STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Charles W. Huffine, M.D.
Master Case No.: M2009-347
Document: Final Order

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

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 Privacy Officer, 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: CHARLES W. HUFFINE, M.D., Credential No. MD.MD.00013207, Respondent.	Master Case No. M2009-347 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER **ON REMAND**

APPEARANCES:

Charles W. Huffine, **M.D.**, the Respondent, by
Peick Conniff, P.S., per
John C. Peick, Attorney at Law

Department of Health Medical Program (Department), by
Office of the Attorney General, per
Kristin G. Brewer, Assistant Attorney General

PANEL: Athalia Clower, PA-C, Panel Chair
Michael T. Concannon, Public Member
Samuel Selinger, M.D.

PRESIDING OFFICERS: Christopher G. Swanson, Health Law Judge and
John F. Kuntz, Review Officer[1]

REMAND

On April 24, 2012, King County Superior Court Judge Richard D. Eadie issued an Order on Judicial Review under No. 11-2-13000-2 SEA (Remand Order). The Remand Order remanded the matter to the Commission "to take those steps necessary to comply with the requirements of RCW 34.05.461(3)." The Commission will determine

[1] **This matter was transferred to Judge Kuntz on or about April-May 2012, as Judge Swanson no longer works for the Department of Health.**

the method of compliance, but their final Order must address the requirements of RCW 34.05.461(3).

On May 17, 2013, the Commission convened to address the requirements of the King County Superior Court's Remand Order and issues the following Final Order on Remand. Changes are reflected in **bold type**.

HEARING

A hearing was held in this matter on September 20-22, 2010, regarding allegations of unprofessional conduct. PROBATION.

ISSUES

Did the Respondent commit unprofessional conduct as defined in RCW 18.130.180(4)?

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

SUMMARY OF PROCEEDING

At the hearing, the Department presented the testimony of the following witnesses:

1. Charles W. Huffine, M.D., the Respondent, as an adverse witness;
2. Russell Vandenbelt, M.D., expert witness;
3. John R. Holttum, M.D., expert witness;
4. Barbara Molloy; and
5. Deborah Schnellman, Division of Health and Recovery, Department of Social and Health Services.

The Respondent presented the testimony of the following witnesses:

1. Charles W. Huffine, M.D., the Respondent;

2. Jan Isenhardt, MSW;

3. Jeff Olund;

4. Arlene VanderDussen;

5. Kenneth Minkoff, M.D., expert; and

6. Dr. Susan Willis, colleague (by video deposition).

The Presiding Officer admitted the following Department exhibits:

Exhibit D-1: Adolescent Risk Behavior: When Do Pediatric Psychologists Break Confidentiality?;

Exhibit D-2: The Respondent's Medical Record for Patient A;

Exhibit D-3: Harborview Medical Center Records for Patient A;.

Exhibit D-4: Curriculum Vitae of Russell Vandenbelt, M.D., P.S.;

Exhibit D-5: Curriculum Vitae of John R. Holttum, M.D.;

Exhibit D-6: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders, American Academy of Child & Adolescent Psychiatry;

Exhibit D-7: Respondent's Statement;

Exhibit D-8: Chemical Dependency Treatment Options for Minors under Age 18, A Guide for Parents, September 2006, Washington State Department of Social and Health Services; and

Exhibit D-9: Billing records of the Respondent.

The Presiding Officer admitted the following Respondent exhibits:

Exhibit R-1: Medical records and chart notes for Patient A;

Exhibit R-5: **Curriculum Vitae** of Dr. Kenneth Minkoff;

Exhibit R-8: Lake Union Psychiatric Group Privacy Practices Notice, dated October 2005; and

Exhibit R-9: Patient A Information Sheet.

