STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Patrick Chau, MD
Docket No.: 06-04-A-1014MD
Document: Final Order

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

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

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

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

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: 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).