RE: Carl J. Brodie, MD
Master Case No.: M2011-1278
Document: Agreed Order

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

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4700
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.
STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of:

CARL J. BRODIE, MD
License No. MD00027570

Respondent

No. M2011-1278

STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER

The Medical Quality Assurance Commission (Commission), through Suzanne L. Mager, Commission Staff Attorney, and Respondent, represented by counsel, stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On June 6, 2014, the Commission issued a Statement of Charges against Respondent.

1.2 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(1), (4), (7), (12), (13), (22), (24) and WAC 246-919-630(2).

1.3 The Commission is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.5 The Commission has the authority to impose sanctions pursuant to RCW 18.130.160 if the allegations are proven at a hearing.

1.6 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order).

1.7 Respondent waives the opportunity for a hearing on the Statement of Charges if the Commission accepts this Agreed Order.

1.8 This Agreed Order is not binding unless it is accepted and signed by the Commission.

1.9 If the Commission accepts this Agreed Order, it will be reported to the National Practitioner Data Bank (45 CFR Part 60), the Federation of State Medical Boards' Physician Data Center and elsewhere as required by law.
1.10 This Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

1.11 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

2. FINDINGS OF FACT

Respondent and the Commission acknowledge that the evidence is sufficient to justify the following findings, and the Commission makes the following findings of fact:

2.1 On July 7, 1990, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active.

Patient A

2.2 Patient A originally presented to Respondent for treatment in 1994 when she was 36 years old with symptoms consistent with a diagnosis of lupus.

2.3 Patient A became divorced in 2006. Respondent began a personal relationship with Patient A beginning in December 2009. The relationship ultimately included sexual intercourse and continues to this day.

2.4 While engaged in a sexual relationship with Patient A, Respondent continued to prescribe her the medications she had been taking.

2.5 Respondent maintained inadequate medical records for Patient A. His records do not contain adequate historical and physical examination information to document how Patient A's condition was assessed and treated.

2.6 Prior to Respondent's personal involvement with Patient A he prescribed various medications over fifteen years of his care. Among the medications prescribed by Respondent for Patient A were Vicodin, Solu-Medrol, OxyContin, and alprazolam. He also prescribed methotrexate, which has a very narrow therapeutic window. Respondent failed to provide documentation that he monitored Patient A appropriately for these medications. Despite the use of multiple psychotropic medications and multiple controlled substances
for which substantial monitoring of efficacy is essential. Respondent's medical records for Patient A contain very limited information to provide a rationale for this treatment and failed to document monitoring or functional benefit. Respondent failed to document any education of Patient A concerning the risks of taking opioid medications. Respondent provided samples of Lunesta to Patient A without documenting dosage or the quantity he provided to her.

2.7 Respondent treated Patient A with thalidomide. There is limited information in the medical record to explain the rationale for such treatment and inadequate informed consent.

2.8 Respondent failed to maintain a longitudinal chart of Patient A's medications, which is a substantial departure from the standard of care for patients treated for chronic conditions.

2.9 Respondent failed to provide appropriate medical supervision of Patient A's care. He noted on November 18, 2009, that he planned to treat her with IV Solu-Medrol and then see her in follow-up. There is documentation that Respondent's nurse provided these infusions to Patient A monthly from November 2009 through May 2010, yet there is no documented follow-up by Respondent during this time. On-going IV infusion of steroids under Respondent's prescription without any follow-up visits or documentation created a risk of harm to Patient A.

2.10 On March 25, 2010, Respondent issued a written referral for Patient A to another physician. Patient A did not see the new physician for treatment until July 7, 2011, at which time it was noted that she was taking several prescription medications.

2.11 Respondent continued treating Patient A at his clinic using infusion therapy through at least May 20, 2010. Respondent stated in writing that during the period between May 2010 and June 2011, Patient A monitored her own care and that he did not provide care to her. Respondent stated that during this time he was no longer treating Patient A and kept no records.

