STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Andrew S. Hwang, MD
Master No.: M2007-57439
Docket No.: 07-10-A-1087MD
Document: Stipulated Findings of Fact, Conclusions of Law and Agreed 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 **ANDREW S. HWANG, MD** Credential No. MD00027252 Respondent	**No. M2007-57439** **(07-10-A-1087MD)** **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 attorney Christopher Keay, stipulate and agree to the following:

1. PROCEDURAL STIPULATIONS

1.1 On December 13, 2007, 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 On December 20, 2007, the Commission entered an Ex Parte Order of Summary Suspension by which it summarily suspended Respondent's credential to practice medicine in the state of Washington.

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

1.5 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.

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

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

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

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

1.10 If the Commission accepts this Agreed Order, it is subject to the federal reporting requirements pursuant to Section 1128E of the Social Security Act and 45 CFR Part 61, RCW 18.130.110 and any other applicable interstate/national reporting requirements. It is a public document and will be available on the Department of Health web site.

1.11 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 Program stipulate to the following facts:

2.1 On May 1, 1990, the state of Washington issued Respondent a credential to practice as a physician and surgeon. Respondent's credential is currently suspended.

2.2 Respondent is board-certified in psychiatry. From November 2001 through January 2002, Respondent treated Patient A, who was at the time a 17-year-old girl.

2.3 Respondent saw Patient A in his office four times. During these visits, Respondent consistently diagnosed Patient A with Major Depression and Attention Deficit Disorder (ADD). In the two (2) months that he treated her, Respondent tried Patient A on thirteen (13) different psychotropic medications: Concerta (methylphenidate); Desyrel (trazodone); Remeron (mirtazapine); Sinequan (doxepin); Effexor XR (venlafaxine); Dexedrine Spansule (dextroamphetamine); Cylert (pemoline); Lithium carbonate; Tegretol (carbamazepine); Depakote (valproic acid);Norvasc (amlodipine); Provigil (modafinil); and Klonopin (clonazepam).

2.4 When Respondent first saw Patient A on November 20, 2001, she was taking a stimulant, Concerta, for ADD. Respondent prescribed or provided Patient A with two (2) anti-depressants, Remeron and Trazodone. By December 13th, Respondent had the patient stop taking Remeron and Trazodone as they were ineffective or caused adverse side effects. Respondent had also started the patient on doxepin, a tricyclic antidepressant which runs a risk for cardiotoxicity, having Patient A take up to 300 milligrams per day. On that date, Respondent also started Patient A on Effexor XR, which is a different type of antidepressant.

2.5 On December 17, 2001, Patient A's mother had called Respondent to report side effects, including that Patient A was "shaky" and was experiencing "clumsiness." Respondent responded by reducing Patient A's daily Effexor XR dose from 225 to 150 milligrams. He did nothing to address whether Patient A was taking too much doxepin or to medically assess her in light of these side effects.

2.6 At Patient A's next visit, January 2, 2002, Respondent wrote, "Parents saw marked improvement in [Patient A], but she is still passive and withdrawn." At that visit, Respondent had the patient continue on Effexor XR and doxepin, reducing the latter to as much as 200 milligrams per day. Respondent also had the patient try, in rapid succession, two (2) stimulants either with or as alternatives to Concerta and four (4) different mood stabilizers.

2.7 On January 10, 2002, Patient A's mother states that she called Respondent to report changes in Patient A's mental status, specifically, that she was having difficulty walking, had driven her car into a ditch, and was mentally confused. According to Patient A's mother, Respondent told her that Patient A should continue in her routines and return at her next scheduled appointment, and he did not instruct her to change Patient A's medication regimen. Respondent denies Patient A's mother's report to him. Respondent claims that he reduced the patient's doxepin to 100 milligrams daily. Respondent noted a doxepin decrease in Patient A's chart. Respondent did not take any steps to medically assess Patient A or address the possibility of tricyclic toxicity.

2.8 Patient A's mother reports that by the time of the next appointment, January 25, 2002, Patient A's mental status had worsened as she continued to have difficulty with her motor skills and confusion. Respondent did not address these problems or medically assess the symptoms that had emerged around January 10th. Instead, Respondent charted that the patient had improved on Norvasc, a calcium channel blocker that Respondent provided to the patient as a mood stabilizer, and that she felt more relaxed around family and guests and felt more confident that she might attend college. He continued her on doxepin at a reduced dosage, Effexor XR, Concerta, and Norvasc. Respondent also added two (2) other medications to the regimen, Provigil, a stimulant used to treat patients who are unusually sleepy during the day, and Klonopin, a benzodiazepine which is generally used for short term treatment of anxiety and insomnia.

