A hearing was held in this matter on May 28-29, 2015, regarding allegations of unprofessional conduct. DISMISSED.

ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(4).

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

At the hearing, the Department presented the testimony of:
the Respondent as an adverse witness; Dr. Michael S. Kennedy, M.D.; and
Dr. Alex De Moraes, M.D.

The Respondent testified in his own defense and also presented the testimony
of: Dr. Alan McDaniel, M.D., and Dr. Timothy Guilford, M.D., witness by telephone.

The Presiding Officer admitted the following Department exhibits:

Exhibit D-1: Curriculum Vitae of Dr. Michael S. Kennedy, M.D.
Exhibit D-3: Complaint regarding Patient A and B, dated November 1, 2012.
Exhibit D-6: The Respondent's Statement regarding Treatment of Patient A.
Exhibit D-7: Patient A's Medical Records from the Respondent.
Exhibit D-8: Patient A's Medical Records from Dr. Kennedy.
Exhibit D-9: Patient A's Medical Records from Overlake Medical Clinic.
Exhibit D-11: The Respondent's Statement regarding Treatment of Patient B.
Exhibit D-12: Patient B's Medical Records from the Respondent.
Exhibit D-13: Patient B's Medical Records from Overlake Medical Clinic.

The Presiding Officer admitted the following Respondent exhibits:


Exhibit R-4: Sfakianakas A. Allergic fungal rhinosinusitis is the most common form of fungal sinus disease. Treatment with topical fluconazole as either a nasal spray or irrigation solution can significantly reduce recurrence of this condition. Ear, Nose, & Throat Journal 90 (8), E1-7 (Aug. 2011).


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 November 9, 1978. At one point, the Respondent was board-certified in family medicine, but that lapsed and he was not recertified. The Respondent has also received training in environmental medicine, and practices at The Northwest Center for Environmental Medicine in Redmond, Washington. The Respondent's physician license is currently active.

1.2 On August 23, 2012, the Respondent diagnosed Patient A with illness due to mold exposure. On July 9, 2012, the Respondent diagnosed Patient B with illness due to mold exposure. The Respondent ordered testing and prescribed non-antifungal medications with limited or no success. While the Respondent's treatment may not
have been beneficial to Patient A and B, these medications did not place the patients at risk of harm and did not harm the patients.

1.3 Patient A saw the Respondent only twice in August 2012, while Patient B saw the Respondent four times over a six-week period beginning July 9, 2012. The Respondent testified there was little remarkable about his treatment of either patient. Neither patient was unique given that the Respondent has many patients with similar ailments and similar protocols that suffer from unknown ailments running the gamut from chronic fatigue, suspected effects from mold exposure, and allergies. No other patient's records were part of the Commission's analysis of the standard of care in this matter.

1.4 Patient A and B presented to the Respondent after significant, unsuccessful treatments by other providers and institutions.

*Patient A*

1.5 Patient A had experienced burning nose, ears, and throat and the sensation of throat swelling after visiting a basement storage locker in a condominium; gone to an ER; been successfully treated with antibiotics and Prednisone; then returned to the storage locker with symptoms recurring. More visits to the ER and a Computed Tomography (CT scan); experiences of vertigo; a trip to an ear, nose, and throat clinic; swollen lymph nodes, neck pain, and headaches; and an environmental assessment of the locker followed, all of that preceding Patient A's first encounter with the Respondent on August 2, 2012. The Respondent listed Patient A's ailments as sinusitis, headaches, hypersensitivity, and environmental exposure—probably mold. The Commission finds
that the Respondent did perform a physical examination, although no entry was made in
the patient's file. The Respondent ordered a 24 hour-urine mycotoxin test. Before
obtaining the results, the Respondent started Patient A on antifungal
medications (Amphotericin B) based on Patient A suffering from yeast vaginitis and
fungal sinusitis. The medications were given as a treatment trial. The Respondent saw
Patient A only one more time, on August 13, 2012, at which time the patient was
described as “doing better.”

1.6 The Statement of Charges alleges the treatment of Patient A was below
the standard of care in his treatment of the patient for a “systemic fungal infection
without support of objective data such as a physical exam and culture.” The
Respondent presented expert testimony on the appropriateness and efficacy of
amphotericin when administered nasally and orally and, given the way Patient A
presented to the Respondent with multiple ailments of unknown origin that could be
related to mold and fungal infection, the Commission is unable to conclude that the
attempts by the Respondent in the two Patient A visits violated the standard of care in
Washington. The Commission finds there is insufficient evidence to find negligence,
malpractice, incompetence re: Patient A. The Commission finds that the trial treatment
plan did not create an unreasonable risk of harm to the patient.

