STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Kristine S. Brecht, MD
Master Case No.: M2019-94
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
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **KRISTINE S. BRECHT, MD** License No. MD.MD.00044369 Respondent.	**No. M2019-94** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND AGREED ORDER**

The Washington Medical Commission (Commission), through Trisha Wolf, Commission Staff Attorney, and Respondent, represented by counsel, Ketia Wick, stipulate and agree to the following.

1. PROCEDURAL STIPULATIONS

1.1 On April 16, 2020, 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(4), (7), (10), and (14) and WAC 246-919-853, -854, -856, -857, -858, and -860.[1]

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.

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[1] WAC 246-919-853, -854, -856, -857, -858, and -860 were repealed and replaced in November 2018; the text cited here were applicable rules for the time in question. WSR 18-23-061.

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 stipulate to the following facts:

2.1 On November 10, 2004, the state of Washington issued Kristine S. Brecht, Respondent, a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is board certified in family medicine.

2.2 In the course of treating many of the patients listed below, Respondent did not properly supervise her physician assistant (PA) and other medical support staff, putting patients at risk.

Patient A

2.3 Patient A, a female patient who was then in her late 60s, began seeing Respondent and her PA in approximately September 2017 and continued seeing them through at least November 2018. Respondent was the supervising physician of PA at all relevant times. Patient A saw Respondent and her PA for neck and back pain secondary to arthritis. No medical records other than patient intake forms exist for Respondent's patient care prior to January 2018, but Respondent and PA began prescribing high dosages of methadone and oxycodone.

2.4 Throughout the time Patient A was treated by Respondent and her PA, Patient A was prescribed high doses of multiple opioids along with muscle relaxers. There were no recorded considerations of the risks posed by the potential interactions of these

medications or the patient's extremely high blood pressure. During this time period, Patient A was prescribed a maximum of 60mg of methadone and 45mg of oxycodone, a morphine equivalent dose (MED) of approximately 667.5. Due to Patient A's age and health, this combination of medications significantly increased the danger of respiratory depression and death.

2.5 Other than generalities such as the one listed above, there is no clear pain diagnosis in the medical records. Respondent never referenced the MED for any medication prescribed for the patient, and never explained why the high dosages were indicated. No rationale was noted when the dosages of opioids were increased. No clinical justification was recorded for the high dosages of opioid medications, and no attempt to taper the dosages was recorded, despite a history of withdrawal symptoms and detoxification noted by a previous provider. Additionally, when Patient A reported dizziness and memory loss, Respondent and PA did not appear to consider whether this may have been related to opioid medications.

2.6 Additionally, the records do not list the basic hallmarks of evidence-based treatment for chronic pain and opioid treatment such as conducting regular urinary drug screenings, regular echocardiograms (EKGs), reviewing the Washington State Prescription Monitoring Program (PMP), conducting baseline liver and renal function labs, running sleep studies, conducting pill counts, and conducting risk assessments for tolerance, dependence, substance abuse, and addiction. No evidence of functional improvement was documented. The results of periodic reviews were not documented, and chart notes were so frequently repeated that it is unclear whether appropriate examinations were completed. All visits just appear from the chart to be fifteen minute medication refill appointments.

2.7 The records reflect several other deficiencies. The only available pain management treatment agreement does not list a pharmacy. Respondent did not document residual quantities of opioid medications before prescribing more, and did not explain why early refills were permitted. Patient A also admitted to taking more medication than prescribed, but the chart does not reflect any consideration of this or discussion of this with the patient. Respondent and her PA responded by increasing Patient A's dose

and frequency of narcotics without any recorded consideration of potential diversion or abuse.

2.8 Review of medical records from other providers was minimal. There is no documentation that these records were reviewed before treating Patient A for chronic pain. No consideration of the patient's psychological comorbidities was documented, despite the patient's history of significant depression even when receiving antidepressants previously. No inquiry into the patient's medications prescribed by other providers, such as antidepressants, is reflected in the chart.

2.9 Patient A was never referred to physical therapy or to a pain specialist. Patient A's medical records do not reflect a consideration of these evaluation or treatment options, despite an MED well over the threshold for mandatory pain management specialist consultation.

Patient B

2.10 Patient B, a female patient who was then in her 50s, began seeing Respondent and her PA in at least January 2014 and continued seeing them through August 2018. In August 2018, Patient B was dismissed from their practice due to a positive urine drug screen for cocaine and methamphetamine as well as medications that were not prescribed to Patient B. This appears to be Patient B's first urine drug screen, despite an opioid treatment agreement signed in 2014.