2.9 On January 26, 2002, Patient A felt very confused, and she did not feel well. The next morning, her parents found her in her room, stuperous and non-responsive. She was taken to the hospital, where she was found to be hypotensive and, ultimately, to have suffered severe brain damage. She was taken off life support and died on January 29th. The Pierce County Medical Examiner's record reports Patient A's triclyclics (doxepin) level at 689.

2.10 In treating Patient A, Respondent violated the standard of care in the following ways:

A. Respondent prescribed a high dose of doxepin under circumstances where the standard of care required him to check blood levels to protect his patient. Respondent never checked Patient A's blood levels.

B. On January 10, 2002, when Respondent learned of changes in Patient A's mental status, including confusion and poor coordination, he failed to immediately assess the patient for possible tricyclic toxicity, including taking blood levels, vital signs, an electrocardiogram (ECG), and a detailed mental status exam. When the patient returned on January 25th in what her mother reports was a worsened condition, Respondent again failed to evaluate her for toxicity.

C. On January 2, 2002, Respondent had Patient A try four (4) different mood stabilizers – Depakote, Lithium, Tegretol, and Norvasc. Respondent utilized these medications without determining that lower risk treatments had been exhausted, or that the severity of symptoms outweighed the inherent health risks. The use of mood stabilizers at that time was not indicated because Patient A did not present with symptoms of mood instability, had improved with standard antidepressants, could not have been considered treatment-resistant to standard antidepressants, and did not exhibit symptoms warranting such an aggressive regimen.

D. Consistent with his practice, Respondent tried Patient A on the four (4) above-referenced mood stabilizers in rapid succession, instructing her to remain on the one that worked best. This practice is substandard, unsafe and reveals a basic misunderstanding of psychopharmacology. The mood stabilizers Respondent provided to Patient A cannot reach an appreciable clinical level, nor

could they be eliminated from her system, in a few days. It is not possible to assess the effects of such medications using Respondent's methods. Respondent failed to determine the therapeutic concentration of three (3) of the mood stabilizers (except Norvasc) by checking blood levels.

E. Also consistent with his practice, Respondent provided Patient A with a handout entitled, "How to Use Mood Stabilizers for Depression". This handout is vague and confusing. By giving multiple potentially dangerous medications to a depressed patient all at once, along with vague instructions, Respondent created an unacceptable safety risk.

F. Respondent utilized a calcium channel blocker in treating Patient A. Calcium channel blockers, such as Norvasc, bear risks for cardiac side effects, particularly when combined with other medications. In treating Patient A, Respondent utilized both doxepin and Norvasc which can affect cardiac function. Respondent violated the standard of care by failing to monitor Patient A's vital signs and administer an ECG when combining two (2) medications with potential cardiac side effects. Respondent failed to inform Patient A or her family of the risks of combining medications with overlapping side effect profiles or the signs of cardiotoxicity, thereby failing to meet community standards for informed consent.

G. Prior to starting a trial of Tegretol or Depakote, the standard of care is to obtain baseline blood tests (CBC and liver studies) for later comparison. Respondent failed to obtain such tests prior to having Patient A try these medications.

H. On January 2, 2002, Respondent charted that Patient A was to discontinue Concerta. He then prescribed both Dexedrine Spansules and Cylert, which the patient was instructed to try in rapid succession in order to judge which was most effective. Respondent failed to utilize an acceptable method for assessing stimulants. The standard of care required separate evaluation of each of these medications to determine effective dose and tolerance, due to individual differences in absorption and metabolism. Respondent also failed to include some collateral or objective rating of symptoms, rather than relying solely on the

patient's subjective impression, which falls below the standard of care for treating children.

I. Respondent's addition of Provigil and Klonopin to Patient A's already complex regimen on January 25, 2002, was contraindicated. Benzodiazepines such as Klonopin are contraindicated in a patient reporting confusion and difficulty in walking. They greatly increase the risk of delirium and injury from falling. Provigil's mechanism of action creates the potential for significant adverse interactions with Concerta, Effexor, and Norvasc, all of which Patient A was taking. Furthermore, the effects of these two (2) medications contradict one another. Klonopin is generally used for short term treatment of anxiety and insomnia. Provigil is only indicated for patients who are unusually sleepy during the day, and it tends to increase anxiety. Respondent should not have provided these two (2) contradictory medications on the same day to the same patient. In addition, Respondent failed to warn the patient and her parents about the complex interaction, including the very serious possibility of turning her reported confusion into delirium with the addition of Klonopin.

