for treatment by the Respondent on October 19, 2004. Intake notes by the Respondent on the patient interview indicated a prior diagnosis of depression of "mild to moderate severity" in

years past, significant weight gain over the years, prior use of Prozac, Paxil, and Wellbutrin for depression without effective results, and a family history of obesity, diabetes, and hypothyroidism.

1.24 On October 19, 2004, the Respondent diagnosed Patient F with "dysthymia and ? borderline hypothyroid but has not been detected by current lab." There is no record of the Respondent ordering any laboratory tests to assist in a hypothyroid diagnosis of Patient F.

1.25 The Respondent kept Patient F on Wellbutrin and Zoloft, which are anti-depressants. He then prescribed Adderall XR 30 mg twice daily to control Patient F's appetite. The Respondent also prescribed Armour Thyroid to Patient F on October 19, 2004. The initial dose of Armour Thyroid was 90 mg/day for two days, then increased to 180 mg/day for one week, then 270 mg/day for another week, and then to 360 mg/day.

1.26 As opined by an expert (Dr. Leung) for the Respondent, Patient F was a "difficult patient" given her twelve year history of depression, various medications that had not been effective, sleep deprivation, etc. The Respondent is attempting in his analysis and prescribing, in the opinion of Dr. Leung, "to do something" to help Patient F. Although there is no indication of actual harm to Patient F from the Armour Thyroid dosage, the excess Armour Thyroid placed Patient F at a risk of harm. As such, the Respondent's treatment of Patient F falls below the standard of care of a reasonably prudent physician practicing in Washington.

Patient G

1.27 Patient G was a 23 year old female when treated by the Respondent beginning August 31, 2004. The Respondent diagnosed Patient G with "mood disorder, non-specific, maybe from sub-clinical hypothyroid." The Respondent ordered laboratory tests that indicated normal thyroid function and commented they were not conclusive. He determined that Patient G should be treated based on his clinical observations and patient interview.

1.28 The Respondent prescribed Armour Thyroid to Patient G on August 31, 2004. The initial dose of Armour Thyroid was 90 mg/day for two days, and then increased to 180 mg/day. One week later, on September 8, 2004, the Armour Thyroid dosage was increased to 270 mg/day. The Respondent noted on September 8, 2004, that Patient G had only then been on Armour Thyroid for 4 days as the pharmacy had to order it but there had been no adverse effects. Also on September 8, 2004, the Respondent added Adderall XR 30 mg once daily.

1.29 On September 24, 2004, the dosage of Armour Thyroid was increased to 360 mg/day. On November 12, 2004, the Respondent increased Patient G's dosage of Adderall 30 mg to twice daily, and then on December 3, 2004, the Respondent approved an increase in her dosage of Adderall 30 mg to three times daily, perhaps as a result of weight gain by Patient G.

1.30 With respect to the last dosage recommended for Adderall, the usual maximum recommended dose of Adderall is 60 mg/day, and by December 3, 2004 the Respondent was recommending up to 90 mg/day of Adderall. With such a dosage, the

patient is at risk for central nervous system over stimulation, tachycardia, and hypertension. The excess Adderall did place Patient G at a risk of harm. Similarly, the 360 mg/day dosage of Armour Thyroid placed Patient G at a risk of harm as it exceeds the recommended maximum of 180 mg/day. With respect to the Respondent's prescribing regimen for both of these medications, his treatment of Patient G falls below the standard of care of a reasonably prudent physician practicing in Washington.

Other Findings

1.31 Although there can be difficulty in reading the Respondent's handwritten patient records in terms of legibility, the Commission does not find those records below the standard of care given the difficulty in deciphering many physicians' handwriting. The Commission also does not find the completeness or organization of the examined patient records in this matter to create a standard of care issue. Given its own experience and the testimony of the psychiatrist experts on the practice of psychiatrists in their record-keeping, especially in non-institutional settings such as the Respondent's, the Commission does not find their format or completeness fall below the standard of care.