2.12 During the period when Respondent stated he was no longer treating Patient A and during which time he maintained no medical records for her, Respondent issued the following prescriptions to Patient A:
2.12.1 On or about November 12, 2010, Patient A filled RX#139909 for doxycycline at a pharmacy in Issaquah, Washington.

2.12.2 On or about November 12, 2010, Patient A filled RX#139910 for metoclopramide at a pharmacy in Issaquah, Washington.

2.12.3 On or about November 26, 2010, Patient A filled RX#1403002 for methotrexate at a pharmacy in Issaquah, Washington. Patient A re-filled this prescription on April 6, 2011.


2.12.5 On or about December 1, 2010, Patient A filled RX#1402087 for trazadone at a pharmacy in Issaquah, Washington.


2.12.7 On or about January 17, 2011, Patient A filled RX#1419266 for zolpidem at a pharmacy in Issaquah, Washington.

2.12.8 On or about April 6, 2011, Patient A filled RX# 1445597 for folic acid at a pharmacy in Issaquah, Washington

2.13 Respondent engaged in unprofessional conduct by engaging in a sexual relationship with Patient A while Patient A was a current Patient, and/or in the alternative did not wait an appropriate amount of time and document formal transfer of care prior to engaging in a sexual relationship with Patient A. Respondent's continued treatment of Patient A after they were in a sexual relationship created a situation that placed Patient A at risk of harm due to the compromise of objectivity in the physician-patient relationship.

**Patient B**

2.14 Respondent first treated Patient B in December 2002. Respondent noted she had a complex clinical presentation consistent with inflammatory arthropathy and possible connective tissue disease.

2.15 Respondent had a personal and sexual relationship with Patient B.

2.16 Although Patient B received care from other providers in late 2003, it appears from the medical records that Respondent and the RN he supervised, as well as the ARNP in his practice, also continued to treat Patient B during the time that Respondent and Patient B were married.

Patient C

2.17 Respondent began treating Patient C in his clinic in January 2001. She was seen every two to four months for monitoring and adjustment of her immune-suppressant medication for lupus and also received monthly infusions.

2.18 Respondent had a sexual relationship with Patient C, which he alleges ended in 1996.

2.19 Patient C has a complex medical history, including resection of a brain tumor with questionable adenopathy or masses at the base of her neck. Many of Respondent's records for Patient C are handwritten, largely illegible, and offer no meaningful clinical information regarding the efficacy or appropriateness of on-going treatment.

2.20 During one of Patient C's visits, Respondent prescribed Xanax for steroid-induced anxiety, Solu-Medrol and methotrexate, and refilled Provigil. Xanax, a benzodiazepine, requires very close monitoring given the potential for physical dependence. The medical records should have been particularly detailed when a patient is receiving multiple psychotropic medications, such as in this instance Provigil in combination with Xanax. Respondent's records were inadequate.

2.21 Methotrexate has a narrow therapeutic window and an FDA black-box warning with eleven potential complications. The warnings include: "Patients should be informed by the physician of the risks involved and be under a physician's care through therapy. Patients should be closely monitored for bone marrow, liver, lung, and kidney toxicities. Methotrexate should be used only in life-threatening neoplastic diseases or in patient with psoriasis or rheumatoid arthritis with severe, recalcitrant, disabling disease which is not adequately responsive to other forms of therapy." Respondent's medical records for Patient C do not document the degree of assessment and monitoring appropriate for use of such a medication.
Aiding and abetting unlicensed practice or practice beyond scope

2.22  Respondent hired Audrey Delarose in August 2009. Ms. Delarose worked for Respondent until March 2011. Ms. Delarose was hired as a medical receptionist and although trained as a medical assistant, was not a certified or licensed health professional. Ms. Delarose sometimes removed IV tubes, prepared chart notes, gave patients injections, and instructed patients on their medications, independently and without supervision. Ms. Delarose’s initials were entered on the nursing notes in patient’s charts when she drew medication and disconnected IVs.