J. Respondent's practice reflects a poor understanding of psychopharmacology. The standard of care requires that when providing patients with multiple medications, the physician exercise greater vigilance to protect against potential side effects and adverse drug-drug interactions. Respondent failed to consider drug toxicity or drug-drug interactions as possible causes for Patient A's mental status changes and neuromuscular symptoms that occurred between January 10th and 25th, 2002. On January 10th, when Patient A's mother says she reported alarming changes in the patient's affect, the reasonably prudent psychiatrist would have conducted a medical assessment and removed the most recent additions to the medication regimen. Patient A's mother reports that Respondent took no such action. On January 25th, Respondent added two (2) more non-indicated medications, one of which was likely to make the reported problem worse.

2.11 Respondent's documentation regarding Patient A also violated the standard of care. Specifically:

A. There is no documentation that Respondent assessed the patient's risk for suicide in any note.

B. There is no clear documentation of target symptoms, clinical indications, clinical reasoning, or risk/benefit analysis for any of Respondent's numerous medication trials.

C. On January 2, 2002, the progress note contradicts the action taken and the parents' report. Respondent wrote, "Parents saw marked improvement in [Patient A], but she is still passive, withdrawn." He then began a series of medications that would have been indicated for emotional volatility or mania, but not for passivity and withdrawal.

D. On January 2, 2002, Respondent gave the patient Dexedrine Spansules and Cylert to try. Although these are controlled substances, there is no documentation of the dose or number of pills given.

E. On January 10, 2002, Respondent noted the patient's difficulty in climbing stairs. However, in his progress note of January 25th, Respondent failed to document any change in the patient's mental and neurological status or how that condition had progressed in the ensuing two-week period. Instead, the note states, "Has made marked improvement with Norvasc 10mg qAM."

2.12 As a result of Respondent's treatment of Patient A, he placed her at a significant risk of harm and possibly contributed to her death.

2.13 In entering this Agreed Order, the Commission has considered the following mitigating factors:

A. Respondent has sought consultation from his peers to understand the issues in his practice that resulted in the Commission's charges against him.

B. Through this consultative process, Respondent has been open to constructive criticism and has demonstrated that he is willing to spend the time and do the remedial work necessary to improve his skills so that, if allowed, he can practice with reasonable skill and safety.

C. Respondent has already commenced a remedial education process in which he has spent several hours consulting with a peer on appropriate practices as they relate to the issues in this case.

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).

3.3 The above violation provides 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 Credential.** Respondent's credential to practice as a physician and surgeon in the state of Washington shall remain **SUSPENDED** unless and until the Commission enters an order reinstating his credential.

4.2 **CPEP.** Respondent shall commence an evaluative process with the Center for Personalized Education for Physicians in Denver, Colorado (CPEP), within 45 days of the effective date of this Agreed Order. 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 might request. With respect to this case, Respondent shall provide CPEP with copies of the Statement of Charges, Motion for Summary Action, expert declaration in support of that motion, the Ex Parte Order of Summary Suspension, and this Agreed Order. Respondent understands that the Commission, through its designee, might provide CPEP with excerpts from the investigative file if CPEP requests it. By signing this Agreed Order, Respondent releases CPEP representatives to discuss with representatives of the Commission and the Department of Health any matters relating to Respondent's evaluation; Respondent waives any privileges or privacy rights he might otherwise have regarding such matters under federal and state law. CPEP shall provide a copy of its evaluation to the Commission's designee and shall communicate with the designee as necessary to keep the Commission informed of Respondent's progress.

4.3 **Disposition of Credential If CPEP Does Not Give a Favorable Evaluation.** If CPEP concludes that Respondent cannot practice psychiatry with reasonable skill and safety, Respondent shall be deemed to have failed to comply with the terms of this Agreed Order, and his credential will be subject to further discipline including revocation.

4.4 **Petition for Reinstatement.** Respondent may not petition for reinstatement of his credential unless and until he receives an evaluation from CPEP stating that he can practice psychiatry with reasonable skill and safety. If Respondent petitions for reinstatement, he will receive notice and shall appear before the Commission. If the Commission grants any such petition, the Commission may, in its discretion, incorporate any recommendations that CPEP makes into a reinstatement order.

4.5 **Disposition of Credential if Reinstated.** If Respondent successfully petitions for reinstatement, he shall be on **PROBATION** for five (5) years from the effective date of reinstatement. If reinstated, the Commission shall mark on Respondent's license certificate that Respondent is on probation.

4.6 **Psychiatric Skills Preceptor Program.** If the Commission reinstates Respondent's credential, Respondent shall consult with and obtain one-on-one medical skills training from a qualified and approved preceptor during the probation period pursuant to the following terms:

A. No less than thirty (30) days prior to petitioning for reinstatement, Respondent shall submit for approval to the Commission or its designee the name of the person Respondent proposes to act as preceptor. Respondent shall also provide the proposed preceptor's *curriculum vitae* and any other documents that reflect the person's qualifications. The Commission shall have discretion to accept or reject the proposed preceptor. If the Commission rejects the proposal, Respondent shall have two weeks in which to propose a different preceptor. The preceptor must be board certified in and practicing psychiatry, licensed to practice medicine for at least ten (10) years, at least two (2) of which must have been in Washington State, and have at least five (5) years of experience educating and training others in psychiatric *practice*.

