STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: David S. Roys, MD
Master Case No.: M2009-897
Document: Statement of Charges

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

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

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

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

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **DAVID S. ROYS, MD** License No. MD00010221 Respondent.	**No. M2009-897** **STATEMENT OF CHARGES**

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission), as designated by the Commission, makes the allegations below that are supported by the evidence contained in file number 2008-129779. The person referred to as Patient A in this Statement of Charges is identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On May 6, 1968, the state of Washington issued David S. Roys, MD, (Respondent) a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is board certified in psychiatry.

1.2 Patient A was referred to Respondent by her psychologist for a psychiatric evaluation due to a longstanding condition of depression with periodic thoughts of suicide. Respondent was to manage her medications while she continued her counseling with her psychologist.

1.3 Patient A started seeing Respondent on or about March 24, 2008, and was diagnosed by Respondent as having "major depression - recurrent", and he wanted to rule out "bi-polar disorder". Patient A expressed thoughts that she was bi-polar.

1.4 Respondent examined Patient A, took her medical history, and assessed her medications that she was taking at that time as prescribed by other physicians.

1.5 Respondent saw Patient A periodically over the next several months and made several changes and adjustments to her medications. Patient A was on various anti-anxiety and anti-depression medications including Clonazepam.

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ORIGINAL

1.6 In early August 2008, Respondent noted that Patient A's mental status was despondent and hopeless. He started her on the anti-depressant Mirtazapine and continued her on Geodon and Lamictal. He advised Patient A to taper off the Clonazepam.

1.7 By the end of August, Patient A manifested serious depression and anxiety to Respondent. He instructed her to decrease the Lamictal from 200 mg back to 100 mg and gave her a 120 tablet prescription for Diazepam (Valium) 10 mg, qid. Respondent told Patient A to return as needed.

1.8 On or about September 3, 2008, Patient A went out to a remote wooded recreational area where she consumed all her Diazepam (Valium). She was found by hikers and taken by ambulance to a hospital for emergency care. She was admitted for in-patient care until September 8, when she was discharged.

1.9 Patient A was stabilized at the hospital after it was determined that Patient A had overdosed with her medications, primarily the Diazepam (Valium), and had attempted suicide. Patient A was diagnosed with major depression. She was provided counseling and subsequently discharged with on a regimen of Lamotrigene, Mirtazapine, and Trazodone.

1.10 Respondent saw Patient A several times in September 2008, and noted that she continued to be depressed. He maintained her on the Lamictal along with various other medications.

1.11 Patient A last saw Respondent on September 29, 2008. Patient A terminated care with the Respondent and sought out another psychiatrist on the grounds that she felt Respondent was not resolving her depression and anxiety problems.

1.12 Respondent's care and prescribing for Patient A was not effective in dealing with her noted depression. Respondent's prescription of Diazepam (Valium) in the amount and dosage he gave Patient A was below the standard of care, given her risk factors for suicide.

1.13 Although Respondent diagnosed Patient A with major depression, and found little evidence of bi-polar disorder, he continued to treat her for bi-polar disorder with the prescriptions of Lamictal and stopped her anti-depressant. Subsequently he treated her anxiety without fully addressing her depression.

1.14 Respondent did not provide a well structured care and monitoring plan for Patient A over the almost six months that he treated her. In spite of the variety of drugs she was taking and her manifested depression and anxiety, Respondent was asking her to return only when she felt the need. And, despite her major depression and feelings of despondence and hopelessness, he prescribed a large amount of Diazepam (Valium) which had the propensity for abuse by Patient A.

1.15 Respondent's records for Patient A do not reflect the kind of coordination with Patient A's psychologist that would be required in monitoring the patient, to better tailor the medication plan with the mental health issues of Patient A that the psychologist was dealing with.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of the Uniform Disciplinary Act, Chapter 18.130 RCW, which provides in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter.
> **(4)** Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.

