APPENDIX A

THE SUPREME COURT OF WASHINGTON

No. 97880-8

Court of Appeals
Case No. 78910-4-I

[Filed: March 4, 2020]

HUNG DANG, M.D.,	)
Petitioner,	)
v.	)
WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,	)
Respondent.	)

ORDER

Department II of the Court, composed of Chief Justice Stephens and Justices Madsen, Wiggins, Gordon McCloud, and Montoya-Lewis, considered at its March 3, 2020, Motion Calendar whether review should be granted pursuant to RAP 13.4(b) and unanimously agreed that the following order be entered.

IT IS ORDERED:

That the petition for review is denied and the Clerk's motion to strike the reply to the answer to the petition for review is granted.

DATED at Olympia, Washington, this 4th day of March, 2020.

For the Court

/s/_____
CHIEF JUSTICE

APPENDIX B

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON DIVISION ONE

Case No. 78910-4-I

[Filed: August 19, 2019]

HUNG DANG, M.D.,

Appellant,

v.

Judicial Review Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

UNPUBLISHED OPINION

SCHINDLER, J. — Hung Dang, MD appeals the superior court order affirming the decision of the Washington State Department of Health Medical Quality Assurance Commission (MQAC). MQAC concluded Dr. Dang committed unprofessional conduct

in violation of the Uniform Disciplinary Act, chapter 18.130 RCW; ordered oversight of his license; and imposed at $5,000 fine. We affirm the amended MQAC decision and final order.

On Call at St. Joseph Medical Center

Dr. Hung Dang is an otolaryngologist, specializing in the treatment of the ear, nose, and throat (ENT). Dr. Dang works at Group Health Cooperative[1] in Tacoma. As a condition of his employment with Group Health, Dr. Dang maintains staff privileges and works as an on-call emergency ENT specialist at St. Joseph Medical Center in Tacoma. St. Joseph is one of several hospitals in the CHI Franciscan Health System and is a level II trauma center. The CHI Franciscan Health System is a nonprofit corporation dedicated to providing healthcare consistent with Catholic Health Initiatives. The other hospitals include St. Francis Hospital in Federal Way, St. Clare Hospital in Lakewood, St. Anthony Hospital in Gig Harbor, and St. Elizabeth Hospital in Enumclaw.

Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, requires hospitals to treat patients that need emergency care. The purpose of EMTALA is to ensure that individuals receive adequate emergency medical care regardless of ability to pay. Jackson v. E. Bay Hosp., 246 F.3d 1248, 1254 (9th Cir. 2001). Under EMTALA, a hospital must

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[1] We note Kaiser Permanente acquired Group Health in 2017. We use "Group Health" throughout the opinion.

provide appropriate emergency medical care or transfer the patient to another medical facility. 42 U.S.C. § 1395dd(b)(1).

An on-call physician may not refuse to provide medical care and treat a patient properly transferred by an emergency room (ER) physician. 42 U.S.C. § 1395dd(d)(1)(B). Under 42 U.S.C. § 1395dd(d)(1)(B), a physician "is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on call for the care of such an individual." A hospital that can provide specialized care may not refuse to accept an appropriate transfer from a referring hospital if the receiving hospital has the capacity to treat the patient. 42 U.S.C. § 1395dd(g), (c)(2)(8). A transfer to a medical facility is appropriate if "the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health," the receiving facility "has available space and qualified personnel for the treatment of the individual," and the receiving facility "has agreed to accept transfer of the individual and to provide appropriate medical treatment." 42 U.S.C. § 1395dd(c)(2)(A), (B).

Statewide Emergency Medical Trauma Care Centers

In 1990, the Washington State Legislature enacted the Statewide Emergency Medical Services and Trauma Care System Act (EMSTCSA), chapter 70.168 RCW, "to establish an efficient and well-coordinated statewide emergency medical services and trauma care system." LAWS OF 1990, ch. 269; RCW 70.168.010(3). The legislature states the intent of EMSTCSA is to "reduce costs and incidence of inappropriate and

inadequate trauma care and emergency medical service and minimize the human suffering and costs associated with preventable mortality and morbidity." RCW 70.168.010(3). The objective of EMSTCSA is to "(a) [p]ursue trauma prevention activities to decrease the incidence of trauma; (b) provide optimal care for the trauma victim; (c) prevent unnecessary death and disability from trauma and emergency illness; and (d) contain costs of trauma care and trauma system implementation." RCW 70.168.010(4).

EMSTCSA requires the Washington State Department of Health to designate trauma care services at hospitals. RCW 70.168.015(5). EMSTCSA categorizes hospitals into one of five levels of care. RCW 70.168.015(4). EMSTCSA designates the level of trauma care services at each hospital as level I to level V, the highest level of trauma care to the lowest level of trauma care. RCW 70.168.015(4), (15), (23). Lower level designated trauma centers can transfer patients to high-level hospitals for care and treatment by a specialist. RCW 70.168.015(23); WAC 246-976-700(8), (9). Designated trauma service care hospitals must provide emergency and trauma services to all patients requiring care without regard to ability to pay. RCW 70.168.130(3)(b).

Uniform Disciplinary Act

The Uniform Disciplinary Act (UDA), chapter 18.130 RCW, governs licensing and discipline of physicians. The purpose of the UDA is (1) to protect the public and (2) to protect the standing of the medical profession in the eyes of the public. In re the Revocation of the License To Practice Medicine &

Surgery of Kindschi, 52 Wn.2d 8, 11, 319 P.2d 824 (1958). The UDA gives the Washington State Department of Health Medical Quality Assurance Commission (MQAC)[2] the authority to regulate, monitor, and discipline physicians. RCW 18.30.040(2)(b)(ix); chapter 18.71 RCW; chapter 18.71A RCW.

Statement of Charges

On April 4, 2016, the Washington State Department of Health Medical Program (Department of Health) filed a statement of charges against Dr. Dang, alleging violation of EMTALA and RCW 18.130.180(1), (4), and (7) with respect to "Patient A," "Patient B," and "Patient C." RCW 18.130.180, "Unprofessional Conduct," provides, in pertinent part:

> (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. . . .
> . . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. . . .
> . . . .
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in

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[2] In July 2019 (LAWS OF 2019, ch. 55, § 7), MQAC became the "Washington Medical Commission."

> question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.[3]

Patient A

On October 20, 2012, 61-year-old Patient A went to the ER at St. Clare Hospital. St. Clare is a level IV trauma center. Patient A had a history of thyroid cancer and undergone prior neck surgery. On October 20, Patient A had "facial swelling, an enlarged tongue with airway obstruction, and difficulty with breathing and swallowing." A CT[4] scan showed

> bilateral lymph node dissection of the neck, enlargement of the base of the tongue with contiguous abnormal soft tissue swelling of the left oral floor and left lateral wall of the oral cavity, possibly representing a recurrent squamous cell carcinoma or an infectious or inflammatory process.

St. Clare did not have an on-call ENT doctor. The ER doctor concluded Patient A needed a higher level of care from an ENT specialist. The ER doctor contacted Dr. Dang at St. Joseph to request transfer of Patient A. Dr. Dang refused to accept the transfer of Patient A because he was not on call for St. Clare but consulted

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[3] The legislature amended RCW 18.130.180 several times after 2016. LAWS OF 2018, ch. 216, § 2; LAWS OF 2018, ch. 300, § 4; LAWS OF 2019, ch. 427, § 17. The amendments do not change the language pertinent to our analysis.

[4] Computed tomography.

with the ER doctor and said the patient could "follow up with the clinic on Monday."

Because of "the dangerous nature of Patient A's possible airway obstruction," the St. Clare ER doctor believed "a more urgent consult" was necessary and transferred Patient A to Harborview Medical Center, a level I trauma center. Harborview accepted the transfer. St. Clare airlifted Patient A to Harborview. An ENT specialist diagnosed Patient A with "acute angioedema" and admitted Patient A to intensive care.

Patient B

On November 23, 2013, 34-year-old Patient B went to the ER at St. Francis Hospital for "sore throat, swelling, and difficulties with swallowing and breathing." St. Francis is a level IV trauma center. A CT neck scan "showed fluid collection and findings consistent with tonsillar abscess." The ER doctor concluded Patient B should be transferred to St. Joseph for consultation and treatment by an ENT specialist. St. Francis staff contacted St. Joseph on-call ENT specialist Dr. Dang to request the transfer. Dr. Dang refused to consult or accept the transfer.

Patient C

On June 8, 2014, 24-year-old Patient C went to the ER at St. Clare. Patient C had pain in his ear and throat and trouble swallowing. The ER doctor diagnosed Patient C with a tonsillar abscess and a potential "life-threatening" airway obstruction.

Patient C was diagnosed with tonsillar abscess (a collection of pus behind the tonsils that

involves pain, swelling, and often radiates into the ear) with mild airway obstruction. The treating staff suspected a retropharyngeal abscess (deep neck space infections that can pose an immediate life-threatening emergency with potential for airway compromise).

The ER doctor contacted St. Joseph on-call ENT specialist Dr. Dang to request a transfer for treatment. Dr. Dang refused to consult or accept transfer of Patient C because he was not on call for St. Clare.

The St. Clare ER doctor contacted Harborview. After learning Harborview did not have the capacity to accept transfer of Patient C, the St. Clare ER doctor called CHI Franciscan Associate Chief Medical Officer Dr. Kim Moore. Dr. Moore authorized transfer of Patient C from St. Clare to St. Joseph for consultation and treatment by the on-call ENT doctor.

When Patient C arrived at St. Joseph, Dr. Dang refused to consult or treat Patient C. Dr. Moore contacted Dr. Dang. Dr. Dang told Dr. Moore he would not treat Patient C. Six hours later, Dr: Moore transferred Patient C to Madigan Army Medical Center for treatment. Madigan is a level II trauma center.