2.23  Dana Rankin began working for Respondent in March 2006, at which time she was not a certified or licensed health professional. Ms. Rankin became certified as a Health Care Assistant in July 2007. Ms. Rankin took a job with another employer in May 2009. While employed by Respondent, Ms. Rankin performed duties for which she was unauthorized, even after having received her Health Care Assistant credential. These duties included authorizing prescription refills for narcotics.

2.24  When Respondent went on vacation for about three weeks in October 2010, he signed blank prescriptions with the intention that his staff, who were not licensed to issue prescriptions, would fill in and issue the refill prescriptions in his absence.

Substandard management of patient care; inadequate medical recordkeeping

2.25  Respondent’s medical records are not organized in a format in which other medical providers reviewing the charts can understand the medical history, the physical examination findings, the clinical impression, the treatment plan, or the patients’ response to treatment. Respondent’s chart notes are hand-written and, when not illegible, are difficult to read. (Patients A, B, C, D, E, F, G, H, I J, K L, M, N, O, and P).

2.26  Respondent failed to consistently maintain prescription flowcharts for his patients. Flowcharts of prescriptions are important for any patient, but are particularly important for patients being treated for chronic conditions, and when a patient is being prescribed controlled substances and/or medications with a narrow therapeutic window. (Patients A, B, C, D, E, F, G, I, J, K L, M, N, O, and P).
2.27 Respondent's medical records include very limited documentation as to the rationale or efficacy of his prescriptions of multiple medications, including psychotropic medications, benzodiazepines, opioids, and medications with "black-box" warnings. Respondent's records fail to document patient education on the risks of the drugs prescribed. Although Respondent routinely prescribed multiple drugs in combination, his records fail to provide information concerning follow-up for possible drug interactions. When prescribing opioids, Respondent's records substantially fail to include sufficient detail to meet the standard of care for managing patients prescribed opioids on a chronic basis. Respondent's records for patients to whom he prescribed opioids indicate that he failed to adequately explore the possibility of aberrant drug behavior.

2.28 Respondent routinely failed to record the notes of a patient visit or otherwise complete his medical recordkeeping at the time of patients' office visits. In several instances, Respondent completed his patient charts from "memory" a much as a year after the patients' office visit.

2.29 Because Respondent's records were so lacking in detail and completeness, other medical providers and even Respondent's own staff were unable to determine the treatment to be given to patients and follow-up office visits sometimes had to be scheduled in order to determine appropriate medication or other treatment.

### Failure to maintain appropriate physician-patient boundaries or objectivity, self-prescribing, and other unprofessional conduct

2.30 Respondent self-prescribed and received the following legend drugs:

1.30.1 Voltaren, October 11, 2010;
1.30.2 Azithromycin, May 29, August 30, and October 2, 2010;
1.30.3 Acyclovir, August 30, October 2, and December 27, 2010, March 5 and April 30, 2011;
1.30.4 Gabapentin, July 10, August 31, Oct 2, October 11, and December 27, 2010 and March 5, 2011.

2.31 While Respondent was involved in a sexual relationship with Patient A, he also wrote at least five prescriptions for Patient A's daughter, Patient Q, between
November 3, 2009 and November 12, 2010. Respondent acknowledged in writing that he maintained no records for Patient Q.

2.32 Respondent hired Patient G to provide information technology support for his practice.

2.33 Respondent on several occasions invited his patients to parties at his home, as well as to other personal events, such as his wedding reception and his brother's birthday party.

**Practice Beyond Scope of License**

2.34 Respondent issued two prescriptions for levothyroxine in the name of Patient A, to be administered to Patient A's dog which was on levothyroxine.

### 3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (4), (7), (12), and (24) and WAC 246-919-630 (2).

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

### 4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order.

4.1 **Probation.** The Commission places Respondent's license on probation for a minimum of 60 months from the effective date of this Stipulation.

