STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: John P. Haws, MD
Master Case No.: M2017-529
Document: Statement of Charges

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:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

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
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: JOHN P. HAWS, MD License No. MD.MD.00015553 Respondent.	No. M2017-529 STATEMENT OF CHARGES

The executive director of the Washington Medical Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in file numbers 2016-12520 and 2017-5188. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On November 1, 1976, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is board certified in psychiatry. Respondent's license is currently active.

1.2 Respondent provided psychiatric services for Patients A, B, C, D, E, and F. Respondent's records include many handwritten notes that are illegible.

1.3 Respondent failed to include any documentation for many patient sessions.

1.4 Respondent failed to document patients' psychiatric status in many of the sessions.

1.5 Respondent failed to document many prescriptions of medications.

1.6 Respondent failed to document the rationale for prescribing medications or dosage changes in many sessions.

1.7 Respondent failed to document assessments, treatment plans, and responses to medications.

1.8 Respondent prescribed opioids to Patients A and B without appropriately documenting all prescriptions in the medical record or complying with the pain management rules that were in effect during the time of the sessions as found in WAC 246-919-850 through -863.

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Case no. 2016-12520

Patient A

1.9 Respondent provided psychiatric services for Patient A from July 2013 through at least March 2017. Patient A struggled with depression, anxiety, and chronic pain. Patient A told Respondent she previously had cirrhosis and had been in substance use treatment programs in the past.

1.10 For the first session with Patient A on July 15, 2013, there is no documentation in the medical record of an initial psychiatric evaluation or any of the basic elements of a standard initial psychiatric evaluation.

1.11 Respondent told the Commission investigator that he saw Patient A approximately every three to four months subsequent to July 2013. Based on Respondent's statement to that effect, a significant number of sessions are not documented in the medical record. Some of the medical record consists of copies of prescriptions that Respondent wrote for Patient A but copies of prescriptions by themselves do not constitute acceptable documentation of treatment sessions.

1.12 Sessions that are documented in the medical record have inadequate documentation, including inadequate interval histories, inadequate mental status assessments, inadequate details of responses to medications, and inadequate assessments for medication side effects.

1.13 Based on a copy of a prescription and the Washington Prescription Monitoring Program's (PMP) report, beginning in December 2013, Respondent wrote a prescription for Hydrocodone APAP 5/500 with five refills. Respondent prescribed Patient A Hydrocodone APAP until at least September 2016. However, the medical record contains no documentation, other than a copy of a prescription of when Respondent initiated prescribing opioid medication for Patient A, and the rationale for doing so. Respondent's communication with the Commission did address these items but they are not documented in the medical record. In conjunction with the absence of medical record documentation of the initiation of opioid treatment, there is no documentation in the medical record of a patient evaluation for pain management, a pain management treatment plan, or informed consent for opioid medication. There is also no documentation that Respondent checked the PMP report for Patient A before prescribing opioid medication for her.

1.14 There is no documentation in the medical record of a risk-benefit analysis of prescribing a medication containing acetaminophen for a patient who reported a history of cirrhosis, even if the condition is asymptomatic or no longer active. There is no documentation of an appropriate work-up or referral to an appropriate specialist to rule out active cirrhosis or any hepatic impairment prior to prescribing an acetaminophen-containing medication.

1.15 On September 28, 2016, Patient A presented to a pharmacy to pick up a prescription for Hydrocodone/Acetaminophen 5-325 Respondent wrote for her. The pharmacy asked Respondent for clarification and diagnosis when they believed Patient A had cirrhosis and presented smelling of alcohol. Respondent told the pharmacy that Patient A had not been drinking and was determined to not have cirrhosis by a Washington State Department of Labor & Industries (L&I) medical specialist but provided no documentation to support this.

1.16 In a subsequent session on March 14, 2017, Respondent and Patient A discussed the September 28 incident at the pharmacy. Respondent documented that Patient A claimed she "was not drunk" and had "years of sobriety" which conflicts with another note from the same visit that Patient A had only "five months of sobriety." Respondent also commented that there was a question of cirrhosis in the past and it would progress if the patient was not sober. This comment contradicts his representation to the pharmacist and to the Commission that Patient A did not have cirrhosis.

1.17 There is no documentation that Respondent checked the PMP report for Patient A during the time that he continued to prescribe opioid medication for her.

1.18 There is no documentation of a risk-benefit analysis of prescribing a benzodiazepine in conjunction with an opioid.

Patient B

1.19 Respondent provided psychiatric services for Patient B from October 2013 through at least March 2017. Patient B was referred by L&I with a history of disc herniation, degenerative spine disease, and multiple surgeries. He also presented with PTSD, major depression, and anxiety. He claimed to be permanently disabled as a result of a work injury he sustained in 2012. The medical record demonstrates ongoing

disagreements between various physician evaluators, L&I, and Respondent regarding whether Patient B's spinal pathology and psychiatric conditions were work related.

1.20 For the first session with Patient B in April 2013, there is no documentation in the medical record of the date of that first session and there is no documentation in the medical record of an initial psychiatric evaluation or any of the basic elements of a standard initial psychiatric evaluation.