Administrative Hearing

Dr. Dang retained an attorney and filed an answer to the statement of charges. Dr. Dang denied the allegations that he violated EMT ALA or RCW 18.130.180(1), (4), and (7). Dr. Dang requested a hearing.

The three-day MQAC hearing began on January 30, 2017. The Department of Health called Dr. Dang; Dr. Moore; expert witness Warren Appleton, MD, JD; and St. Francis ER doctor Sarah Sliva to testify. Dr. Dang called expert witnesses Robert Bitterman, MD, JD and Dr. Alan Pokorny and his practice partner Dr. Alex Moreano to testify. The presiding chief health law judge admitted a number of exhibits into evidence, including the Franciscan Health System (FHS) medical records for Patients A, B, and C; the 2012 FHS bylaws; and orthopedic surgery records for Dr. Dang.

Dr. Dang testified he was acting as an on-call doctor only for St. Joseph. Dr. Dang testified he agreed to consult on Patient A. Dr. Dang asserted he did not refuse to consult on Patient B. Dr. Dang testified that he did not refuse to accept the transfer of Patient C. Dr. Dang said he told Dr. Moore that he was "not physically capable" of treating Patient C. Dr. Dang testified that in late February or early March 2014, he had ankle surgery. Dr. Dang said that he fell and injured his heel on June 8, 2014 and took a "hydrocodone and acetaminophen combination ... pill" for the pain.

Dr. Moore testified that she approved the transfer of Patient C from the St. Clare ER to St. Joseph's ER. Dr. Moore said Dr. Dang "refused to come in and see the patient." Dr. Moore called Dr. Dang and "asked him to go in and see the patient as the on-call ear, nose and throat doctor." Dr. Dang told Dr. Moore he "would not go in to see the patient because the patient had come from St. Clare." Dr. Moore testified that Dr. Dang did

not give "any other reason why he would not or could not come in and see the patient."

Dr. Moore testified Dr. Dang had a duty to come to the St. Joseph ER on June 8, 2014 to consult and treat Patient C. Dr. Moore said that "when a request is made for consult," the FHS bylaws state the "consultant must appear as - as reasonably as patient's needs dictate and if they are unable to care for the patient, then that physician needs to assist to find someone else who can." If the on-call doctor is unavailable, "the physician should try to find coverage or backup" and let the emergency department "know that there is a crisis" and that the physician is "not going to be available for call so if a patient presents that needs their services, they can start to look outside of that hospital." Dr. Moore testified Dr. Dang "did not tell me that he was unable to perform his [on-]call duties."

Expert witness Dr. Appleton testified that in his opinion, Dr. Dang violated the professional conduct of licensed health care providers under RCW 18.130.180 and EMTALA. Dr. Appleton testified that because of the dangerous nature of the airway obstruction, the ER doctor could not discharge Patient A and follow the advice of Dr. Dang to wait until the following Monday. Dr. Appleton testified Dr. Dang violated the standard of care by refusing to consult and admit Patient B to St. Joseph. Dr. Appleton testified the condition of tonsillar abscess of Patient B was an emergency that required immediate treatment by an ENT specialist. Dr. Appleton testified the tonsillar abscess of Patient C was an unstable medical emergency condition and the

refusal of Dr. Dang to consult and admit the patient violated the standard of care and EMTALA.

Dr. Dang's expert witnesses Dr. Bitterman and Dr. Pokorny testified that Dr. Dang did not violate the standard of care or EMTALA.

Dr. Moreano is an ENT surgeon and practice partner with Dr. Dang at Group Health in Tacoma. Dr. Moreano testified Group Health affiliated with St. Joseph in Tacoma. Dr. Moreano said that as the on-call ENT specialist at St. Joseph, he regularly receives calls from the ER doctor at St. Clare and St. Francis to consult. Dr. Moreano testified that he and the other two members of the Group Health ENT practice group, Dr. Dang and Dr. Ken Deem, "decided" to tell the ER doctors from the other FHS hospitals that "by the bylaws of the [FHS] system we were not obligated to get involved in - in the care of those patients." However, Dr. Moreano conceded, "We were told by our own [Group Health] leadership that we must comply with their request that we manage the patients from their entire system."

MQAC Decision and Order

On September 29, 2017, MQAC issued a 22-page decision, "Findings of Fact, Conclusions of Law, and Final Order." The MQAC decision sets forth extensive findings of fact that address FHS, EMTALA, statewide emergency medical trauma centers, and the emergency medical conditions of Patients A, B, and C. MQAC made a number of credibility findings. MQAC expressly found Dr. Dang's testimony that he did not refuse to consult on Patient B and that he was unable to treat

Patient C not credible. MQAC found Dr. Appleton's expert testimony that Dr. Dang violated RCW 18.130.180 and EMTALA more credible than the expert witnesses who testified on behalf of Dr. Dang.

MQAC found FHS has a procedure to transfer patients.

> FHS has a Patient Placement Center, which may be used to organize or facilitate an orderly patient intake/transfer process. However, use of a Patient Placement Center does not preclude 'doctor to doctor' consults or transfer requests. Further, practitioners are not required by FHS to use the transfer/placement center. Moreover, failure to utilize a Patient Placement Center does not relieve a practitioner from his/her obligations under the Emergency Treatment and Active Labor Act.[5]

With respect to Patient A, MQAC concluded Dr. Dang did not violate RCW 18.130.180 or EMTALA. Specifically, MQAC found that with respect to Patient A, Dr. Dang "was not on-call" at St. Clare Hospital but consulted with the St. Clare ER doctor and suggested Patient A follow up with the clinic two days later.

MQAC concluded there was "insufficient evidence to find that the Respondent violated EMTALA with regard to Patient B." But MQAC concluded Dr. Dang violated RCW 18.130.180:

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[5] Footnotes omitted.

> [T)he Respondent's refusal to consult with the emergency room doctor concerning the care of Patient B lowered the standing of the profession in the eyes of the public. In addition, the Respondent's refusal to consult with a fellow physician, acting in good faith to help a patient, created an unreasonable risk of harm to Patient B.

With respect to Patient C, MQAC concluded Dr. Dang violated EMTALA and RCW 18.130.180:

> Patient C was experiencing an emergency medical condition, which had not been stabilized, and his transfer to [St. Joseph] was appropriate. As such, the Respondent violated EMTALA when he failed to treat Patient C, while on call for [St. Joseph]. However, assuming arguendo that the transfer was improper, the Respondent (as the on-call specialist), was nonetheless obligated under EMTALA to appear and treat Patient C once he was transferred to [St. Joseph]. In addition, the Respondent's failure to identify a backup or to inform Dr. Moore (or [St. Joseph]) that he was unavailable at a time contemporaneous to the transfer, was inconsistent with Respondent's explanation. Lastly, the Respondent's refusal to treat Patient C created an unreasonable risk of harm to Patient C and lowered the standing of the profession in the eyes of the public.

MQAC ordered oversight of Dr. Dang's medical license for two years and imposed monitoring requirements and a $5,000 fine.

Motion To Reconsider

On October 11, 2017, the Department of Health filed a motion for reconsideration to correct two scrivener's errors in the final order. Dr. Dang did not file a response or object. On December 20, 2017, MQAC issued "Amended Findings of Fact, Conclusions of Law, and Final Order" correcting the two scrivener's errors.

Superior Court Appeal

Dr. Dang filed a petition for judicial review in superior court. The superior court affirmed the amended MQAC final order but modified the monitoring period to begin May 26, 2017 instead of September 29, 2017. Dr. Dang appeals the superior court "Order on Petition for Judicial Review."

Standard of Review

The Washington Administrative Procedure Act (WAPA), chapter 34.05 RCW, governs judicial review of disciplinary proceedings under the UDA, chapter 18.130 RCW. On review, we sit in the same position as the superior court and apply the WAPA standards directly to the record before the agency. Tapper v. Emp't Sec. Dep't, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). As the party challenging MQAC's decision, Dr. Dang bears the burden of establishing the decision is invalid under one or more of the WAPA criteria. RCW 34.05.570(1)(a).

Under RCW 34.05.570(3), we will reverse only if (1) the administrative decision is based on an error of law, (2) the administrative decision is unsupported by substantial evidence, (3) the administrative decision is

arbitrary or capricious, (4) the administrative decision violates the constitution, (5) the order is inconsistent with a rule of the agency, (6) the agency employed improper procedures, or (7) the order is outside the agency's statutory authority. Tapper, 122 Wn.2d at 402. We review conclusions of law de novo. Haley v. Med. Disciplinary Bd., 117 Wn.2d 720, 730, 818 P.2d 1062 (1991). However, we give due deference to the expertise and knowledge of MQAC and substantial weight to the interpretation of the law the agency administers when it is within the agency's expertise. Haley, 117 Wn.2d at 728. MQAC may rely on its experience and specialized knowledge to evaluate the evidence when finding unprofessional conduct. RCW 34.05.452(5); WAC 246-11-160(2); In re Disciplinary Proceeding Against Brown, 94 Wn. App. 7, 13-14, 972 P.2d 101 (1998).