PROCEDURAL HISTORY

On December 15, 2010, the Adjudicative Service Unit served the parties with a true and correct copy of the Commission's Findings of Fact, Conclusions of Law and Final Order (Final Order). Under the terms and conditions of the Final Order, the Commission placed the Respondent's license to practice medicine in the state of Washington on probation for a period of five years. During the probationary period, the Respondent was also required to complete additional conditions, including a prohibition of treating adolescents with substance abuse/dependency issues, successful completion of the Center for Personalized Education for Physicians (CPEP), payment of a $5,000 fine, and personal appearances before the Commission. The Commission's Final Order did not contain specific credibility findings regarding the testimony of the expert witnesses for the parties.

On December 23, 2010, the Respondent filed a request for reconsideration of the Final Order with the Commission. The Department opposed the Respondent's request. After reviewing the briefs submitted by the parties, the Commission denied the Respondent's request for reconsideration but did clarify the language in Paragraphs 3.3 and 3.6 of the Final Order and issued the

Amended Findings of Fact, Conclusions of Law and Final Order (Amended Order) on March 17, 2011.

The Respondent filed a petition for judicial review in King County Superior Court to appeal the Commission's Amended Order. Judge Richard A. Eadie of the King County Superior Court issued a Clarification on Order of Judicial Review, Docket No. 11-2-13000-2 SEA, on March 30, 2012. Under this Order, the Superior Court reversed and remanded the matter to the Commission for further consideration in light of the requirements of RCW 34.05.461(3) (any finding based substantially on credibility of evidence or demeanor of witnesses shall be so identified).

On April 24, 2012, Judge Eadie issued an Order on Judicial Review under Docket No. 11-2-13000-2 SEA. Under this Order, Judge Eadie remanded the case to the Commission to take those steps necessary to comply with the requirements of RCW 34.05.461(3). The Order further provided that the Commission will determine the method of compliance, but its final Order must address the RCW 34.05.461(3) requirements.

The parties were notified that they could submit briefs for consideration on the Final Order on Remand. The Department submitted its Briefing on Credibility on November 19, 2012. The Respondent submitted his Brief Regarding Assessment of Credibility on December 10, 2012. The Respondent filed its Reply to Respondent's Brief on Credibility/Motion to Strike on December 17, 2012,

requesting that any issues raised by the Respondent other than the issue of credibility be stricken as outside the scope of the proceedings.

In reaching its decision in the Final Order on Remand, the Commission considered the following materials: the Amended Findings of Fact, Conclusions of Law and Final Order; the Deposition Upon Oral Examination of Susan Hayes Willis, M.D., dated August 31, 2010;[2] the September 20-22, 2010 hearing transcript; the exhibits admitted at the hearing; the March 30, 2012 and April 24, 2012 King County Superior Court Orders issued by Judge Eadie; and copies of the briefs submitted by the parties.

CREDIBILITY FINDINGS

Each party presented two expert witnesses at the hearing (John R. Holttum, M.D., and Russell Vandenbelt, M.D. for the Department; Susan Hayes Willis, M.D., and Kenneth Minkoff, M.D. for the Respondent). In general, the Commission finds that the expert testimony provided by the Department's experts to be more convincing and credible, given their: analysis; knowledge; focus on the special circumstances of Patient A and his deteriorating behavior; and lack of any bias based on the lack of any affiliation with the Respondent.

Specifically, Dr. Holttum, a board certified psychiatrist in general psychiatry and child/adolescent psychiatry, testified that confidentiality can and

[2] **At the hearing, the Commission observed the video deposition of Dr. Willis; the written transcript of the Willis deposition was provided to the Commission for review.**

should be breached for safety reasons if there is a likelihood of harm to the adolescent based on what is occurring and being conveyed in the therapeutic relationship. Dr. Holttum's overall summary of the Respondent's treatment of Patient A is consistent with the Commission's findings in Paragraph 1.26 below.

Dr. Vandenbelt has been board certified not only in psychiatry since 1989, but more importantly to the Commission, certified in Addiction Medicine by the American Society of Addition Medicine since 1987. Dr. Vandenbelt's expert opinion was based on the American Academy of Psychiatry standards. Dr. Vandenbelt's practice includes inpatients, outpatients and adolescents in Washington State.