1.32 Based on the testimony of the Respondent, the expert witnesses, and the record, the Commission recognizes and finds that there may be appropriate circumstances to use stimulants and thyroid medication in a treatment regimen incorporated by psychiatrists, especially in those circumstances where the traditional, "front-line," drugs have been tried and not been successful with long-term, chronically depressed patients. Clearly, the Respondent is a believer in such alternative

approaches for some of his patients. But thyroid medication and stimulants can not be used without the necessary foundation and monitoring for the effects that can occur, such as cardiomyopathy, cardiac rhythm disturbances, tremors, and hypertension. The use of these medications requires a more careful and vigorous approach, and laboratory testing, than what occurred in the Respondent's care of the patients noted in these findings. While thyroid supplementation to antidepressant medication is a recognized treatment, the doses of thyroid medication used by the Respondent were greatly in excess of what is usually considered safe.

II. CONCLUSIONS OF LAW

2.1 At all times material to the Statement of Charges, the Respondent has been licensed to practice medicine in the state of Washington. The Commission has jurisdiction to hear this matter, pursuant to Chapter 18.71 RCW - Physicians, and Chapter 18.130 RCW - the Uniform Disciplinary Act.

2.2 The Washington Supreme Court has held that the standard of proof in disciplinary proceedings against physicians before the Commission is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534, *cert. denied*, 535 U.S. 904 (2002). In all findings forming the basis of this order, the Commission has applied the clear and convincing standard.

2.3 The Commission reviewed the admitted exhibits and considered the testimony, including the demeanor of all witnesses. Further, the Commission used its experience, competency, and specialized knowledge to evaluate the evidence presented in this case. RCW 34.05.461(5). There was substantial expert testimony on

this matter from both the Respondent and the Department. Expert testimony is sometimes helpful, but not essential, for the Commission in considering a case and in determining the standard of care. *Johnston v. Washington State Medical Disciplinary Board*, 99 Wn.2d 466 (1983); *Brown v. State Department of Health, Medical Disciplinary Board*, 94 Wn. App. 7, *review denied* 138 Wn.2d 1010 (1999).

2.4 The Uniform Disciplinary Act (the UDA) defines what conduct, acts, or conditions constitute unprofessional conduct. With respect to his care of each of the eight patients noted in the Statement of Charges, the Respondent has been charged with violating RCW 18.130.180(4). Any such violation constitutes unprofessional conduct under the UDA. RCW 18.130.180(4) provides as follows:

> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

2.5 Based on Finding of Fact 1.32 which is generally applicable to the Respondent's practice, and Findings of Fact: (i) Paragraphs 1.9 through 1.13 for Patient A; (ii) Paragraphs 1.14 through 1.18 for Patient D; (iii) Paragraphs 1.19 through 1.22 for Patient E; (iv) Paragraphs 1.23 through 1.26 for Patient F; and (v) Paragraphs 1.27 through 1.30 for Patient G, the Department proved by clear and convincing evidence that the Respondent's conduct constitutes unprofessional conduct as defined in RCW 18.130.180(4). The Respondent's conduct in those cases, for the reasons stated, does not meet the standard of care of a reasonably prudent physician practicing in Washington State.

2.6 Upon a finding of unprofessional conduct, the Commission may issue an order providing for one or a combination of sanctions including, *inter alia*, revocation of the physician's license, suspension, probation, censure, and fines. *See generally* RCW 18.130.160.

> In determining what action is appropriate, the disciplinary authority must first consider what sanctions are necessary *to protect or compensate the public.* Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder. *Id.* (emphasis added)

2.7 The Respondent requested the Commission not to find unprofessional conduct. After conceding on multiple occasions during the hearing the need for laboratory testing on a going-forward basis to assist in monitoring the potentially harmful effects (including a hyperthyroid state) of Armour Thyroid dosages, the Respondent desired to avoid the stigma and financial effect which could be imposed by third-party payers (managed care, insurance companies) on his practice in the event of a finding of unprofessional conduct and sanctions. The Respondent claims the Statement of Charges, the summary suspension imposed on his practice on May 25, 2006, and the Department's case at hearing are misguided (beyond the need for lab testing). In any event, the Respondent claims to have become more enlightened since the 2003-2004 patient care that was the subject of this proceeding, and he should be trusted without required sanction or monitoring at this stage. Given his dangerous use of Armour Thyroid, at times, the promise of the Respondent to do better in the future does not address the Commission's requirement to arrive at a sanction that can protect the public.

2.8 On the other hand, the Department requested one or more of a variety of possible sanctions, including a full assessment by the Center for Personalized Education for Physicians (CPEP) in Colorado, other intensive training, a "mentor" of the Respondent's practice for some period, fines, and prescriptive practice monitoring.