B. Respondent shall commence a preceptor program immediately after reinstatement. Respondent shall provide the preceptor with copies of the Statement of Charges, Motion for Summary Action, expert declaration in support of that motion, the Ex Parte Order of Summary Suspension, this Agreed Order, the reinstatement order, any modification to this Agreed Order, the CPEP evaluation report, and any other materials that the preceptor requests. The Commission shall provide the preceptor with a copy of Patient A's medical records from this case.

C. During the probation period, the preceptor shall monitor Respondent's care of at least five (5) patients per month by observing Respondent's interactions with patients, reviewing his charts and prescribing practices, and consulting with Respondent in order to assure that he is fully educated and practicing within the standard of care. Every month, the preceptor shall observe Respondent in separate sessions with at least two (2) of Respondent's patients and review Respondent's charts and prescription records for those two patients, as well as the charts and prescription records for three (3) additional patients. In subsequent months, the preceptor may, in the preceptor's discretion, continue to focus on Respondent's treatment of some or all of those five (5) patients, or the preceptor may review the care provided to different patients. The preceptor shall also meet with Respondent at least twice a month to discuss the patients under review, as well as Respondent's practices in general, and shall provide Respondent with information and refer him to any literature that the preceptor believes Respondent should review to improve his practices. Respondent shall read any recommended literature and discuss what he has learned with the preceptor during subsequent meetings. The Commission recognizes that if it reinstates Respondent's credential, it may take some time for Respondent to grow his practice and that, at least initially, he may not have a sufficient number of patients to fully comply with the preceptor program. To the extent that is the case, the preceptor shall review sessions, charts, and prescriptions for all patients under Respondent's care.

D. During the probation period, the preceptor shall periodically report in writing to the Commission's designee regarding Respondent's skills and progress, any concerns the preceptor might have with those skills, and any other concerns that the preceptor might have. The first report shall be due on the first day of the first month after reinstatement. Subsequent reports are due every three months thereafter for the duration of the probation period. The Commission shall consider any report that Respondent's skills are less than satisfactory to constitute a violation of this Agreed Order.

E. By signing this Agreed Order, Respondent releases the preceptor to discuss with representatives of the Commission and the Department of Health any matters relating to the preceptor program; Respondent waives any privileges or privacy rights he might otherwise have regarding such matters under federal and state law. The preceptor shall communicate with the Commission's designee as necessary to keep the Commission informed of Respondent's progress.

F. During the program, the preceptor shall report to the Commission's designee on any concerns the preceptor might have regarding Respondent's ability to practice with reasonable skill and safety or if Respondent is not compliant with the program. If the preceptor believes the program needs to be extended or otherwise modified, the program shall be so modified subject to the approval of the Commission's designee.

4.7 **Practice Audits.** If the Commission reinstates Respondent's credential, Respondent shall permit a Department of Health Investigator to audit patient records and review practices during the probation period. The Investigator will contact Respondent's office to give advance notice before each audit. The audits and reviews will take place at Respondent's place of employment or practice up to two (2) times per year during this period.

4.8 **Compliance Appearances.** If the Commission reinstates Respondent's credential, Respondent shall appear in person before the Commission six (6) months from the effective date of reinstatement, or as soon thereafter as the Commission's schedule permits, and shall present proof that Respondent is complying with this Agreed

Order and any additional terms of reinstatement. Respondent shall subsequently appear for the duration of the probation period at six (6) month intervals. After three (3) years of such appearances, Respondent may petition to discontinue his compliance appearances if he has been in full compliance with the terms of this Agreed Order and any reinstatement order. The Commission will give Respondent notice of the compliance hearings. If Respondent is found to be out of compliance with this Order, the Commission may impose additional sanctions under RCW 18.130.160 to protect the public.

4.9 **Fine.** Respondent shall pay a fine of one thousand dollar ($1,000.00) within six (6) months of 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. Failure to pay the fine within six (6) months shall constitute a violation of this Agreed Order.

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

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

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 credential.

4.13 **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 thirty (30) days of the change.

4.14 **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. ACCEPTANCE

I, ANDREW S. HWANG, 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.

ANDREW S. HWANG, MD
RESPONDENT

April 9, 2008
DATE

CHRISTOPHER KRAY WSBA# 13143
ATTORNEY FOR RESPONDENT

4-09-08
DATE

6. ORDER

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

DATED: April 10, 2008

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

Frederick H Dore Jr MD
PANEL CHAIR

PRESENTED BY:

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

4-10-08
DATE