1.21 Respondent's records for Patient B date back to late 2015. Respondent's notes to L&I indicate Patient B's visits on December 9 and 16, 2015, February 24, 2016, and March 1, 2016, were session numbers 99, 100, 108, and 109. This implies that a significant number of sessions are not documented in the medical record.

1.22 Sessions that are documented in the medical record have inadequate documentation, including inadequate interval histories, inadequate mental status assessments, inadequate details of responses to medications, and inadequate assessments for medication side effects. Respondent's notes consist mostly of disagreements and complaints about L&I and, for the most part, do not include psychiatric status and treatment of Patient B.

1.23 The PMP report shows prescriptions by Respondent for Patient B of oxycodone between September 2014 and May 2015, and of morphine between September 2014 and April 2015. However, there is no documentation in the medical record of the initiation of and ongoing prescription of opioid medication for Patient B or of the rationale of opioid treatment. Respondent's communication with the Commission did address these items but they are not documented in the medical record. In addition, there is no documentation in the medical record of a patient evaluation for pain management, a pain management treatment plan, or informed consent for opioid medication. There is no documentation that Respondent checked the PMP report for Patient B before prescribing opioid medication for him.

1.24 There is no documentation of a risk-benefit analysis before prescribing morphine simultaneously with oxycodone.

1.25 There is no documentation of a risk-benefit analysis of prescribing a benzodiazepine in conjunction with two opioids.

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1.26 There is no documentation in the medical record of the dose per pill, number of doses per day, or number of pills prescribed for some medications, e.g. Vyvanse and lorazepam.

1.27 There is no documentation at all in the medical record of some medications that, according to the PMP report, Respondent prescribed for Patient B, e.g. Adderall, Ritalin, Lyrica, and some benzodiazepines.

1.28 There is no documentation that Respondent checked the PMP report for Patient B during the time that he continued to prescribe opioid medication for him.

Case no. 2017-5188

Patients C, D, E, and F

1.29 Respondent's records include many handwritten notes that are illegible.

1.30 Respondent failed to include any documentation for many patient sessions.

1.31 Respondent failed to document patient psychiatric status in many of the sessions.

1.32 Respondent failed to document some prescriptions of medications.

1.33 Respondent failed to document the rationale for prescribing medications, or the rationale for prescribing combinations of medications with potentially additive or deleterious effects, or the rationale for changing doses of medications in many of the sessions.

1.34 Respondent frequently used his chart notes to express dissatisfaction with L&I or to give the claims manager directions. The use of the patient records for this purpose and the manner of documentation was so far below the customary level of professional documentation expected of a medical professional that it could harm the standing of the profession. Examples of this are as follows:

A. A chart note of July, 2016 regarding Patient A which states, "Plan of care: 'to have L&I sanctioned.'"

B A chart note for Patient F in May 2016 which states, "It has become quite evident that L&I is trying to block the diagnosis of PTSD despite the claimant's evidence of PTSD. This is certainly the case with [Patient F]. Why such inhumane actions?!" Another chart note of June, 2016 regarding Patient F which states, "Why do you not

respond to [Patient F]'s needs – do you really care? Are you trying to force him to a lawyer? Are you trying to stop his therapy?"

C. A chart note of August, 2015 regarding Patient C which states, "Session #5 – I find it totally counter to this man's mental health to have stopped some of his medications and not alerted me. It is vital that [Patient C] take citalopram 40 mg QD, clonazepam 1 mg TID and Ambien for sleep 10mg QHS. He was told these are narcotics and they are NOT! I request a state evaluation of his recommendations if these are not immediately authorized by L&I."

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), (7), (13), (22) and WAC 246-919-853 through -857, -860, and 863.

> **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:
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> ...
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> (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 or applicant 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;
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> ...
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> (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;
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> ...
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> (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;
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> ...
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> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

...

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

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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.

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(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);

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(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 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.

WAC 246-919-863 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:
(1) If a physician or osteopathic physician:
(a) Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or

(b) Has a subspecialty certificate in pain medicine by an ABMS-approved board; or
(c) Has a certification of added qualification in pain management by the AOA; or
(d) A minimum of three years of clinical experience in a chronic pain management care setting; and
(i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and
(ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for physicians or three years for osteopathic physicians; and
(iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.
(2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.
(3) If an advanced registered nurse practitioner (ARNP):
(a) A minimum of three years of clinical experience in a chronic pain management care setting;
(b) Credentialed in pain management by the Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity;
(c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and
(d) At least thirty percent of the ARNP's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic
(4) If a podiatric physician:
(a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or
(b) A minimum of three years of clinical experience in a chronic pain management care setting; and
(c) Credentialed in pain management by the Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity; and
(d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

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3. NOTICE TO RESPONDENT

The charges in this document affect the public health and safety. The executive director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: June 4, 2020.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

Melanie de Leon

MELANIE DE LEON
EXECUTIVE DIRECTOR

ROBERT W. FERGUSON
ATTORNEY GENERAL

Kristin G Brew

KRISTIN G. BREWER, WSBA# 38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

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

Patient A

Patient B

Patient C

Patient D

Patient E

Patient F