STATE OF WASHINGTON
MEDICAL DISCIPLINARY BOARD

In the Matter of Disciplinary Action Concerning

LEO J. BOLLES, M.D.,
Respondent.

NO. PM 4631
FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

THIS MATTER having come on regularly for hearing before the State of Washington Medical Disciplinary Board; respondent, Leo J. Bolles, M.D., appearing personally and through counsel, Patrick A. Trudell, and the State of Washington Department of Licensing, Business and Professions Administration, Medical Section appearing by and through its attorney, Lesley A. Allan, Assistant Attorney General; the Board, having heard the testimony and reviewed the evidence and record herein, makes the following:

I. FINDINGS OF FACT

1.1 That respondent, Leo J. Bolles, M.D., is licensed to practice medicine and surgery in the State of Washington and was so licensed at all times material hereto.

1.2 That, while a motion for summary order of dismissal was contained in the written record, respondent did not argue or raise the motion and thus, the Board did not address the motion.

1.3 That respondent's attempted treatment of patient as evidenced by the nature and quantity of intravenous medications prescribed by him does not support respondent's
contention that he merely diagnosed "relative" adrenal insufficiency.

1.4 That respondent misdiagnosed patient [redacted] as having an adrenal insufficiency problem.

1.5 That misdiagnosing a patient as having adrenal insufficiency is an unsafe medical practice.

1.6 That a patient's knee reflex alone is not an indication that the patient has a thyroid problem.

1.7 That contrary to respondent's testimony, respondent's own medical records reflected the patient's skin condition as normal.

1.8 That there were no medical indications sufficient for respondent to prescribe thyroid medication for patient [redacted].

1.9 That the records reflected that patient [redacted] was hypertensive.

1.10 That prescribing thyroid medication to a patient with high blood pressure with no indications of thyroid problems is an unsafe medical practice.

1.11 That the patient [redacted] suffered no serious harm as a result of respondent's unsafe medical practices.

II. CONCLUSIONS OF LAW

From the foregoing Findings of Fact, the Board makes the following Conclusions of Law:

2.1 That the Board has jurisdiction over the respondent, Leo J. Bolles, M.D., and over the subject matter herein.
2.2 That the state has the burden of proving the charges in the Statement of Charges by a preponderance of the evidence.

2.3 That the state has failed to carry its burden of proof with regards to the charges contained in paragraphs II and V of the Statement of Charges, dated March 2, 1988.

2.4 That the state has failed to establish an element of the charges based on RCW 18.72.030(11), i.e. serious harm to the patient.

2.5 That grounds exist to order corrective action by the respondent based on RCW 18.72.150(5).

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Board hereby ORDERS that respondent, Leo J. Bolles, M.D., shall not treat any patients with thyroid medications for assumed thyroid dysfunction based solely on depressed reflexes; it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall not prescribe or treat patients with high blood pressure by use of thyroid medications when there are no or insufficient medical indications for diagnosing a thyroid problem; it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall prescribe or otherwise treat patients with thyroid medications only if he diagnoses thyroid problems in the patient(s) based on the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology; it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall not prescribe or treat any patients with intravenous adrenal
cortical steroids unless a diagnosis of adrenal insufficiency is based on the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology; it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall obtain 50 CME credits per year in addition to the currently required number of CME credits for all licensees licensed to practice under chapter 18.71 RCW for a period of three years from the date of this order and the additional CME credits shall be obtained in the area of endocrinology and respondent must obtain the Medical Disciplinary Board's approval of the course(s) prior to commencing the course(s); it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall maintain a patient index file containing the names of patients, diagnoses, and dates of treatment for any and all patients with endocrine problems as defined in the current edition of Williams' textbook on endocrinology and the patient index file shall be subject to random review by a representative from the Board who shall report his or her findings directly to the Board; it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall cooperate in full with practice reviews conducted by representatives from the Board at least twice per year, which shall include, but not be limited to, a random selection and review of all patients' records to monitor respondent's compliance with this order; it is further

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER - 4
ORDERED that respondent, Leo J. Bolles, M.D., shall appear before the Board in twelve months from the date of this order or as soon thereafter as the Board's calendar will allow; it is further

ORDERED that any failure to comply with this order or any violation of the laws regulating the practice of medicine and surgery in the State of Washington whether uncovered during monitoring of this order or based upon an independent investigation shall constitute grounds for disciplinary action; it is further

ORDERED that respondent, Leo J. Bolles, M.D., shall be and is responsible for ensuring his compliance with this order, including but not limited to, ensuring that his personal appearance occurs in a timely fashion unless delay of his personal appearance is authorized by the Board due to scheduling problems for the Board; it is further

ORDERED that paragraphs II and V of the Statement of Charges, dated March 2, 1988, and the charges alleging grounds for disciplinary action pursuant to RCW 18.72.030(11) in the same Statement of Charges shall be and are dismissed with prejudice.

DATED this 5th day of February, 1989.

STATE OF WASHINGTON
MEDICAL DISCIPLINARY BOARD

By: JAMES P. DUNLAP, M.D.
Chairman

MDB/BOLLES.ORD

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER - 5
STATE OF WASHINGTON
MEDICAL DISCIPLINARY BOARD

In the Matter of Disciplinary Action Concerning

LEO J. BOLLES, M.D.

Respondent

STRICTED ORDER NO. PM 4631

STATEMENT OF CHARGES

MICHAEL J. MURPHY, Secretary of the Washington State Medical Disciplinary Board, and acting in that capacity, states and alleges as follows:

I.

The respondent has been issued a license to practice medicine by the State of Washington.

II.

Respondent failed to diagnose and appropriately treat the condition of diabetes in patient [redacted].

III.

Respondent misdiagnosed patient [redacted] as having an adrenal insufficiency problem.

IV.

Respondent treated patient [redacted] with thyroid medication when there was no indication of a problem with the patient's thyroid.

V.

Respondent made a diagnosis of allergy to inhalants without performing proper allergy testing.

VI.

The conduct described in paragraphs II, III, IV and V constitutes grounds for disciplinary action pursuant to RCW 18.72.030(11) which defines unprofessional conduct to include incompetency or negligence in the practice of medicine and surgery resulting in serious harm to the patient; and/or constitutes unsafe practice warranting corrective action under RCW 18.72.150(5).
WHEREFORE, Michael J. Murphy, alleges that the conduct referred to in this statement of charges affects the public health, safety and welfare, that a notice be issued and served as provided by law to the respondent giving him the opportunity to defend against the accusations of this statement of charges, and provided that if he shall fail to defend against these accusations, that he shall be subject to such discipline as is appropriate under RCW 18.72.230 or to corrective action under RCW 18.72.150(5).

DATED this 24th day of March, 1981.

Michael J. Murphy
Secretary, Washington State
Medical Disciplinary Board

By: GLORIA J. WESTERFELD
Executive Secretary
STATE OF WASHINGTON
MEDICAL DISCIPLINARY BOARD

In the Matter of Disciplinary Action Concerning ) NO. 86-04-0162MD
LEO J. BOLLES, M.D., ) (formerly PM 4631)
Respondent. ) FINDINGS OF FACT,
) CONCLUSIONS OF LAW,
) AND ORDER ON COMPLIANCE/
) PROGRESS REVIEW

THIS MATTER having come before the State of Washington Medical Disciplinary Board for a compliance/progress review pursuant to the Findings of Fact, Conclusions of Law, and Order, dated February 15, 1989, and Order on Compliance/Progress Review, dated May 29, 1990; respondent, Leo J. Bolles, appearing personally and by and through counsel, Pat Trudell; the Board, having heard the testimony, reviewed the record herein, and being otherwise advised on the premises, now makes the following:

I. FINDINGS OF FACT

1.1 That respondent, Leo J. Bolles, is licensed to practice medicine and surgery in the State of Washington and said practice is subject to corrective action as contained in the February 15, 1989 Findings of Fact, Conclusions of Law and Order.

1.2 That the May 29, 1990 Order on Compliance/Progress Review further clarified the February 15, 1989 Findings of Fact, Conclusions of Law and Order, after describing some concerns with respondent's compliance with the portion of the order requiring CME in the area of endocrinology in courses approved by the Board and finding respondent in substantial compliance with that provision of the February 15, 1989 Order.