The standard of proof in a medical disciplinary proceeding is that findings of fact must be proved by clear and convincing evidence. Nguyen v. Dep't of Health, Med. Quality Assur. Comm'n, 144 Wn.2d 516, 529, 29 P.3d 689 (2001). We review MQAC's findings of fact like any other proceeding under WAPA for substantial evidence. Ancier v. Dep't of Health. Med. Quality Assur. Comm'n, 140 Wn. App. 564, 572, 166 P.3d 829 (2007). Evidence is substantial if it is sufficient to persuade a reasonable person of the truth or correctness of the order. Ancier, 140 Wn. App. at 572-73. We take MQAC's evidence as true and draw all inferences in MQAC's favor. Ancier, 140 Wn. App. at 573. We will not weigh conflicting evidence or substitute our judgment regarding witness credibility for that of MQAC. Davis v. Dep't of Labor & Indus., 94

Wn.2d 119, 12 No. 78910-4-1/13 124, 615 P.2d 1279 (1980). Unchallenged agency factual findings are verities on appeal. Darkenwald v. Emp't Sec. Dep't, 183 Wn.2d 237, 244, 350 P.3d 647 (2015). After determining whether substantial evidence supports the findings of fact, the court determines whether the findings in turn support the conclusions of law and judgment. Nguyen, 144 Wn.2d at 530.

Unprofessional Conduct in Violation of RCW 18.130.180(1) and (4)

Dr. Dang claims that absent a finding that he owed a duty of care to Patients B or C, MQAC erred in deciding he violated RCW 18.130.180(1) and (4).

The plain language of RCW 18.130.180(1) and (4) does not require MQAC to find a duty of care. RCW 18.130.180(1) states, in pertinent part, that "unprofessional conduct" is "[t]he 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." RCW 18.130.180(4) states, in pertinent part, that "unprofessional conduct" is "[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed."

MQAC concluded Dr. Dang violated RCW 18.130.180(1) and (4) by refusing to consult or treat Patients B and C. MQAC found the "refusal to consult" with the ER doctor concerning treatment and care of Patient B "lowered the standing of the profession in the eyes of the public" and "created an unreasonable risk of

harm to Patient B." MQAC concluded that the "refusal to treat Patient C created an unreasonable risk of harm to Patient C and lowered the standing of the profession in the eyes of the public."

Dr. Dang cites Khung Thi Lam v. Global Medical Systems, Inc., 127 Wn. App. 657, 111 P.3d 1258 (2005), to argue that without finding he owed a duty of care, MQAC could not conclude he violated RCW 18.130.180(1) and (4). Khung Thi Lam is inapposite. In Khung Thi Lam, the court held the plaintiff must establish a duty of care to prevail on a medical malpractice claim. Khung Thi Lam, 127 Wn. App. at 669.

Dr. Dang argues his conduct did not constitute an act of moral turpitude under RCW 18.130.180(1). In Haley, the Washington Supreme Court held that the conduct of a physician constitutes an act of moral turpitude if the physician abuses the status of the profession or lowers the standard of the profession in the eyes of the public. Haley, 117 Wn.2d at 731-32. The conduct "must indicate unfitness to bear the responsibilities of, and to enjoy the privileges of, the profession." Haley, 117 Wn.2d at 731.

> To perform their professional duties effectively, physicians must enjoy the trust and confidence of their patients. Conduct that lowers the public's esteem for physicians erodes that trust and confidence, and so undermines a necessary condition for the profession's execution of its

> vital role in preserving public health through medical treatment and advice.

Haley, 117 Wn.2d at 734.

Dr. Dang cites In re the License To Practice Pharmacy of Farina, 94 Wn. App. 441, 972 P.2d 531 (1999), to argue his conduct did not constitute moral turpitude. Farina is inapposite. In Farina, the court addressed the difference between moral turpitude and violation of a criminal statute. Farina, 94 Wn. App. at 460. The court concluded violation of a criminal statute does not necessarily constitute an act of moral turpitude. Farina, 94 Wn. App. at 460-61. Conduct that meets the definition of "moral turpitude" is an act of "inherent immorality." Farina, 94 Wn. App. at 460-61.

Dr. Dang also claims MQAC applied a subjective standard in determining he committed unprofessional conduct in violation of RCW 18.130.180(1). The record does not support his argument. Substantial evidence supports the MQAC finding that Dr. Dang refused to consult or treat Patients Band C and the findings support the conclusion that Dr. Dang violated RCW 18.130.180(1) and (4).

Dr. Dang asserts that because there is no distinction between the circumstances of Patient A and Patient B, MQAC erred in reaching a different conclusion for Patient B. The record does not support his argument. MQAC found Dr. Dang did not refuse to consult with the ER physician with respect to Patient A and said, "Patient A could follow up with the clinic on Monday (two days later)."

MQAC found Dr. Dang committed unprofessional conduct in violation of RCW 18.130.180(1) and (4) with respect to Patient B. MQAC found that unlike Patient A, Dr. Dang refused to consult with the ER doctor about the care and treatment of Patient B.

> [Dr. Dang]'s refusal to consult with the emergency room doctor concerning the care of Patient B lowered the standing of the profession in the eyes of the public. In addition, [Dr. Dang]'s refusal to consult with a fellow physician, acting in good faith to help a patient, created an unreasonable risk of harm to Patient B.

Challenge to MQAC Finding Violation of EMTALA

Dr. Dang contends MQAC did not have the authority to address whether he violated EMTALA. In his prehearing statement in the MQAC proceeding, Dr. Dang argued MQAC did not have the authority to address whether he violated EMTALA. However, Dr. Dang did not raise the argument again.

The Department of Health contends Dr. Dang waived the right to raise this argument on appeal. We agree. In an appeal of a decision governed by WAPA, an appellant can raise an issue for the first time on only if (1) the appellant did not know and had no duty to discover facts that gave rise to the issue, (2) the appellant did not have an opportunity to raise the issue, or (3) the issue arose from a change in controlling law or a change in agency action and the interests of justice require resolution. RCW 34.05.554(1)(a)-(d); King County v. Boundary Review Bd. for King County,

122 Wn.2d 648, 668, 860 P.2d 1024 (1993). An appellant must do more than raise the issue below. Boundary Review Bd., 122 Wn.2d at 670; Kitsap All. of Prop. Owners v. Cent. Puget Sound Growth Mgmt. Hr'gs Bd., 160 Wn. App. 250, 271-72, 255 P.3d 696 (2011).

Nonetheless, we note that under the plain and unambiguous language of RCW 18.130.180(7), MQAC has the authority to determine whether "[v]iolation of any state or federal statue 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," constitutes unprofessional conduct.[6]

Dr. Dang contends the United States Department of Health and Human Services Secretary has the exclusive authority to initiate proceedings under EMT ALA, and only the United States Court of Appeals has jurisdiction over EMTALA claims.

The Department of Health filed charges under the UDA, not EMTALA. The authority of MQAC under the UDA does not conflict with EMTALA. EMTALA specifically states that "[t]he provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). In Goldfarb v. Virginia State Bar, 421 U.S. 773, 792, 95 S. Ct. 2004, 44 L. Ed. 2d 572 (1975), the United States Supreme Court recognized the

[6] Emphasis added.

compelling state interest in regulating healthcare professionals:

> [S]tates have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions.

Violation of RCW 18.130.180(7)

Dr. Dang argues the evidence does not support the conclusion that he violated RCW 18.130.180(7). We disagree. Substantial evidence supports the conclusion that Dr. Dang violated RCW 18.130.180(7) by refusing to treat Patient C in violation of federal law. The ER doctor transferred Patient C to St. Joseph for treatment because he "was experiencing an emergency medical condition, which had not been stabilized." MQAC found the "transfer to [St. Joseph] was appropriate. As such, the Respondent violated EMTALA when he failed to treat Patient C, while on call for [St. Joseph]." Unchallenged finding of fact 1.17 states that "[a]fter Patient C arrived at [St. Joseph], the Respondent was again contacted and he continued to refuse to consult or to treat Patient C."

Dr. Moore testified that she recommended transferring Patient C from the St. Clare emergency department to the St. Joseph emergency department for treatment. Dr. Moore testified the St. Joseph emergency department (ED) doctor called her after he

transferred Patient C because Dr. Dang refused to treat Patient C. Dr. Moore testified:

A So after the patient was transferred ED to ED, the ED physician at St. Joseph contacted Dr. Dang and he refused to come in and see the patient, so they called me.
Q Okay. And what did you do?
A And I called Dr. Dang.
Q Okay. You spoke with him directly?
A Yes.
Q Okay. What did he tell you or did you ask him to accept the patient or do you recall the conversation?
A To the best of my recollection, I believe that I asked him to go in and see the patient as the on-calf ear, nose and throat doctor.
Q Okay. And what did he respond?
A He said he would not go in to see the patient because the patient had come from St. Clare.
Q Okay. Did he give you any other reason why he would not or could not come in and see the patient?
A No.
Q Okay. Did he inform you that he had been injured —
A No.
Q — or that he was otherwise unavailable?
A No.

Substantial evidence supports the MQAC finding that Dr. Dang violated RCW 18.130.180(7) and EMTALA by refusing to treat Patient C after St. Clare transferred Patient C to St. Joseph.

Denial of Request To Admit Documentary Evidence

Dr. Dang contends MQAC abused its discretion by denying his request to admit documentary evidence. Dr. Dang argues the evidence would have refuted the testimony of Dr. Moore and denial of his request is prejudicial.

At the end of his case, Dr. Dang sought to introduce new documentary evidence to rebut the testimony of Dr. Moore. "The new evidence was in the form of .a string of emails addressed to and from the Respondent, Dr. Moore, and a number of addressees who did not testify at [the] hearing." The MQAC findings describe the documentary evidence:

> The emails ranged in time from the year 2011 to 2014. [Dr. Dang's attorney] represented that: a) the emails were taken from the Respondent's personal home computer; b) the emails had been in the Respondent's possession; and c) they were not previously disclosed to [the Department of Health's attorney].

WAC 246-11-390(7) states:

> Documentary evidence not offered in the prehearing conference will not be received into evidence at the adjudicative proceeding in the absence of a clear showing that the offering party had good cause for failing to produce the evidence at the prehearing conference.[7]

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[7] Dr. Dang asserts MQAC erred by not engaging in an analysis under Burnet v. Spokane Ambulance, 131 Wn.2d 484, 933 P.2d

MQAC ruled Dr. Dang did not show good cause for failing previously to produce the documentary evidence:

> Here, Dr. Moore was identified at the prehearing conference as a witness. The Respondent knew or should have known that any documents containing prior statements by Dr. Moore could become relevant. This is especially true given that the documents have been in the Respondent's sole possession since 2011 and 2014, respectively. Thus, these documents should have been disclosed if the Respondent desired to have them become part of the record. Moreover, any uncertainties pertaining to Dr. Moore's testimony could have been resolved by deposing her. However, the Respondent's failure to do either has resulted in prejudice to the Department at this stage of the proceeding. Consequently, the Respondent has failed to demonstrate the necessary good cause for failing to produce the evidence at the prehearing conference.[8]

The record supports the MQAC finding that Dr. Dang did not show good cause because he did not produce the documentary evidence at the prehearing conference.

1036 (1997). Burnet does not apply to an administrative proceeding. WAC 246-11-390 controls.

[8] Footnote omitted.

RCW 34.05.461 (8)(a)

Dr. Dang argues the final order should be reversed because MQAC did not issue the final order within the 90-day time limit under RCW 34.05.461(8)(a). The Department of Health argues the 90-day time limit is directory, not mandatory. We agree with the Department of Health.

RCW 34.05.461 (8)(a) states, in pertinent part, that "final orders shall be served in writing within ninety days after conclusion of the hearing or after submission of memos, briefs, or proposed findings ... unless this period is waived or extended for good cause shown." A statute setting a time within which a public officer is to perform an official act is directory unless the nature of the act or the language of the statute makes clear that the time designation limits the power of the officer. Niichel v. Lancaster, 97 Wn.2d 620, 623-24, 647 P.2d 1021 (1982). When the time for or manner of performing the authorized action is not essential to the purpose of the statute, the time and manner provisions are considered directory. Niichel, 97 Wn.2d at 624.

Amended Findings of Fact, Conclusions of Law, and Final Order

Dr. Dang cites RCW 34.05.470(3) to argue the Amended Findings of Fact, Conclusions of Law, and Final Order is unlawful because the presiding officer did not comply with the 20-day time limit to file an amended final order.

The Department of Health filed a timely motion for reconsideration of the final order to correct two scrivener's errors. Dr. Dang did not file a response to

the motion or object. On December 20, 2017, MQAC issued an amended final order correcting the two scrivener's errors:

> [MQAC] notes that two Scrivener's errors occurred in the Final Order. A Scrivener's error appears in Paragraph 1.3, which reads "[t]he Respondent was employed by [St. Joseph] at all times ... ["] instead of "[t]he Respondent was employed by Group Health Cooperative at all times relevant to this matter." In addition, a Scrivener's error appears in Paragraph 1.10, which reads "[s]pecifically, the Respondent was not on-call at [St. Joseph] . . . ," instead of "[s]pecifically, the Respondent was not on-call at St. Clare Hospital and thus had no duty to treat or accept the transfer of Patient A."[9]

Dr. Dang argues that because he filed the petition for judicial review in superior court before the presiding officer issued the amended final order, CR 60(a) controls. But the civil rules do not apply to administrative agency proceedings. See Delacey v. Clover Park Sch. Dist., 117 Wn. App. 291, 296, 69 P.3d 877 (2003).

Due Process

For the first time on appeal, Dr. Dang contends MQAC violated his procedural right to due process on a number of grounds. Subject to certain limited exceptions that are not applicable here, RCW 34.05.554(1) bars a litigant from raising issues on

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[9] Emphasis in original; some alteration in original.

appeal not raised before the agency. With the exception of his claim that MQAC did not consider the telephonic testimony, we decline to consider the arguments he raises for the first time on appeal.

Procedural due process requires notice and an opportunity to be heard " 'at a meaningful time and in a meaningful manner.' " Amunrud v. Bd. of Appeals, 158 Wn.2d 208, 216, 143 P.3d 571 (2006)[10] (quoting Mathews v. Eldridge, 424 U.S. 319, 333, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976)). "The process due depends on what is fair in a particular context." In re Det. of Morgan, 180 Wn.2d 312, 320, 330 P.3d 774 (2014). In Mathews, the United States Supreme Court articulated a balancing test to aid in determining when, and to what extent, procedural protections are required:

> [D]ue process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Mathews, 424 U.S. at 335.

Dr. Dang contends he did not have a meaningful opportunity to be heard during the three-day

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[10] Internal quotation marks omitted.

administrative hearing. The record does not support his argument. Dr. Dang was represented by counsel, he called expert witnesses to testify on his own behalf, his practice partner testified, he testified, and MOAG admitted documentary evidence he presented.

The transcript of the MQAC hearing indicates the testimony of the witnesses who testified by telephone is not "audible." Dr. Dang contends that because the transcript shows the testimony of his expert witnesses Dr. Bitterman and Dr. Pokorny and the testimony of Dr. Sliva was "not audible," MQAC ignored that testimony. The record does not support his argument.

The witnesses testified at the hearing. The Amended Findings of Fact, Conclusions of Law, and Final Order makes clear that MQAC, Dr. Dang, his attorney, and the attorney for the Department of Health heard the testimony of Dr. Sliva, Dr. Bitterman, and Dr. Pokorny. The Department of Health attorney addressed the testimony of these witnesses in closing argument. Dr. Dang's attorney cited and relied on the testimony of Dr. Sliva, Dr. Bitterman, and Dr. Pokorny in closing argument. The record shows that in the decision, MQAC did not rely on the transcript from the hearing. The transcript of the hearing is not prepared until after a petition for judicial review is filed. See RCW 34.05.566.[11]

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[11] RCW 34.05.566 states, in pertinent part, "(1) Within thirty days after service of the petition for judicial review, or within further time allowed by the court or by other provision of law, the agency shall transmit to the court the original or a certified copy of the agency record for judicial review of the agency action."

We affirm the Amended Findings of Fact, Conclusions of Law, and Final Order.[12]

s/_____

WE CONCUR:

s/_____ s/_____

[12] The Department of Health does not contest the determination that the effective date of the two-year oversight monitoring period is May 26, 2017.

APPENDIX C

IN THE SUPERIOR COURT
OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

Case No. 17-2-28129-8 KNT

[Filed: August 9, 2018]

HUNG DANG, M.D.,

Petitioner,

v.

Judicial Review of Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

ORDER ON PETITION FOR JUDICIAL REVIEW

THIS MATTER came before the Court on Petitioner's Petition for Judicial Review on June 29, 2018. The Petitioner, Hung Dang, M.D., appeared pro se and the Respondent appeared through its attorney of record, Christina L. Pfluger, Assistant Attorney

General. The Court, having considered the arguments of the parties, having reviewed the administrative record, and the following pleadings:

1. Petition for Judicial Review dated October 27, 2017;

2. Trial Brief of Petitioner dated April 10, 2018;

3. Respondent' Response to Petitioner's Trial Brief dated May 1, 2018; and

4. Reply Brief of Petitioner dated May 15, 2018

Now enters the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Pursuant to RCW 34.05.570(3), a court shall grant relief from an agency order in an adjudicative proceeding only if it determines that:

   (a) The order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied;

   (b) The order is outside the statutory authority or jurisdiction of the agency conferred by any provision of law;

   (c) The agency has engaged in unlawful procedure or decision-making process, or has failed to follow a prescribed procedure;

(d) The agency has erroneously interpreted or applied the law;

(e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;

(f) The agency has not decided all issues requiring resolution by the agency;

(g) A motion for disqualification under RCW 34.05.425 or 34.12.050 was made and was improperly denied or, if no motion was made, facts are shown to support the grant of such a motion that were not known and were not reasonably discoverable by the challenging party at the appropriate time for making such a motion;

(h) The order is inconsistent with a rule of the agency unless the agency explains the inconsistency by stating facts and reasons to demonstrate a rational basis for inconsistency; or

(i) The order is arbitrary or capricious.

2. The burden of demonstrating the invalidity of the agency action is on the party asserting the invalidity and the court shall only grant relief if it determines that the person seeking judicial relief has been substantially

prejudiced by the action complained of RCW 34.05.570(1)(a), (d).

3. The court further being aware that in reviewing matters within agency discretion, the court shall limit its function to assuring that the agency has exercised its discretion in accordance law, and shall not itself undertake to exercise the discretion that the legislature has placed in the agency. RCW 34.05.574. Additionally, the court' review is limited to the agency record and must not consider new evidence or issues unless an exception has been met; the court finds no exception has been shown by the Petitioner to admit new evidence or issues not previously raised before the agency and in the record. RCW 34.05.558; RCW 34.05.562(1).

4. There is substantial evidence in the administrative record to support the Commission's findings of fact.

5. All unchallenged findings of fact are verities on appeal and the Petitioner did not challenge paragraphs 1.1 through 1.2.

6. The Commission was reasonable in relying upon on the testimony and evidence provided at the hearing.

7. There is no error of law in the Medical Commission' conclusion that the Petitioner committed unprofessional conduct as defined in RCW 18.130.180(1), (4), and (7). Further,

the Medical Commission has the expertise required for these determinations.

8. The Medical Commission has the authority to determine whether a violation of EMTALA (42 USC § 1395dd(d)(1)) occurred pursuant to their authority to find unprofessional conduct when a licensee violates a federal statute or rule that regulates the profession under RCW 18.130.180(7).

9. The Medical Commission did not violate the appearance of fairness doctrine.

10. The Medical Commission did not violate the Petitioner's Due Process Rights. The Petitioner received notice of the charges of unprofessional conduct and was provided a meaningful opportunity to be heard before a panel of impartial Commission members. A court will not disturb an administrative decision so long as a party is given adequate notice and an opportunity to be heard and any alleged procedural irregularities do not undermine the fundamental fairness of the proceedings. *Sherman v. State*, 128 Wn.2d 164, 184, 905 P.2d 355 (1995).

11. There were a number of procedural irregularities in the investigation and adjudication process:

(a) The court finds the investigation and adjudication took longer than the aspirational time periods identified in chapter 246-14 WAC;

(b) The Findings of Fact, Conclusions of Law, and Final Order was issued later than ninety (90) days after the conclusion of the hearing and more than ninety (90) days beyond the Presiding Officer' extension for good cause (*See* RCW 34.05.461(8)(a));

(c) The Presiding Officer' Post-Hearing Order No. 2: Order Setting Briefing Schedule on the Department' timely Petition for Reconsideration was signed one (1) day and served two (2) days beyond the required twenty (20) days required by WAC 246-11-580; and

(d) The testimony of witnesses who testified by telephone – specifically, the testimony of Drs. Sliva, Pokorny and Bitterman – was not recorded in a way that allowed the testimony to be transcribed and presented on appeal as required by RCW 34.05.449(4).

12. The procedural irregularities enumerated in paragraph 11 did not undermine the fundamental fairness of the proceedings and did not violate the Petitioner's Due Process Rights; however, the court finds that Petitioner has been prejudiced by the failure to comply with deadlines for issuing the decision.

(a) WAC 246-14-010 and WAC 246-14-030 indicate that the time periods set in chapter 246-14 WAC are aspirational and are not expected to apply in every case and the

expiration of the time periods does not stop the case from proceeding. The Petitioner has not shown that the length of investigation or adjudication prejudiced him or undermined the fundamental fairness of the proceedings. In addition, some of the delay was at his or his counsel's request. In addition, Dr. Dang did not object to the delay prior to or at the time of the hearing.

(b) The Petitioner has not shown any authority that the ninety (90) day requirement s jurisdictional or otherwise allows the court to overturn the Commission' order if the timeline is not met.

(c) However, the delay in the order has prejudiced the Petitioner by extending the period of time period he has been subject to sanctions or the possible imposition of sanctions. Although the Petitioner's license was not restricted during the pendency of the proceeding or order, a two-year period of monitoring that should have been completed as of May 26, 2019 had the order been timely issued, has been extended to September 29, 2019.

(d) Although the Presiding Officer issued Post-Hearing Order No. 2 beyond the twenty (20) days allowed by WAC 246-11-580, the Petitioner has not shown he was prejudiced by the late action nor has Petitioner shown that the fairness of the proceeding was undermined by the Presiding Officer' delay in

acting on the Department's timely Petition for Reconsideration. There is no dispute that the two errors identified in the Department' timely Petition for Reconsideration were, in fact, errors. Furthermore, the Commission did not rely on the incorrect facts in making its determination in the Final Order.

(d) Dr. Dang has failed to identify any testimony by the telephonic witnesses that is material to the arguments he has made on review. Moreover, he has not attempted or proposed a reconstruction of the missing record as permitted by Rule of Appellate Procedure 9.4, although he himself urged (for other purposes) that the Rules of Appellate Procedure apply.

12. There were no violations or errors under the APA standards for review.

Based on the foregoing, this court hereby ORDERS:

1. The effective date of the Final Order shall be deemed to be May 26, 2017 and not September 29, 2017. Accordingly, Dr. Dang may petition the Commission in writing to terminate the Final Order on or after May 26, 2019 if he has fully complied with all requirements of the Final Order;

2. In all other respects, the Petition for Judicial Review is DENIED;

3. Dr. Dang's request for attorney's fees and costs is DENIED;

4. Dr. Dang's motion for reconsideration of the court's Order Denying Stay of Final MQAC Order is DENIED.

DATED this 9th day of August, 2018.

Electronic signature is attached

s/_____
JUDGE JANET M. HELSON

King County Superior Court J
udicial Electronic Signature Page

Case Number: 17-2-28129-8
Case Title: DANG VS STATE OF WASHINGTON OF HEALTH ET ANO

Document Title: ORDER ON PETITION FOR REVIEW

Signed by: Janet Helson
Date: 8/9/2018 3:29:36 PM

s/_____
Judge/Commissioner: Janet Helson

APPENDIX D

STATE OF WASHINGTON DEPARTMENT OF HEALTH MEDICAL QUALITY ASSURANCE COMMISSION

Master Case No. M2014-1258

[Filed December 20, 2017]

In the Matter of:	)
HUNG H. DANG, Credential No. MD.MD.60034194,	)
Respondent.	)

APPEARANCES:

Hung H. Dang, the Respondent, by Rebecca Ringer and Laura Martin, Attorneys at Law

Department of Health Medical Program (Department), by Office of the Attorney General, per Debra Defreyn, Assistant Attorney General

PANEL: Mark Johnson, M.D., Chair
Warren Howe, M.D.
Yanling Yu, Ph.D.

PRESIDING OFFICER: Roman S. Dixon Jr., Chief Health Law Judge

AMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

AMENDMENT

This Final Order was entered on September 29, 2017. On October 11, 2017, the Department filed its Petition for Reconsideration. Specifically, the Department requested "that two findings within the Findings of Fact in the Final Order" be corrected.[1] On November 1, 2017, the Adjudicative Service Unit issued Post Hearing Order No. 2: Order Setting Briefing Schedule (Briefing Schedule). Per the Briefing Schedule, the Respondent's Response brief was due on November 13, 2017. To date, the Respondent has failed to respond to the Department's Petition for Reconsideration.[2] After review of the Petition and the evidence, the Commission amends the Findings of Fact, Conclusions of Law, and Final Order issued as follows in **bold** type.

SCRIVENER'S ERROR

The Commission notes that two Scrivener's errors occurred in the Final Order. A Scrivener's error appears in Paragraph 1.3, which reads "[t]he Respondent was employed by SJMC at all times . . ." instead of "[t]he Respondent was employed by **Group Health Cooperative** at all times relevant to this

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[1] The Department's Petition for Reconsideration was timely and conformed to the requirements of WAC 246-11-580.

[2] On November 1, 2017, the Respondent filed his Petition for Judicial Review in King County Superior Court.

matter." In addition, a Scrivener's error appears in Paragraph 1.10, which reads "[s]pecifically, the Respondent was not on-call at SJMC . . . ," instead of "[s]pecifically, the Respondent was not on-call at **St. Clare Hospital** and thus had no duty to treat or accept the transfer of Patient A." Under the rationale of Civil Rule (CR) 60(a) and the significant decision *In re Jantz,* OPS No. 90-07-31-065 MA (June 28, 1993), these corrections are entered and the corrections are in **bold** type.

INTRODUCTION

A hearing was held in this matter on January 30, 2017 – February 1, 2017, regarding allegations of unprofessional conduct. CONDITIONS IMPOSED.

ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(1), (4), and (7) and EMTALA, 42 USC § 1395dd(d)(1)(B) and (g).

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 Hung H. Dang, M.D., the Respondent; Kim Moore, M.D.; Warren Appleton, M.D., JD, FABEM, Expert Witness; and Sarah G. Sliva, M.D. The Respondent testified on his own behalf and also presented the testimony of Robert Bitterman, J.D.,

M.D., Expert Witness; Alex Moreano, M.D.; and Alan Porkorny, M.D., Expert Witness.

Amendment of the Corrected Statement of Charges

The Department noted that the Corrected Statement of Charges contained an error with regard to Patient B. Specifically, the Department noted that paragraphs 1.7 through 1.9 should indicate that Patient B was seen in the ER of St. Francis Hospital, instead of St. Clare Hospital. Accordingly, the Department requested that the Corrected Statement of Charges be amended. The Respondent did not object. Motion to Amend GRANTED.

Respondent's Motion to Admit New Documentary Evidence

On the third day of hearing, prior to resting his case-in-chief, the Respondent sought to introduce new documentary evidence to rebut the testimony of Kim Moore, M.D.[3] The new evidence was in the form of a string of emails addressed to and from the Respondent, Dr. Moore, and a number of addressees who did not testify at hearing. The emails ranged in time from the year 2011 to 2014. Attorney Ringer represented that: a) the emails were taken from the Respondent's personal home computer; b) the emails had been in the Respondent's possession; and c) they were not previously disclosed to AAG Defreyn. Attorney Ringer argued that the documents were relevant, would speak

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[3] Dr. Moore testified on the first day of hearing during the Department's case-in-chief.

to Dr. Moore's credibility and only became necessary after Dr. Moore's testimony. As such, they should be admitted as rebuttal evidence.[4] AAG Defreyn argued that the Respondent failed to demonstrate the necessary good cause to admit the documents at this stage of the proceeding. Specifically, the documents were in the Respondent's exclusive control and they were not identified prior to hearing. Further, the Respondent's surprise by Dr. Moore's testimony is not good cause, because the Respondent could have, but failed to depose Dr. Moore. Lastly, admitting the documents would be fundamentally unfair because the emails may not represent the complete story as they were sent to and from numerous individuals who did not testify at hearing. As such, the documents should be excluded.

The purpose of rules relative to discovery is to avoid surprise in trial and to secure more perfect justice. *Peacock v. Piper*, 81 Wash. 2d 731, 504 P.2d 1124 (1973). In addition, the discovery rules are intended to make a trial less a game of blind man's bluff and more a fair contest with the basic issues and facts disclosed to the fullest practical extent. *Taylor v. Cessna Aircraft Co., Inc.*, 39 Wash. App. 828, 696 P.2d 28 (Div. 3 1985). Consequently, "[D]ocumentary evidence not offered in the prehearing conference shall not be received into

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[4] The Respondent did not seek leave of the court to recall Dr. Moore as a rebuttal witness. Rather, Attorney Ringer indicated "the Respondent would not object to the ***Department recalling Dr. Moore*** to clarify these issues." In addition, the Respondent did not recall Dr. Moore as a witness in his case-in-chief; despite having listed Dr. Moore as a witness.

evidence at the adjudicative proceeding in the absence of a clear showing that the offering party had good cause for failing to produce the evidence at the prehearing conference." WAC 246-11-390(7).

Here, Dr. Moore was identified at the prehearing conference as a witness. The Respondent knew or should have known that any documents containing prior statements by Dr. Moore could become relevant. This is especially true given that the documents have been in the Respondent's sole possession since 2011 and 2014, respectively. Thus, these documents should have been disclosed if the Respondent desired to have them become part of the record.[5] Moreover, any uncertainties pertaining to Dr. Moore's testimony could have been resolved by deposing her. However, the Respondent's failure to do either has resulted in prejudice to the Department at this stage of the proceeding. Consequently, the Respondent has failed to demonstrate the necessary good cause for failing to produce the evidence at the prehearing conference. Motion to admit is DENIED.[6]

The Presiding Officer admitted the following Department exhibits:

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[5] However, nothing would have prevented the Respondent from questioning Dr. Moore about any alleged prior statements while she was subject to cross-examination.

[6] *See* ER 403 and untimely per WAC 246-11-390(7); *see* also Prehearing Order No. 2: Order Defining Conduct of Hearing, dated January 6, 2017).

Exhibit D-1: Letter from Ann Clark, R.N., Franciscan Health System to Kate Mitchell, CMS Division of Survey and Certification, dated June 16, 2014.

Exhibit D-2: Letter from Ann Clark, Risk Manager, St. Joseph Medical Center to Tim Slavin, DOH Health Care Investigator, dated July 17, 2014.

Exhibit D-3: Letters from Department of Health (DOH) Health Care Investigator Tim Slavin to the Respondent, dated August 11, 2014 and August 25, 2014.

Exhibit D-4: Letter from the Respondent to Investigator Slavin, faxed on September 2, 2014.

Exhibit D-5: Medical records for Patient A supplied by Franciscan Health System.

Exhibit D-6: Medical records for Patient B supplied by Franciscan Health System.

Exhibit D-7: Medical records for Patient C supplied by Franciscan Health System.

The Presiding Officer admitted the following Respondent exhibits:

Exhibit R-7: Franciscan Health Systems, Medical Staff Bylaws (July 26, 2012).

Exhibit R-8: Franciscan Health Systems, Rules and Regulations (Approved July 26, 2012).

Exhibit R-9: Franciscan Health Systems, Patient Placement Center Flowchart.

Exhibit R-10: June 22, 2015 Declaration of Ken Deem, M.D.

Exhibit R-11: June 23, 2015 Declaration of Alex Moreano, M.D.

Exhibit R-13: Dr. Dang's orthopedic surgery records regarding his right Achilles tendon repair.

The Presiding Officer excluded the following documents:

Exhibit R-14: Email from Dennis Elonka, M.D., to the Respondent, dated October 11, 2011. Attached thereto is a string of emails to several other addresses (Excluded - ER 403 and Untimely per WAC 246-11-390(7); *see* also Prehearing Order No. 2: Order Defining Conduct of Hearing, dated January 6, 2017).

Exhibit R-15: Email string from Allister Stone to the Respondent and several other addressees (Dr. Moore was listed as cc'd in one or more of the emails), dated October 6, 2011, (Excluded - ER 403 and Untimely per WAC 246-1 F390(7); see also Prehearing Order No. 2: Order Defining Conduct of Hearing, dated January 6, 2017).

Exhibit R-16: Email string from Craig Iriye, M.D., to Marc Mora (the Respondent, Dr. Moore, and several other addressees were listed as cc'd in one or more emails), dated April 30, 2014 (Excluded -

ER 403 and Untimely per WAC 246-11-390(7); see also Prehearing Order No. 2: Order Defining Conduct of Hearing, dated January 6, 2017).

Exhibit R-17: Email string from Craig Iriye, M.D., to the Respondent and several other addressees, dated April 30, 2014. Attached thereto appears to be an email from Dr. Moore to Craig Iriyie, also dated April 30, 2014 (Excluded - ER 403 and Untimely per WAC 246-11-390(7); see also Prehearing Order No. 2: Order Defining Conduct of Hearing, dated January 6, 2017).

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 August 29, 2008.

1.2 The Respondent's license is currently active. The Respondent also has an active license in Oklahoma. The Respondent specializes in otolaryngology treatment with respect to ear, nose, and throat (ENT) issues.

Franciscan Health System (FHS)

1.3 The Franciscan Health System (FHS) is a non-profit corporation, whose purpose is to serve as a health system providing patient care, education, and research consistent with the Mission Statement of FHS and Catholic Health Initiatives (CHI).[7] Hospitals within the FHS include St. Anthony, St. Clare, St.

[7] *See* Exhibit R-7.

Elizabeth, St. Francis, and St. Joseph Medical Center (SJMC).[8] The Respondent was employed by **Group Health Cooperative** at all times relevant to this matter.

FHS has a Patient Placement Center, which may be used to organize or facilitate an orderly patient intake/transfer process.[9] However, use of a Patient Placement Center does not preclude 'doctor to doctor' consults or transfer requests.[10] Further, practitioners are not required by FHS to use the transfer/placement center. Moreover, failure to utilize a Patient Placement Center does not relieve a practitioner from his/her obligations under the Emergency Treatment and Active Labor Act.

Emergency Medical Statewide Trauma Care (EMSTC) Centers

1.4 Per the Emergency Medical Statewide Trauma Care (EMSTC) rules, hospitals are required to be categorized in one of five levels of care in order to receive state funds for trauma services. Under this system, level I is the highest trauma center and V is the lowest. Both St. Clare and St. Francis are level IV

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[8] This allegations in the present case involve St. Clare, St. Francis, and St. Joseph Medical Center.

[9] *See* Exhibit R-9.

[10] *See* Exhibits R-7 through R-9.

trauma centers.[11] Accordingly, lower level centers are able to transfer patients to higher level facilities in order to increase the level of care available to those patients.

EMTALA

1.5 The Emergency Treatment and Active Labor Act (EMTALA) was instituted to address discrimination and it mandates non-discriminatory medical screening examinations.[12] Under EMTALA, a hospital with an emergency department, must provide for appropriate medical screening examinations within the capability of the hospital's emergency department, to determine whether or not an emergency medical condition exists.[13] In general, if any individual comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either: a) within the staff and facilities available at the hospital, for such further medical examination and any treatment necessary to stabilize the medical condition, or b) for transfer of the individual to another medical facility.[14] A hospital that

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[11] Harborview Medical Center is a level I trauma center; Madigan Army Medical Center is a level II center.

[12] *See* 42 U.S.C. 1395dd.

[13] *Id.*

[14] *See* 42 U.S.C. 1395dd(b)(1). An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably result in placing the health of

has specialized capabilities or facilities may not refuse to accept from a referring hospital an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.[15]

Patient A

1.6 Patient A was a sixty-one year old patient, who was seen in the emergency room (ER) at St. Clare Hospital on October 20, 2012. St. Clare is a level IV trauma care center. Patient A was seen for facial swelling, an enlarged tongue with airway obstruction, and difficulty with breathing and swallowing.[16] Patient A was 74 inches tall and weighed approximately 300 lbs. In addition, Patient A had a history of thyroid cancer, had undergone prior neck surgery and was on an ace-inhibitor.[17]

1.7 A physical examination of Patient A noted increased saliva and drooling, hoarseness, swelling,

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the individual in serious jeopardy, serious impairment to bodily functions. See 42 U.S.C. 1395dd((e)(1).

[15] *Id.* A transfer to a medical facility is appropriate if, *inter alia,* the transferring hospital provides the medical treatment within its capacity which, minimizes the risks to the individual's health; the receiving facility has available space and qualified personnel for treatment of the individual; and, has agreed to accept transfer of the individual and provide appropriate medical treatment. *See* 42 U.S.C. 1395dd(C)(2).

[16] Exhibit D-5.

[17] *Id.*

induration of the floor of the mouth and left anterior cervical triangle swelling. The examination of the mouth was noted as "crowded." A CT scan showed bilateral lymph node dissection of the neck, enlargement of the base of the tongue with contiguous abnormal soft tissue swelling of the left oral floor and left lateral wall of the oral cavity, possibly representing a recurrent squamous cell carcinoma or infectious or inflammatory process.

1.8 Based on Patient A's prior medical history and current condition (as determined by a physical examination), the ER physician was concerned that Patient A's condition could worsen and he needed a specialist, who could render a higher level of care. St. Clare Hospital did not have an ENT physician on-call. As such, the ER physician from St. Clare Hospital contacted the Respondent at the neighboring St. Joseph Medical Center (SJMC), a level II trauma center. The Respondent refused to accept transfer of Patient A. The Respondent reasoned that he was not on-call for St. Clare and stated that Patient A could follow up with the clinic on Monday (two days later).

1.9 Nonetheless, the attending physician felt a more urgent consult was necessary due to the dangerous nature of Patient A's possible airway obstruction. The attending physician contacted Harborview, a level I trauma center, which accepted the transfer for an emergency ENT and surgical consultation. Patient A was airlifted to Harborview where he was assessed with acute angioedema and admitted to intensive care for overnight monitoring.

1.10 Here, there is insufficient evidence to find that the Respondent violated the standard of care to Patient A. Specifically, the Respondent was not on-call at **St. Clare Hospital** and thus, had no duty to treat or accept the transfer of Patient A. In addition, Patient A was not transferred to SJMC. Consequently, there is insufficient evidence to find an EMTALA violation with regard to Patient A.