2.2 The above violation provides grounds for imposing sanctions under RCW 18.130.160.

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3. NOTICE TO RESPONDENT

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

DATED: June 28, 2010.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

DANI NEWMAN
DISCIPLINARY MANAGER

TRACY BAHM, WSBA #22950
ASSISTANT ATTORNEY GENERAL

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CONFIDENTIAL SCHEDULE
M2009-897

The health care information in this Statement of Charges is confidential and is NOT to be released without the consent of the individual(s) named herein, pursuant to RCW 42.56.240(1).

Patient A: [redacted]

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: David S. Roys, MD
Master Case No. M2009-897
Document: Amended Statement of Charges

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

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

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **DAVID S. ROYS, MD** License No. MD00010221 Respondent.	**No. M2009-897** **AMENDED STATEMENT OF CHARGES**

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission), as designated by the Commission, makes the allegations below that are supported by the evidence contained in file number 2008-129779. The person referred to as Patient A in this Amended Statement of Charges is identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On May 6, 1968, the state of Washington issued David S. Roys, MD, (Respondent) a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is board certified in psychiatry.

1.2 Patient A was referred to Respondent by her therapist for a psychiatric evaluation due to a longstanding condition of depression with periodic thoughts of suicide. Respondent was to manage her medications while she continued her counseling with her therapist.

1.3 Patient A started seeing Respondent on or about March 24, 2008, and was diagnosed by Respondent as having "major depression - recurrent", and he wanted to rule out "bi-polar disorder". Patient A expressed thoughts that she was bi-polar.

1.4 Respondent examined Patient A, took her medical history, and assessed her medications that she was taking at that time as prescribed by other physicians.

1.5 Patient A was on various anti-anxiety medications, including clonazepam, and on various anti-depression medications. Respondent saw Patient A periodically over the next several months and made several changes and adjustments to her medications. Respondent took Patient A off of Effexor, which she was taking for

depression and which she felt had previously been helpful but had ceased being effective.

1.6 In early August 2008, Respondent noted that Patient A's mental status was despondent and hopeless. He started her on the anti-depressant Mirtazapine and continued her on Geodon and Lamictal. He advised Patient A to taper off the Clonazepam.

1.7 By the end of August, Patient A manifested serious depression and anxiety to Respondent. He instructed her to decrease the Lamictal from 200 mg back to 100 mg and gave her a 120 tablet prescription for Diazepam (Valium) 10 mg, qid. Respondent told Patient A to return as needed.

1.8 On or about September 3, 2008, Patient A went out to a remote wooded recreational area where she consumed all her Diazepam (Valium). She was found by hikers and taken by ambulance to a hospital for emergency care. She was admitted for in-patient care until September 8, when she was discharged.

1.9 Patient A was stabilized at the hospital after it was determined that Patient A had overdosed with her medications, primarily the Diazepam (Valium), and had attempted suicide. Patient A was diagnosed with major depression. She was provided counseling and subsequently discharged with on a regimen of Lamotrigene, Mirtazapine, and Trazodone.

1.10 Respondent saw Patient A several times in September 2008, and noted that she continued to be depressed. He maintained her on the Lamictal along with various other medications.

1.11 Patient A last saw Respondent on September 29, 2008. Patient A terminated care with the Respondent and sought out another psychiatrist on the grounds that she felt Respondent was not resolving her depression and anxiety problems.

1.12 The rationale for Respondent's care and prescribing for Patient A's depression was not adequately documented in the medical record. Respondent treated Patient A for bipolar depression by prescribing Lamictal and by stopping her antidepressant, but did not document in the medical record the factors which supported the decision to treat Patient A as having bipolar depression instead of unipolar depression.

1.13 On August 26, 2008, Respondent prescribed a large amount of diazepam (Valium) for Patient A at a time when Patient A reported increasing suicidal ideation. Prescribing the diazepam in that amount and dosage, at that particular time, put Patient A at increased risk that she could utilize the diazepam in an overdose attempt, which she did.

1.14 Respondent did not provide a well structured care and monitoring plan for Patient A over the almost six months that he treated her. In spite of the variety of drugs she was taking and her manifested depression and anxiety, Respondent on several occasions did not schedule appropriate follow-up visits, and instead instructed her to return only when she felt the need.

