STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

FILED
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Adjudicative Clerk Office

In the Matter of the License to Practice as a Physician and Surgeon of: **ROBERT I. FINK, MD** License No. MD00016904 Respondent.	**No. M2016-712** **STATEMENT OF ALLEGATIONS AND SUMMARY OF EVIDENCE**

The Executive Director of the Medical Quality Assurance Commission (Commission), on designation by the Commission, makes the allegations below, which are supported by evidence contained in Commission file number 2015-9663. The patients referred to in this Statement of Allegations and Summary of Evidence are identified in the attached Confidential Schedule.

1. ALLEGATIONS

1.1 On September 12, 1978, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

1.2 Respondent is a psychiatrist who became socially involved with Patients A, B and C. Respondent first met Patient C who later referred Patients A and B, a couple, to do various repair jobs on his properties. Because of Respondent's personal relationships with Patients A, B, and C, Respondent violated the standard of care by also serving as their medical provider.

Boundary violations with Patient A

1.3 Respondent began treating Patient A in 2007. Respondent thought he could maintain confidentiality and objectivity in his treatment of Patient A while maintaining a personal relationship.

1.4 Patient A is diagnosed with attention deficit hyperactivity disorder (ADHD) and has a history of substance abuse. Respondent dismissed several indications that Patient A was still abusing substances, including her openly admitting that she misused substances. Patient A and Respondent corresponded via email.

1.5 In 2011, Respondent allowed Patients A and B to move into his home. Subsequently, Respondent and Patient A entered a sexual relationship. Patient A performed repair work on Respondent's home and Respondent and Patient A went to

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the casino together. Respondent took Patient A to the railroad tracks where he took photographs of her posing in a costume.

1.6 In 2015, Respondent terminated his relationship with Patient A to move to New Zealand for work. Both Patients A and B moved out of Respondent's home and no longer work for him.

Inappropriate treatment and prescribing practices

1.7 Respondent prescribed Patients A, B, and C medications generally used to treat chronic non-cancer pain. Respondent failed to consult with or refer Patients A, B, and C to a pain management specialist. At no time did Respondent attempt to properly evaluate pain levels, establish a treatment plan, document that he discussed the risks and benefits of treatment, and failed to document treatment alternatives prior to prescribing opioid pain medication.

1.8 In his first letter to the Commission, Respondent stated that he thought it might be all right to treat friends on occasion but later realized that he was unable to manage their health care needs appropriately, and as intended.

2. SUMMARY OF EVIDENCE

2.1 Patient records contained in file 2015-9663.

2.2 Respondent's statement to the Commission, dated November 24, 2015.

2.3 Commission investigator's memorandum to file documenting interview of Patient A, dated January 29, 2016.

2.4 Thumb drive supplied by Patient A, through her counsel, containing photocopies of the photographs that Respondent took of her.

2.5 Respondent's statement to the Commission, dated May 13, 2016.

3. ALLEGED VIOLATIONS

3.1 The facts alleged in Section 1, if proven, would constitute unprofessional conduct in violation of RCW 18.130.180 (1), (4), (7), (11), and (24); WAC 246-919-630; and WAC 246-919-853-857, -860, which provide in part:

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RCW 18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

...

(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;

...

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

...

(11) Violations of rules established by any health agency;

...

(24) Abuse of a client or patient or sexual contact with a client or patient;

... .

WAC 246-919-630 Sexual misconduct.
(1) The following definitions apply throughout this section unless the context clearly requires otherwise.
(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.
(b) "Physician" means a person licensed to practice medicine and surgery under chapter 18.71 RCW.