Findings of Fact, Conclusions of Law, and Order - 1
1.3 That the February 15, 1989 Findings of Fact, Conclusions of Law and Order required respondent to make compliance appearances before the Board twelve months from the date of the order or as soon thereafter as the Board’s schedule will allow.

1.4 That the number of CME completed by respondent in the area of endocrinology in courses approved by the Board is again unclear during this compliance period.

1.5 That during the course of the hearing, there was testimony and other evidence which raised concerns with the quality of respondent’s practice. Examples of such testimony and evidence include but is not limited to:

   a. A current patient’s record in which the last recorded blood pressure for the patient was in 1985;

   b. A patient obtaining medication from respondent’s staff based only upon the patient’s statements to the staff that respondent had ordered the medication for the patient and for whom respondent indicated that he was unaware that the patient was obtaining said medication;

   c. Respondent’s treatment of patients as if the patient had abnormal values on laboratory results even when the laboratory reports indicate that the results were within normal ranges;

   d. Respondent’s use of adrenal cortical steroids for "relative" adrenal insufficiency.

1.6 That the concerns raised by the testimony and evidence at the compliance hearing warrants continued scrutiny of respondent’s practice of medicine and surgery in the State of Washington.
II. CONCLUSIONS OF LAW

From the foregoing Findings of Fact, the Board makes the following Conclusions of Law:

2.1 That the Board has jurisdiction over respondent, Leo J. Bolles, and over the subject matter herein.

2.2 That an order should be entered reflecting the Board’s concerns with respondent’s compliance with the February 15, 1988 Findings of Fact, Conclusions of Law and Order and addressing some means of assuring better compliance with the required CME attendance.

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Board hereby ORDERS that Leo J. Bolles shall comply with the terms of the February 15, 1988 Findings of Fact, Conclusions of Law and Order as clarified by the May 29, 1990 Order on Compliance/Progress Review and this order; it is further

ORDERED that respondent shall submit a complete listing of all CMEs taken since the February 15, 1988 Findings of Fact, Conclusions of Law and Order, including those taken as required by RCW 18.71.080 and the February 15, 1988 Findings of Fact, Conclusions of Law and Order, no later than thirty (30) days prior to respondent’s next compliance appearance before the Board; it is further

ORDERED that respondent shall submit evidence of having completed fifty (50) hours of CME in the area of endocrinology in Board approved courses no later than thirty (30) days prior to
respondent's next compliance appearance before the Board; it is further

ORDERED that respondent shall appear before the Board for a compliance appearance in twelve months from the date of this Order or as soon thereafter as the Board's schedule will allow.

DATED this 20th day of June, 1991.

STATE OF WASHINGTON
MEDICAL DISCIPLINARY BOARD

[Signature]

JOHN W. HUFF, M.D.
Acting Chairman
STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice of Medicine of

Leo Joseph Bolles, MD,
License No. 4165,
Respondent.

No. 86-04-0162MD; 91-05-0236MD
91-07-0155MD; 92-03-0014MD
92-04-0027MD

STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER

The Medical Quality Assurance Commission by and through Department of Health Staff Attorney Michael L. Farrell and the Respondent, Leo J. Bolles, M.D., individually and by and through his counsel of record, Patrick Trudell, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

1.1 The Respondent, Leo J. Bolles, M.D., is licensed to practice medicine in the State of Washington at all times relevant to this action.

1.2 On February 17, 1995, the Commission issued a Statement of Charges regarding the professional practice of the Respondent.

1.3 The Statement of Charges alleges that the Respondent violated RCW 18.130.180(4), (6), (7), (9), and (22).

1.4 The Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.5 The Respondent understands that he has the right to defend himself against allegations in the Statement of Charges by presenting evidence in his behalf at the hearing.

1.6 The Respondent understands that, should the State in fact prove at the hearing the allegations in the Statement of Charges, the Commission has the power and authority to impose sanctions under RCW 18.130.160.

1.7 The Respondent and the Commission agree to expedite the resolution of this matter by means of Stipulated Findings of Fact, Conclusions of Law, and Agreed Order.

1.8 The Respondent waives the opportunity for a hearing on the Statement of Charges contingent upon the entry of the following Agreed Order.
1.9 The Respondent acknowledges that the Agreed Order is not binding unless and until it is accepted by the Commission.

1.10 The Respondent acknowledges that should this Stipulated Findings of Fact, Conclusions of Law and Agreed Order be accepted it will be subject to the reporting requirements of RCW 18.130.110 and interstate/national reporting, including, but not limited to, the National Practitioner Data Bank per 45 CFR 60.

Section 2: STIPULATED FACTS

The State and the Respondent stipulate to the following facts:

2.1 On February 15, 1989, the Medical Disciplinary Board (now the Medical Quality Assurance Commission), following a formal hearing, issued Findings of Fact, Conclusions of Law, and Order which placed certain restrictions on the Respondent's license, including the following two restrictions:

a. Not prescribe or treat any patients with intravenous adrenal cortical steroids unless a diagnosis of adrenal insufficiency is based on the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology;

b. Prescribe or treat patients with thyroid medication only if he diagnoses thyroid problems in the patient(s) based on the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology.

2.2 After the issuance of the February 15, 1989, Order, the Respondent administered or had administered doses of intravenous therapy with solutions containing adrenal cortical extract to fourteen patients without making a diagnosis of adrenal insufficiency according to the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology. The Respondent was using this intravenous therapy as nontraditional treatment to treat adrenal dysfunction and other conditions not related to adrenal dysfunction.

2.3 After issuance of the February 15, 1989, Order, the Respondent prescribed thyroid to patients three and nine based on low T-4 test results, but normal TSH results. The Respondent continued patient six on thyroid medication based on her history of thyroid disease and her clinical presentation. The Respondent continued thyroid treatment to patient ten in a larger dose than she at that time needed.

2.4 At all times material to these charges, the Respondent's use of parenteral drugs and injections containing adrenal cortical extract was without an approved new drug application from the Federal Food and Drug Administration and from the Washington State Department of Agriculture. The Respondent's use of parenteral drugs and injections containing adrenal cortical extract was for nontraditional treatment.
2.5 On April 24, 1991 and May 1, 1991, the Respondent treated Patient Fifteen with a device known as a "T.E.N.S. BK Digital Display Function Generator" and told Patient Fifteen it would destroy the viruses in her body. The Respondent was using this device for nontraditional treatment in the course of his professional practice.

2.6 In June 1991, the Respondent had Patient Sixteen undergo allergy testing through the use of a device known as an "Interro Electrodiagnosis Machine." This device is adulterated pursuant to 21 U.S.C. 351(f)(1)(B), because the Federal Food and Drug Administration has neither granted pre-market approval pursuant to 21 U.S.C. 360(e), nor granted an investigational device exemption, pursuant to 21 U.S.C. 360(g). The Respondent was using this device for nontraditional treatment in the course of his professional practice.

2.7 In January 1992, the Respondent diagnosed Patient Seventeen, who was suffering from behavioral problems such as irritability, hyperactivity and aggressiveness, as well as fatigue, as having reactive hypoglycemia. The Respondent prescribed adrenal cortical extract for Patient Seventeen, along with various vitamin supplements and dietary recommendations to treat Patient Seventeen's reactive hypoglycemia.

2.8 The Respondent took chest x-rays of Patients Eighteen through Twenty Two in his office, but used poor technique in developing and washing the films rendering them unusable.

Section 3: CONCLUSIONS OF LAW

The State and the Respondent do not object to entry of the following Conclusions of Law:

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

3.2 The above facts, if proved at hearing, constitute a commission of unprofessional conduct as defined by RCW 18.130.180(6), (7), and (9).