---

1 Mycotoxin is a toxin produced by a fungus.
2 Amphotericin B is an antibiotic derived from strains of the actomycete Streptomtces nodosus and used
in treating systemic fungal infection.
Patient B

1.7 Patient B was a more complex problem and is now under the care of Dr. Alex De Moraes. Patient B still suffers from a continuing malady. Prior to Patient B’s first encounter with the Respondent on July 9, 2012, she had seen her primary care provider on six occasions. She had been evaluated by various experts for a multitude of medical conditions without any significant findings or effective treatment.

1.8 Patient B presented to the Respondent on April 18, 2012. She complained of insomnia, fatigue, decreased concentration, isolating herself, being irritable, increased crying, and elevated blood pressure. The Respondent’s day-to-day and week-to-week details in June 2012 show Patient B suffering from chest pain, breathing issues, pain in anterior neck, hoarse voice, and sweats at night, resulting in an EKG, a chest x-ray, a chest CT scan, and a cardiac work-up. These tests were all negative.

1.9 The Respondent diagnosed Patient B with an illness due to mold exposure. The diagnosis was indicated by Patient B’s well-documented clinical history, allergy test results, and laboratory confirmation of toxic exposure to mold in water-damaged buildings. The Respondent’s treatment program included having Patient B move out of her home and office due to environmental exposure to mold; checking the urine myotoxin level; comprehensive stool analysis to include culture for
fungus and venous blood gases; and prescribing cholestyramine to bind mycotoxins, oxygen therapy, and Itraconazole.

1.10 At Patient B’s July 26, 2012 appointment, she was not doing well. The Respondent subsequently recommended enhanced external counter pulsation (EECP Therapy). The EECP Therapy administered by the Respondent to Patient B is “off-label” in that EECP treatment is a Food and Drug Administration (FDA) approved mechanism generally used for angina and heart failure to increase oxygen delivery to the tissues. The Respondent believes that EECP, administered in his office as he owns the system/mechanism that the patient is hooked-up to, may be helpful for a variety of illnesses unrelated to cardiac disease, such as chronic fatigue syndrome. However, this treatment regime is very unusual and not proven. The Respondent charges up to $200 per session, though Patient B received multiple sessions at $100 per treatment. None of the Respondent or the Department’s experts in this matter had heard of EECP treatment being used for treating patients like the Respondent’s Patient B for suspected issues with mold or chronic fatigue. The results/readings of the EECP treatments for Patient B were not part of the record in this case. The Respondent himself could not opine why he thought EECP “worked” for his patients. The Commission is skeptical of any efficacy for EECP treatment, but is unable to

---

3 Venous blood is blood that has passed through the capillaries of various tissues other than the lungs and is found in the veins, in the right chamber of the heart, and in pulmonary arteries.

4 Itraconazole is a blood-spectrum antifungal administered orally to treat systemic fungal infections and onychomycosis.
conclude that using EECP in a practice like the Respondent's that, by its nature, is dealing with alternative treatment possibilities for patients such as A and B that present with mold and fungal related illnesses, constitutes unprofessional conduct under the facts presented.

1.11 The Commission is also concerned that the Respondent has a practice of ordering potentially unnecessary and certainly unusual laboratory tests. Specifically, the Respondent ordered venous blood gas assays for Patient B to verify his claim that the patient was suffering hypoxia, and subsequent acidosis, at the cellular level. There are much more common blood tests that could have been utilized and that could have provided more valuable information, but the Respondent chose not to use them. Separately, the Respondent, without reasonable justification, ordered costly, intermittent home oxygen therapy for Patient B. Although the Commission is permitted to use, and did use, its experience, competency, and specialized knowledge in its findings and conclusions in this matter (RCW 34.05.461(5)), and therefore has significant doubt on the efficacy of some of these practices and testing by the Respondent, the Respondent's use of non-traditional treatment does not amount to unprofessional conduct. Neither the Department's nor the Respondent's experts felt comfortable opining on these two approaches (venous blood gas and home oxygen).

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.
2.2 The Washington Supreme Court has held the standard of proof in
disciplinary proceedings against physicians is proof by clear and convincing evidence.

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

2.4 Based upon the above Findings of Fact, Paragraphs 1.1 through 1.11, the
Commission concludes that the Department failed to prove by clear and convincing
evidence that the Respondent committed unprofessional conduct as defined in
RCW 18.130.180(4), which states:

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
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;

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, this case is
DISMISSED.

Dated this 26 day of June, 2015.

Medical Quality Assurance Commission

MICHAEL CONCANNON, J.D.
Panel Chair