The Commission finds the testimony and opinions from the Respondent's experts less persuasive. Specifically, Dr. Minkoff practices in Massachusetts. He testified that he was not familiar with Washington law on consent by minor or adolescent patients or parental rights to request treatment over the objections of the adolescent. Dr. Minkoff has not treated adolescent patients since the 1990s.

The Respondent's second expert, Dr. Willis, is board certified in child and adolescent psychiatry. Dr. Willis neither provides drug or substance abuse treatment to adolescent patients nor has she treated an adolescent who was using the large amount of drugs used by Patient A in this case. She testified that she has not dealt with the issue of whether to breach confidentiality in the face of a serious risk to the adolescent patient. Dr. Willis has shared office space with Respondent for the past 20 years.

The Respondent argues that he also presented standard of care evidence (that is, expert testimony) in this matter.[3] To the extent the Respondent argues that his expertise should be considered, the Commission does not find his expertise to be persuasive in this matter. The Respondent is the subject of the disciplinary proceeding and has a financial interest in the outcome of the proceeding. The creation of a therapeutic alliance with Patient A through the use of motivational enhancement therapy is not, by itself, below the standard of care. The Commission finds the Respondent's continued use of motivational enhancement therapy did not insulate him from exercising his professional judgment and ensuring Patient A's safety. This is especially true given Patient A's escalating substance abuse and addiction problems.

Based on the exhibits and testimony presented, the Commission enters the following:

I. FINDINGS OF FACT

1.1 The Respondent was granted a license to practice as a physician and surgeon in the state of Washington on July 11, 1973. The Respondent's credential is currently active. The Respondent is a psychiatrist, limiting his practice to the treatment of adolescent patients. The Respondent is not board certified.

[3] **See the Respondent's Brief Regarding Assessment of Credibility, page 6, line 13.**

1.2 In October and November 2005, the Respondent evaluated Patient A, a 15-year-old male, for suicide risk and substance abuse issues. The Respondent evaluated Patient A again in July and August 2006, following which, the Respondent provided treatment to Patient A until July 2007, when Patient A overdosed on Methadone.

1.3 Patient A was originally referred to the Respondent by a family therapist who was counseling the stepmother and father of Patient A. Patient A's parents had expressed concern that Patient A was suicidal and sought an evaluation. The concern was precipitated by a report to Patient A's mom from a friend of Patient A that Patient A had taken an overdose of Oxycontin with the goal of suicide. Patient A's parents initiated the evaluation process by bringing Patient A in to see the Respondent.

1.4 At the outset of the evaluation process, the Respondent had a general discussion with the patient and his parents about confidentiality. He did not disclose the specific circumstances under which information revealed during treatment would be disclosed to Patient A's parents.

1.5 During the evaluation process, Patient A indicated that his friend had fabricated the story about the suicide attempt to avoid getting in trouble for jumping out of a boat during a party at which the youths were consuming alcohol aboard the friend's family boat. Despite the friend's fabrication, Patient A acknowledged the moderate use of marijuana and the rare use of alcohol in his discussion with the Respondent. Patient A noted that many of his friends drink and use marijuana. The Respondent's evaluation also briefly touched upon Patient A's health history, including possible

symptoms of attention deficit disorder. The Respondent accepted Patient A's statements at face value, and did not use any other method, such as drug testing, to gather additional information regarding Patient A's mental health or substance abuse history. The only other source of information the Respondent obtained during this evaluation was information from Patient A's parents.

1.6 Following the October 2005 evaluation, the Respondent told Patient A's parents that it was his assessment that Patient A had no suicidal ideation, and that Patient A was not inclined to abuse medication, due to a greater than average need for control. The Respondent did not document the basis for his conclusions. The Respondent told Patient A that he did not advocate for Patient A being in treatment.

1.7 In July 2006, Patient A was again referred to the Respondent for evaluation. The second evaluation was also initiated by Patient A's parents. At the time of the second evaluation, Patient A was experiencing problems with school, was continuing to experiment with drugs and alcohol, and was in turmoil with his family.