3.3 The above facts, if proved at hearing, constitute grounds for sanctions under RCW 18.130.160.

Section 4: AGREED ORDER

Based on the preceding Stipulated Facts and Conclusions of Law, the Commission hereby orders that this Agreed Order supersedes all previous orders, including the Findings of Fact, Conclusions of Law, and Order, dated February 15, 1989; the Findings of Fact, Conclusions of Law, and Order on Compliance/Progress Review, dated May 29, 1990; and the Findings of Fact, Conclusions of Law, and Order on Compliance/Progress Review, dated June 20, 1991; and hereby orders the Respondent to comply with the following terms and conditions:

4.1 If the Respondent diagnoses a patient with a possible adrenal gland or thyroid gland problem, the Respondent shall refer the patient to a board-certified endocrinologist approved by the Commission or the Commission's designee. The Respondent may treat the patient, but the Respondent shall follow the recommendations of the board-certified

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endocrinologist for the treatment of the endocrine problem. The Respondent shall maintain a patient index file containing the name of each patient the Respondent has diagnosed with a possible adrenal gland or thyroid gland problem. The file shall contain the name of the patient, the diagnosis, and the dates of treatment, as well as the name, address and phone number of the endocrinologist to whom the patient was referred.

4.2 The Respondent shall not use any device, as defined in 21 U.S.C. § 321(h), in the practice of medicine unless (a) the Food and Drug Administration specifically approves the device, approves an application for pre-market approval, or approves an application for an investigational device exemption, and (b) the device is used for the specific diagnostic or therapeutic purposes permitted by the Food and Drug Administration. Furthermore, the Respondent shall not refer patients to medical doctors who use such devices.

4.3 The Respondent shall comply with all laws and regulations concerning the use of devices in the Food and Drug Act, 21 U.S.C. § 301 et seq., 21 CFR § 801 et seq., and RCW 69.04.

4.4 The Respondent shall not make any representation, whether oral or written, which in any way implies that the Food and Drug Administration has approved, licensed, or otherwise endorsed a device, as defined in 21 U.S.C. § 321(h), which has not been approved. If the Respondent uses such a device in his practice, he must have his patients sign a written notice acknowledging the precise status of the device with the Food and Drug Administration. If the device has not been approved, the notice shall state that the Food and Drug Administration has not approved the device because there is not sufficient evidence that the device is efficacious.

4.5 The Respondent shall not take x-rays and shall not permit his employees to take x-rays.

4.6 The Respondent shall ensure that all care delivered to patients falls within acceptable standards of medical practice.

4.7 COMPLIANCE:

A. The Respondent shall appear before the Commission every six months for the first year from the date this Agreed Order is signed by the Commission, or as soon thereafter as the Commission's schedule permits, and present proof that he is complying with the Order. After the first year, the Respondent shall continue to make such compliance appearances annually or as soon thereafter as the Commission's schedule permits, until further order of the Commission.

B. In order to monitor compliance with the Order the Respondent agrees that a representative of the Commission may make announced visits semi-annually to the Respondent's practice to:

(1) Inspect office and or medical records;

(2) Interview office staff or the Respondent's supervisors;

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(3) Review other aspects of the Respondent's practice.

C. All costs of compliance shall be borne by the Respondent.

D. If the Respondent violates the terms/conditions of the Commission's Order in any respect the Commission may:

   (1) Summarily suspend the Respondent's license to practice under RCW 18.130.050(7);

   (2) Impose conditions as appropriate under RCW 18.130.160 to protect the public, following notice to the Respondent and the opportunity to be heard; and/or

   (3) Issue charges of unprofessional conduct under RCW 18.130.180.

4.8 The Respondent may petition the Board for a change in the terms/conditions of the Order no sooner than two years from the date it is signed by the Commission.

4.9 RESIDENCE:

   A. The Respondent shall inform the Commission, in writing, of changes in his practice and residence address.

   B. In the event the Respondent leaves the State of Washington to reside or to practice outside the State of Washington, the Respondent must notify the Commission in writing of the dates of departure and return.

   C. Any period of time during which the Respondent resides and/or practices outside the State of Washington shall not apply to the reduction of the duration of the suspension or probation.

4.10 Pursuant to RCW 18.130.160(8) the Respondent shall pay a $1000 fine within ninety (90) days of the effective date of this Order. The fine shall be payable to the State Treasurer and sent to the following address:

   Executive Secretary
   Medical Quality Assurance Commission
   1300 SE Quince Street, M/S EY 25
   Post Office Box 47866
   Olympia, Washington 98504-7866.

4.11 The Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Washington.

4.12 The Commission's jurisdiction over the Respondent shall continue until the Respondent files a written petition for termination of the Board's jurisdiction and, if the Board so requests,
appears personally before the Commission. Termination of the Commission's jurisdiction shall be by written order of the Commission.

4.13 This Agreed Order will be subject to the reporting requirements of RCW 18.130.110 and the National Practitioner Data Bank, 45 CFR 60.

4.14 This Agreed Order is not binding on the Respondent or the Commission unless accepted by the Commission.

4.15 This Agreed Order shall become effective ten (10) days from the date the Order is signed by the Commission chair, or upon service of the Order on the Respondent, whichever date is sooner.

I, Leo J. Bolles, M.D., hereby certify that I have read this Agreed Order in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it, and in witness whereof I affix my signature this 11th day of December, 1995.

Leo J. Bolles, M.D.
Respondent
Section 5: ORDER

The Commission accepts the Stipulated Findings of Fact, Conclusions of Law, and Agreed Order. IT IS ORDERED that all parties shall be bound by the terms and conditions of section IV.

DATED this 13th day of Dec, 1995.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

By: [Signature]
Panel Chair

Presented by:

Michael L. Farrell WSBA #16022
Department of Health Staff Attorney

STIPULATED TO AND APPROVED FOR ENTRY:

[Signature]
Leo J. Bolles, M.D.
Respondent

[Signature]
Patrick Trudell WSBA #11363
Attorney for the Respondent

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License

No. 86-04-0162MD; 91-05-0236MD
91-07-0155MD; 92-03-0014MD
92-04-0027MD

LEO J. BOLLES, M.D.

STATEMENT OF CHARGES

Respondent.

The Program Manager of the State of Washington Department of Health upon designation by the disciplining authority states and alleges as follows:

Sections 1: LICENSE STATUS

1.1 At all times materials to this Statement of Charges Respondent has been licensed to practice medicine by the State of Washington.

Section 2: CONFIDENTIAL SCHEDULE

2.1 The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

Section 3: FACTUAL ALLEGATIONS

3.1 On February 15, 1989, the Medical Disciplinary Board (now the Medical Quality Assurance Commission) issued Findings of Fact, Conclusions of Law and Order (the 1989 Order) placing certain conditions on Respondent's license to practice medicine. The Board modified the Order in 1990 (the 1990 Order). These two Orders required Respondent to

a. Not prescribe or treat any patients with intravenous adrenal cortical steroids unless a diagnosis of adrenal insufficiency is based on the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology.

b. Prescribe or treat patients with thyroid medication only if he diagnoses thyroid problems in the patient(s) based on the standard guidelines for such diagnosis in the current edition of Williams' textbook of endocrinology;

c. Maintain a chronological listing of all patients treated for an endocrinological condition, even though the condition is not the primary diagnosis for that patient. The
chronological listing shall show the patient's name, date, diagnoses, and dates of all treatments and all subsequent visits related to the endocrinological condition.

3.2 References in Respondent's patient records to "IV4" or "IV5" were indications the patient received intravenous therapy with solutions containing adrenal cortical extract.

3.3 Between October 1990 and June 1991, Respondent administered or had administered multiple doses of IV4 (with chelation) and multiple doses of IV5 to Patient One without adequate objective clinical indications of adrenal insufficiency.

3.4 Beginning on April 24, 1991, Respondent ordered weekly IV5 administration for Patient Two, without adequate objective clinical indications of adrenal insufficiency.

3.5 Between May 12, 1988 and December 27, 1989, Respondent administered or had administered multiple doses of IV5 to Patient Three without adequate objective clinical indications of adrenal insufficiency.

3.6 Between April 2, 1990 and October 30, 1990, Respondent administered or had administered multiple doses of IV5 and IV5 with Germanium to Patient Four without adequate objective clinical indications of adrenal insufficiency.

3.7 Between October 2, 1990 and October 23, 1990, Respondent administered or had administered multiple doses of IV5 to Patient Five without adequate objective clinical indications of adrenal insufficiency.

3.8 Between June 6, 1991 and July 13, 1991, Respondent administered or had administered multiple doses of IV5 to Patient Six, and sent further weekly doses to Patient Six after she moved out of town, without adequate objective clinical indications of adrenal insufficiency.

3.9 Between May 6, 1991 and August 6, 1991, Respondent administered multiple doses of IV5 to Patient Seven without adequate objective clinical indications of adrenal insufficiency.