1.15 Respondent's care and treatment plan did not include periodic communication and coordination with Patient A's therapist through the course of treatment. In addition, Respondent did not contact Patient A's therapist following the session on August 26, 2008, at the time of Patient A's increased suicidality, to alert the therapist to this development and to coordinate management of the increases suicidality.

1.16 Respondent did not establish a crisis plan with Patient A during the session on August 26, 2008, at the time of Patient A's increased suicidality. Specifically, there was not mutually agreed plan for what actions the patient would take in the event that she felt that she was at risk of acting on her suicidal thoughts.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of the Uniform Disciplinary Act, Chapter 18.130 RCW, which provides in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter.
> **(4)** Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.

2.2 The above violation provides grounds for imposing sanctions under RCW 18.130.160.

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3. NOTICE TO RESPONDENT

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

DATED: February 10, 2011.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

DANI NEWMAN
DISCIPLINARY MANAGER

TRACY BAHM, WSBA #22950
ASSISTANT ATTORNEY GENERAL

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CONFIDENTIAL SCHEDULE
M2009-897

The health care information in this Statement of Charges is confidential and is NOT to be released without the consent of the individual(s) named herein, pursuant to RCW 42.56.240(1).

Patient A: [redacted]

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: David S. Roys, MD
Master Case No.: M2009-897
Document: Statement of Allegations

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

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

The following information has been withheld:

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

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

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

DAVID S. ROYS, MD
License No. MD00010221

Respondent

No. M2009-897

STATEMENT OF ALLEGATIONS AND SUMMARY OF EVIDENCE

The Disciplinary Manager of the Medical Quality Assurance Commission (Commission), on designation by the Commission, makes the allegations below, which are supported by evidence contained in program file number 2009-129779. The patient referred to in this Statement of Allegations and Summary of Evidence is identified in the attached Confidential Schedule.

1. ALLEGATIONS

1.1 On May 6, 1968, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is board-certified in psychiatry.

1.2 Patient A was referred to Respondent by her therapist for a psychiatric evaluation due to longstanding depression with periodic thoughts of suicide. The understanding was that Respondent would manage Patient A's medications while the therapist continued counseling with Patient A.

1.3 Respondent first saw Patient A on March 24, 2008. Respondent diagnosed Patient A as having recurrent major depression, and wanted to rule out bipolar disorder.

1.4 Respondent examined Patient A, took her medical history, and assessed the medications she was taking. These medications were prescribed by previous physicians.

1.5 Respondent changed Patient A's depression medication. He took her off of Effexor, which Patient A felt had previously been helpful but had ceased being effective.

1.6 Respondent prescribed Lamictal, a mood stabilizer used for bipolar illness. Over the next five months Respondent continued Patient A on this medication, periodically increasing the dosage up to 200 mg. In June 2008, Respondent also started Patient A on

Geodon (an atypical antipsychotic agent, indicated in bipolar disorder), to help reduce anxiety.

1.7 Respondent was aware that Patient A was taking clonazepam (Klonopin, an anxiety medication) at bedtime. By August of 2008, Respondent had advised Patient A to taper off of Clonazepam, when Patient A reported that she was feeling more depressed and manifesting anxiety. Respondent noted that Patient A's mental status was despondent and hopeless. Respondent started Patient A on the anti-depressant mirtazapine (Remeron) and continued her on Geodon and Lamictal.

1.8 On August 26, 2008, Respondent noted that Patient A was extremely anxious, depressed, and increasingly suicidal. Respondent advised Patient A to reduce Lamictal from 200 mg. to 100 mg. Respondent prescribed a quantity of 120 diazepam (Valium, an anti-anxiety medication) 10mg. tablets for Patient A, one tablet to be taken four times per day as needed. Respondent noted that Patient A would return on a prn (as needed) basis.

1.9 On September 3, 2008, Patient A went to a remote wooded recreational area and consumed all of her diazepam. Patient A was found by hikers and taken by ambulance to a hospital for emergency care. Patient A was hospitalized until September 8, 2008.

1.10 After Patient A's discharge from the hospital, Respondent saw Patient A four times over the following three weeks for anxiety and depression. Patient A subsequently sought out another psychiatrist.