1.8 During the second evaluation process, the Respondent talked to Patient A about substance use, family issues, and issues with the law, including a minor in possession criminal matter. The Respondent accepted Patient A's statements at face value. While the Respondent received some additional information from Patient A's parents, he did not use any other method, such as drug testing, to gather information regarding Patient A's mental health or substance abuse. The Respondent recommended group therapy treatment to Patient A. The Respondent did not document his diagnosis or the basis for his recommended treatment plan.

1.9 In September 2006, Patient A began attending adolescent group therapy run by the Respondent. In December 2006, Patient A also began attending individual therapy sessions.

1.10 The Respondent's treatment of Patient A focused on building a therapeutic alliance with Patient A, and the use of motivational enhancement. A therapeutic alliance occurs when rapport and trust are present between the practitioner and patient, so that the patient is more likely to actively participate in treatment. A proper therapeutic alliance requires the practitioner and the patient to set tasks, goals, and ground rules for treatment, including discussion of the practitioner's obligation to protect patient safety. Under motivational enhancement, the practitioner and the patient are to engage in a partnership to assist the patient to examine his behavior and its consequences. The desired effect of motivational enhancement therapy is positive change, initiated by the patient, over a period of time. Motivational enhancement deemphasizes the use of direct confrontation and unilateral action by the practitioner; as it may undermine the partnership and diminish the effectiveness of therapy. The Respondent did not reference motivational enhancement principles, or his rationale for their use, in his treatment notes.

1.11 During the course of group and individual sessions over the next 10 months, Patient A consistently revealed serious substance abuse, with periodic abstinence, followed by relapse. The Respondent was well aware that Patient A's substance abuse was escalating in terms of both consumption and consequences,

including being pulled over by the police and being found in possession of alcohol and drugs, as well as crashing his car.

1.12 In October 2006, Patient A reported to the Respondent taking LSD and driving while intoxicated. On December 5, 2006, the Respondent noted Patient A was in an addictive pattern with bouts of escalating use, including taking 80 mg of Oxycontin, five to six tablets per night. This use is considered to be lethal for the typical person without tolerance.

1.13 On December 18, 2006, Patient A's pattern of alcohol had escalated to three-quarters of a fifth of hard liquor in an evening, two to three six packs of beer, or a bottle of wine in an evening three to four nights a week. In March 2007, the Respondent noted "massive use with tolerance up and likely true addiction; out of control."

1.14 On many occasions, Patient A attended group therapy under the influence of a substance or substances. Patient A told of, and even bragged to the group about, his regular consumption of high doses of Oxycontin, his abuse of alcohol, his regular consumption of marijuana, and his history of experimentation with other drugs such as LSD, cocaine, and methadone. Although information about Patient A's substance abuse was revealed through therapy, the Respondent did not use drug testing to verify the types and amount of substances being used or address the issue in any other way.

1.15 Throughout the course of the Respondent's treatment, Patient A exhibited erratic and sometimes violent behavior. Patient A's mother, who shared custody of Patient A with Patient A's father, eventually kicked Patient A out of her house after he

exhibited a pattern of abusive and dangerous behavior. Patient A stole approximately $45,000.00 from his mother to maintain his drug abuse.

1.16 Patient A's history included Attention Deficit Disorder. Over the course of his treatment, Patient A exhibited symptoms of depression, as well as symptoms associated with other mental health conditions. Although the Respondent prescribed medication for Patient A's depression, he did not attempt to gather additional information regarding Patient A's mental health. Patient A's depression symptoms got progressively worse, including exhibiting problems with memory, missing appointments, and withdrawing from friends. The Respondent did not attempt to determine whether Patient A's symptoms resulted from mental health issues, substance abuse, or both. The Respondent did not do any further assessment of Patient A for suicide risk. The Respondent selected a type of antidepressant medication (Citalopram) that was unlikely to interact with Patient A's substance use.

1.17 The Respondent did not counsel Patient A about the risks of overdose or withdrawal. The Respondent did not counsel Patient A about dangers of mixing the substances used by Patient A. The Respondent did not seek drug testing to confirm the scope and extent of Patient A's substance abuse or the potential for harm.