3.10 Between January 1989 and May 14, 1992, Respondent administered or had administered multiple doses of IV5 to Patient Eight without adequate objective clinical indications of adrenal insufficiency.

3.11 Between September 1988 and April 1992, Respondent administered or had administered multiple doses of IV5 to Patient Nine without adequate objective clinical indications of adrenal insufficiency.

3.12 Between 1984 and May 1992, Respondent administered or had administered multiple doses of IV4 and IV5 to Patient Ten without adequate objective clinical indications of adrenal insufficiency.
3.13 Between October 1991 and January 1992, Respondent administered or had administered multiple doses of IV5 to Patient Eleven without adequate objective clinical indications of adrenal insufficiency.

3.14 Between August 1991 and May 1992, Respondent administered or had administered multiple doses of IV5 to Patient Twelve without adequate objective clinical indications of adrenal insufficiency.

3.15 Between September 1991 and May 1992, Respondent administered or had administered multiple doses of IV5 to Patient Thirteen without adequate objective clinical indications of adrenal insufficiency.

3.16 In February 1992, Respondent administered or had administered one dose of IV4 to Patient Fourteen without adequate objective clinical indications of adrenal insufficiency.

3.17 Beginning on January 4, 1990, Respondent prescribed thyroid extract for Patient Three without adequate objective clinical indications of hypothyroidism or thyroid disease.

3.18 Beginning on July 3, 1991, Respondent increased the maintenance dose of synthroid to Patient Six without adequate objective clinical indications of hypothyroidism.

3.19 Beginning on April 7, 1992, Respondent prescribed thyroid extract for Patient Nine without adequate objective clinical indications of hypothyroidism.

3.20 Beginning in May 1991, Respondent prescribed synthroid to Patient Ten without adequate objective clinical indications of hypothyroidism.

3.21 During a 1991 compliance review, Respondent failed to produce a chronological listing containing information on Patients Three and Four required by the 1989 Order, as modified by the 1990 Order.

3.22 During a 1993 compliance review, Respondent failed to produce a chronological listing containing information on Patients Eleven and Fourteen required by the 1989 Order, as modified by the 1990 Order.

3.23 At all times material to these charges, Respondent's use of parenteral drugs and injections containing adrenal cortical extract, without an approved new drug application from the Federal Food and Drug Administration and from the Washington State Department of Agriculture, violated RCW 69.04.570.

3.24 On April 24, 1991 and May 1, 1991, Respondent treated Patient Fifteen with a device known as a "T.E.N.S. BK Digital Display Function Generator" and told Patient Fifteen it would destroy the viruses in her body. Respondent's use of this device rendered the device "misbranded" pursuant to 21 U.S.C. 352(o), and, therefore, a violation of RCW 69.04.005(5).
3.25 When Patient Fifteen filed a complaint with the Medical Disciplinary Board, Respondent's clinic director wrote to Patient Fifteen stating that the complaint violated the agreement with Respondent that all disputes were subject to arbitration, and that if Patient Fifteen did not withdraw the complaint within ten days, Respondent would file suit in superior court.

3.26 In June 1991, Respondent had Patient Sixteen undergo allergy testing through the use of a device known as an "Interro Electrodiagnosis Machine." This device is adulterated pursuant to 21 U.S.C. 351(f)(1)(B), because the Federal Food and Drug Administration has neither granted premarket approval pursuant to 21 U.S.C. 360(e), nor granted an investigational device exemption, pursuant to 21 U.S.C. 360(g). By using an adulterated device, Respondent violated RCW 69.04.040(1) and (3).

3.27 In January 1992, Respondent diagnosed Patient Seventeen, who was suffering from rage and aggressive behavior, as having reactive hypoglycemia. Respondent prescribed adrenal cortical extract for Patient Seventeen without performing sufficient tests to establish Patient Seventeen's adrenal hormonal status.

3.28 Respondent took chest x-rays of Patients Eighteen through Twenty Two in his office, but used poor technique in developing and washing the films rendering them unusable.

Section 4: ALLEGED VIOLATIONS

4.1 The facts alleged in paragraphs 3.1 through 3.22, if proved, constitute a violation of RCW 18.130.180(9), which defines as unprofessional conduct:

Failure to comply with an order issued by the disciplining authority.

4.2 The facts alleged in paragraphs 3.2 through 3.16, 3.23, 3.24, and 3.26, if proved, constitute a violation of RCW 18.130.180(7), which defines as unprofessional conduct:

Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.

4.3 The facts alleged in paragraphs 3.2 through 3.20, 3.24, 3.26 through 3.28, if proved, constitute a violation of RCW 18.130.180(4), which defines as unprofessional conduct:

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.
4.4 The facts alleged in paragraph 3.25, if proved, constitute a violation of RCW 18.130.180(22), which defines as unprofessional conduct:

Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action.

4.5 The facts alleged in paragraphs 3.2 through 3.20, and 3.27, if proved, constitutes a violation of RCW 18.130.180(6), which defines as unprofessional conduct:

The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, the addiction to or diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself.

It is further alleged that the allegations specified and conduct referred to in this Statement of Charges affect the public health, safety and welfare, and the Medical Quality Assurance Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against the accusations of the Statement of Charges.

If Respondent fails to defend against these allegations, Respondent shall be subject to such discipline as is appropriate under RCW 18.130.160.

DATED this 17th day of February, 1995.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

By: Beverly A. Teeter
Program Manager

Pat DeMarco WSBA #16897
Assistant Attorney General
Licensing Division
P.O. Box 40110
Olympia, Washington 98504-0110
CONFIDENTIAL INVESTIGATIVE REPORT
PREPARED FOR THE
MEDICAL DISCIPLINARY BOARD

**********
Case # 91-05-0236MD

RESPONDENT: LEO J. BOLLES, M.D.

**********

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APPENDIX E -- EVIDENCE/EXHIBITS
APPENDIX F -- POSSIBLE VIOLATIONS
APPENDIX G -- ACTIVITY REPORT
APPENDIX H -- REQUEST FOR INVESTIGATION

Investigator: JAMES M. RICH

APPROVED BY: [Signature] DATE: 10/14/91
APPENDIX A

RESPONDENT INFORMATION

LEO J. BOLLES, M.D.

BUSINESS ADDRESS:
15611 Bellevue-Redmond Rd.
Bellevue, Wa. 98008
Telephone No. (206) 881-2224

LICENSE NUMBER: 0004165

DATE ISSUED: 8-1-52

EXPIRATION DATE: 2-10-91

BIRTH DATE: 3-10-21

SPECIALIZATION: Preventive Medicine

PREVIOUS REGULATORY ACTION: Yes

PREVIOUS COMPLAINT HISTORY: Yes

ATTORNEY IDENTIFICATION: William Kerns
10800 N. E. 8th #1000
Bellevue, WA 98004
(206) 453-7799

APPENDIX B

COMPLAINANT INFORMATION

HM
WK

APPENDIX C

CONTACT LIST

Terry O'Neal
Administrator
Bolles Clinic

91-05-0236MD BOLLES
APPENDIX D

GENERAL SUMMARY

The complainant, a 55-year-old female, has made several allegations against Dr. Bolles and his clinic staff. This followed two clinic visits occurring on 4-24-91 and 5-1-91.