2.9 The Commission concludes a certain degree of monitoring by and reporting to the Commission during a probationary period, especially on the Respondent's prescriptive practices, is necessary to arrive at a just sanction that protects the public. However, the Commission does not believe a CPEP assessment or other intensive training is necessary to assure the Respondent's competency.

2.10 In addition, RCW 18.130.160(8) provides the Commission may levy a fine for each unprofessional conduct violation not to exceed $5,000 per violation, and this addresses what sanction is necessary to *compensate the public.* The Commission finds that a somewhat minimal fine against the Respondent of $2,500 is appropriate. Given the number of violations with respect to the noted patients, the law would permit a more substantial fine than the $2,500 imposed.

III. ORDERS

Based on the foregoing, the Commission hereby issues in this case the following ORDERS:

3.1 The license of the Respondent, Patrick Chau, to practice as a physician and surgeon is hereby REINSTATED FROM THE SUMMARY SUSPENSION, and is instead placed on PROBATION for two years subject to the following requirements:

(A) If not already in place, the Respondent must institute and continuously implement appropriate prescribing practices for his thyroid medications to include but not be limited to periodic laboratory testing to avoid hyperthyroidism and other harmful effects of such thyroid use.

(B) No less than three practice reviews shall be performed by the Commission or its designee on the Respondent's practice, with the first one to occur within six months of the date of this Order, and then at the twelve month and twenty-four month intervals dating from this Order. Each such review shall provide a general overview of the Respondent's practice, with special emphasis on the Respondent's prescription protocol for thyroid medications and stimulants, and the documentation of thyroid lab testing, in his psychiatric practice. Further, the Commission representative shall inspect office records, medication logs and medical records as needed, and interview the Respondent, any professional staff or partners, and office staff.

(C) Upon written request from the Commission, the Respondent shall appear before the Commission at six month intervals during the first year of this Order (after the required practice review(s) have been completed) to demonstrate his compliance with the terms of this Order, with the first compliance appearance in May 2007 or as soon thereafter as the Commission's schedule permits. At any time beginning after the second practice review required by this Order has occurred (i.e. after approximately 12 months from the date hereof), the Respondent may file a written petition to appear before the Commission to request a modification or termination of the probationary conditions of this Order. Any modification or early termination of this Order

shall occur at the Commission's sole discretion. The third practice review shall occur after the Respondent has been under probation for two years (if not earlier terminated).

3.2 The Respondent is hereby fined the amount of $ 2,500.00, payable on or before May 1, 2007. The fine shall 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, P.O. Box 1099, Olympia, Washington 98507-1099.

3.3 The charges in this matter with respect to Patients B, C, and H, as set forth in the Statement of Charges Paragraphs 1.14, 1.15, and 1.28-.29 (respectively), are hereby DISMISSED.

3.4 The Respondent shall be responsible and shall pay for any and all costs involved in his compliance with any and all conditions in this Order, and comply with all federal, state, and local laws, and all administrative rules governing the practice of the medical profession in Washington.

3.5 The Respondent shall inform the Commission, in writing, of any changes in his residential or professional practice(s) addresses within twenty (20) days of the change.

3.6 Periods of either residency (without a practice) or practicing outside the state of Washington shall not apply to the reduction of the two year period of probation contemplated by this Order.

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IV. 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 the Respondent fails to comply with the terms and conditions of this Order, the Commission may hold a hearing to require the 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, the Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 8 day of November, 2006.

Medical Quality Assurance Commission

JUDITH TOBIN, Public Member.
Panel Chair

FOR INTERNAL USE ONLY: (Internal tracking numbers)
Program Nos. 2004-03-0048, 2004-03-0078, 2004-06-0035, 2004-08-0001, 2004-11-0026, & 2005-07-0030

CLERK'S SUMMARY

Charges	Action
RCW 18.130.180(4)	Violated

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/national reporting requirements. If adverse action 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 10 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:

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

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on 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, however, the 30-day period will begin to run upon the resolution of that petition. RCW 34.05.470(3).