1.18 Although the Respondent warned Patient A about the danger of his conduct, the Respondent did not offer ultimatums to Patient A, believing that it would undermine the effectiveness of therapy. Instead, the Respondent continued to employ motivational enhancement in an attempt to get Patient A to see the negative consequences of his behavior and effect change on his own.

1.19 The Respondent did not directly inform Patient A's parents about his worsening condition. Although the Respondent suggested that Patient A's behavior should be taken seriously and that he shared Patient A's parents' concerns about his worsening condition, the Respondent did not inform them about Patient A's conduct and specify the specific dangers associated with it. The Respondent also discouraged the placement of Patient A in drug treatment, advocating instead for Patient A to self-regulate and initiate any treatment on his own.

1.20 On the morning of July 27, 2007, Patient A's father found his son sleeping and was not able to wake him. Patient A was taken by ambulance to Harborview Medical Center where it was determined that he had overdosed on 180 mg. of methadone. Patient A was released from the hospital on July 29, 2007.

1.21 Following his overdose, Patient A entered substance abuse treatment at a 30-day treatment program, followed by a 90-day inpatient program. Patient A did not receive any further therapy from the Respondent and did not return to the adolescent group.

Confidentiality and Disclosure

1.22 Due to the patient's age, the practitioner treating an adolescent psychiatric patient has duties of confidentiality and duties of disclosure that differ from those that apply to an adult. The practitioner is obligated to give notice of these duties to both the patient and his parents. The practitioner is generally obligated to keep treatment information confidential unless the adolescent patient consents to disclosure. However,

the patient's specific diagnosis, the general plan of treatment and the patient's general progress in treatment must be revealed to parents.

1.23 The practitioner must also disclose confidential treatment information and make an appropriate intervention when a risk to life or other major danger exists. The duty of disclosure is triggered even if the risk or danger is not immediate. The practitioner is obligated to consider the intensity, frequency, and duration of health risk behaviors in determining whether or not disclosure is warranted. The desire to keep information confidential to prevent the potential compromise of the therapeutic alliance, or because a particular method of therapy, such as motivation enhancement, is preferred, does not justify the withholding of confidential treatment information when a risk to life or other major danger necessitates its disclosure.

1.24 The Respondent's failure to disclose necessary information to Patient A's parents was a violation of the standard of care. Throughout the treatment process, Patient A's parents should have been apprised of Patient A's specific diagnosis, including Patient A's addiction to substances, his worsening condition, and his lack of progress in treatment, so that they could make effective treatment decisions.

1.25 Beginning in October 2006, when Patient A reported driving under the influence, and through Patient A's escalating substance abuse and addiction, Patient A's conduct posed a risk to life or other major danger. The dangers associated with Patient A's conduct included harm or death to Patient A and others due to driving under the influence of substances, harm or death to Patient A in the form of overdose,

and harm or death to Patient A in the form of seizure or other serious withdrawal symptoms.

1.26 At this point, the Respondent should have ensured that Patient A's parents were aware of his specific conduct: Patient A's parents should have been informed of Patient A's conduct in driving under the influence of substances, the massive amount of OxyContin he was using, and his massive use followed by sudden disuse of the drug. Patient A's parents should also have been told of the specific danger Patient A's conduct posed to himself and others so that they could take immediate action, including drug treatment. The Respondent should have disclosed this information even if it would have resulted in compromise of therapeutic alliance or termination of the therapeutic relationship.

Motivational Enhancement

1.27 Use of motivational enhancement therapy alone is below the standard of care for a physician and surgeon in the state of Washington when it fails to address conduct that is life threatening to the patient or others. Motivational enhancement, by definition, relies on the patient to gradually recognize the negative consequences of his conduct and slowly take action to change the conduct. When conduct threatens life or other major danger, the standard of care requires immediate action by the practitioner to protect the patient and others. The Respondent breached the standard of care by continuing to use only motivational enhancement therapy to address such conduct with Patient A.