Summary of allegations include: 1. Mis-diagnosis and treatment of her condition using the laboratory results of another patient. 2. Used an unproved means of providing "TENS" therapy which caused significant neck and shoulder pain. 3. Carelessness and lack of response from the Bolles Clinic staff. 4. Suspicion that the Bolles clinic may be trying to make more money by getting patients to schedule additional office visits and take unnecessary tests. (Ref. Appendix E, Tab 1, pgs. 1 - 3A; Tab 3, pgs. 11-16, 18 & 40-41)

As to the mis-diagnosis, believed she had a "Toxic" condition. Upon reviewing the lab report that was used to make this determination, (Ref. Appendix E, Tab 1, pg. 3) it appears this determination came from a borderline low WBC count and a Sedimentation Rate of 28 with their lab normal reference of 0-20. Treatment consisted of RC-11 to reduce her sedimentation rate and a combination of Vitamins A, B & C for her WBC count. RC-11 is reported to be a herbal product. Dr. Bolles states this product is non-harmful and that an adjustment had been made for the cost of this product. However, as per the letter of cooperation, Dr. Bolles has not complied with the request for billing ledgers so that this could be verified. From Mr. O'Neil's letter of 8-6-91 to , it is unclear as to what billing adjustment was made. (Ref. Appendix E, Tab 1, pgs. 1 & 3; Tab 2, pg. 7, 12, 14, 18, & 39)

The "TENS" treatment appears to be a major issue in this case, having caused significant chronic pain in her neck and shoulder areas. This pain has continued for five months post treatment and is now reportedly starting to subside. "TENS", as the term is used by Dr. Bolles, seems to be misleading as it is not the same TENS treatment as commonly used by physical medicine. The modality Dr. Bolles uses is a device called the CES 100Hz (Cranial Electrotherapy Stimulation) distributed by CES Labs. This particular piece of equipment does appear to be approved by the FDA under specific guidelines for the treatment of Anxiety, Stress related withdrawal syndrome, Depression and Insomnia. (Ref. Appendix E, Tab 2, pg. 10).

Use of the CES as described in the reference literature provided by Dr. Bolles, explains the options for the user to receive the current by use of "pre-gelled electrodes placed behind each ear, or fitted headpieces with/without an audio dimension."
This device has a single output frequency of 100 Hz, amplitude is adjustable for 0 to 1.0 Ma. The literature shows the audio headpiece has a frequency response from 20 - 25,000 Hz.

In contrast to the literature supplied by Dr. Bolles, he states this device called CES stands for Central Electron Stimulation. Dr. Bolles states "The patient was given electro stimulation, a type of TENS-type treatment, with specific frequencies that have been reported to be beneficial for allergies, chemical toxicity and viruses. The patient's feet were placed on electrodes in water to which electrolytes were added to facilitate better electrical contact, similar to using electrode paste when doing an EKG." Dr. Bolles' further discussion goes on to attempt to justify use of micro-amps for electrical stimulation when milli-amps have already been approved by the FDA. It appears from discussion with Dr. Bolles, his statement, the literature he has provided as a reference, the terms TENS & CES used deceptively, indications for treatment, the salamander experience, and his method of applying this electrical stimulation have all been thrown about in an attempt to confuse the issue and justify his use of what appears to be a non-approved medical device that has caused significant pain to the complainant.

requested laboratory test results explained and was told she would have to make another appointment. It appears, due to her insistence, that Dr. Bolles decided to send her a letter of explanation for the heavy metal and mineral analysis that had been performed on a sample of her hair. (Ref. Appendix E, Tab 3, pgs. 19 & 16)

I find what appears to be some inconsistencies of test Interro results or the interpretation of, as brought up in the statement of Dr. Bolles. Specifically the result of Streptococcus Rheumaticus, which Dr. Bolles says the test only indicated a sensitivity to this organism and not necessarily an active infection. By looking at the test results it does not appear to be any different than the EBV, Mono, and Weed Pollen results "6X Lycr". (Ref. Appendix E, Tab 3, pgs. 7 & 30)

By history, Dr. Bolles notes that has a hypothyroid condition. As per previous MDB actions, the requirement exists for a special file card for each patient with an endocrinological condition, to be kept on file. Search of the Endocrine File Card system failed to show a card for . (Ref Appendix E, Tab 3, pg. 36)

The letter of cooperation delivered to Dr. Bolles requested additional specific information, which to date has not been complied with. (Ref. Appendix E, Tab 2, pg. 4-5, items 3, 5, 7, & 8.)
On September 27, 1 1, __________ called to advise this investigative unit that she had received a threatening letter from the Bolles Clinic. This letter reminds me of her agreement for arbitration in dispute resolution. (Ref. Appendix E, Tab 4, rgs. 44 & 45) The Bolles Clinic alleges that __________ complaint to the MDB was without merit, frivolous, and designed to avoid payment of an outstanding sum of $155.61. The Bolles Clinic letter states: "Unless you withdraw your complaint and pay the sum of $155.61 within ten days from the date of this letter, we will file suit under the agreement, requiring substantial legal expenses on our part. If you refuse to submit to arbitration, we will simply file suit in Superior Court requesting you do so."

Needless to say, __________ is extremely upset and intimidated over being threatened with a lawsuit from Dr. Bolles. __________ maintains that she will not withdraw the complaint. She maintains that her complaint was not filed to avoid payment as she considered the billing dispute to be a separate matter. (Ref. Appendix E, Tab 4, pg. 43).
PRACTICE REVIEW

MEDICAL SOCIETY STATUS: Non member

COURT RECORD REVIEW: Not accomplished.

PRACTICE: ___ Private/solo  X  Group (with Acupuncturist)

SPECIALIZATION: "Preventive Medicine"

BOARD CERTIFICATION: ___ CERTIFIED  ___ ELIGIBLE

NUMBER OF PATIENTS SEEN PER/WEEK: Unknown

CURRENT HOSPITAL PRIVILEGES AT: Unknown, Dr. failed to comply with request for this information.

CURRENT HOSPITAL PRACTICE PROBLEMS: Unknown.

FORMER HOSPITAL PRACTICE PROBLEMS: Unknown.

SPECIALISTS / CONSULTANTS USED FOR REFERRALS: As needed.

SUPERVISION OF PA's and/or NP's: ___ Yes  X  No

CURRICULUM VITAE: Reference Tab 2, pg. 8A

CME: Dr. Bolles failed to comply with request for this information.

OTHER: Currently under MDB compliance case # 86-04-0162MD and additional case # 91-07-0155MD currently under investigation.
# APPENDIX E

## EVIDENCE/EXHIBITS

<table>
<thead>
<tr>
<th>TAB</th>
<th>PAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td>Copy of lab test results for another patient used to treat in error.</td>
</tr>
<tr>
<td>3A</td>
<td></td>
<td>Memo to File, RE Telephone conversation with about her complaint. dated 9-23-91.</td>
</tr>
<tr>
<td>2.</td>
<td>4 - 5</td>
<td>Letter of cooperation hand delivered to Dr. Bolles, dated 7-31-91.</td>
</tr>
<tr>
<td>6</td>
<td>6 - 8</td>
<td>Letter statement from Dr. Bolles in response to letter of cooperation dated 8-20-91.</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Note from medical records clerk at the Bolles Clinic indicating Dr. Bolles' CV would be updated and forwarded, dated 8-29-91.</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Manufacturers brochure on the CES Labs 100 Hz kit used by Dr. Bolles as &quot;TENS&quot; and referred to in his letter statement.</td>
</tr>
<tr>
<td>3.</td>
<td>11</td>
<td>Copy of letter to Dr. Bolles from dated 5-6-91.</td>
</tr>
<tr>
<td>12</td>
<td>12 - 13</td>
<td>Copy of letter to Dr. Bolles from dated 5-23-91.</td>
</tr>
<tr>
<td>14</td>
<td>14 - 15</td>
<td>Copy of letter to from staff member of Dr. Bolles dated 5-28-91.</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>Copy of letter to from Dr. Bolles dated 5-28-91.</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>Copy of Medical Record request of for her Bolles' Clinic records to be sent to the Polyclinic in Seattle.</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>Copy of letter to from Terry O'Neil, Administrator for the Bolles Clinic, dated 8-6-91.</td>
</tr>
</tbody>
</table>
## APPENDIX E

### EVIDENCE/EXHIBITS

<table>
<thead>
<tr>
<th>TAB</th>
<th>PAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>19 - 39</td>
<td>Copy of 's Bolles Clinic medical record.</td>
</tr>
<tr>
<td>40 - 41</td>
<td>Copy of Billing Invoice for office visit of 4-24-91.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>42</td>
<td>Fax cover letter dated 9-30-91.</td>
</tr>
<tr>
<td>43</td>
<td>Letter from explaining her stand on her complaint and demand letter from Dr. Bolles.</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Copy of letter from Dr. Bolles to dated 9-25-91.</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Copy of &quot;Patient agreement for testing, treatment and dispute resolution&quot; dated 4-24-91.</td>
<td></td>
</tr>
</tbody>
</table>