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

Attachment H

EDMUND G. BROWN, JR., Attorney General
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Supervising Deputy Attorney General [97276]
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Amended Accusation Against: **Patrick Kin-Yee Chau, M.D.** 5501 NE 109th Court, Suite L-1 Vancouver, WA 98662 Address of Record Physician and Surgeon's Certificate No.G 68517 Respondent.	**Case No. 16-2006-175852** **STIPULATION FOR SURRENDER OF LICENSE**

In the interest of a prompt and speedy resolution of the above entitled action that is consistent with the public interest and the responsibility of the Medical Board of California (hereinafter the "Board"), the parties hereby agree to the following Stipulated Surrender of License and Order ("Stipulation") which will be submitted to the Board for approval and adoption as the final disposition of First Amended Accusation No. 16-2006-175852 (hereinafter "Amended Accusation") pending in this matter.

1. David T. Thornton, (Complainant) is the Executive Director of the Medical Board of California. He brought this action solely in his official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California,

and by Susan K. Meadows, Deputy Attorney General. A true and correct copy of the Amended Accusation is attached hereto and made a part hereof as Exhibit A.

2. Respondent, Patrick Kin-Yee Chau, M.D., (hereinafter "respondent") is represented in this proceeding by his attorney, Stephen R. Rasmussen, of Hoffman, Hart & Wagner, LLP, whose address of record is Twentieth Floor, 1000 S.W. Broadway, Portland, Oregon 97205.

3. On or about May 7, 1990, the Medical Board of California issued Physician's and Surgeon's Certificate No. G 68517 to respondent. Respondent's license is renewed and current with an expiration date of July 31, 2007.

ADVISEMENT AND WAIVERS

4. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Amended Accusation. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

5. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Amended Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

6. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

7. For the purpose of this proceeding, respondent admits that cause exists to impose discipline on his medical license pursuant to Business and Professions Code sections 141(a) and 2305.

8. This stipulation shall be subject to approval by the Division of Medical

Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by respondent or his counsel. By signing the stipulation, respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the stipulation shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

9. The parties understand and agree that facsimile copies of this stipulation, including facsimile signatures thereto, shall have the same force and effect as the originals.

10. This stipulation is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties.

11. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 68517 issued to respondent, Patrick Kin-Yee Chau, M.D., is surrendered and accepted by the Board.

12. Upon acceptance of the stipulation by the Board, respondent understands that he will no longer be permitted to practice as a physician and surgeon in California, and agrees to surrender and cause to be immediately delivered to the Board or its designee both his license and wallet certificate before the effective date of the decision.

13. Respondent fully understands and agrees that if he ever files an application for licensure or a petition for reinstatement of his license in the State of California, the Board shall treat it as a petition for reinstatement of a revoked license. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the

time the petition is filed. For purposes of the reinstatement proceeding only, and not for purposes of any other proceeding, all of the charges and allegations contained in the Amended Accusation shall be deemed to be true, correct, and admitted by respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and have fully discussed it with my attorney. I understand the stipulation and the effect it will have on my license. By signing this stipulation, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a physician and surgeon in the State of California. I enter into this Stipulation for Surrender of License voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board. I will cause to be delivered to the Board both my license and wallet certificate before the effective date of the decision.

DATED: January 25th, 2007

PATRICK KIN-YEE CHAU, M.D.
Respondent

I have read and fully discussed with respondent the terms and conditions and other matters contained in this Stipulation For Surrender of License. I approve its form and content.

DATED: January 26, 2007

STEPHEN R. RASMUSSEN
HOFFMAN, HART &WAGNER, LLP
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulation For Surrender of License is hereby respectfully submitted for consideration by the Board.

DATED: 1-30-07.

EDMUND G. BROWN JR., Attorney General
of the State of California

SUSAN K. MEADOWS
Deputy Attorney General

Attorneys for Complainant

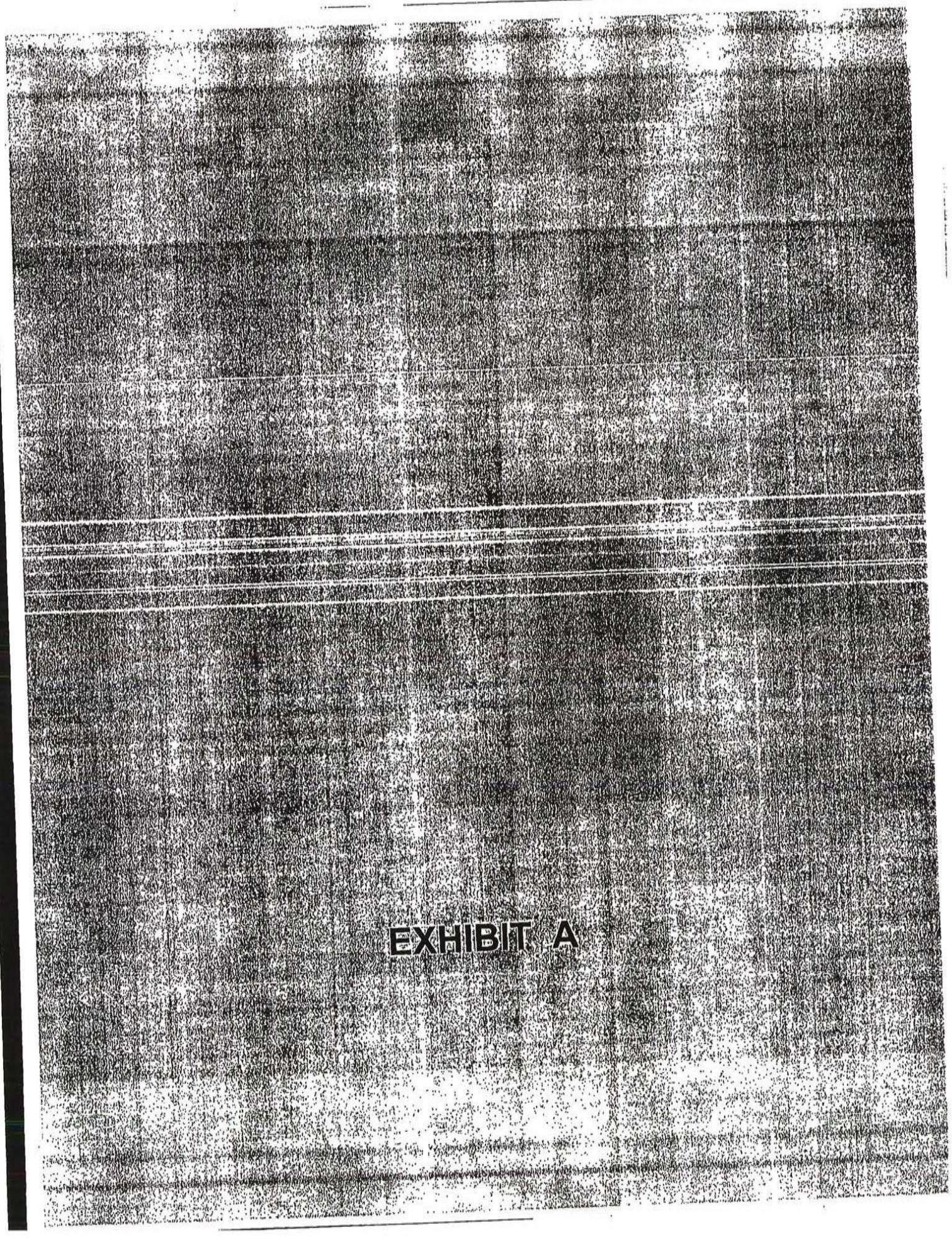
EXHIBIT A

APPLICATION ATTACHMENT

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 27, 20 0
BY Valerie Moore ANAL

12-27-06

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: PATRICK KIN-YEE CHAU, M.D. 5501 NE 109th Court, Suite L-1 Vancouver, WA 98662 Physician's and Surgeon's Certificate No. G 68517 Respondent.	Case No. 16-2006-175852 **FIRST AMENDED ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant David T. Thornton is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this First Amended Accusation solely in his official capacity.

2. On or about May 7, 1990, Physician and Surgeon's Certificate No. G 68517 was issued by the Board to Patrick Kin-Yee Chau, M.D. (hereinafter "respondent"). This certificate expires on July 31, 2007. On July 12, 2006, pursuant to Section 2310(a) of the Business and Professions Code, a full out of state suspension order of no practice was issued by the Board. On December 8, 2006, respondent's license to practice was fully restored.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period of not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring if probation is imposed.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

"(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein."

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

4. Respondent is subject to discipline within the meaning of section 2305 and/or section 141 of the Code as more particularly set forth herein below.

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

5. On May 25, 2006, the Washington Department of Health Medical Quality Assurance Commission (hereinafter "Commission") issued a summary suspension of respondent's medical license. After a hearing, which convened on or about September 29-30, 2006, the Commission issued an order dated November 8, 2006, which reinstated respondent's license to practice medicine, and placed his license on probation for two years including, but not limited to, the following conditions: Respondent must implement appropriate prescribing practices for his thyroid medications to include, but not be limited to, periodic laboratory testing to avoid hyperthyroidism; respondent's practice is subject to periodic reviews and inspection by the Commission or its designee, and respondent must pay a $2,500.00 fine. The basis for this action was respondent's inappropriate care and treatment of 5 patients who he diagnosed with thyroid dysfunction. The respondent treated these five patients by prescribing Amour Thyroid (desiccated thyroid), and for one patient, in addition to the Amour Thyroid, he prescribed Adderall (amphetamine), as therapy for hypothyroidism. Respondent's prescribing practices with respect to these five patients placed them at a significant risk of harm.

6. Attached hereto as Exhibit A, and made a part hereof, is a certified copy of the Commission's Findings of Fact, Conclusions of Law, and Final Order.

7. The action by the Commission regarding respondent's license to practice medicine, as set forth above, constitutes unprofessional conduct and/or grounds for disciplinary action within the meaning of section 2305 of the Code and/or section 141(a) of the Code. Therefore, cause for discipline exists.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged and that following the hearing the Division issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G 68517 heretofore issued to respondent;

2. Ordering respondent to pay the Division the costs of probation monitoring upon

order of the Division; and,

3. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants; and,

4. Taking such other and further action as the Division deems necessary and proper.

DATED: December 27, 2006.

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

Chau.1st Amended Acc

Attachment I

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Amended Accusation Against:	
PATRICK KIN-YEE CHAU, M.D.	File No. 16-2006-175852
Physician's and Surgeon's Certificate No. G 68517	
Respondent.	

DECISION

The attached Stipulation for Surrender of License is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 8, 2007.

IT IS SO ORDERED March 1, 2007.

MEDICAL BOARD OF CALIFORNIA

By: Cesar A. Aristeiguieta, M.D., Chair
Panel A
Division of Medical Quality

APPLICATION ATTACHMENT

EDMUND G. BROWN, JR., Attorney General
of the State of California
JOSE R. GUERRERO
Supervising Deputy Attorney General [97276]
SUSAN K. MEADOWS
Deputy Attorney General [115092]
455 Golden Gate Avenue, Suite 11000
San Francisco, California 94102
Telephone: (415) 703-5552
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Amended Accusation Against: **Patrick Kin-Yee Chau, M.D.** 5501 NE 109th Court, Suite L-1 Vancouver, WA 98662 Address of Record Physician and Surgeon's Certificate No.G 68517 Respondent.	**Case No. 16-2006-175852** **STIPULATION FOR SURRENDER OF LICENSE**

In the interest of a prompt and speedy resolution of the above entitled action that is consistent with the public interest and the responsibility of the Medical Board of California (hereinafter the "Board"), the parties hereby agree to the following Stipulated Surrender of License and Order ("Stipulation") which will be submitted to the Board for approval and adoption as the final disposition of First Amended Accusation No. 16-2006-175852 (hereinafter "Amended Accusation") pending in this matter.

1. David T. Thornton, (Complainant) is the Executive Director of the Medical Board of California. He brought this action solely in his official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California,

and by Susan K. Meadows, Deputy Attorney General. A true and correct copy of the Amended Accusation is attached hereto and made a part hereof as Exhibit A.

2. Respondent, Patrick Kin-Yee Chau, M.D., (hereinafter "respondent") is represented in this proceeding by his attorney, Stephen R. Rasmussen, of Hoffman, Hart & Wagner, LLP, whose address of record is Twentieth Floor, 1000 S.W. Broadway, Portland, Oregon 97205.

3. On or about May 7, 1990, the Medical Board of California issued Physician's and Surgeon's Certificate No. G 68517 to respondent. Respondent's license is renewed and current with an expiration date of July 31, 2007.

ADVISEMENT AND WAIVERS

4. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Amended Accusation. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

5. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Amended Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

6. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

7. For the purpose of this proceeding, respondent admits that cause exists to impose discipline on his medical license pursuant to Business and Professions Code sections 141(a) and 2305.