4.2 **Boundaries Program.** Respondent must successfully complete the Comprehensive edition of the Professional Boundaries course offered by Professional Boundaries, Inc. This includes the "Primer" teleconference program; the three-day, in-person course; and the 12-week Maintenance and Accountability teleconference seminars. Respondent must submit his certificates of completion of each component to the Commission. Respondent must provide the course administrators and instructors
with a copy of this Order prior to the course and must provide authorization to the
course administrators and instructors for them to communicate with Commission staff.
The mailing address for the required certificates of completion is: Compliance Officer,
Medical Quality Assurance Commission, POB 47866, Olympia, Washington 98504-
7866.

4.3 **Opioid Prescribing Courses.** Within two months of the effective date of
this Order, Respondent must successfully complete the following continuing medical
education (CME) courses on the Commission's pain management rules and on opioid
prescribing for chronic, non-cancer pain:

4.3.1 University of Washington's COPE-REMS (Collaborative Opioid
Prescribing Education-Risk Evaluation and Mitigation Strategy) course, available
at: [http://trainingexchange.org/our-programs/cope-rems](http://trainingexchange.org/our-programs/cope-rems), and

4.3.2 Opioid Dosing Guideline and DOH Pain Management Rules Online
CME Activity, available at:
Both courses are free of cost and available online, 24 hours each day. Respondent
must complete all of the reading required by each course and must complete all aspects
of each course entirely on his own. Respondent must receive a passing score on each
course's examination. Respondent must submit proof of his successful completion of both
courses to: Compliance Officer, Medical Quality Assurance Commission, PO Box 47866,
Olympia, Washington 98504-7866.

4.4 **Psychodiagnostic Evaluation.** Within six (6) months of the effective
date of this Agreed Order, Respondent must undergo a multi-disciplinary,
psychodiagnostic evaluation at either the Gabbard Center or Acumen Assessments,
Inc.. To assist in the evaluation, Respondent must provide the evaluator with a copy of
this Agreed Order and any releases for information requested by the evaluator,
including authorization for the evaluator to communicate with Commission staff.
Respondent must provide the Commission timely notice of his evaluation so the
Commission can provide the evaluator portions of the file in this matter, as requested by
the evaluator. Respondent must assure that the evaluator provides the Commission
with an evaluative report and all raw data that support the evaluator's findings.
Respondent must follow all treatment recommendations and/or conditions set by the
evaluator. The report must include:
4.4.1 A description of the evaluation process and Respondent's cooperation with that process;
4.4.2 Recommendations, if any, for mental health counseling or other treatment the evaluator believes Respondent should undergo;
4.4.3. If the evaluator determines that Respondent can practice as a physician and surgeon without posing an unreasonable risk of harm to clients or the public, a detailed description of any and all practice conditions and/or restrictions the evaluator recommends, including could include on-going mental health counseling.

4.5 **Risk-Management Consultation and Written Protocol.** Within two months of the effective date of this Order, Respondent will obtain an on-site consultation from his malpractice carrier's risk managers to address the appropriate use of Medical Assistants and other staff who provide patient care. Respondent will develop a written protocol which will assure his continued compliance with all registration and certification requirements for the staff in his practice, whether contracted or employed by Respondent. Within three months of the effective date of this Order, Respondent will submit the protocol for the Commission's review and approval to Compliance Officer, Medical Quality Assurance Commission, P.O. Box 47866, Olympia, Washington, 98504-7866. Once approved by the Commission, Respondent will adhere to the protocol.

4.6 **Prohibition against Treating or Prescribing for Himself, Romantic Partner, or Family Members.** Respondent is prohibited from treating his romantic partner and his and his romantic partner's family members. Respondent is prohibited from prescribing medications for himself, his romantic partner, and his and his romantic partner's family members. This prohibition includes legend drugs as well as controlled substances.

4.7 **Practice Reviews.** Respondent agrees that a representative of the Commission may make announced semi-annual visits to Respondent's practice to review Respondent's recordkeeping, medication management including medication flowcharts, compliance with the Commission's pain management regulations, and compliance with this Order. The review may include inspection of office and medical records in consultation with office staff and an interview of Respondent and office staff.

4.8 **Compliance Appearances.** Respondent must appear before the Commission 12 months from the effective date of this Stipulation, or as soon thereafter
as the Commission’s schedule permits, and annually thereafter until the Order is terminated.

4.9 **Fine.** Respondent must pay a fine to the Commission in the amount of $35,000, which, if not paid within 90 days of the effective date of this Order, must be paid at least quarterly, in installments of at least $5,000 each. The first installment must be paid by July 1, 2015, with full payment due by January 2, 2017. The fine must be paid by certified or cashier’s check or money order, made payable to the Medical Quality Assurance Commission and mailed to the Department of Health, P.O. Box 1099, Olympia, Washington 98507-1099.

4.10 **Termination of Stipulation.** Respondent may petition the Commission in writing to terminate this Stipulation after completing all requirements of the Stipulation, including the term of probation. The Commission will issue a notice scheduling a date and time for Respondent to appear, unless the Commission waives the need for a personal appearance.

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

4.12 **Compliance Costs.** Respondent is responsible for all costs of complying with this Agreed Order.

4.13 **Violation of Order.** If Respondent violates any provision of this Agreed Order in any respect, the Commission may initiate further action against Respondent’s license.

4.14 **Change of Address.** Respondent shall inform the Commission and the Adjudicative Clerk Office, in writing, of changes in Respondent’s residential and/or business address within thirty (30) days of the change.

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

5. COMPLIANCE WITH SANCTION RULES
5.1 The Commission applies WAC 246-16-800, et seq., to determine appropriate sanctions. Tier B of the "Practice Below Standard of Care" sanction schedule applies to cases in which substandard practices created the risk of moderate to severe patient harm. Tier B of the "Sexual Misconduct" sanction schedule applies to cases in which sexual contact or romantic relationships of patients with their physician put patients at risk of harm.

5.2 Respondent's care of Patients A through P put them at risk of moderate to severe harm. Respondent's sexual contact and romantic relationships with patients A, B, and C, put them at risk of harm due to the compromise of objectivity in the physician-patient relationship.

5.3 Tier B of each schedule requires the imposition of sanctions ranging from two years of oversight to five years of oversight, unless revocation. Under WAC 246-16-800(3)(d), the starting point for the duration of the sanctions is the middle of the range. The Commission uses aggravating and mitigating factors to move towards the maximum or minimum ends of the range.

5.4 The aggravating and mitigating factors in this case justify the maximum end of the Tier B range. The aggravating factors are: Respondent engaged in sexual misconduct with three patients; Respondent failed to manage appropriately the pain and psychotropic medications of multiple patients, over a period of multiple years; Respondent permitted multiple staff to exceed their scopes of practice over a period of multiple years, including his direction to them to issue prescription refills even though they were not licensed to do so; and, Respondent engaged in multiple boundary violations, over a period of multiple years. The mitigating factor is: the Commission has not received patient complaints concerning the quality of Respondent's care, many of whom he has treated for over 20 years. The aggravating factors outweigh the mitigator.

5.5 The sanctions are appropriate given the facts of the case. The Commission believes they will adequately protect the public. The sanctions include five years' probation; a psychodiagnostic evaluation and agreement to follow the evaluator's recommendations; continuing medical education on opioid prescribing, pain management, and boundaries; development of, and adherence to, a protocol to assure all staff are
appropriately credentialed at all times; semi-annual practice reviews, annual appearances before the Commission; and a fine.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. RESPONDENT'S ACCEPTANCE

I, CARL J. BRODIE, MD, Respondent, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.

CARL J. BRODIE, MD
RESPONDENT

12-23-14

DATE

THOMAS H. FAIN, WSBA# 7117
ATTORNEY FOR RESPONDENT

12-26-14

DATE

STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND AGREED ORDER
NO. M2011-1278

ORIGINAL
8. COMMISSION'S ACCEPTANCE AND ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED: 8 Jan 2015.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

[Signature]
PANEL CHAIR

PRESENTED BY:

[Signature]
SUZANNE L. MAGER, WSBA# 19284
COMMISSION STAFF ATTORNEY