## APPENDIX F

### POSSIBLE VIOLATIONS

1. RCW 18.130.180 (1) (4) (8a) (9) (16)
## APPENDIX G

### ACTIVITY REPORT

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5-29-91</td>
<td>Intake of Complaint.</td>
</tr>
<tr>
<td>2</td>
<td>5-31-91</td>
<td>Complaint reviewed by Dr. Miller.</td>
</tr>
<tr>
<td>3</td>
<td>6-06-91</td>
<td>Case received by MIU.</td>
</tr>
<tr>
<td>4</td>
<td>6-07-91</td>
<td>Case assigned to investigator J. M. Rich.</td>
</tr>
<tr>
<td>5</td>
<td>7-31-91</td>
<td>Dr. Bolles advised of complaint and given letter of cooperation by hand delivery.</td>
</tr>
<tr>
<td>6</td>
<td>8-30-91</td>
<td>Received statement and medical records from Dr. Bolles. Also received note from medical records clerk that Dr. Bolles' CV was being updated and would be forwarded.</td>
</tr>
<tr>
<td>7</td>
<td>9-17-91</td>
<td>TC to Mr. O'Neil, Administrator of Bolles Clinic, RE non receipt of CV.</td>
</tr>
<tr>
<td>8</td>
<td>9-18-91</td>
<td>Visit to Bolles Clinic. Requested additional information from medical record that had not previously been copied and forwarded as requested, i.e., specifically that of records that made reference to her medication of Synthroid, the treatment prescribed at the Bolles Clinic and a copy of the 4-24-91 clinic invoice. Receptionist was cooperative with request.</td>
</tr>
<tr>
<td>9</td>
<td>9-24-91</td>
<td>Received Dr. Bolles' CV.</td>
</tr>
<tr>
<td>10</td>
<td>9-27-91</td>
<td>TC received from said she received a threatening letter from Dr. Bolles. Copy of correspondence faxed to MDB.</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Discussed the threats complaint with Dr. Miller and Staff Attorney M. Youngs. They will discuss case further at the case staff conference this week.</td>
</tr>
<tr>
<td>12</td>
<td>9-30-91</td>
<td>Case file completed. To be forwarded to MDB program management for disposition.</td>
</tr>
</tbody>
</table>
CONFIDENTIAL INVESTIGATIVE REPORT
PREPARED FOR THE
MEDICAL DISCIPLINARY BOARD

*************
Case # 91-07-0155MD

RESPONDENT: LEO J. BOLLES, M.D.

*************

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APPENDIX H -- REQUEST FOR INVESTIGATION

Investigator: JAMES M. RICH

APPROVED BY: "James H. Smith" DATE: 10-16-91
APPENDIX A

RESPONDENT INFORMATION

LEO J. BOLLES, M.D.

BUSINESS ADDRESS:
15611 Bellevue-Redmond Rd.
Bellevue, Wa. 98008
Telephone No. (206) 881-2224

LICENSE NUMBER: 0004165

DATE ISSUED: 8-1-52

EXPIRATION DATE: 2-10-91

BIRTH DATE: 3-10-21

SPECIALIZATION: Preventive Medicine

PREVIOUS REGULATORY ACTION: Yes

PREVIOUS COMPLAINT HISTORY: Yes

ATTORNEY IDENTIFICATION: William Kerns
10800 N. E. 8th #1000
Bellevue, WA. 98004
(206) 453-7799

APPENDIX B

COMPLAINANT INFORMATION

---

APPENDIX C

CONTACT LIST

Terry O'Neal
Administrator
Bolles Clinic

91-07-0155MD BOLLES

Page 2 of 6
APPENDIX D

GENERAL SUMMARY

In June 1991, the complainant, was evaluated at the Bolles Clinic. The primary reason for consulting Dr. Bolles was for her allergy condition which she felt was getting worse following her heart attack and for the possibility of receiving EDTA chelation therapy for her heart condition. (Ref. Appendix E, Tab 1, pgs. 1-5)

During the evaluation she was asked to fill out multiple forms & questionnaires. She states in her letter of complaint that she realized Dr. Bolles practiced controversial medicine. However, what bothered her was that no, or at best, an incomplete medical history was taken. It appears from Dr. Bolles' statement and the medical records that a brief history had been taken by a clinic staff person. It relates that she felt very rushed throughout her visit and especially so during Dr. Bolles' examination. (Ref. Appendix E, Tab 3, pgs. 24, 31, 34, & 41)

Several additional concerns were expressed by One concern was Dr. Bolles' method of evaluating her "internal system such as nerves, digestive, etc." This was done with "Kinesiology testing". Dr. Bolles states this testing suggested a weakness of the adrenal and liver. From statement, it appears Dr. Bolles felt she may need Vit B-6 and prescribed Potassium as he was not aware that she had been on a Vit. B complex and Potassium supplements for some time. (Ref. Appendix E, Tab 1, pgs. 2-3; Tab 2, pg. 20 B; Tab 3, pgs. 24 - 55).

Further concerns expressed by is the use of the Interro Electrodiagnosis machine for allergy testing. This test also is reported to identify Ascarid (round worms) by an electrodiagnostic method at acupuncture points to identify antigens/antibodies. (Ref. Appendix E, Tab 1, pgs. 3-4; Interro brochure between pgs. 11 & 12; pg. 12; Tab 2, pg. 20 B; Tab 3, pgs. 25 - 30)
# APPENDIX E

## EVIDENCE/EXHIBITS

<table>
<thead>
<tr>
<th>TAB</th>
<th>PAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1 - 5</td>
<td>Letter of complaint from complainant dated 7-29-91.</td>
</tr>
<tr>
<td></td>
<td>6 - 18</td>
<td>Test results, informational material given to by the Bolles Clinic.</td>
</tr>
<tr>
<td>2.</td>
<td>19 - 20</td>
<td>Letter of cooperation to Dr. Bolles dated 8-9-91.</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Letter from Medical Records clerk RE Dr. Bolles' updated CV dated 8-29-91.</td>
</tr>
<tr>
<td></td>
<td>22 - 23</td>
<td>CV of Dr. Bolles.</td>
</tr>
<tr>
<td>3.</td>
<td>24 - 55</td>
<td>Received clinical medical records from Dr. Bolles on</td>
</tr>
</tbody>
</table>

## APPENDIX F

## POSSIBLE VIOLATIONS

1. RCW 18.130.180 (4)
### APPENDIX G

#### ACTIVITY REPORT

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>7-29-91</td>
<td>Intake of Complaint.</td>
</tr>
<tr>
<td>2.</td>
<td>7-30-91</td>
<td>Complaint reviewed by Dr. Miller.</td>
</tr>
<tr>
<td>3.</td>
<td>7-31-91</td>
<td>Case received by MIU.</td>
</tr>
<tr>
<td>4.</td>
<td>8-06-91</td>
<td>Case assigned to investigator J. M. Rich.</td>
</tr>
<tr>
<td>5.</td>
<td>8-09-91</td>
<td>Letter of cooperation to Dr. Bolles via certified mail.</td>
</tr>
<tr>
<td>6.</td>
<td>8-23-91</td>
<td>Received statement and medical records from Dr. Bolles.</td>
</tr>
<tr>
<td>7.</td>
<td>9-02-91</td>
<td>Received note from medical records clerk that Dr. Bolles' CV was being</td>
</tr>
<tr>
<td></td>
<td></td>
<td>updated and would be forwarded.</td>
</tr>
<tr>
<td>8.</td>
<td>9-17-91</td>
<td>TC to Mr. O'Neal, Administrator of Bolles Clinic, RE non receipt of CV.</td>
</tr>
<tr>
<td>9.</td>
<td>9-24-91</td>
<td>Received Dr. Bolles' CV.</td>
</tr>
<tr>
<td>10.</td>
<td>10-11-91</td>
<td>Investigational case file completed and forwarded to MDB Program Management.</td>
</tr>
</tbody>
</table>
CONFIDENTIAL INVESTIGATIVE REPORT
PREPARED FOR THE
MEDICAL DISCIPLINARY BOARD

************
Case # 92-03-0014MD

RESPONDENT: LEO J. BOLLES, M.D.