(c) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.
(2) A physician shall not engage in sexual misconduct with a current patient or a key third party. A physician engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party:
(a) Sexual intercourse or genital to genital contact;
(b) Oral to genital contact;
(c) Genital to anal contact or oral to anal contact;
(d) Kissing in a romantic or sexual manner;
(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;
(f) Examination or touching of genitals without using gloves;
(g) Not allowing a patient the privacy to dress or undress;
(h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;
(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;
(j) Soliciting a date;
(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the physician.
(3) A physician shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the physician:
(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or
(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.
...
(5) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors, including, but not limited to, the following:
(a) Documentation of formal termination;
(b) Transfer of the patient's care to another health care provider;
(c) The length of time that has passed;
(d) The length of time of the professional relationship;
(e) The extent to which the patient has confided personal or private information to the physician;
(f) The nature of the patient's health problem;
(g) The degree of emotional dependence and vulnerability.
(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.
(7) It is not a defense that the patient, former patient or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(8) A violation of any provision of this rule shall constitute grounds for disciplinary action.

WAC 246-919-853 Patient evaluation. The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.

(1) The patient's health history shall include:
(a) Current and past treatments for pain;
(b) Comorbidities; and
(c) Any substance abuse.
(2) The patient's health history should include:
(a) A review of any available prescription monitoring program or emergency department-based information exchange; and
(b) Any relevant information from a pharmacist provided to a physician.
(3) The initial patient evaluation shall include:
(a) Physical examination;
(b) The nature and intensity of the pain;
(c) The effect of the pain on physical and psychological function;
(d) Medications including indication(s), date, type, dosage, and quantity prescribed;
(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:
(i) History of addiction;
(ii) Abuse or aberrant behavior regarding opioid use;
(iii) Psychiatric conditions;
(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;
(v) Poorly controlled depression or anxiety;
(vi) Evidence or risk of significant adverse events, including falls or fractures;
(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;
(viii) Repeated visits to emergency departments seeking opioids;
(ix) History of sleep apnea or other respiratory risk factors;
(x) Possible or current pregnancy; and
(xi) History of allergies or intolerances.
(4) The initial patient evaluation should include:
(a) Any available diagnostic, therapeutic, and laboratory results; and
(b) Any available consultations.
(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:
(a) The diagnosis, treatment plan, and objectives;
(b) Documentation of the presence of one or more recognized indications for the use of pain medication;
(c) Documentation of any medication prescribed;
(d) Results of periodic reviews;

(e) Any written agreements for treatment between the patient and the physician; and
(f) The physician's instructions to the patient.

WAC 246-919-854 Treatment plan.
(1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall include, at a minimum:
(a) Any change in pain relief;
(b) Any change in physical and psychosocial function; and
(c) Additional diagnostic evaluations or other planned treatments.
(2) After treatment begins the physician should adjust drug therapy to the individual health needs of the patient. The physician shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The physician shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.
(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

WAC 246-919-855 Informed consent. The physician shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

WAC 246-919-856 Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing physician shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:
(1) The patient's agreement to provide biological samples for urine/serum medical level screening when requested by the physician;
(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;
(3) Reasons for which drug therapy may be discontinued (e.g., violation of agreement);
(4) The requirement that all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;
(5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
(6) A written authorization for:
(a) The physician to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies; and
(b) Other practitioners to report violations of the agreement back to the physician;

(7) A written authorization that the physician may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;
(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;
(9) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and
(10) Acknowledgment that if the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

WAC 246-919-857 Periodic review. The physician shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.
(1) During the periodic review, the physician shall determine:
(a) Patient's compliance with any medication treatment plan;
(b) If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers; and
(c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards treatment objectives.
(2) The physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The physician shall consider tapering, changing, or discontinuing treatment when:
(a) Function or pain does not improve after a trial period;
(b) There is evidence of significant adverse effects;
(c) Other treatment modalities are indicated; or
(d) There is evidence of misuse, addiction, or diversion.
(3) The physician should periodically review information from any available prescription monitoring program or emergency department-based information exchange.
(4) The physician should periodically review any relevant information from a pharmacist provided to the physician.