Substance Abuse and Mental Health

1.28 A "dual diagnosis" is characterized both as a psychiatric condition, such as depression, and a substance abuse diagnosis. When information suggests the possibility of a dual diagnosis, the standard of care requires the practitioner to gather data to determine whether symptoms are resulting from substance abuse, a psychiatric condition, or both. The practitioner may accomplish this by interviewing the patient; making collateral contacts with the patient's family, friends, school, etc.; and under appropriate circumstances, requesting the patient be tested for use of substances.

1.29 Patient A presented to the Respondent with several issues, including possible depression and attempted suicide coupled with abuse of a seriously addictive narcotic, Oxycontin; a deteriorating family situation; continued experimentation with drugs and alcohol; and attendant legal problems arising from drug and alcohol use.

1.30 As part of the evaluations and treatment, the Respondent should have made a more exhaustive inquiry about Patient A's substance use and mental health issues, including pursuing drug testing and other investigation. The Respondent should have used this information to make a diagnosis about any underlying substance abuse and psychiatric conditions, including noting symptoms that may be caused by one or the other. The Respondent should then have formulated a treatment plan. The Respondent's evaluation and treatment did not adequately address the dual diagnosis issues presented by Patient A., and for that reason, the Respondent did not meet the standard of care.

Harm and Risk of Harm

1.31 The Respondent's failure to meet the standard of care in his evaluation and treatment of Patient A, created an unreasonable risk that Patient A would be harmed.

1.32 The dangers associated with Patient A's conduct included harm or death to Patient A due to driving under the influence of substances, harm or death to Patient A in the form of overdose, and harm or death to Patient A in the form of seizure or other serious withdrawal symptoms.

1.33 Had the Respondent properly conducted the evaluation and treatment of Patient A, including seeking drug testing, the extent of Patient A's substance abuse and mental health issues could have been detected and appropriate treatment interventions could have been put in place at the outset. Likewise, had the Respondent discontinued the use of motivational enhancement therapy to address the Respondent's life-threatening and dangerous conduct, offered ultimatums to Patient A, and disclosed necessary information to Patient A's parents, action could have been taken. As a result, Patient A would have been protected from overdosing and the other risks presented by his conduct.

1.34 The Respondent did not express remorse for this conduct.

II. CONCLUSIONS OF LAW

2.1 The Medical Quality Assurance Commission (Commission) has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.

2.2 The standard of proof in a **physican's** professional disciplinary hearing is clear and convincing evidence. ***Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), cert. denied, 535 U.S. 904 (2002).**

2.3 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

2.4 The Department proved with clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which states:

> (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 upon Findings of Fact 1.1 to 1.34, the Respondent's conduct did not meet the standard of care for a physician and surgeon in the state of Washington.

Sanctions

2.6 In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160. The sanction rules for unprofessional conduct contained in WAC 246-16-800 through 246-16-890 apply. The Respondent's conduct falls under WAC 246-16-810, tier B, applying to a violation of the standard of care causing a moderate to severe risk of patient harm. The sanction range contained in the rule adequately addresses the Respondent's conduct.

2.7 On January 29, 2007, a Findings of Fact, Conclusions of Law, and Final Order was entered by the Commission. The Commission found the Respondent committed unprofessional conduct and violated the standard of care due to boundary violations with a patient. The Commission fully reinstated the Respondent's credential on July 29, 2009. The Respondent's disciplinary history was considered for purposes of sanctions.

2.8 The aggravating factors in this case are: 1. prior Commission action; 2. multiple violations; 3. vulnerability of the victim; 4. conduct causing harm and potential for harm; and 5. lack of remorse. There are no mitigating factors.

2.9 Harm and potential for harm is the most significant aggravating factor. The primary duty of a physician and surgeon is protection of the patient. This duty trumps a practitioner's desire to protect patient confidentiality, maintain the therapeutic alliance, or use a particular method of treatment. The Respondent failed to uphold his duty. Based upon the aggravating factors, the sanctions should be placed at the higher end of the range of sanctions.