************

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APPENDIX F  --  POSSIBLE VIOLATIONS
APPENDIX G  --  ACTIVITY REPORT
APPENDIX H  --  REQUEST FOR INVESTIGATION

Investigator: JAMES M. RICH

APPROVED BY: [Signature]  DATE: 1-7-93
APPENDIX A

RESPONDENT INFORMATION

Leo J. Bolles, M. D.
15611 Bellevue-Redmond Rd.
Building D, Suite A
Bellevue, WA. 98008

Telephone No. (206) 885-1893

LICENSE NUMBER: 004165
DATE ISSUED: 8-1-55
EXPIRATION DATE: 3-10-93
BIRTH DATE: 3-10-21
SPECIALIZATION: General Practice, Alternative Medicine
HOSPITAL PRIVILEGES AT: None
PREVIOUS REGULATORY ACTION: Yes
PREVIOUS COMPLAINT HISTORY: Yes
ATTORNEY IDENTIFICATION: Terry M. Rosell, RN, JD
MEDICAL SOCIETY STATUS: N/A, Non Member
PRACTICE: _X_ Private/solo ___ Group
BOARD CERTIFICATION:"N/A" as per Dr. Bolles.
CURRENT HOSPITAL PRIVILEGES AT: None
CURRENT HOSPITAL PRACTICE PROBLEMS: None
FORMER HOSPITAL PRACTICE PROBLEMS: Unknown
SUPERVISION OF PA's and/or NP's: ___ Yes _X_ No
CURRICULUM VITAE: Declined to be sent, reference made to previous CV held by MDB in old cases.
CME: Declined to send up dated list. Makes reference to previous CME credits on file with MDB Compliance Officer.
APPENDIX B

COMPLAINANT INFORMATION

Address at time of complaint.

Telephone No.

CURRENT BUSINESS ADDRESS:

ATTONEY IDENTIFICATION: None

APPENDIX C

CONTACT LIST

John E. Dunne, M. D.
Southlake Professional Group
Renton Plaza Building
1400 Talbot Rd. S. #203
Renton, WA. 98055
(206) 235-7383
APPENDIX D

GENERAL SUMMARY

The complainant in this case is who had been practicing in a 14 year old. The case involves his patient expresses his concern over the medical practices of Leo J. Bolles, M. D., the Respondent. (Ref. Appendix E, pg. 1)

had been seen for a pattern of increasingly violent rage reactions during the previous few years. Psychological evaluations had been conducted by a Psychologist in and also a Psychiatrist in Renton. Diagnostically it was difficult to place into any specific diagnosis, but he was felt to most closely resemble Obsessive/Compulsive Personality Disorder. It was recommended that treatment could consist of some residential inpatient type care along with medication to help control his rages. (Ref. Appendix E, pg. 2-7 & contents of envelope marked pg. 10)

At the time was referred for psychiatric evaluation in the Puget Sound area, his parents had also made an appointment for him to be evaluated by Dr. Bolles. Dr. Bolles conducted multiple tests that included amino acid studies, 5 hour glucose tolerance test, cortisol level, Vit B6 challenge test, EAV testing (electronic diagnostic device), Chem. Screening panel, CBC, UA, Hair Mineral analysis, blood Dark Field Evaluation, etc. condition was diagnosed to be amino acid, vitamin and cortisol deficiencies. Recommended treatment has included Vit C, B6, B12, Amino Acids, dietary changes, ACE (Adrenal Cortical Extract), Doctor's Signature Anti-depression drops, Crystal water drops, Bach Flower Remedy drops and other treatments. (Ref. Appendix E, pgs. 25-74)

The parents of brought a number of injectables to office and requested he administer them as prescribed by Dr. Bolles. These substances included Vit. B6, B12, ACE (adrenal cortical extract), and calcium Gluconate. declined to administer these substances as he felt they were inappropriate, potentially dangerous and irrelevant to condition/diagnosis.

During course of this investigation difficulties arose in obtaining records/documentation as requested in letter of cooperation. (Ref. Appendix E, pgs. 11-24)
APPENDIX E

EVIDENCE/EXHIBITS

PAGE  DESCRIPTION
1  Letter of complaint from

2 - 7  Copy of patient medical records and correspondence from

8 - 9  Letter of request for medical records to Dr. Dunne, consulting psychiatrist.

10  Confidential envelope, with copy of patient psychiatric records from Dr. Dunne.

11 - 13  Letter of cooperation to Dr. Bolles.

14  Notice of Appearance from attorney of Dr. Bolles.

15 - 17  Statement of Dr. Bolles.

18 - 20  Letter from Dr. Bolles' attorney challenging request for medical records.

21 - 22  Letter from Gail Zimmerman to attorney for Dr. Bolles.

23 - 24  Letter from Staff Attorney G. Kelley to attorney for Dr. Bolles.

25 - 73  Copy of medical records from Dr. Bolles.

74  Copy of letter from parents of patient in support of Dr. Bolles.

ATTACHMENT A  Medical Reference material submitted by Dr. Bolles.

APPENDIX F

POSSIBLE VIOLATIONS

1. RCW 18.130.180 (4), (8a)
## APPENDIX G
### ACTIVITY REPORT

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Action taken</th>
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<tbody>
<tr>
<td>1.</td>
<td>3-6-92</td>
<td>Complaint received/intake.</td>
</tr>
<tr>
<td>2.</td>
<td>3-9-92</td>
<td>Complaint reviewed by Dr. Miller.</td>
</tr>
<tr>
<td>3.</td>
<td>3-12-92</td>
<td>Complaint reviewed by Staff Case Conference.</td>
</tr>
<tr>
<td>4.</td>
<td>3-12-92</td>
<td>Case assigned to J. M. Rich for investigation.</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>TC to office, attempt to obtain bottle of the injectable ACE prescribed by Dr. Bolles. Office Nurse said mother of patient took all medications with her.</td>
</tr>
<tr>
<td>6.</td>
<td>4-29-92</td>
<td>TC to discussed case and requested copies of medical records.</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>Medical record request to Dr. Dunne, consulting psychiatrist for psychiatry evaluation.</td>
</tr>
<tr>
<td>8.</td>
<td>5-5-92</td>
<td>Received copy of medical records from</td>
</tr>
<tr>
<td>9.</td>
<td>5-7-92</td>
<td>Received copy of psychiatric evaluation from Dr. Dunne.</td>
</tr>
<tr>
<td>10.</td>
<td>5-14-92</td>
<td>Letter of cooperation hand delivered to Dr. Bolles.</td>
</tr>
<tr>
<td>11.</td>
<td>6-5-92</td>
<td>Received Notice of Appearance from Attorney for Dr. Bolles along with his statement. Not all information/documents requested were forwarded.</td>
</tr>
<tr>
<td>12.</td>
<td>6-8-92</td>
<td>Received letter from attorney for Dr. Bolles questioning several RCW's.</td>
</tr>
<tr>
<td>13.</td>
<td>6-16-92</td>
<td>Response letter to attorney for Dr. Bolles from Gail Zimmerman.</td>
</tr>
<tr>
<td>14.</td>
<td>6-26-92</td>
<td>Response letter to attorney for Dr. Bolles from Staff Attorney G. Kelly.</td>
</tr>
<tr>
<td>15.</td>
<td>1-4-93</td>
<td>Investigative case file completed and forwarded to MDB Program Management for further disposition.</td>
</tr>
</tbody>
</table>
DEPARTMENT OF HEALTH
PROFESSIONAL LICENSING SERVICES
MEDICAL INVESTIGATIONS UNIT

CONFIDENTIAL INVESTIGATIVE REPORT
PREPARED FOR THE
MEDICAL DISCIPLINARY BOARD

***********

Case # 92-04-0027

RESPONDENT: LEO J. BOLLES, M.D.