Patient B

1.11 Patient B was a thirty-four year old patient who was seen in the St. Francis ER on November 23, 2013.[18] Patient B complained of a sore throat and difficulties with swallowing and breathing, which had been present off and on for a week.[19] Patient B was also determined to also have uvular deviation to the left, due to swelling from a right oropharynx.[20] In addition, a neck CT scan showed fluid collection and findings consistent with tonsillar abscess.[21] Based on the physical examination and the CT scan results, the ER physician determined that it was necessary to transfer Patient B to SJMC for further treatment and to consult with an ENT specialist.[22] The Respondent, who was

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[18] St Francis is a level IV trauma center.

[19] *See* Exhibit D-6.

[20] *Id.*

[21] *Id.*

[22] *Id.*

the ENT specialist on call for SJMC, was contacted for transfer.

1.12 St. Francis contacted the Respondent and attempted to discuss Patient B's case. The Respondent refused discuss the case, to admit Patient B or agree to a transfer.[23] Consequently, Patient B ultimately had his abscess successfully drained by an ER physician at St. Francis Hospital, who had experience with the procedure, and was discharged with no ill effects.[24]

1.13 Here, there is insufficient evidence to find that the Respondent violated EMTALA with regard to Patient B. However, the Respondent's refusal to consult with the emergency room doctor concerning the care of Patient B lowered the standing of the profession in the eyes of the public. In addition, the Respondent's refusal to consult with a fellow physician, acting in good faith to help a patient, created an unreasonable risk of harm to Patient B.

Patient C

1.14 Patient C was a twenty-four year old patient who was seen in the St. Clare ER on June 8, 2014. Patient C complained of ear pain, sore throat and

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[23] At hearing, the Respondent testified that he did not refuse to consult or treat Patient B. Rather, he told the doctor calling on behalf of St. Francis to "let me call you back when I get home, so I can look at information to see if this is an appropriate transfer." The Panel was not persuaded by Respondent's testimony and deemed this act a efusal to consult.

[24] *Ibid.*

trouble swallowing and was subsequently diagnosed with a tonsillar abscess with mild airway obstruction.[25] The treating staff suspected a retropharyngeal abscess.[26]

1.15 The attending physician spoke with the Respondent who was the on-call ENT specialist at SJMC: The Respondent refused to accept a transfer or to consult on Patient C, stating that he was "not on-call" for St. Clare.[27] The Respondent failed to inform the attending physician that Respondent was injured or otherwise unavailable to treat Patient C.[28] In addition, the Respondent failed to inform SJMC that he was unavailable or to designate/contact a backup on-call provider.

1.16 The ER physician from St. Clare Hospital then contacted Harborview Hospital in Seattle (a level

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[25] *See* Exhibit D-7.

[26] Retropharyngeal abscesses are deep neck space infections that can pose an immediate life-threatening emergency with potential for airway compromise.

[27] *Ibid.*

[28] At hearing, the Respondent testified that an injury suffered prior to being contacted about Patient C rendered him unavailable to treat Patient C, due to pain and having taken narcotic pain medication. The Panel was not persuaded by Respondent's after-the-fact justification.

I trauma center), which did not have capacity to accept Patient C.[29]

1.17 The ER physician next contacted Dr. Moore, one of the Associate Chief Medical Officers (ACMO) within the Franciscan Health System. Dr. Moore accepted transfer of Patient C to SJMC. After Patient C arrived at SJMC, the Respondent was again contacted and he continued to refuse to consult or to treat Patient C.[30] Next, Dr. Moore contacted the Respondent, who again refused to treat Patient C in the SJMC emergency department. The Respondent failed to inform Dr. Moore that he was injured or unavailable to treat Patient C.

1.18 Approximately six hours after the Respondent was initially contacted, Patient C was ultimately transferred to Madigan Army Medical Center's Emergency Department (another level II trauma center), where he was treated successfully.[31]

1.19 Here, Patient C was experiencing an emergency medical condition, which had not been stabilized, and his transfer to SJMC was appropriate. As such, the Respondent violated EMTALA when he failed to treat Patient C, while on call for SJMC. However, assuming arguendo that the transfer was improper, the Respondent (as the on-call specialist), was nonetheless obligated under EMTALA to appear

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[29] *See* Exhibit D-7.

[30] *Id.*

[31] *Id.*

and treat Patient C once he was transferred to SJMC. In addition, the Respondent's failure to identify a backup or to inform Dr. Moore (or SJMC) that he was unavailable at a time contemporaneous to the transfer, was inconsistent with Respondent's explanation. Lastly, the Respondent's refusal to treat Patient C created an unreasonable risk of harm to Patient C and lowered the standing of the profession in the eyes of the public.

Credibility Finding

1.20 The Respondent denies committing unprofessional conduct as alleged in the Statement of Charges regarding Patients A through C. The Commission finds the testimony of Warren Appleton, M.D., JD, FABEM to be more credible regarding the standard of care in Washington than that of the Respondent and Respondent's experts. In addition, the Commission found the documentary evidence and Dr. Appleton's testimony more persuasive than that of the Respondent's testimony. Lastly, Dr. Moore testified that the Respondent did not express an inability to care for Patient C. Rather, that he would not do so. The Commission was persuaded by this evidence that the Respondent refused to treat Patient C.

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.

Nguyen v. Department of Health, 144 Wn.2d 516, 534 (2001), *cert. denied,* 535 U.S. 904 (2002).

2.3 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(1), which states:

> 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.

An act of moral turpitude is an act of "baseness, vileness, or the depravity in private and social duties which man owes to his fellow man." *In re Farina,* 94 Wn. App. 441, 460 (1999). To relate to the practice of the profession under RCW 18.130.180(1), the "conduct must indicate unfitness to bear the responsibilities of,

and enjoy the privileges of, the profession." *Haley v. Medical Disciplinary Board,* 117 Wn. 2d 720, 731 (1991). Conduct may indicate unfitness to practice the profession if (1) it raises reasonable concerns that the individual may abuse the status of the profession to harm members of the public or (2) it lowers the standing of the profession in the eyes of the public. *Haley v. Medical Disciplinary Board,* 117 Wn. 2d at 733.

2.4 Here, the Respondent's refusal to aid and consult with fellow physicians, while acting as an on-call specialist, constitute acts of moral turpitude and lowers the standing of the profession in the eyes of the public.

2.5 The Department proved 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 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;

2.6 Here, the Respondent's refusal to consult with fellow physicians and treat patients, while acting as an on-call specialist, created an unreasonable risk of patient harm.

2.7 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(7), which states:

> 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;

2.8 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in EMTALA, 42 USC Sec. 1395dd(d)(1)(B), which states:

> (1) CIVIL MONEY PENALTIES
>
> (B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—
>
> (i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or
>
> (ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

> is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1128A of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).

Here, the Respondent violated EMTALA when he failed to appear in the SJMC emergency department to treat Patient C, white on call for SJMC as an ENT specialist.

2.9 The Department did not prove by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in EMTALA, 42 USC Sec. 1395dd(g), which states:

> (g) Nondiscrimination
>
> A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

2.10 The Department requests three years of probation, a CME course (preapproved by the Commission), a 1,000 word research paper presented to the local medical society or health organization, personal appearances, and a $5,000 fine. The Respondent requests that no violation be found and no sanctions imposed.

2.11 Safeguarding the public's health and safety is the paramount responsibility of every disciplining authority and in determining what action is appropriate, the disciplining authority must first consider what sanctions are necessary to protect or compensate the public. See RCW 18.130.160. In doing so, public safety must be considered before the rehabilitation of the Respondent. *Id.*

2.12 The Respondent's conduct falls in Tier B of the Practice Below the Standard of Care schedule. WAC 246-16-810. The panel considered the following aggravating factors when determining the sanction in this matter: none. The panel considered the following mitigating factors when determining the sanction in this matter: no prior discipline and issues remedied and unlikely to reoccur.

III. ORDER

3.1 The Respondent's license to practice as a physician and surgeon in the state of Washington is SUBJECT TO OVERSIGHT.

3.2 Oversight. The Respondent's license to practice as a Physician and surgeon in the state of Washington shall be subject to oversight for a period of two years from the effective date of this Order. The

Respondent must complete the ethics course and presentation of the paper in Paragraphs 3.6 and 3.7 below prior to filing a petition for termination. The Commission will issue a notice scheduling a date and time for the Respondent to appear, unless the Commission waives the need for a personal appearance.

3.3 Monitoring. The Respondent shall cause the Chief of Surgery of the hospital where privileges are held to submit quarterly reports attesting to the Respondent's good behavior. The reports will be due for the duration of the oversight period commencing no sooner than 90 days from the effective date of this order.

3.4 Fine. The Respondent will pay a fine to the Commission in the amount of $5,000 dollars within 6 months of the effective date of this order. The fine must be paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to: Department of Health, Medical Quality Assurance Commission, P.O. Box 1099, Olympia, Washington 98507-1099.

3.5 Personal Appearances. Respondent must personally appear at a date and location determined by the Commission in approximately six (6) months after the effective date of this Agreed Order, or as soon thereafter as the Commission's schedule permits. Thereafter, Respondent must make personal appearances annually or as frequently as the Commission requires unless the Commission waives the need for an appearance. Respondent must participate in a brief telephone call with the

Commission's Compliance Unit prior to the appearance. The purpose of appearances is to provide meaningful oversight over Respondent's compliance with the requirements of this Agreed Order. The Commission will provide reasonable notice of all scheduled appearances.

3.6 Ethics Course. The Respondent must begin an Ethics Course preapproved by the Commission within 6 months and must successfully complete all aspects of the program. Successful completion means the Respondent must receive an unconditional pass at the conclusion of the course. The Respondent must submit to the Commission copies of any papers that he is required to produce as part of the coursework and his certificate of completion.

3.7 Paper. Research paper shall discuss Inter-Professional Responsibility concerning EMTALA and Physician Consults. The paper must be a minimum of one thousand (1,000) words, contain a bibliography, refer to any relevant CME completed in Paragraph 3.6, and state how Respondent intends to apply what he learned in his practice. The paper must be submitted within two (2) months after completing the related CME pursuant to Paragraph 3.6. Respondent should be prepared to discuss the subject matter of the written paper(s) with the Commission at the initial personal appearance. The paper must be submitted to the Commission in both electronic and printed format to the addresses below:

1. Medical.compliance@doh.wa.gov

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

3.8 Compliance Orientation. Respondent shall complete a compliance orientation in person or by telephone within sixty (60) days of the effective date of this Agreed Order. Respondent must contact the Compliance Unit at the Commission by calling (360) 236-2763, or by sending an email to: Medical.compliance@doh.wa.gov within ten (10) days of the effective date of this Agreed Order. Respondent must provide a contact phone number where Respondent can be reached for scheduling purposes.

3.9 Obey all laws. Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

3.10 Compliance Costs. Respondent is responsible for all costs that Respondent incurs in complying with this Agreed Order.

3.11 Violation of Order. If Respondent violates any provision of this Final Order in any respect, the Commission may initiate further action against Respondent's license.

3.12 Change of Address. Respondent shall inform the Commission and the Adjudicative Clerk Office in writing, of changes in Respondent's residential and for business address within thirty (30) days of the change.

3.13 Effective Date of Order. The effective date of this Final Order is the date the Adjudicative Clerk Office places the signed Final Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Final Order.

3.14 Termination. Respondent may petition the Commission in writing to terminate this Final Order after two years.

Dated this 20 day of December, 2017.

Medical Quality Assurance Commission

/s/_____
MARK JOHNSON, M.D.
Panel Chair

CLERK'S SUMMARY

Charge	**Action**
RCW 18.130.180(1)	Violated
RCW 18.130.180(4)	Violated
RCW 18.130.180(7)	Violated
EMTALA	
42 USC § 1395dd(d)(1)(B)	Violated
42 USC § 1395dd(g)	Not Violated

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

APPENDIX E

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON DIVISION ONE

Case No. 78910-4-I

[Filed: October 23, 2019]

HUNG DANG, M.D.,

Appellant,

v.

Judicial Review Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

ORDER DENYING MOTION FOR RECONSIDERATION

Appellant Dr. Hung Dang filed a motion for reconsideration of the opinion filed on August 19, 2019. Respondent Washington State Department of Health Medical Quality Assurance Commission filed an answer to the motion. A majority of the panel has

determined that the motion should be denied. Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

FOR THE COURT:

s/_____
Judge

APPENDIX F

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON DIVISION ONE

Case No. 78910-4-I

[Filed: October 23, 2019]

HUNG DANG, M.D.,

Appellant,

v.

Judicial Review Agency Action of the WASHINGTON STATE DEPARTMENT OF HEALTH, MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

ORDER GRANTING MOTION TO PUBLISH

Appellant Dr. Hung Dang filed a motion to publish the opinion filed on August 19, 2019. Respondent Washington State Department of Health Medical Quality Assurance Commission filed an answer to the motion. A majority of the panel has determined that

the motion should be granted. Now, therefore, it is hereby

ORDERED that appellant's motion to publish the opinion is granted.

FOR THE COURT:

s/_____
Judge

APPENDIX G

No. 97880-8

SUPREME COURT OF THE STATE OF WASHINGTON

No. 78910-4

COURT OF APPEALS, DIVISION ONE OF THE STATE OF WASHINGTON

[Filed: November 21, 2019]

HUNG DANG, MD,

Petitioner,

v.

WA STATE DEPARTMENT OF HEALTH MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent.

PETITION FOR REVIEW

* * *

[pp.14-15]

appeal. Decision 16. Yet, the COA went on to rule on this "waived" issue. Even if this Court considers a 2-page long argument not adequate to preserve this issue, precedents and court rules for raising the issue of jurisdiction for the first time on appeal exist. Maynard Inv. Co., Inc. v. McCann, 77 Wn.2d 616, 621, 465 P.2d 657 (1970).

> "The ordinary rule that errors not raised below will not be considered on appeal has been treated as subject to an exception where the matter raised for the first time on appeal was of such a character as to render the judgment of the lower court void, as where the court had **no jurisdiction of the subject matter**."*Id* at 621.
>
> "Courts are created to ascertain the facts in a controversy and to determine the rights of the parties according to justice. Courts should not be confined by the issues framed or theories advanced by the parties if the parties ignore the mandate of a statute or an established precedent."*Id* at 623.

"The text of RAP 2.5(a) clearly delineates three exceptions that allow an appeal as a matter of right." State v Blazina, 182 Wn.2d at 833. As such, even for the first time on appeal, court rules and precedents allowed me to raise the issue that MQAC lacks EMTALA subject matter jurisdiction.

2. **Whether RCW 18.130.180(1) and (4) prohibit a physician from exercising his or her speech and independent medical opinion.**

MQAC concluded that I violated RCW 18.130.180(1) and (4) for my "refusal to aid and consult with fellow physicians, while acting as an on-call specialist, constitutes acts of moral turpitude and lowers the standing of the profession in the eyes of the public"(COL 2.3 and 2.4) and that my "refusal to consult with fellow physicians and treat patients, while acting as an on-call specialist, created an unreasonable risk of patient harm" (COL 2.5 and 2.6). Yet, no provision in the UDA mandates an on-call specialist to automatically enter into a professional relationship with and render his or her services to ER physicians and patients without his or her consent or consideration for his or her capabilities. The UDA, chapter 18.130 RCW, does not prohibit an on-call physician from exercising his or her speech and independent medical judgment in deciding whom to consult or treat, especially when that physician was physically incapable and did not feel competent to take care of a particular patient.

3. **Whether it is a violation of the Due Process Clause of the US Constitution and the Washington Constitution Art. 1, § 10 for MQAC to serve and amend its Final Order beyond the statutory time limits of RCW 34.05.470(3) and .461(8)(a).**

"Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests within the meaning of

the Due Process Clause of the Fifth or Fourteenth Amendment." Mathews v. Eldridge, 424 U.S. 319, 332, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976). A medical license is a constitutionally protected property interest which must be afforded due process." Nguyen v. Department of Health Medical Quality Assurance Commission, 144 Wn.2d 516, 523, 29 P.3d 689 (2001). A physician's license, professional

* * *

APPENDIX H

COURT OF APPEALS, DIVISION ONE

OF THE STATE OF WASHINGTON

Case No. 78910-4

HUNG DANG, MD,

Pro Se Appellant

v.

WA STATE DEPARTMENT OF HEALTH MEDICAL QUALITY ASSURANCE COMMISSION,

Respondent

MOTION FOR RECONSIDERATION

* * *

[pp.3-4]

First, a clarification is needed for this Court's ruling, "We affirm the amended MQAC decision and final order" because there are the MQAC's Findings of Fact, Conclusions of Law, and Final Order dated September 29th, 2017 and the Amended Findings of Fact, Conclusions of Law, and Final Order dated

December 20th, 2017, as well as the Superior Court's Order on Petition for Judicial Review dated August 9th, 2018. This Court needs to clarify which of these three documents was or were referred to in this unpublished opinion.

Second, this Court's opinion in this case is not only unprecedented but also raises serious constitutional and legal issues because the Court has given MQAC expansive legal authorities beyond those of RCW 18.130.050 and contrary to 42 U.S.C §1320a–7a. Additionally, the decision conflicts with many of the Supreme Court's precedents. Therefore, I seek this Court to reconsider its unpublished opinion.

A. The Uniform Disciplinary Act (UDA) Does Not Prohibit an On-Call Physician from Exercising His or Her Professional Speech and Medical Judgement.

In its Findings of Fact, Conclusions of Law, and Final Order, MQAC cited that I violated RCW 18.130.180(1), (4), and (7) for my "refusal to aid and consult with fellow physician, while acting as an on-call specialist", "refusal to consult with fellow physicians and treat patients, while acting as an on-call specialist", and "fail[ure] to appear in the SJMC 4 emergency department to treat patient C, while on call for SJMC as an ENT specialist". COL 2.3 to 2.8. However, there is no language in the UDA prohibiting an on-call specialist from exercising his or her medical judgement and professional speech to refuse accepting transfers or entering into a consensual professional relationship with anyone based on his or her professional and physical capacity. Nothing in the plain

language of the UDA, chapter 18.130 RCW, mandates an on-call specialist to offer his or her professional services to everyone who asks, especially when he or she did not feel capable at the time. As a matter of law, such conclusions by MQAC have no legal basis. This Court overlook this very important and critical matter of law.

B. RAP 2.5(e) Permits a Claim of Lack of MQAC Jurisdiction Over EMTALA to Be Made for the First Time on Review.

"The text of RAP 2.5(a) clearly delineates three exceptions that allow an appeal as a matter of right." State v. Blazina, 182 Wn.2d 827, at 833, 344 P.3d 680 (2015). Accordingly, even for the first time on appeal, I am allowed to raise a claim that MQAC lacks statutory authorization and subject matter jurisdiction over EMTALA. "The ordinary rule that errors not raised below will not be considered on appeal has been treated as subject to an exception where the matter raised for the first time on appeal was of such a character as to render the judgment of the lower court void, as where the court had no jurisdiction of the subject matter." Maynard Inv.

* * *