2.11 Patient B saw Respondent and her PA for back and knee pain as well as hypertension. No medical records were produced by Respondent for care before January 2016, but Respondent and her PA were prescribing high doses of opioids as well as muscle relaxers and gabapentin. Patient B was a long-term (30 years) tobacco user, putting her in the moderate risk category for opioid abuse and addiction. Respondent and her PA also treated Patient B for a rash that might have been a side effect of a medication, but all prescriptions were refilled without concern for the apparent allergic response.

2.12 Throughout the time Patient B was treated by Respondent and her PA, Patient B was prescribed high doses of multiple opioids along with benzodiazepines, muscle relaxers, and gabapentin. There is no recorded consideration of the risks posed by potential interactions of these medications. During this time period, Patient B was

prescribed a maximum of 120mg of methadone and 120mg of oxycodone, an MED of approximately 1620.

2.13 Other than generalities such as the one listed above, there is no clear pain diagnosis in the medical records. Respondent never referenced the MED for any medication prescribed for the patient, and never explained why the high dosages were indicated. No rationale was noted when the dosages of opioids were increased. No clinical justification was recorded for the high dosages of opioid medications, and no attempt to taper the dosages was recorded. Visits were often too short to evaluate this complex pain patient. Cymbalta was prescribed off and on without any discussion in the chart of the patient's possible psychiatric comorbidities and suspicious injuries suggesting impaired attention or judgment.

2.14 Additionally, the records do not list the basic hallmarks of evidence-based treatment for chronic pain and opioid treatment such as conducting regular urinary drug screenings, reviewing the PMP, conducting baseline renal function labs, detailed charting results of appropriate liver function tests, running sleep studies, conducting pill counts, and conducting risk assessments for substance abuse and addiction. Functional responses to treatment were seldom documented. Pain scores were only noted intermittently. The results of periodic reviews were not documented, and the chart notes were so frequently repeated that it is unclear whether appropriate examinations were completed.

2.15 The records reflect several other deficiencies. The only available opioid treatment agreement was not signed until February 2014 and does not list a pharmacy. Patient B used multiple pharmacies to fill opioid prescriptions during the period of at least November 2016 to August 2018. Respondent did not document residual quantities of opioid medications before prescribing more, and did not explain why early refills were permitted. When Patient B received a prescription for buprenorphine from another provider, Respondent and PA never questioned Patient B about why she received this prescription, which could suggest an addiction or other reasons to review the patient's condition and prescriptions.

2.16 Review of medical records from other providers was minimal; for example, there is no evidence that records from previous providers were reviewed before treating Patient B for chronic pain. An imaging study was included in the patient's records, but no

discussion of the findings was included; including whether the findings supported the diagnoses and objectives of treatment.

2.17 Patient B was never referred to physical therapy or to a pain specialist. Patient B's medical records do not reflect a consideration of these evaluation or treatment options, despite an MED well over the threshold for mandatory pain management specialist consultation.

Patient C

2.18 Patient C, a male patient who was then in his late 40s, began seeing Respondent and her PA in at least July 2017 and continued seeing them through at least March 2019. There is no clear record of a new patient visit to establish care. Patient C saw Respondent and her PA for back pain, arthritis, ankle pain, and insomnia. No medical records exist prior to December 2017 or after November 2018, but Respondent and her PA were prescribing high doses of oxycodone and methadone during at least part of the time period.

2.19 During the time Patient C saw Respondent and her PA, Patient C was prescribed up to 120mg of oxycodone a day and 80mg of methadone daily, an MED of approximately 1140. His prescriptions did not change throughout the entire period of the medical records. Respondent also prescribed sedatives without any recorded consideration of the risks posed by the potential interactions of these medications.

2.20 Other than generalities such as the one listed above, there is no clear pain diagnosis in the medical records. Respondent never referenced the MED for any medication prescribed for the patient, and never explained why the high dosages were indicated. No rationale was noted when the dosages of opioids were increased. No clinical justification was recorded for the high dosages of opioid medications, and no attempt to taper the dosages was recorded. Visits were often too short to evaluate this complex pain patient.

2.21 Additionally, the records do not list the basic hallmarks of evidence-based treatment for chronic pain and opioid treatment such as conducting regular urinary drug screenings, performing EKGs, reviewing the PMP, conducting baseline liver and renal function labs, running sleep studies, conducting pill counts, and conducting risk assessments for substance abuse and addiction. Minimal evidence of functional

improvement was documented, despite the patient's employment in the construction industry. The results of periodic reviews were not documented, and the chart notes were so frequently repeated that it is unclear whether appropriate examinations were completed. Pain scores were only noted intermittently.

2.22 The records reflect other deficiencies. Respondent did not document residual quantities of opioid medications before prescribing more, and often did not explain why early refills were permitted. Respondent began seeing Patient C in July 2017 but the only opioid treatment agreement on file was not signed until October 2017.