8. This stipulation shall be subject to approval by the Division of Medical

Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by respondent or his counsel. By signing the stipulation, respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the stipulation shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

9. The parties understand and agree that facsimile copies of this stipulation, including facsimile signatures thereto, shall have the same force and effect as the originals.

10. This stipulation is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties.

11. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 68517 issued to respondent, Patrick Kin-Yee Chau, M.D., is surrendered and accepted by the Board.

12. Upon acceptance of the stipulation by the Board, respondent understands that he will no longer be permitted to practice as a physician and surgeon in California, and agrees to surrender and cause to be immediately delivered to the Board or its designee both his license and wallet certificate before the effective date of the decision.

13. Respondent fully understands and agrees that if he ever files an application for licensure or a petition for reinstatement of his license in the State of California, the Board shall treat it as a petition for reinstatement of a revoked license. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the

time the petition is filed. For purposes of the reinstatement proceeding only, and not for purposes of any other proceeding, all of the charges and allegations contained in the Amended Accusation shall be deemed to be true, correct, and admitted by respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and have fully discussed it with my attorney. I understand the stipulation and the effect it will have on my license. By signing this stipulation, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a physician and surgeon in the State of California. I enter into this Stipulation for Surrender of License voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board. I will cause to be delivered to the Board both my license and wallet certificate before the effective date of the decision.

DATED: January 25th, 2007

PATRICK KIN-YEE CHAU, M.D.
Respondent

I have read and fully discussed with respondent the terms and conditions and other matters contained in this Stipulation For Surrender of License. I approve its form and content.

DATED: January 26, 2007

STEPHEN R. RASMUSSEN
HOFFMAN, HART &WAGNER, LLP
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulation For Surrender of License is hereby respectfully submitted for consideration by the Board.

DATED: 1-30-07.

EDMUND G. BROWN JR., Attorney General
of the State of California

SUSAN K. MEADOWS
Deputy Attorney General

Attorneys for Complainant

EXHIBIT A

APPLICATION ATTACHMENT

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 27, 20 0
BY Valerie Moore ANAL

12-27-06

BILL LOCKYER, Attorney General
of the State of California
JOSE R. GUERRERO
Supervising Deputy Attorney General
SUSAN K. MEADOWS, State Bar No. 115092
Deputy Attorney General
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455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
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Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: PATRICK KIN-YEE CHAU, M.D. 5501 NE 109th Court, Suite L-1 Vancouver, WA 98662 Physician's and Surgeon's Certificate No. G 68517 Respondent.	Case No. 16-2006-175852 **FIRST AMENDED ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant David T. Thornton is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this First Amended Accusation solely in his official capacity.

2. On or about May 7, 1990, Physician and Surgeon's Certificate No. G 68517 was issued by the Board to Patrick Kin-Yee Chau, M.D. (hereinafter "respondent"). This certificate expires on July 31, 2007. On July 12, 2006, pursuant to Section 2310(a) of the Business and Professions Code, a full out of state suspension order of no practice was issued by the Board. On December 8, 2006, respondent's license to practice was fully restored.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period of not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring if probation is imposed.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

"(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein."

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

4. Respondent is subject to discipline within the meaning of section 2305 and/or section 141of the Code as more particularly set forth herein below.

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

5. On May 25, 2006, the Washington Department of Health Medical Quality Assurance Commission (hereinafter "Commission") issued a summary suspension of respondent's medical license. After a hearing, which convened on or about September 29-30, 2006, the Commission issued an order dated November 8, 2006, which reinstated respondent's license to practice medicine, and placed his license on probation for two years including, but not limited to, the following conditions: Respondent must implement appropriate prescribing practices for his thyroid medications to include, but not be limited to, periodic laboratory testing to avoid hyperthyroidism; respondent's practice is subject to periodic reviews and inspection by the Commission or its designee, and respondent must pay a $2,500.00 fine. The basis for this action was respondent's inappropriate care and treatment of 5 patients who he diagnosed with thyroid dysfunction. The respondent treated these five patients by prescribing Amour Thyroid (desiccated thyroid), and for one patient, in addition to the Amour Thyroid, he prescribed Adderall (amphetamine), as therapy for hypothyroidism. Respondent's prescribing practices with respect to these five patients placed them at a significant risk of harm.

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WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged and that following the hearing the Division issue a decision:

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order of the Division; and,

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DATED: December 27, 2006.

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