1.11 Respondent did not adequately document the rationale for his treatment of Patient A's depression. Respondent treated Patient A for bipolar depression but did not document the factors supporting his decision to treat Patient A as having bipolar depression instead of unipolar depression.

1.12 On August 26, 2008, despite Patient A's reports of increasing suicidal ideation, Respondent prescribed a large amount of diazepam (Valium) for Patient A. The quantity and dosage of Respondent's prescription of diazepam for Patient A, in her condition, put Patient A at increased risk for an overdose attempt. Although the potential for a lethal outcome with diazepam alone was low, had Patient A taken the diazepam in conjunction with alcohol or another central nervous system depressant the potential for a lethal outcome would have been substantially greater.

1.13 Respondent did not provide a well structured care and monitoring plan for Patient A over the nearly six months that he treated her. In spite of the variety of drugs she was taking and her manifested depression and anxiety, on several occasions Respondent did not schedule appropriate follow-up visits, and instead instructed Patient A to return when she felt the need.

1.14 Respondent's care and treatment plan did not include periodic communication and coordination with Patient A's therapist. Respondent should have contacted Patient A's therapist on August 26, 2008, to alert the therapist about Patient A's increased suicidality and to coordinate their management of this issue.

1.15 Respondent did not establish a crisis plan with Patient A during the session on August 26, 2008. Specifically, there was no mutually-agreed plan for what actions the patient would take in the event that she felt that she was at risk of acting on her suicidal thoughts.

2. SUMMARY OF EVIDENCE

2.1 Medical records pertaining to Patient A from Respondent's office.

2.2 Medical records pertaining to Patient A from Overlake Hospital Medical Center.

2.3 Medical records pertaining to Patient A from Nancy Stokely, ARNP

2.4 Letter from Respondent to the Commission investigator, dated December 4, 2008.

3. ALLEGED VIOLATIONS

3.1 The facts alleged in Section 1, if proven, would constitute unprofessional conduct in violation of RCW 18.130.180(4), which provides in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:
>
> ...
>
> (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;
>
> ...

4. NOTICE TO RESPONDENT

4.1 The Commission has determined that this case may be appropriate for resolution through a Stipulation to Informal Disposition pursuant to RCW 18.130.172(2). A proposed Stipulation to Informal Disposition is attached, which contains the disposition the Commission believes is necessary to address the conduct alleged in this Statement of Allegations and Summary of Evidence.

4.2 If Respondent agrees that the disposition imposed by the Stipulation to Informal Disposition is appropriate, Respondent should sign and date the Stipulation to Informal Disposition and return it within fourteen (14) days to the Medical Quality Assurance Commission at PO Box 47866, Olympia, WA 98504-7866.

4.3 If Respondent does not agree that the terms and conditions contained in the Stipulation to Informal Disposition are appropriate, Respondent should contact Jim McLaughlin, Staff Attorney for the Medical Quality Assurance Commission, PO Box 47866, Olympia, WA 98504-7866, (360) 236-2790 within fourteen (14) days.

4.4 If Respondent does not respond within fourteen (14) days, the Commission will assume Respondent has declined to resolve the allegations by means of a Stipulation to Informal Disposition.

4.5 If Respondent declines to resolve the allegations by means of a Stipulation to Informal Disposition pursuant to RCW 18.130.172(2), the Commission may proceed to formal disciplinary action against Respondent by filing a Statement of Charges, pursuant to RCW 18.130.172(3).

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4.6 The cover letter enclosed with this Statement of Allegations and Summary of Evidence was mailed to the name and address currently on file for Respondent's license. Respondent must notify, in writing, the Commission if Respondent's name and/or address changes.

DATED: March 18 ,2011.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

DANI NEWMAN
DISCIPLINARY MANAGER

JAMES MCLAUGHLIN, WSBA #27349
DEPARTMENT OF HEALTH STAFF ATTORNEY

CONFIDENTIAL SCHEDULE

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

Patient A [redacted]

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: David S. Roys, MD
Master Case No.: M2009-897
Document: Withdrawal of Statement of Charges

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

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

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

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

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **DAVID S. ROYS, MD** License No. MD00010221 Respondent.	**No. M2009-897** **NOTICE AND ORDER FOR WITHDRAWAL OF STATEMENT OF CHARGES**

1. FACTS

1.1 On or about February 10, 2011, the Medical Quality Assurance Commission (Commission) served an Amended Statement of Charges against Respondent.

1.2 On or about February 12, 2011, Respondent filed an answer to the Statement of Charges with the Adjudicative Clerk Office.

1.3 Based on Respondent's entry into a Stipulation to Informal Disposition resolving this matter, the Disciplinary Manager, through the Office of the Attorney General, requests withdrawal of the Statement of Charges.

Dated: 8-24, 2011.

TRACY BAHM, WSBA # 22950
ASSISTANT ATTORNEY GENERAL
by KRISTIN G. BREWER, WSBA # 39494

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ORIGINAL

2. ORDER

2.1 Based on the Foregoing, the Commission hereby ORDERS that the Statement of Charges is WITHDRAWN.

DATED: 24 August, 2011.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

PANEL CHAIR

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: David S. Roys, MD
Master Case No.: M2009-897
Document: Stipulation to Informal Disposition

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.

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

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **DAVID S. ROYS, MD** License No. MD00010221 Respondent.	**No. M2009-897** **STIPULATION TO INFORMAL DISPOSITION**

Pursuant to the Uniform Disciplinary Act, Chapter 18.130 RCW, the Medical Quality Assurance Commission (Commission) issued a Statement of Allegations and Summary of Evidence (Statement of Allegations) alleging the conduct described below. Respondent does not admit any of the allegations. This Stipulation to Informal Disposition (Stipulation) is not formal disciplinary action and shall not be construed as a finding of unprofessional conduct or inability to practice.

1. ALLEGATIONS

1.1 On May 6, 1968, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is board-certified in psychiatry. Respondent's license is currently active.

1.2 Patient A was referred to Respondent by her therapist for a psychiatric evaluation due to longstanding depression with periodic thoughts of suicide. The understanding was that Respondent would manage Patient A's medications while the therapist continued counseling with Patient A.

1.3 Respondent first saw Patient A on March 24, 2008. Respondent diagnosed Patient A as having recurrent major depression, and wanted to rule out bipolar disorder.

1.4 Respondent examined Patient A, took her medical history, and assessed the medications she was taking. These medications were prescribed by previous physicians.

1.5 Respondent changed Patient A's depression medication. He took her off of Effexor, which Patient A felt had previously been helpful but had ceased being effective.

ORIGINAL

1.6 Respondent prescribed Lamictal, a mood stabilizer used for bipolar illness. Over the next five months Respondent continued Patient A on this medication, periodically increasing the dosage up to 200 mg. In June 2008, Respondent also started Patient A on Geodon (an atypical antipsychotic agent, indicated in bipolar disorder), to help reduce anxiety.

1.7 Respondent was aware that Patient A was taking clonazepam (Klonopin, an anxiety medication) at bedtime. By August of 2008, Respondent had advised Patient A to taper off of Clonazepam, when Patient A reported that she was feeling more depressed and manifesting anxiety. Respondent noted that Patient A's mental status was despondent and hopeless. Respondent started Patient A on the anti-depressant mirtazapine (Remeron) and continued her on Geodon and Lamictal.

1.8 On August 26, 2008, Respondent noted that Patient A was extremely anxious, depressed, and increasingly suicidal. Respondent advised Patient A to reduce Lamictal from 200 mg. to 100 mg. Respondent prescribed a quantity of 120 diazepam (Valium, an anti-anxiety medication) 10mg. tablets for Patient A, one tablet to be taken four times per day as needed. Respondent noted that Patient A would return on a prn (as needed) basis.

1.9 On September 3, 2008, Patient A went to a remote wooded recreational area and consumed all of her diazepam. Patient A was found by hikers and taken by ambulance to a hospital for emergency care. Patient A was hospitalized until September 8, 2008.

1.10 After Patient A's discharge from the hospital, Respondent saw Patient A four times over the following three weeks for anxiety and depression. Patient A subsequently sought out another psychiatrist.

1.11 Respondent did not adequately document the rationale for his treatment of Patient A's depression. Respondent treated Patient A for bipolar depression but did not document the factors supporting his decision to treat Patient A as having bipolar depression instead of unipolar depression.

1.12 On August 26, 2008, despite Patient A's reports of increasing suicidal ideation, Respondent prescribed a large amount of diazepam (Valium) for Patient A. The quantity and dosage of Respondent's prescription of diazepam for Patient A, in her condition, put Patient A at increased risk for an overdose attempt. Although the

potential for a lethal outcome with diazepam alone was low, had Patient A taken the diazepam in conjunction with alcohol or another central nervous system depressant the potential for a lethal outcome would have been substantially greater.

1.13 Respondent did not provide a well structured care and monitoring plan for Patient A over the nearly six months that he treated her. In spite of the variety of drugs she was taking and her manifested depression and anxiety, on several occasions Respondent did not schedule appropriate follow-up visits, and instead instructed Patient A to return when she felt the need.

1.14 Respondent's care and treatment plan did not include periodic communication and coordination with Patient A's therapist. Respondent should have contacted Patient A's therapist on August 26, 2008, to alert the therapist about Patient A's increased suicidality and to coordinate their management of this issue.

1.15 Respondent did not establish a crisis plan with Patient A during the session on August 26, 2008. Specifically, there was no mutually-agreed plan for what actions the patient would take in the event that she felt that she was at risk of acting on her suicidal thoughts.

2. STIPULATION

2.1 The Commission alleges that the conduct described above, if proven, would constitute a violation of RCW 18.130.180(4).

2.2 The parties wish to resolve this matter by means of a Stipulation to Informal Disposition (Stipulation) pursuant to RCW 18.130.172(1).

2.3 Respondent agrees to be bound by the terms and conditions of this Stipulation.

2.4 This Stipulation is of no force and effect and is not binding on the parties unless and until it is accepted by the Commission.

2.5 If the Commission accepts the Stipulation it will be reported to the Health Integrity and Protection Databank (HIPDB)(45 CFR Part 61), the Federation of State Medical Board's Physician Data Center, and elsewhere as required by law. HIPDB will report this Stipulation to the National Practitioner Data Bank (45 CFR Part 60).

2.6 The Statement of Allegations and this Stipulation are public documents. They will be placed on the Department of Health web site, disseminated via the Commission's listserv, and disseminated according to the Uniform Disciplinary Act

(Chapter 18.130 RCW). They are subject to disclosure under the Public Records Act, Chapter 42.56 RCW, and shall remain part of Respondent's file according to the state's records retention law and cannot be expunged.

2.7 The Commission agrees to forego further disciplinary proceedings concerning the allegations.

2.8 Respondent agrees to successfully complete the terms and conditions of this informal disposition.

2.9 A violation of the provisions of Section 3 of this Stipulation, if proved, would constitute grounds for discipline under RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

3. INFORMAL DISPOSITION

The Commission and Respondent stipulate to the following terms.

3.1 **Probation.** The Commission places Respondent's license on probation for a period of two years from the effective date of this Stipulation.

3.2 **Continuing Education.** Within one year of the effective date of this Stipulation, Respondent agrees to successfully complete Category I continuing medical education that addresses the topic of outpatient management of the acutely suicidal psychiatric patient. On March 3-4, 2011, Respondent completed 13 hours of Category I CME in a course entitled "Reducing and Managing Suicidality in Your Clients." Respondent has therefore completed the requirement of this paragraph.

3.3 **Practice Reviews.** Respondent will permit a representative of the Commission to conduct practice reviews at approximately six months and eighteen months from the effective date of this Stipulation. A practice review will include: (1) an announced visit to, and inspection of, Respondent's office by the Commission representative; (2) interviews with Respondent, staff, and any practice partners; (3) the inspecting and/or copying of patient charts selected by the Commission representative. It is expected that Respondent's care for patients going forward will not have the issues raised in this case. In the review of patient charts, the Commission will be particularly focusing on: (a) Respondent's development and documentation of a crisis plan for patients who are acutely suicidal or at increased risk for attempting suicide or self-harm; (b) Respondent's documented moderation in the amounts of medication prescribed for patients who are acutely suicidal or at increased risk for attempting suicide or self-harm;

(c) Respondent's documentation of his rationale for his diagnoses for patients, including his rationale for the diagnoses of depressive disorders and his rationale for concluding it is either bipolar or unipolar depression; (d) Respondent's documented periodic contact and coordination with, when applicable, other mental health providers, and whether Respondent has made immediate contact with other providers when a patient is acutely suicidal or at increased risk of attempting suicide or self-harm; (e) whether Respondent has instituted and documented planned patient follow-up, instead of follow-up prn (as needed)—for patients with limited mental health benefits, whether Respondent's office has documented contacts with the patient's health plan to determine of additional benefits can be requested.

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

3.5 **Costs.** Respondent must assume all costs that he incurs in complying with this Stipulation.

3.6 **Violations.** If Respondent violates any provision of this Stipulation in any respect, the Commission may take further action against Respondent's license.

3.7 **Change of Address.** Respondent must inform the Commission and the Adjudicative Clerk Office in writing, of changes in his residential and/or business address within thirty days of such change.

3.8 **Termination.** Respondent may petition the Commission in writing to terminate this Stipulation after two years from its effective date. Upon a petition, Respondent will appear in person before the Commission at a date and location determined by the Commission. At the appearance, the Commission will review Respondent's compliance with this Stipulation and the results of the practice reviews. Respondent will answer questions from the Commission concerning his compliance and regarding his practice. The Commission has the discretion to: (a) grant the petition and terminate this Stipulation in full, or (b) terminate the probation and require an additional practice review or require other terms before terminating this Stipulation. Nothing in this provision affects the Commission's authority to take additional action for noncompliance.

3.8 **Effective Date.** The effective date of this Stipulation to Informal Disposition is the date the Adjudicative Clerk Office places the signed Stipulation into

the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Stipulation.

4. COMPLIANCE WITH SANCTION RULES

4.1 The Commission applies WAC 246-16-800, *et seq.,* to determine appropriate sanctions. Tier B of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices result in moderate patient harm or the risk of moderate to severe patient harm. Respondent's care for Patient A, particularly his prescribing of medication in large quantity and his lack of sufficient response in the context of Patient A's expression of suicidal thoughts, put Patient A at risk of severe harm and actually resulted in moderate harm in the form of a suicide attempt and subsequent hospitalization.

4.2 Tier B 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.

4.3 The term of oversight in this order is at least two years. The balance of mitigating factors over a single aggravating factor in this case, justifies an oversight period at the minimum end of the range.

4.4 The mitigating factors are: (a) Respondent fully cooperated with the Commission's investigation of this matter; (b) Respondent is willing to take remedial steps to resolve the issues in this case; (c) the diagnostic area of psychiatry at issue in this matter is highly susceptible to differences in expert opinion about diagnosis, due to the difficulties inherent in differentiating between unipolar and bipolar depression.

4.5 The aggravating factor is that Respondent was also subject to a disciplinary order entered by the Commission in 1996 for issues related to prescribing.

5. RESPONDENT'S ACCEPTANCE

I, DAVID S. ROYS, Respondent, certify that I have read this Stipulation to Informal Disposition in its entirety; that my counsel of record has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Commission without my appearance. If the Commission accepts the Stipulation to Informal Disposition, I understand that I will receive a signed copy.

DAVID S. ROYS
RESPONDENT

8/9/2011
DATE

PAMELA ANDREWS, WSBA #14248
ATTORNEY FOR RESPONDENT

8/9/11
DATE

SCANNED

ORIGINAL

6. COMMISSION'S ACCEPTANCE

The Commission accepts this Stipulation to Informal Disposition. All parties shall be bound by its terms and conditions.

DATED: 24 August, 2011.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

PANEL CHAIR

PRESENTED BY:

JAMES MCLAUGHLIN, WSBA #27349
DEPARTMENT OF HEALTH STAFF ATTORNEY