STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Patrick K. Chau, MD
Master Case No.: M2008-117887
Docket No.:
Document: 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	**No. M2008-117887**
PATRICK K. CHAU, MD License No. MD00030053 Respondent	**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 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).

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.

//

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.

//

//

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.

//

//

//

//

//

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
PANEL CHAIR

PRESENTED BY:

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

10-15-09
DATE