2.10 Based upon the findings of fact and conclusions of law, the Respondent's license to practice as a physician and surgeon should be placed on probation and conditions should be placed upon the Respondent's practice to ensure public protection.

III. ORDER

3.1 The Respondent's license to practice as a physician and surgeon in the state of Washington shall be placed on PROBATION for at least five years commencing

on the date of entry of this Order. During the course of probation, the Respondent shall comply with all of the following terms and conditions.

3.2 The Respondent shall pay a fine to the Commission in the amount of $5,000 within four months of the date of entry of this order.

3.3 The Respondent shall not provide treatment to adolescents with substance abuse/dependence issues where there is a pattern of use leading to significant problems or distress, and shall provide written notice of this restriction to his adolescent patients and their parents. The Respondent shall refer to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) for the definitions of "substance abuse" and "substance dependence." If such a substance abuse/dependence issue is revealed during treatment of an adolescent, the Respondent shall cease treatment, and refer the patient to another provider. The Respondent shall document in his treatment notes that the appropriate notice and referral was provided.

3.4 The Respondent shall work with a preceptor to create forms for appropriately documenting diagnosis, treatment plan, and progress. The preceptor shall be a medical doctor licensed in the state of Washington, board certified in the field of adolescent psychiatry, and approved by the Commission or its designee. The preceptor may not be an advanced registered nurse practitioner, a provider for which the Respondent shares office or professional space, an employee of the Respondent, or an individual for which the Respondent shares a financial interest.

3.5 The Respondent shall contact and enroll in the Center for Personalized Education for Physicians in Colorado (CPEP) within four months of the date of entry of this Order.

3.6 The Respondent must fully cooperate with the evaluation process and provide CPEP with any information, documents, or releases that are requested. CPEP will provide a written report and send it to the Commission or its designee regarding the evaluation, including recommendations for the scope and length of any additional evaluation or clinical training, or anything else affecting the Respondent's practice of medicine. The Respondent must satisfactorily complete all CPEP recommendations. The Respondent must provide CPEP with copies of this Order. The Commission may provide CPEP with excerpts from the application file. The Respondent will authorize CPEP to discuss with the Commission any matters relating to the Respondent's evaluation and compliance with recommendations. The Respondent will waive any privileges or privacy rights under federal and state law regarding disclosures to the Commission. The Respondent shall ensure that CPEP provides a copy of its evaluations and written reports to the Commission. CPEP shall communicate as necessary to keep the Commission informed of the Respondent's progress.

3.7 The Respondent shall appear before the Commission six months from the date of entry of this Order or as soon thereafter as the Commission's schedule permits, and shall present proof that he is complying with this Order. The Respondent shall continue to make such compliance appearances every 12 months or as frequently as the Commission otherwise requires, until the Respondent's license is fully reinstated.

3.8 The Respondent may not seek modification of this order for four years from the date of entry of this Order. The Respondent must, at that time, be prepared to provide proof of satisfactory compliance with the terms and conditions imposed in this Order. The Respondent must personally appear before the Commission at any such hearing. Upon notice and an opportunity for the Respondent to be heard, the Commission may impose additional conditions after reviewing the documents submitted and reviewing the Respondent's compliance with this Order.

3.9 The Respondent may not seek reinstatement of his license for five years from the date of this Order. The Respondent must, at that time, be prepared to provide proof of satisfactory compliance with the terms and conditions imposed in this Order. The Respondent must personally appear before the Commission at any such hearing. Upon notice and an opportunity for the Respondent to be heard, the Commission may impose additional conditions after reviewing the documents submitted and reviewing the Respondent's compliance with this Order.

3.10 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in his residential and/or business address within 30 days of such change.

3.11 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Order.

3.12 Failure to Comply. Protecting 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 and/or revocation of the Respondent's license

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. At that hearing, the Respondent must show cause why his license 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 given notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 11th day of June. 2013.

Medical Quality Assurance Commission

ATHALIA CLOWER, PA-C,
Panel Chair

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 or national reporting requirements. If discipline 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:

Department of Health Medical Program
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of 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, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3). The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx