IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

DALE E. ALSAGER, D.O., individually and with respect to his licensure as an Osteopathic Physician and Surgeon, Credential No. OP00001485, Appellant, v. WASHINGTON STATE BOARD OF OSTEOPATHIC MEDICINE AND SURGERY, a State Board and Agency as established by law under RCW 18.57.003; WASHINGTON STATE DEPARTMENT OF HEALTH, an administrative agency of the State of Washington; ADJUDICATIVE SERVICE UNIT, a unit of the Washington State Department of Health; and JOHN F. KUNTZ, Health Law Judge, Presiding Officer, Adjudicative Service Unit, Department of Health, Respondents.	No. 39301-8-II UNPUBLISHED OPINION

Houghton, J. — Dale Alsager, a licensed doctor of osteopathic medicine, appeals the trial court's decision upholding an order by the Department of Health's (Department) Board of Osteopathic Medicine and Surgery (Board) imposing professional sanctions on him. He argues that the Board (1) erred in accepting the cause of death as listed on a patient's death certificate as the patient's legal cause of death, (2) based its conclusions of law on erroneous standards of care,

(3) imposed sanctions in excess of its statutory and constitutional authority, and (4) made findings of fact substantial evidence did not support. We affirm.

FACTS

The State of Washington issued Alsager a license to practice osteopathic medicine in 1995. Alsager treated the patients at issue in this case, A, B, C, D, E, F, and G,[1] at various times between 2001 and 2006 at his practice in Maple Valley. Patients A through E are related to one another. And Patients F and G were involved in a relationship with each other.

Alsager treated Patient A for lower back pain and numbness in his left knee. Alsager prescribed Duragesic and Percocet (opioids) for pain, without conducting a physical examination. Over the next several days, Alsager increased Patient A's dosage for Duragesic and Percocet and prescribed clonazepam (a benzodiazepine anti-seizure medication). Patient A returned to Alsager for care several years later, after which Alsager diagnosed Patient A with colitis and prescribed oxycodone (an opioid pain medication), Xanax (a benzodiazepine anti-anxiety medication), and alprazolam (Xanax).

Later in 2005, Patient A visited Alsager after a car accident. Alsager continued to give Patient A prescriptions. Then on September 13, Patient A saw Alsager and asked for more medication because of continued pain. Alsager provided Patient A with a fentanyl (opioid) patch, along with other pain prescriptions. The next morning, Patient A died. The King County Medical Examiner concluded that Patient A died from acute intoxication due to fentanyl, diazepam (a

[1] The record and both parties refer to patients by letters instead of their names to protect patient confidentiality. We do the same.

benzodiazepine anti-anxiety medication), oxycodone, and carbamazepine (anti-seizure medication).

Alsager treated Patient B for back pain. Similar to Patient A, Alsager prescribed various opioids and benzodiazepines for Patient B. Alsager also diagnosed Patient B with colitis and prescribed intravenous and oral antibiotics regularly. Alsager further administered vitamin B12 and folate (vitamin B) injections to Patient B even though Alsager did not verify the need for the injections. Throughout Alsager's treatment of Patient B, Alsager never referred Patient B to any other medical professionals to address his health issues.

Alsager treated Patient C for a series of ailments over the years. Alsager prescribed benzodiazepines to Patient C for anxiety. Alsager continued this treatment regimen and made no other attempts to find alternative care for Patient C's anxiety. Alsager also administered vitamin B12 and folate injections to Patient C, much like Patient B.

Alsager treated Patient D for shoulder pain, without referring Patient D to an orthopedic specialist. Alsager administered shoulder joint injections, which did not improve Patient D's condition. Alsager then prescribed Soma (muscle relaxant medication) and benzodiazepines in order to treat muscle spasms. Even though Alsager later learned that the police arrested Patient D for prescription drug forgery, Alsager continued to provide him with pain medications. Patient D altered a prescription a few months later, and Alsager again failed to address Patient D's pain medication dependency.

Alsager treated Patient E for chronic pain. Despite a series of occurrences that should have suggested that Patient E was abusing pain medications, such as information from

Patient E's employer that he seemed drugged at work, that Patient E reportedly abused his wife, and that Patient E had a history of alcoholism, Alsager increased Patient E's pain medication dosage. Alsager also diagnosed Patient E with rheumatoid arthritis even though Patient E did not present with the proper signs and symptoms. Alsager did not refer Patient E to a rheumatologist. Alsager also administered injections of immunosuppressants, vitamin B12, and folate, all without adequate testing.

Alsager treated Patient F for chronic pain. Despite evidence that Patient F was not taking pain medication as prescribed, Alsager did not document any steps he took to address this. Alsager relied on Patient F's own diagnosis of rheumatoid arthritis to serve as the basis of continued pain treatment. Despite underlying infections, Alsager administered a series of joint and spinal injections to Patient F.

Alsager treated Patient G for chronic pain as well. Patient G's primary source of pain stemmed from a fractured wrist. Although Patient G also saw an orthopedist for his wrist injury, Alsager administered joint injections and apparently did not confer with the orthopedist. Although Patient G's urinalysis tested positive for marijuana but negative for the opioids Alsager prescribed, Alsager did not seek to determine why Patient G was not taking the pain medication. Patient G then experienced seizures from benzodiazepine withdrawal. Patient G continued to see Alsager following Patient G's release from the hospital for the seizures. Alsager prescribed more benzodiazepines for Patient G soon thereafter.

On August 1, 2006, the Department, through the Board, issued a Statement of Charges against Alsager, alleging unprofessional conduct under RCW 18.130.180(4) and (7)[2] for

providing treatment to Patients A, B, C, D, E, F, and G that fell below the standard of care. On August 8, the Board issued an "Ex Parte Order of Summary Restriction" that "prohibited Alsager from prescribing Schedule II or Schedule III controlled substances, pending further proceedings before the Board."[3] Clerk's Papers (CP) at 77.

The administrative hearing began on April 21, 2008. At the outset, the presiding officer dismissed the allegation that Alsager violated RCW 18.130.180(7) because the parties could not determine which state or federal statute or administrative rule Alsager violated. The hearing continued only on whether Alsager violated RCW 18.130.180(4). Three Board members, all osteopathic physicians, heard testimony from several doctors, including John Lacy, M.D. (medical examiner); Jon Hillyer M.D. (the Department's expert); James Song, M.D. (Patient A's neurologist); Wayne Anderson, D.O. (Alsager's witness); Thomas Ray, M.D. (Alsager's witness); and Alsager himself.

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[2] RCW 18.130.180 provides in relevant part:

> The following conduct, acts, or conditions constitute unprofessional conduct for any license holder . . . under the jurisdiction of this chapter:
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> . . . .
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> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
>
> . . . .
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.

Former RCW 18.130.180 (1995) was in effect at the time the State issued charges against Alsager. The relevant statutory provisions at issue, however, did not change in the current version enacted in 2008.

[3] As the order denotes, the Board has authority to take emergency action to address immediate dangers to public health, safety, or welfare.

Hillyer, an anesthesiologist specializing in pain management, testified about his review of the medical records for Patients A, B, C, D, E, F, and G. Hillyer described in detail how Alsager's care for each patient fell below the requisite standard.

With regard to Patient A, Hillyer testified that Alsager prescribed pain medications in unusually high doses and that the circumstances did not support this treatment approach, particularly in light of Patient A's seizure condition. Song testified that he treated Patient A for a seizure condition and that he had forwarded that information to Alsager. As to Patient F, Hillyer testified that Alsager failed to refer Patient F to a rheumatologist after diagnosing him with rheumatoid arthritis.

Anderson, an osteopathic physician specializing in neurology and pain management, testified on Alsager's behalf. Anderson testified specifically as to Patient A's cause of death, which he believes resulted from sudden unexplained death in epilepsy patients (SUDEP syndrome). Anderson also testified that Alsager's care for Patients A, B, C, D, E, F, and G did not fall below the standard of care. Ray, a forensic pathologist, also testified specifically as to Patient A's cause of death, which he believes resulted from seizures, not pain medications.

The Board issued a corrected final order on August 15, which found, by clear and convincing evidence, that Alsager committed unprofessional conduct. The Board imposed a series of sanctions and restrictions on his ability to practice medicine. Specifically, the Board (1) prohibited him from prescribing Schedule II and Schedule III controlled substances until he completed a Board approved training course or residency regarding pain management; (2) required that any and all diagnostic MRI, CT, or Dexa scans taken be reviewed by a qualified

radiologist; and (3) ordered Alsager to pay a $20,000 administrative fine.

Alsager sought judicial review of the Board's final order in the superior court. The superior court, in its appellate capacity, affirmed the board's final order on May 1, 2009. Alsager appeals.

ANALYSIS

Standard of Review

We apply the standards of the Washington Administrative Procedure Act, chapter 34.05 RCW, directly to the agency record in reviewing agency adjudicative proceedings. *William Dickson Co. v. Puget Sound Air Pollution Control Agency*, 81 Wn. App. 403, 407, 914 P.2d 750 (1996). Under that act, we may reverse an administrative order (1) if it is based on an error of law, (2) if substantial evidence does not support it, (3) if it is arbitrary or capricious, (4) if it violates the constitution, (5) if it is beyond statutory authority, or (6) when the agency employs improper procedures. RCW 34.05.570(3)(d), (e), (h), (i), (a), (b), (c); *State Employment Sec. Dep't v. Tapper*, 122 Wn.2d 397, 402, 858 P.2d 494 (1993).

We review issues of law arising out of an administrative agency decision de novo. *Kellum v. Dep't of Retirement Sys.*, 61 Wn. App. 288, 291, 810 P.2d 523 (1991). We accord substantial weight to the agency's interpretation of the law it administers, particularly when the issue falls within the agency's expertise. *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 728, 818 P.2d 1062 (1991); *US West Commc'ns, Inc. v. Wash. Utils. & Transp. Comm'n*, 86 Wn. App. 719, 728, 937 P.2d 1326 (1997).

With regard to issues of fact, we review the evidence submitted to determine whether it

constituted substantial evidence to support the agency's factual findings. RCW 34.05.570(3)(e). At the agency level in medical disciplinary proceedings, the standard of proof is clear and convincing evidence. *Nguyen v. Dep't of Health, Quality Assurance Comm'n*, 144 Wn.2d 516, 518, 29 P.3d 689 (2001). Substantial evidence is that which is sufficient " 'to persuade a fair-minded person of the truth of the declared premises'." *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 607, 903 P.2d 433, 909 P.2d 1294 (1995) (quoting *Nghiem v. State*, 73 Wn. App. 405, 412, 869 P.2d 1086 (1994)) (internal quotation marks omitted). And medical review boards are able to rely on their own expertise in evaluating medical practices. *Wash. Med. Disciplinary Bd.* v. *Johnston*, 99 Wn.2d 466, 482, 663 P.2d 457 (1983).

Patient A's Cause of Death

Alsager first contends that the Board erred in relying on Patient A's cause of death as listed on his death certificate. He argues that the statute establishing this as Patient A's "legally accepted cause of death" creates an unconstitutional conclusive presumption. Appellant's Br. at 29; RCW 70.58.180.

When a party challenges the constitutionality of a statute, we presume the statute to be constitutional, placing the burden on the party challenging it to prove its unconstitutionality beyond a reasonable doubt. *Tunstall v. Bergeson*, 141 Wn.2d 201, 220, 5 P.3d 691 (2000). We are hesitant to strike a statute unless fully convinced that the statute violates the constitution. *Tunstall*, 141 Wn.2d at 220. And whenever possible, we construe the statute as constitutional. *Philippides v. Bernard*, 151 Wn.2d 376, 391, 88 P.3d 939 (2004). " '[A] statute does not create an unconstitutional conclusive presumption unless it requires a trier of fact to presume from the

State's proof of one fact some other fact that constitutes a necessary element of the crime.' "

State v. Mertens, 148 Wn.2d 820, 826-27, 64 P.3d 633 (2003) (quoting *State v. Crediford*, 130 Wn.2d 747, 757, 927 P.2d 1129 (1996)).

RCW 70.58.180 states in relevant part,

> The cause of death, the manner and mode in which death occurred, as noted by the coroner or medical examiner, or if none, the prosecuting attorney or the health officer and incorporated in the death certificate filed with the department shall be the legally accepted manner and mode by which the deceased came to his or her death and shall be the legally accepted cause of death.

And finding of fact 1.25 states,

> The King County Medical Examiner's Office has established the cause of death for Patient A. This is the official cause of death recorded on the death certificate. For that reason, the Board has no need to choose between the alternative causes of death for Patient A (acute intoxication due to combined effects of the drugs or death from seizure). The Board views its responsibility to determine whether the care [Alsager] provided to Patient A was incompetence or negligence of the type that results in injury to Patient A or creates an unreasonable risk that Patient A may be harmed. In other words, did [Alsager's] treatment of Patient A fall below the standard of care for an osteopathic physician in the state of Washington.

CP at 59.

RCW 70.58.180 does not create a conclusive presumption because it does not require the fact finder to presume anything relating to the charges against Alsager. That Patient A's "legally accepted cause of death" was death from acute intoxication due to fentanyl, diazepam, oxycodone, and carbamazepine did not require the Board to conclude or presume that Alsager was responsible.

Moreover, as finding 1.25 states, the cause of death had nothing to do with the Board's duty to determine whether Alsager's treatment violated the standard of care. The other findings

that served as the Board's basis for its conclusion that Alsager violated the standard of care were not based on Patient A's legal cause of death but were based on specific instances of misconduct. The record does not support Alsager's argument that the Board relied on the death certificate and abrogated its duty to find, by clear and convincing evidence, that he violated the standard of care. Thus, his argument fails.

Standard of Care

Alsager next contends that the law requires the Board to promulgate rules setting out the standards of care[4] for adjudging unprofessional conduct. And he asserts that the Board erred in creating "ad hoc" standards of care to be applied against him. Appellant's Br. at 32.

Alsager's contention stems from a flawed premise. The Board did not create "ad hoc" standards of care that it applied against Alsager. The Board applied the standard as defined by RCW 18.130.180(4), which provides that "[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed" constitutes unprofessional conduct.

Simply because the Board has the express statutory authority "[t]o adopt standards of professional conduct or practice" under RCW 18.130.050(14) (formerly (12)) does not mean that its failure to have such rules in effect voids the proceedings. *See Allan v. Univ. of Wash.*, 140 Wn.2d 323, 346-47, 997 P.2d 360 (2000) (an agency should establish a rule when the questioned

[4] Alsager discusses the Board's adoption of the 2002 Guidelines for Management of Pain in his brief. *See* WAC 246-853-510 through -540. As the Board correctly points out, however, it did not allege or attempt to prove that he violated these guidelines. Thus, we do not discuss this further.

agency action will affect the public in a general way and where notice to and comment by the affected public seems useful).

The Board acted within its statutory authority under RCW 18.130.050. Because Alsager fails to cite any valid authority requiring the Board to adopt a set of administrative rules relating to unprofessional conduct, his argument fails.

Sanctions

Alsager further contends that the Board erred when it imposed sanctions.[5] Specifically, he argues that the Board (1) improperly imposed sanctions outside of the Statement of Charges when it required that all diagnostic scanning be reviewed by a qualified radiologist and required Alsager to schedule an office inspection to confirm appropriate shielding for his scanning equipment; (2) assessed a $20,000 fine in excess of its statutory authority; and (3) assessed an unconstitutionally excessive fine.

Once the Board finds that a physician has committed unprofessional conduct, the Board must impose appropriate sanctions to protect the public. RCW 18.130.160. We accord an agency's determination of sanctions considerable judicial deference. *Brown v. State Dep't of Health*, 94 Wn. App. 7, 16, 972 P.2d 101 (1999). We may reverse an arbitrary and capricious agency order. RCW 34.05.570(3)(i). An agency acts arbitrarily and capriciously when it engages in willful and unreasoning action without consideration of and in disregard of the facts and

[5] Alsager also argues that the ex parte order issued along with the Board's Statement of Charges, which limited his ability to prescribe Schedule II and Schedule III controlled substances, deprived him of his due process rights. The Board, however, may issue ex parte emergency orders without a pre-deprivation hearing. *See Jones v. State*, 140 Wn. App. 476, 492-93, 166 P.3d 1219 (2007), *review granted*, 164 Wn.2d 1019 (2008).

circumstances. *Heinmiller*, 127 Wn.2d at 609.

Sanctions Outside the Statement of Charges

Alsager first asserts that the Board's requirement that all diagnostic scanning be reviewed by a qualified radiologist and that he schedule an office inspection to confirm appropriate shielding for his scanning equipment were improper sanctions because they fell outside the Statement of Charges. But the Statement of Charges against Alsager alleged that he improperly diagnosed and treated rheumatoid arthritis, for which he used the scanning equipment. He fails to show how the Board acted arbitrarily and capriciously in imposing these sanctions. Thus, his argument fails.

Fine in Excess of the Board's Statutory Authority

Alsager also asserts that the Board's $20,000 monetary penalty is in excess of the statutorily authorized amount. RCW 18.130.160(8) authorizes the Board to impose a "fine for each violation of this chapter, not to exceed five thousand dollars per violation." Alsager incorrectly reads the statute as though it imposes a limit of $5,000 per statutory provision violated, which the statute does not.[6] In this case, he violated RCW 18.130.180(4) in more than four instances. Thus, his argument fails.

Unconstitutionally Excessive Fine

Alsager next contends that the Board's $20,000 fine is unconstitutionally excessive. He fails, however, to demonstrate exactly how the Board's fine is unconstitutionally excessive. The

[6] Alsager further argues that this statute is ambiguous and that the rule of lenity requires this court to construe the statute as he does. *See State v. Lively*, 130 Wn.2d 1, 14, 921 P.2d 1035 (1996) (the rule of lenity requires this court to construe ambiguous statutes favorably to the accused in criminal matters). Even if the rule applied here, the statute is not ambiguous.

Board found his conduct to violate the standard of care involving seven patients on multiple occasions. In light of this and the considerable deference we give to the Board's imposition of sanctions, Alsager's argument fails.

Findings of Fact

Finally, Alsager contends that substantial evidence does not support several of the Board's findings of fact.[7] He specifically discusses findings of fact 1.2, 1.5, 1.19, 1.21, 1.22, 1.23, 1.25,[8] and 1.48. The clear and convincing evidence standard applies to proceedings affecting a medical license. *Nguyen*, 144 Wn.2d at 518. Where the evidentiary standard is clear, cogent, and convincing, we must determine whether the substantial evidence in support of the findings of fact is "highly probable" and whether the findings, in turn, support the conclusions of law. *DewBerry v. George*, 115 Wn. App. 351, 362, 62 P.3d 525 (2003). Evidence is substantial when there is " 'sufficient quantum to persuade a fair-minded person of the truth of the declared premises.' " *Clausing v. State*, 90 Wn. App. 863, 871, 955 P.2d 394 (1998) (quoting *Olmstead v. Dep't of Health*, 61 Wn. App. 888, 893, 812 P.2d 527 (1991)). But "we do not overturn an agency decision even where the opposing party reasonably disputes the evidence with evidence of equal

[7] Alsager assigns error to all but two of the Board's findings of fact. But he does not "set forth a separate concise statement of each error which [he] contends was made by the agency issuing the order, together with the issues pertaining to each assignment of error" for all of his assigned errors, only some. RAP 10.3(h). He also incorporates by reference his discussion of the assignments of error in his petition for judicial review to the superior court below. A party cannot simply incorporate superior court briefs by reference into his appellate brief. *See Patterson v. Superintendent of Pub. Instruction*, 76 Wn. App. 666, 675-76, 887 P.2d 411 (1994). We discuss the assignments of error Alsager properly raises in his appellate brief. And, in any event, our review of the record discloses adequate evidence to support, by clear and convincing evidence, each finding of fact he disputes.

[8] We discuss finding 1.25 under the heading "Patient A's Cause of Death" above.

dignity." *Ferry County v. Concerned Friends of Ferry County*, 121 Wn. App. 850, 856, 90 P.3d 698 (2004). And we do "not weigh the evidence or substitute our judgment regarding witness credibility for that of the agency." *Premera v. Kreidler*, 133 Wn. App. 23, 32, 131 P.3d 930 (2006).

Finding of Fact 1.2

Finding 1.2 states:

> [Alsager] conducted a general osteopathic medical practice in Maple Valley, Washington. [Alsager] is, by training, a family practitioner. [Alsager] is not a pain management specialist, but was providing pain management treatment to his patients during the relevant time period. Pain management treatment includes the use of opioid medications in the treatment of acute[4] pain and chronic[5] pain. Chronic pain may not have a well-defined onset, and by definition does not respond to treatment directed at its causes.[6]
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> [4] "Acute" is defined as being sharp or severe, having rapid onset, severe symptoms, and a short course. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 31.
> [5] "Chronic" is defined as long draw out, of long duration, designating a disease showing little change or of slow progression and long continuance. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 289.
> [6] Washington Board of Osteopathic Medicine and Surgery Guidelines for Management of Pain, OP96.22 DOC, effective date September 13, 2002.

CP at 50. Substantial evidence supports the specific finding that Alsager "is not a pain management specialist." Inferences drawn from Hillyer's testimony regarding all of the patients support this. Although Alsager's curriculum vitae includes a series of pain management courses and lectures, it does not denote pain management as a "specialty."

Finding of Fact 1.5

Finding 1.5 states:

> A general review of the treatment provided to [each patient] reveals that [Alsager's] treatment practices fall below the standard of care for the practice of

osteopathic medicine in the state of Washington in several areas.

CP at 51. Although labeled as a finding of fact, this appears to be a conclusion of law. We are not bound by the designation and treat findings of fact that are really conclusions of law as such, and we review them under the de novo standard. *See Robel v. Roundup Corp.*, 103 Wn. App. 75, 85, 10 P.3d 1104 (2000), *aff'd in part, rev'd in part on other grounds*, 148 Wn.2d 35, 59 P.3d 611 (2002). Sufficient findings support this conclusion.

Finding of Fact 1.19 (Patient A)

Finding 1.19 states:

> [Alsager] treated Patient A during two separate time periods. The first treatment period occurred from October 2001 to February 2002. At the initial visit on October 11, 2001, [Alsager] diagnosed Patient A with low back pain based on Patient A's report of a five year old football injury. Based on his physical examination and the patient's subjective pain report, [Alsager] prescribed Percocet, a 50 microgram duragesic patch, and celebrex for Patient A's joint pain. There were no objective findings which would support starting the patient with such a high dosage of medication. Other than medication refills and some counseling, [Alsager] did not create a functional plan for the treatment of Patient A. [Alsager's] stated treatment goal was the temporary control of Patient A's pain complaints until [Alsager] could determine the actual cause of the patient's complaints.

CP at 56-57. Hillyer reviewed Alsager's Patient A's medical records and testified to his findings in detail before the Board. Hillyer's testimony provides substantial evidence to support this finding.

Finding of Fact 1.21 (Patient A)

Finding 1.21 states:

> [Alsager] then resumed treatment of patient A in July 2005. Low back pain treatment was resumed, including the renewed prescription of opiate medication (Roxicodone), Xanax for the patient's irritable bowel/anxiety, Compazine for nausea, and Alprzolam for insomnia. As with this treatment approach in 2001,

> [Alsager] prescribed these medications following a physical examine [sic] and based on Patient A's subjective pain complaints. In fact, [Alsager] began the prescription of medications at the same levels prescribed in the 2001-2002 period, without any sufficient explanation or objective medical findings to support that treatment approach. There is no indication in [Alsager's] treatment record that he attempted to obtain information regarding the medical or osteopathic treatment Patient A received during the intervening period, or any attempt to obtain any treatment records from the intervening period. There is no indication that [Alsager] considered prescribing opiate medication at a lesser dose or lesser potency for the patient.

CP at 57-58. Again, Hillyer reviewed Alsager's Patient A's medical records for this period as well and testified to his findings in great detail before the Board. His testimony provides substantial evidence to support this finding.

Finding of Fact 1.22 (Patient A)

Finding 1.22 states:

> On August 2, 2005, Patient A had a motor vehicle accident where his truck went off the road and into a ditch. While awaiting discharge following treatment in the emergency room, Patient A was observed to have a seizure. Patient A was treated for his seizure condition by neurologist James Song M.D., and was prescribed Dilantin. This information was forwarded to [Alsager].

CP at 58. Substantial evidence, based on the testimony of Song, Patient A's neurologist, supports this finding.

Finding of Fact 1.23 (Patient A)

Finding 1.23 states:

> [Alsager] saw Patient A on September 13, 2005, and provided him with a 100 microgram Fentanyl (duragesic) patch. Fentanyl is the highest potency opiate available for non-parenteral use.[10] It is used only in opiate tolerant patients in a stepwise fashion.[11] The 100 microgram Fentanyl patch is the highest dose for such a duragesic. There is no indication that [Alsager] prescribed a 75 microgram patch prior to prescribing the 100 microgram patch to Patient A. [Alsager] had the 100 microgram patch in his medication safe and gave it to Patient A.

> [10] "Parenteral" denotes any route other than the alimentary canal such as intravenous, subcutaneous, intramuscular, or mucosal. The "alimentary canal" route refers to drugs taken orally, and absorbed in the stomach or intestines. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), pages 1048 and 53.
> [11] Fentanyl duragesic patches are available in 12, 25, 50, 75, and 100 mcg strengths.

CP at 58. Substantial evidence, based on Hillyer's testimony, supports this finding.

Finding of Fact 1.48 (Patient F)

Finding 1.48 states:

> [Alsager] diagnosed Patient F with rheumatoid arthritis. There are no objective findings and no x-ray evidence to support that diagnosis. The patient's rheumatoid factor lab results were in the normal range. The standard of practice requires that a diagnosis of rheumatoid arthritis be confirmed by a rheumatologist.[13] [Alsager] should have referred Patient F out to a rheumatologist for confirmation and co-management of the patient, but he failed to do so. [Alsager's] failure to do so falls below the standard of care in Washington.
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> [13] [Alsager] contended that [a rheumatologist] previously diagnosed Patient F as having rheumatoid arthritis. That information was not reflected in [Alsager's] treatment records for Patient F.

CP at 67. Hillyer reviewed Patient F's medical records and shared his findings with the Board regarding all of the issues addressed in this finding of fact. Again, his testimony provides substantial evidence to support this finding. Alsager's arguments fail.

Affirmed.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record pursuant to RCW 2.06.040, it is so ordered.

Houghton, J.

We concur:

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Van Deren, C.J.

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Penoyar, J.