2.23 Patient C's medical records do not include any records from outside providers. Therefore, there was no documentation that Patient C's previous medical records were reviewed before treating the patient for chronic pain. Respondent and her PA merely took over prescribing from anther another provider without attempting to change or rationalize Patient C's doses or medication combinations.

2.24 Patient C was never referred to physical therapy or to a pain specialist. Patient C's medical records do not reflect a consideration of these evaluation or treatment options, despite an MED well over the threshold for mandatory pain management specialist consultation.

Patient D

2.25 Patient D, a female patient who was then in her 40s, began seeing Respondent and her PA in at least 2017 and continued seeing them through at least November 2018. There is no clear record of a new patient visit to establish when Patient D's care began. Patient D saw Respondent and her PA for chronic back pain management, rheumatoid arthritis, and right leg sciatica. Patient D also self-reported a history of severe endometriosis, fibromyalgia, depression, and anxiety. Respondent did not produce medical records prior to November 2017, but Respondent was prescribing high doses of oxycodone and methadone during at least part of that time.

2.26 During the time Patient D saw Respondent and her PA, Patient D was prescribed daily doses of 80mg of methadone and up to 120mg of oxycodone, an MED of approximately 1140. At this time, Patient D was also prescribed daily doses of 1mg of clonazepam without any recorded consideration of the risks posed by the potential interactions of these medications. Her prescriptions did not change throughout the entire

period of the medical records. Patient D's primary care provider originally prescribed the clonazepam. There was no clear documentation for why Respondent and her PA took over prescribing. No consideration of the patient's psychological comorbidities was documented, despite the patient's history of significant depression and anxiety and her report of social phobia significantly impacting her quality of life.

2.27 Other than generalities such as the one listed above, there was no clear pain diagnosis in the medical records. Respondent never referenced the MED for any medication prescribed for Patient D. No clinical justification was recorded for the high dosages of opioid medications, and no attempt to taper the dosages was recorded.

2.28 Additionally, the records do not list the basic hallmarks of evidence-based treatment for chronic pain and opioid treatment such as conducting regular urinary drug screenings, reviewing the PMP, conducting baseline liver and renal function labs, running sleep studies, conducting pill counts, making changes in drug choices, and conducting risk assessments for substance abuse and addiction. Minimal evidence of functional improvement was documented. The results of periodic reviews were not documented, and the chart notes were so frequently repeated that it is unclear whether appropriate examinations were completed. Additionally, Respondent and her PA never discussed Patient D's self-reported depression.

2.29 The records reflect several other deficiencies. Respondent began seeing Patient D in July 2017 but the only opioid treatment agreement on file was not signed until October 2017. Respondent did not document residual quantities of opioid medications before prescribing more, and often did not explain why early refills were permitted.

2.30 Review of medical records from other providers was minimal; for example, there was no documentation that Patient D's previous medical records were reviewed before treating her for chronic pain.

2.31 Patient D was never referred to physical therapy, a pain specialist, a mental health provider, or an obstetrician/gynecologist. Patient D's medical records do not reflect a consideration of these evaluation or treatment options, despite an MED well over the threshold for mandatory pain management specialist consultation.

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Patient E

2.32 Patient E, a male patient who was then in his 60s, began seeing Respondent and her PA in October 2014 and continued seeing them through at least January 2019. Patient E began seeing Respondent for pain management following a lumbar spinal fusion as well as back pain and diabetic neuropathy. Patient E's new patient visit only lasted 25 minutes, which was too short for a highly complex patient with significant comorbidities, including diabetes, liver dysfunction, and hypertension, to consider in the context of high dose narcotic prescribing. Respondent and her PA prescribed Patient E high doses of methadone and oxycodone. Patient E was a high risk patient due to a history of previous IV drug use, smoking, and alcohol consumption.

2.33 Throughout the time Patient E was treated by Respondent and her PA, Patient E was prescribed high doses of multiple opioids. During this time period, Patient E was often prescribed a maximum of 376mg of methadone and 360mg of oxycodone daily, a morphine equivalent dose (MED) of more than 5000. By June 2015, Patient E was prescribed a daily dose of 4800mg of gabapentin without any recorded consideration of the risks posed by the potential interactions of these medications. Respondent did not note red flags for diversion such as Patient E paying cash for tablets beyond what insurance will cover.

2.34 Respondent continued to list general diagnoses and repetitive diagnoses such as the ones above. Visits were often ten minutes long and chart notes were highly repetitive. There was no ongoing clear pain diagnosis in the medical records. Respondent never referenced the MED for any medication prescribed for Patient E. No changes in drug choices were made. No clinical justification was recorded for the high dosages of opioid medications, and no attempt to taper the dosages was recorded. Instead, the dosages were increased at the patient's request. For instance, the patient requested that he receive additional methadone for physical therapy. Respondent increased the methadone but failed to decrease the amount of methadone prescribed thereafter when the patient was no longer participating in physical therapy. Respondent does not note if she has seen the patient personally or if only her PA had examined Patient E. When Patient E's function began to taper off, no new imaging or physical examination was conducted.