WAC 246-919-860 Consultation—Recommendations and requirements.
(1) The physician shall consider, and document the consideration, referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care,

monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.
(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED)(oral). In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-919-863 is required, unless the consultation is exempted under WAC 246-919-861 or 246-919-862. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.
(a) The mandatory consultation shall consist of at least one of the following:
(i) An office visit with the patient and the pain management specialist;
(ii) A telephone consultation between the pain management specialist and the physician;
(iii) An electronic consultation between the pain management specialist and the physician; or
(iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist.
(b) A physician shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the physician, the physician shall maintain it as part of the patient record.
(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-919-850 through 246-919-863, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

4. NOTICE TO RESPONDENT

4.1 The Commission has determined that this case may be appropriate for resolution through a Stipulation to Informal Disposition pursuant to RCW 18.130.172(2). A proposed Stipulation to Informal Disposition is attached, which contains the disposition the Commission believes is necessary to address the conduct alleged in this Statement of Allegations and Summary of Evidence.

4.2 If Respondent agrees that the disposition imposed by the Stipulation to Informal Disposition is appropriate, Respondent should sign and date the Stipulation to Informal Disposition and return it within fourteen (14) days to the Medical Quality Assurance Commission at P.O. Box 47866, Olympia, Washington 98504-7866.

4.3 If Respondent does not agree that the terms and conditions contained in the Stipulation to Informal Disposition are appropriate, Respondent should contact Seana Reichold, Staff Attorney for the Medical Quality Assurance Commission, P.O. Box 47866, Olympia, Washington 98504-7866, (360) 236-2791 within fourteen (14) days.

4.4 If Respondent does not respond within fourteen (14) days, the Commission will assume Respondent has declined to resolve the allegations by means of a Stipulation to Informal Disposition.

4.5 If Respondent declines to resolve the allegations by means of a Stipulation to Informal Disposition pursuant to RCW 18.130.172(2), the Commission may proceed to formal disciplinary action against Respondent by filing a Statement of Charges, pursuant to RCW 18.130.172(3).

4.6 The cover letter enclosed with this Statement of Allegations and Summary of Evidence was mailed to the name and address currently on file for Respondent's license. Respondent must notify, in writing, the Commission if Respondent's name and/or address changes.

DATED: September 20, 2016.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE
COMMISSION

Melanie de Leon

MELANIE DE LEON
EXECUTIVE DIRECTOR

SMReichold

SEANA M. REICHOLD, WSBA# 49163
COMMISSION STAFF ATTORNEY

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CONFIDENTIAL SCHEDULE

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

Patient A

Patient B

Patient C

[redacted]

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **ROBERT I. FINK, MD** License No. MD00016904 Respondent.	**No. M2016-712** **STIPULATION TO INFORMAL DISPOSITION**

Pursuant to the Uniform Disciplinary Act, Chapter 18.130 RCW, the Medical Quality Assurance Commission (Commission) issued a Statement of Allegations and Summary of Evidence (Statement of Allegations) alleging the conduct described below. Respondent does not admit any of the allegations. This Stipulation to Informal Disposition (Stipulation) is not formal disciplinary action and shall not be construed as a finding of unprofessional conduct or inability to practice.

1. ALLEGATIONS

1.1 On September 12, 1978, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

1.2 Respondent is a psychiatrist who became socially involved with Patients A, B and C. Respondent first met Patient C who later referred Patients A and B, a couple, to do various repair jobs on his properties. Because of Respondent's personal relationships with Patients A, B, and C, Respondent violated the standard of care by also serving as their medical provider.

Boundary violations with Patient A

1.3 Respondent began treating Patient A in 2007. Respondent thought he could maintain confidentiality and objectivity in his treatment of Patient A while maintaining a personal relationship.

1.4 Patient A is diagnosed with attention deficit hyperactivity disorder (ADHD) and has a history of substance abuse. Respondent dismissed several indications that Patient A was still abusing substances, including her openly admitting that she misused substances. Patient A and Respondent corresponded via email.

1.5 In 2011, Respondent allowed Patients A and B to move into his home. Subsequently, Respondent and Patient A entered a sexual relationship. Patient A

performed repair work on Respondent's home and Respondent and Patient A went to the casino together. Respondent took Patient A to the railroad tracks where he took photographs of her posing in a costume.

1.6 In 2015, Respondent terminated his relationship with Patient A to move to New Zealand for work. Both Patients A and B moved out of Respondent's home and no longer work for him.

Inappropriate treatment and prescribing practices

1.7 Respondent prescribed Patients A, B, and C medications generally used to treat chronic non-cancer pain. Respondent failed to consult with or refer Patients A, B, and C to a pain management specialist. At no time did Respondent attempt to properly evaluate pain levels, establish a treatment plan, document that he discussed the risks and benefits of treatment, and failed to document treatment alternatives prior to prescribing opioid pain medication.

1.8 In his first letter to the Commission, Respondent stated that he thought it might be all right to treat friends on occasion but later realized that he was unable to manage their health care needs appropriately, and as intended.

2. STIPULATION

2.1 The Commission alleges that the conduct described above, if proven, would constitute a violation of RCW 18.130.180 (1), (4), (7), (11), and (24); WAC 246-919-630; and WAC 246-919-853-857, -860.

2.2 The parties wish to resolve this matter by means of a Stipulation pursuant to RCW 18.130.172(1).

2.3 Respondent agrees to be bound by the terms and conditions of this Stipulation.

2.4 This Stipulation is of no force and effect and is not binding on the parties unless and until it is accepted by the Commission.

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

2.6 The Statement of Allegations and this Stipulation are public documents. They will be placed on the Department of Health web site, disseminated via the

Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). They are subject to disclosure under the Public Records Act, Chapter 42.56 RCW, and shall remain part of Respondent's file according to the state's records retention law and cannot be expunged.

2.7 The Commission agrees to forego further disciplinary proceedings concerning the allegations.

2.8 Respondent agrees to successfully complete the terms and conditions of this informal disposition.

2.9 A violation of the provisions of Section 3 of this Stipulation, if proved, would constitute grounds for discipline under RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

3. INFORMAL DISPOSITION

Based on the Allegations made in Section 1 of this Stipulation, the Commission and Respondent stipulate to the following terms:

3.1 **Voluntary Surrender.** Respondent is retiring from the practice of medicine and agrees to voluntarily surrender his license to practice as a physician and surgeon and agrees not to resume the practice of medicine in the state of Washington, including any temporary, emergency, or volunteer practice. This voluntary surrender is permanent and is effective on the effective date of this Stipulation described below. Respondent acknowledges that he is ineligible to renew, reactivate, or to practice subject to a retired active license as a physician and surgeon in the state of Washington.

3.2 **Return of License.** Respondent agrees to immediately return his wallet license card and wall license certificate, if they exist, to:

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

3.3 **Effective Date of Order.** The effective date of this Stipulation is the date the Adjudicative Clerk Office places the signed Stipulation into the U.S. mail.

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4. COMPLIANCE WITH SANCTION RULES

4.1 The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. WAC 246-16-800(2)(b)(iii) provides that surrender of a license may be imposed when the license holder is at the end of his or her effective practice and surrender alone is enough to protect the public. Respondent is at the end of his effective practice as a physician and surgeon. Voluntary surrender of Respondent's license to practice as a physician and surgeon with no right to reinstate or re-apply is sufficient to protect the public.

5. RESPONDENT'S ACCEPTANCE

I, ROBERT I. FINK, MD, Respondent, certify that I have read this Stipulation in its entirety; that my counsel of record, DONNA M. MONIZ, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Commission without my appearance. If the Commission accepts the Stipulation, I understand that I will receive a signed copy.

Robert I Fink MD
ROBERT I. FINK, MD
RESPONDENT

21 September 2016
DATE

DONNA M. MONIZ, WSBA# 12762
ATTORNEY FOR RESPONDENT

9-22-16
DATE

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6. COMMISSION'S ACCEPTANCE

The Commission accepts this Stipulation. All parties shall be bound by its terms and conditions.

DATED: October 7, 2016.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE
COMMISSION

PANEL CHAIR

PRESENTED BY:

SEANA M. REICHOLD, WSBA# 49163
COMMISSION STAFF ATTORNEY

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