2.35 Additionally, the records do not list the basic hallmarks of evidence-based treatment for chronic pain and opioid treatment such as conducting regular urinary drug screenings, conducting EKGs, running sleep studies, reviewing the PMP, conducting baseline liver and renal function labs, conducting pill counts, and conducting risk assessments for substance abuse and addiction. No compelling evidence of functional improvement was documented. The results of periodic reviews were not documented, and the chart notes were so frequently repeated that it is unclear whether appropriate examinations were completed. Pain scores were noted intermittently.

2.36 The records reflect several other deficiencies. Neither of the available opioid treatment agreements listed a pharmacy. Patient E used multiple pharmacies to fill opioid prescriptions during the period of at least February 2017 to January 2019. Respondent did not document residual quantities of opioid medications before prescribing more, and did not explain why early refills were permitted.

2.37 Review of medical records from other providers was minimal; for example, only Patient E's medication list, dosing, and generic diagnosis from his previous provider were included in the medical record, and there is no documentation that these records were reviewed before treating the patient for chronic pain. Some imaging studies, operative notes, and chart notes from an orthopedic surgeon were included in the patient's records, but no discussion of the findings is included; including whether the findings support the diagnosis and objectives of treatment. The patient's blood pressure fluctuated, reaching as high as 184/119 in 2018 without any coordination with his primary care provider.

2.38 Patient E was never referred to a pain specialist. Patient E's medical records do not reflect a consideration of this treatment option, despite an MED well over the threshold for mandatory pain management specialist consultation.

Patient F

2.39 On or about August 22, 2018, Respondent performed liposuction on Patient F's abdomen, pubic region, thighs, and back. Patient F was a female patient in her late 60s. Despite operating on a large area, Respondent used oral sedation rather than intravenous sedation or general anesthesia, which are more commonly used for this type of procedure. Over sedation is a concern with the amount of medications given.

Furthermore, the combination and dosages of zolpidem, oxycodone, and lorazepam administered by Respondent created a likelihood that Patient F would remain sedated for an unreasonable length of time and potentially after discharge.

2.40 Respondent's records relating to the procedure were lacking. Vital signs should have been noted every three to five minutes rather than every fifteen. The time listed for the end of the procedure on Patient F's medical records is the same as her discharge time, so there was no allowance for recovery time, or post-operative monitoring before discharge. No clear discharge planning or procedure was in place, and no post-operative monitoring was recorded. Patient F should have been monitored for at least 30-60 minutes post-operatively, particularly due to the amount of oral sedative administered. The oral sedatives were reversed with additional medication. However, the time at which the medication was administered was not noted.

2.41 Patient F's medical records state that she was ambulatory at the time of discharge. However, this is inconsistent with the finding that Patient F was not ambulatory seven hours after discharge, suggesting that the patient was inappropriately discharged. Patient F's oxygen saturation was only 89 seven hours after discharge. Patient F was ultimately admitted overnight to a hospital following discharge, further demonstrating that she was over sedated.

Patient G

2.42 On or about January 24, 2018, Respondent performed a bilateral breast augmentation on Patient G, a female patient in her mid-30s, as well as liposuction on Patient G's abdomen, "love handles," and lower back. High doses of oral medication were used as the sedative rather than intravenous sedation or general anesthesia. In particular, Respondent should have had intravenous access for emergency management during the procedure. Respondent was assisted by a medical assistant and a nursing aide, neither of whom had advanced cardiac life support (ACLS) certifications. Typically, at least two providers in the operating room have ACLS certification and a registered nurse or licensed practical nurse assist in the operating room. The nursing aide was only licensed in South Carolina and the medical assistant only had an expired interim license, so the Respondent was not assisted by properly licensed personnel.

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2.43 Respondent's records relating to the procedure were lacking. Vital signs should have been noted every three to five minutes rather than every fifteen. The medical records do not state whether compression devices were used during the procedure. The discharge time was listed as five minutes after the end time of the procedure, so there was no allowance for recovery time, or post-operative monitoring before discharge. No clear discharge planning or procedure was in place, and no post-operative monitoring was recorded. Due to the amount of oral sedation used, Patient G should have been monitored for at least 30 to 60 minutes post operatively.

2.44 Post-operatively, Patient G developed deep vein thrombosis in her left leg, a pulmonary embolism in her right lung, and a hematoma in her right breast. These complications should have been addressed more completely by Respondent. Respondent was out of town when these complications became emergent and did not have physician back-up coverage.

Patient H

2.45 On or about July 27, 2017, Respondent performed a breast augmentation on Patient H, a female patient in her mid-30s. Respondent used oral sedation rather than general anesthesia or intravenous sedation. In particular, Respondent should have established intravenous access for emergency management. Patient H experienced memory loss following the procedure due to the high amount of oral sedation medications used during the procedure.

2.46 Patient H's vitals were monitored every fifteen minutes during the procedure instead of every three to five minutes. Patient H experienced both blood pressure and pulse spikes during the procedure indicating that the patient was in pain and may not have been properly anesthetized. The medical records do not state whether appropriate compression devices were used during the procedure.

2.47 According to Patient H's medical records, she was discharged at the same time her procedure ended, so there was no allowance for recovery time, or post-operative monitoring before discharge. No clear discharge planning or procedure was in place, and no post-operative monitoring was recorded. Due to the amount of oral sedation used, Patient H should have been monitored for at least 30 to 60 minutes post operatively.

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Patient I

2.48 On or about October 25, 2019, Respondent performed a full abdominoplasty on Patient I, a female patient in her mid-50s, as well as liposuction on her abdominal area. Respondent used oral sedation and nitrous oxide for the three and a half hour procedure rather than general anesthesia or intravenous sedation. In particular, Respondent should have established intravenous access for emergency management. An anesthesiologist or certified registered nurse anesthetist should have been present. Patient I was a poor risk for having this type of procedure at this type of facility using this type of anesthetic. Respondent did not consult Patient I's primary care provider.

2.49 Prior to performing the procedure, Respondent did not obtain an adequate medical history or perform an adequate physical examination. Respondent's medical records for Patient I do not include documentation of a true physical examination. The "History and Physical Examination" form does not actually contain all the key components of a standard current pre-procedural history and physical exam, including a history of present illness, family history, social history, a complete physical examination, diagnostic studies, and assessment/plan. Patient I's reported previous liver test results or abnormalities should have prompted Respondent to request liver function or enzyme tests and to inquire further about Patient I's medical history. The labs ordered by Respondent did not include liver function tests.

2.50 Respondent's records relating to the procedure are lacking. The procedure note does not include standard components such as pre- and post-operative diagnosis, type of anesthesia and sedation, location of incisions, devices and techniques used for liposuction, what type of closure was done and materials used, how hemostasis was achieved, how the umbilicus was dissected and relocated, or any specimen for pathology. The chart contained no rationale for, or times of administering, a reversal agent more than once. Vital signs should have been noted more frequently than every fifteen minutes. The time listed for the end of the procedure on Patient I's medical records is the same as her discharge time, so there was no allowance for recovery time, or post-operative monitoring before discharge. No clear discharge planning or procedure was in place, and no post-operative monitoring was recorded. Patient I should have been monitored for at least 30-

60 minutes post-operatively, particularly due to the high amount of oral sedative administered.

2.51 At a post-operative visit three days after the procedure, Patient I was having difficulty breathing and had an oxygen saturation level of 88%. Respondent did not address this appropriately, offer Patient I supplemental oxygen, or call an ambulance. Patient I died two days later due to multi-system organ failure, septic shock, and aspiration pneumonia.

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), (10), and (14) and WAC 246-919-853, -854, -856, -857, -858, and -860.

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 **Compliance Orientation.** Respondent must complete a compliance orientation in person or by telephone within **sixty (60) days** of the effective date of this Agreed Order. Respondent must contact the Compliance Unit at the Commission by calling (360) 236-2763, or by sending an email to: Medical.compliance@wmc.wa.gov within **twenty (20) days** of the effective date of this Agreed Order. Respondent must provide a contact phone number where Respondent can be reached for scheduling purposes.

4.2 **Probation.** Upon the effective date of this Agreed Order, the Commission places Respondent's license on probation. Respondent may petition to modify this Agreed Order and end the requirements of this Paragraph after **three (3) years** have passed from the effective date.

4.3 **Temporary Practice Restrictions.** Upon the effective date of this Agreed Order, Respondent will not perform any procedures that require sedation. Respondent is also prohibited from prescribing DEA Schedule II-IV controlled substances upon the effective date of this Agreed Order. Respondent may petition to terminate these restrictions in whole or in part after completing the terms in paragraph 4.12 below.

4.4 **Permanent Practice Restrictions.** Upon the effective date of this Agreed Order, Respondent is prohibited from performing procedures that require sedation without a physician anesthesiologist or a certified registered nurse anesthetist to provide sedation and anesthesia. The anesthesiologist or anesthetist must have an unrestricted license in Washington state with no disciplinary history and be board certified by the American Board of Anesthesiology, the American Osteopathic Board of Anesthesiology, or the NBCRNA. Upon the effective date of this Agreed Order, Respondent is also prohibited from supervising physician assistants and from delegating the management of her pain management and primary care practice to a mid-level provider, such as a physician assistant or advanced registered nurse practitioner.

4.5 **Electronic Medical Record Keeping.** Respondent will fully implement an electronic medical record keeping system to timely and fully maintain a record of medical encounters for each patient. The medical records will document, as applicable, patient histories, examination, treatment planning, informed consent, and treatment provided. Respondent should use a professionally accepted format that complies with regulatory guidelines and meets the standard of care. Respondent must create accurate and adequate records for all patients. In keeping such records, clinical records should not inappropriately use "copy and paste" entries of the electronic medical record. The records should contain, as appropriate and applicable, treatment plans with corresponding objectives and further planned diagnostic evaluation. Respondent will also review the Commission's Guideline on Medical Records.[2]

4.6 **Medical Record Keeping Continuing Medical Education (CME). Within nine (9) months** of the effective date of this Agreed Order, Respondent must successfully complete a course approved in advance by the Commission or its designee discussing

[2] https://wmc.wa.gov/sites/default/files/public/Medical%20Records.pdf.

medical record keeping. Approval may be obtained by contacting the Compliance Unit using the contact information in paragraph 4.1 above. The following courses are pre-approved:

A. "CPEP Medical Record Keeping Seminar,[3]" Center for Personalized Education for Physicians (CPEP);

B. "Medical Record Keeping,[4]" University of California San Diego's Physician Assessment and Clinical Education Program (PACE); and

C. "PBI Medical Record Keeping (MR-17),[5]" Professional Boundaries, Inc. (PBI).

This continuing education must be in addition to mandatory continuing education hours required for license renewal. **Within one (1) month** of completion, Respondent must provide the Commission with proof of her completion of the course using the contact information in paragraph 4.1 above.

4.7 **Pain Management CME.** **Within six (6) months** of the effective date of this Agreed Order, Respondent must successfully complete a course approved in advance by the Commission or its designee discussing management of chronic pain. Approval may be obtained by contacting the Compliance Unit using the contact information in paragraph 4.1 above. The following courses are pre-approved:

A. "Annual John D. Loeser Pain Conference,[6]" UW Medicine, Continuing Medical Education;

B. "Annual Pain Medicine Meeting,[7]" American Society of Regional Anesthesia and Pain Medicine;

C. "AAMP Annual Meeting,[8]" American Academy of Pain Medicine; and

D. "Basics of Chronic Pain Management,[9]" CPEP.

[3] https://www.cpepdoc.org/cpep-courses/medical-records-keeping-seminar/.
[4] http://www.paceprogram.ucsd.edu/CME/record.aspx.
[5] https://pbieducation.com/courses/mr-17/.
[6] https://uw.cloud-cme.com/default.aspx?P=0&EID=6592.
[7] https://www.asra.com/events-education/pain-medicine-meeting.
[8] https://painmed.org/annual-meeting-academy-pain-medicine.
[9] https://www.cpepdoc.org/cpep-courses/basics-of-chronic-pain-management/.

If continuing medical education credit is offered for the course, it must be in addition to mandatory continuing education hours required for license renewal. Within **one (1) month** of completion, Respondent must provide the Commission with proof of her completion of the course using the contact information in paragraph 4.1.

4.8 **Compliance Audits.** Respondent will permit a representative of the Commission to conduct compliance audits of Respondent's records and review Respondent's general practice. The first compliance audit will occur at approximately **nine (9) months** from the effective date of this Agreed Order. Subsequent compliance audits will occur annually or at an interval otherwise determined by the Commission. After the first compliance audit and each subsequent compliance audit, the Commission will have discretion to determine if additional compliance audits are needed. Compliance audits may include, among other things, a review of Respondent's management of chronic pain patients and cosmetic surgery patients selected by the Commission Representative. The Commission may take additional action if the compliance audits reveal ongoing concerns regarding Respondent's practice. Respondent may petition to modify this Agreed Order and end the requirements of this Paragraph after **three (3) years** have passed from the effective date.

4.9 **Licensing Protocol.** Within **eight (8) months** of the effective date of this Agreed Order, Respondent must develop a protocol detailing procedures for ensuring that all of her employees have and maintain active Washington State licenses for their profession, including procedures for verifying active licensure status when a new employee is hired. Respondent must review Chapter 246-12 WAC Administrative Procedures and Requirements for Credentialed Health Care Providers and incorporate relevant requirements into the protocol, particularly focusing on the relevant requirements found in WAC 246-12-020 through -051. Respondent may also review the relevant professional standards and licensing found at Title 246 WAC. The written protocol must be submitted to the Commission's Compliance Unit using the contact information found in paragraph 4.1 above.

4.10 **Fine.** Within **thirty-six (36) months** of the effective date of this Agreed Order, Respondent must pay twenty-five thousand dollars ($25,000) to the Commission. Respondent may pay the fine in quarterly installments of $2,083.33 or 2,083.34 each.

The first payment is due **thirty (30) days** after the effective date of this Agreed Order. Subsequent payments are due every three months thereafter. The fine will be paid by certified check or money order, made payable to the Department of Health, and mailed to: Washington Medical Commission, Department of Health, P.O. Box 1099, Olympia, Washington, 98507-1099.

4.11 **Personal Appearances.** Within **twelve (12) months** of the effective date of this Agreed Order, Respondent must personally appear at a date and location determined by the Commission, or as soon thereafter as the Commission's schedule permits. Thereafter, Respondent must make personal appearances annually or as frequently as the Commission requires unless the Commission waives the need for an appearance. Respondent must participate in a brief telephone call with the Commission's Compliance Unit prior to the appearance. The purpose of appearances is to provide meaningful oversight over Respondent's compliance with the requirements of this Agreed Order. The Commission will provide reasonable notice of all scheduled appearances. Respondent may petition to modify this Agreed Order and end the requirements of this Paragraph after **three (3) years** have passed from the effective date.

4.12 **Petition for Modification.** Respondent may petition to modify the practice restrictions found in paragraph 4.3 above in whole or in part after the below conditions relevant to each restriction have been met. The petition must be made in writing. The Commission will have sole discretion to grant the petition, grant the petition subject to terms and conditions, or deny the petition.

4.12.1 **Clinical Competency Assessment.** Respondent must engage in an evaluation of her pain management, controlled substance prescribing, and primary care clinical skills as well as her cosmetic surgery skills at PACE.[10] The evaluation must include a review of technical skills; office practices, policies, and procedures; patient selection procedures; pre-operative patient evaluations and care; surgical procedure selection; anesthesia methodology; intraoperative patient safety; management of complications; and post-operative care. The

[10] http://www.paceprogram.ucsd.edu/Assessment/Assessment.aspx.

evaluation must also include an assessment of Respondent's clinical decision making and judgment as well as a neurocognitive evaluation. Respondent must notify the Commission's Compliance Unit using the contact information in paragraph 4.1 above when the assessment is scheduled.

4.12.1.1 Respondent will fully cooperate with the evaluation process and provide PACE with any information, documents, or releases that are requested.

4.12.1.2 PACE will provide a written report to the Commission regarding the evaluation, including recommendations for the scope and length of any additional evaluation or clinical training, treatment for any medical or psychological conditions, or anything else affecting Respondent's practice of medicine. Respondent must contract with PACE to monitor her satisfactory compliance with recommendations. The Commission may take additional action or modify this Agreed Order based on the results of the assessment.

4.12.1.3 Respondent will provide PACE with a copy of the Statement of Charges and this Agreed Order. The Commission may provide PACE with documents and records from its investigative files.

4.12.1.4 Respondent authorizes PACE and third-party evaluators to discuss with the Commission any matters relating to Respondent's evaluation and compliance with recommendations. Respondent waives any privileges or privacy rights under federal and state law regarding disclosures by PACE and third-party evaluators to the Commission.

4.12.1.5 PACE and third-party evaluators shall provide a copy of evaluations and written reports to the Commission and shall communicate as necessary to keep the Commission informed of Respondent's progress. The Commission will provide a copy of all evaluations and written reports received from PACE or third-party evaluators to Respondent in the event that PACE does not do so. Respondent will provide the Commission with copies of evaluations and written reports if PACE or third-party evaluators fail to do so.

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4.12.1.6 Respondent acknowledges that she will not be allowed to dispute the reports or recommendations by PACE or third-party evaluators to the Commission.

4.12.2 **Intensive Opioid Prescribing CME.** Respondent must complete a structured intensive course in the safe prescribing of opioid medications for chronic pain. The course must be approved in advance by the Commission or its designee. Pre-approval may be obtained by contacting the Compliance Unit using the contact information in paragraph 4.1 above. The following courses are pre-approved:

A. "Intensive Course in Controlled Substance Prescribing,[11]" Case Western Reserve University School of Medicine, Continuing Medical Education Program;

B. "PBI Prescribing: Opioids, Pain Management, and Addiction,[12]" PBI;

C. "Physician Prescribing Course,[13]" PACE; and

D. "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls,[14]" CPEP.

If continuing medical education credit is offered for the course, it must be in addition to mandatory continuing education hours required for license renewal. Within **one (1) month** of completion, Respondent must provide the Commission with proof of her completion of the course using the contact information in paragraph 4.1.

4.12.3 **Scholarly Paper.** Respondent must research and write a scholarly paper that summarizes and discusses the current Washington pain management rules, found at WAC 246-919-850 through -985, how they have changed from the previous pain management rules, and how she will apply the rules to her practice. The paper must be typewritten, a minimum of one thousand (1,000) words, and contain an annotated bibliography. Respondent should be prepared to discuss the subject matter of the written paper with the Commission a personal appearance if

[11] https://cwru.cloud-cme.com/default.aspx?p=4000&search=controlled.
[12] https://pbieducation.com/courses/rx-21/.
[13] http://www.paceprogram.ucsd.edu/CME/prescribing.aspx.
[14] https://www.cpepdoc.org/cpep-courses/prescribing-controlled-drugs/.

pursuing modification. The paper must be submitted to the Commission to the following address: Medical.compliance@wmc.wa.gov.

4.13 **Demographic Census.** Washington law[15] requires physicians and physician assistants to complete a demographic census with their license renewal. Respondent must submit a completed demographic census[16] to the Commission within thirty (30) days of the effective date of this Agreed Order, or at the time of renewal, whichever comes first.

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

4.15 **Costs.** Respondent must assume all costs of complying with this Agreed Order.

4.16 **Violations.** If Respondent violates any provision of this Agreed Order in any respect, the Commission may initiate further action against Respondent's license.

4.17 **Change of Address or Name.** Respondent must inform the Commission and Adjudicative Clerk Office in writing, of changes in her residential and/or business address and/or her name within thirty (30) days of such change.

4.18 **Self-Reporting.** Respondent must report in writing, by email to medical.compliance@wmc.wa.gov, within thirty (30) days of the occurrence of any of the following events:

A. Denial, restriction, suspension, or revocation of any healthcare-related license for the Respondent in another state;

B. Denial, restriction, suspension, or revocation of privileges for the Respondent in any healthcare facility;

C. Any felony or gross misdemeanor charge against the Respondent; and

D. The filing of a complaint in superior court or federal district court against Respondent alleging negligence or request for mediation pursuant to chapter 7.70 RCW.

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[15] RCW 18.71.080(1)(b) and 18.71A.020(4)(b).
[16] https://wmc.wa.gov/licensing/renewals/demographic-census.

This requirement supplements and does not supersede the reporting obligations imposed by WAC 246-16-230.

4.19 **Effective Date.** 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.

4.20 **Termination.** The practice restrictions agreed to under paragraph 4.4 are permanent and Respondent may not petition for termination. Respondent may petition to modify applicable provisions of this section of the Agreed Order.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies WAC 246-16-800, *et seq.,* to determine appropriate sanctions. Tier C of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices caused severe harm or death to a human patient. Respondent's failure to perform an adequate physical examination, conduct a thorough medical history, and get timely lab results caused her to perform a procedure for which Patient I was a poor candidate, ultimately leading to her death. Respondent also failed to treat Patient I in appropriate manner when her oxygen saturation level was dangerously low at a follow-up appointment, also contributing to her death. Given these considerations, Tier C applies to Respondent's conduct.

5.2 Tier C requires the imposition of sanctions ranging from three (3) years of oversight to permanent oversight. WAC 246-16-800(3)(d) states that the starting point for the duration of oversight is the middle of the range. The Commission uses aggravating and mitigating factors to move toward the maximum or minimum ends of the range.

5.3 While all but one of the sanctions in this Agreed Order can be completed in five years, there is no end to the duration of the Agreed Order because the sanction agreed to under paragraph 4.4 is permanent. The sanctions agreed to under paragraph 4.4 requiring that Respondent not perform procedures requiring sedation without an anesthesiologist or anesthetist, not supervise physician assistants, and not delegate practice management to midlevel providers are at the high end of the duration contemplated under Tier C. The Commission notes six aggravating factors in relation to this term: the number and frequency of the acts of unprofessional conduction, injuries

caused by the unprofessional conduct, the potential for further injury to be caused by the unprofessional conduct, the gravity of the unprofessional conduct, the vulnerability of the patients, and Respondent's abuse of trust as well as one mitigating factor: Respondent's cooperation with the investigation. The Commission believes the terms and conditions of this Agreed Order will adequately protect the health and safety of the public.

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, KRISTINE S. BRECHT, 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.

Kristine Brecht — 7-12-2021

KRISTINE S. BRECHT, MD
RESPONDENT

DATE

Ketia Wick — 7/13/2021

KETIA B. WICK, WSBA NO. 27291
ATTORNEY FOR RESPONDENT

DATE

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8. COMMISSION'S ACCEPTANCE AND ORDER

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

DATED: 4 August, 2021.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

CM Robert MD

PANEL CHAIR

PRESENTED BY:

TRISHA WOLF, WSBA NO. 48118
COMMISSION STAFF ATTORNEY