***********

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APPENDIX B -- COMPLAINANT INFORMATION
APPENDIX C -- CONTACT LIST
APPENDIX D -- GENERAL SUMMARY
APPENDIX E -- EVIDENCE/EXHIBITS
APPENDIX F -- POSSIBLE VIOLATIONS
APPENDIX G -- ACTIVITY REPORT
APPENDIX H -- REQUEST FOR INVESTIGATION

Investigator: JAMES M. RICH

APPROVED BY: [Signature] DATE: 7/19/83
APPENDIX A

RESPONDENT INFORMATION

Leo J. Bolles, M. D.
15611 Bellevue-Redmond Rd.
Building D, Suite A
Bellevue, WA. 98008

Telephone No. (206) 885-1893

LICENSE NUMBER: 004165
DATE ISSUED: 8-1-55
EXPIRATION DATE: 3-10-93
BIRTH DATE: 3-10-21
SPECIALIZATION: General Practice, Alternative Medicine
HOSPITAL PRIVILEGES AT: None
PREVIOUS REGULATORY ACTION: Yes

PREVIOUS COMPLAINT HISTORY: Yes
ATTORNEY IDENTIFICATION: Terry M. Rosell, RN, JD
MEDICAL SOCIETY STATUS: N/A, Non Member
PRACTICE: X Private/solo   _ Group
BOARD CERTIFICATION:"N/A" as per Dr. Bolles.
CURRENT HOSPITAL PRIVILEGES AT: None
CURRENT HOSPITAL PRACTICE PROBLEMS: None
FORMER HOSPITAL PRACTICE PROBLEMS: Unknown
SUPERVISION OF PA's and/or NP's: ___ Yes  X No
CURRICULUM VITAE: Declined to be sent, reference made to previous
CV held by MDB in old cases.
CME: Declined to send up dated list. Makes reference to previous
CME credits on file with MDB Compliance Officer.
APPENDIX B
COMPLAINANT INFORMATION

Anonymous

APPENDIX C
CONTACT LIST

Dept. of Health
PLS
Radiologic Technologist Unit

Michael Odlaug
Manager, X-Ray Control
Dept. of Health
Division of Radiation Protection
1151 Third Ave. #700
Seattle, WA. 98101
(206) 464-6840

Joseph F. Kramer, M. D.
Puyallup Radiological Associates
800 S. Meridian
Puyallup, WA. 98371
(206) 845-9511
APPENDIX D

GENERAL SUMMARY

On March 19, 1992 I received a telephone complaint from an anonymous complainant who said the Bolles Clinic was utilizing a medical assistant to take X-Rays who was not registered or certified as a Radiologic Technician as required by RCW 18.84. I was further advised that Dr. Bolles had instructed clinic staff to tell any inspectors/investigators that he himself took all x-rays to avoid having to have someone registered. (Ref. Appendix E, pg. 1 and Attachment A)

I contacted DOH, PLS, Radiologic Technician Unit to verify that the Bolles Clinic did not have a registered or certified radiologic technician. No record found. I was advised that the Bolles Clinic had been notified of the new RCW 18.84 requirements.

I contacted Mr. Mike Odlaug, Manager of Dept. Health, Radiation Protection Division. I discussed my concerns and he said he would conduct an onsite inspection of the Bolles Clinic X-Ray Dept. On April 2, 1992 Mr. Odlaug conducted his inspection of the Bolles Clinic. His inspection identified multiple radiation safety and quality problems. Additionally, he confirmed the complainants information that Dr. Bolles and his staff claimed Dr. Bolles actually took the X-Rays. However, Mr. Odlaug concluded that Dr. Bolles does not actually take the films. This was evidenced by the fact that when Mr. Odlaug asked Dr. Bolles for assistance in activating the machine, Dr. Bolles did not even know what button to press. Mr. Odlaug further felt that the quality of films taken were of such poor quality as to render them unusable for diagnostic purposes. A list of six patient films were given as reference. (Ref. Appendix E, pgs. 2-6).

On April 14, 1992 Mr. Odlaug received a response from the Bolles Clinic that they had or were in the process of correcting deficiencies noted on inspection report. (Ref. Appendix E, pgs. 8-10)

On May 14, 1992 I hand delivered a letter of cooperation to Dr. Bolles. In that letter patient medical records and x-ray were requested along with other standard information. (Ref. Appendix E, pgs. 11-13) On June 9, 1992 I received a letter statement form Dr. Bolles. In this letter he explained that he was aware of the requirement to have a registered or certified radiologist technician or that a physician must take the x-rays. He states that due to the number of x-rays taken in his clinic it did not warrant or justify the hiring of a new employee to take the films so he would do it himself.
It appears that Dr. Bolles does not fully understand the law, as there is no requirement for a clinic to hire a certified radiology technician, only that a person who takes the x-rays for a clinic must be registered. As previously described from information obtained, it appears Dr. Bolles only says he takes the x-rays, in an attempt to avoid the requirements of RCW 18.84.

Dr. Bolles' letter also admits to having problems with x-ray quality, but feels they have been sufficient to determine if abnormalities exist. He sites a specific incident of hilar adenopathy that he was able to detect. He also discusses the corrective action he has taken. (Ref. Appendix E, pgs. 16-17, 25-38, & Attachment B, D, & H)

Dr. Bolles sent the x-rays requested but declined to send patient records on the advice of his attorney. Further correspondence from his attorney challenges the need to send patient records. (Ref. Appendix E, pgs. 18-24)

Due to the observations of Mr. Odlaug and personal review of the requested films, it appeared that the films quality for diagnostic purposes was in question. I requested Joseph F. Kramer, M. D., Radiologist, to review the films and comment on their diagnostic quality and interpretation. (Ref. Appendix E, pg. 39)

Dr. Kramer reviewed the subject radiographs and returned them with a written report of specific and general comments. His general discussion/comments are as follows:

"The findings on these series of films suggest a group of people who are taking x-rays who have had probably no training at all except for some suggestions from the film salesmen. I can't believe any reasonably intelligent person who read a basic book on radiography would commit these errors. I might point out that even though these films were taken under supervision of a medical doctor there is absolutely nothing in a medical doctor's training that exposes him to the science of taking or developing x-rays. I'm not sure about the legal aspect of a M.D. taking x-rays without adequate knowledge. Ethically it has to be wrong. The frightening aspect of this series of films is that the people involved apparently do not know that they do not know what they are doing." (Ref. Appendix E, pg. 41)
Specific discussion as to film quality, interpretation and medical record findings are as follows:

Patient #1, ........... . This is a 40 yo female at the time the chest film was taken. Consultant interpreted these films as essentially normal, however, due to technique these films were taken and developed by render them to be non-diagnostic radiographs. Clinic progress notes of 2-11-92 show that the patient complained of difficult breathing with pain in Lt. chest radiating to back. Injury secondary to a skiing accident. In a different handwriting than that of the original note, it is noted that chest x-ray did not show any evidence of fracture. Chondral cartilage injury Lt. chest. No indication that a physical exam was completed. An additional note indicates she was treated with a rib belt and received an Rx of "C48" Sig. take 4 q 2h to stimulate healing.

Patient #2, ........... . Patient with a history of chronic cough. On 2-17-92 patient received chest x-ray, progress notes indicate "chest x-ray suggestive of Rt. hilar adenopathy". Radiology consultant interpretation of the films as being overexposed. Lack of proper washing following developing and fixing has caused film to oxidize. It is of question if film was initially of diagnostic quality, however at this time it is completely unusable.

Patient #3, ........... . This is a 48 yo female whose clinical chart, history and review of systems, note "cough on & off". " Chest x-ray neg." Radiology consultant feels that the initial technique was probably adequate. Due to improper film processing, film is unusable at this time.

Patient #4, ........... . This is an 85 yo male who gave history consistent with CHF. Chart notes "chest x-ray suggestive of Lt. heart failure." Radiological consultant states film showed bilateral pleural effusions, L>R. Cardiac silhouette enlarged. Film findings represent CHF. Film is under-penetrated as thoracic spine is barely visible. Developing technique also has difficulties. Interesting that the chart notes do not indicate treatment until the next visit and then makes reference that the lasix dose was decreased and patient was to continue with lanoxin.

Patient #5, ........... . Clinical chart note indicates history of cough x 3 mo. "Chest x-ray did not show any evidence of pneumonitis. Note: It appears that radiology consultant did not read this film or it was missed when his notes were transcribed.
Patient #6, This patient's medical records were not sent by Dr. Bolles as requested. Radiology consultant interpreted chest x-ray as having patchy infiltrate RLL with small pleural effusion on Rt. Imp. Pneumonitis, RML and probable RLL. Film probably diagnostic at time it was taken, again, film was not properly washed following developing and has now turned yellow.

The last film has no name. It was submitted by Dr. Bolles to be representative of current x-rays after x-ray machine was worked on and developer changed. This film represents either poor technique or poor development. Improper positioning is also noted.
# APPENDIX E

## EVIDENCE/EXHIBITS

<table>
<thead>
<tr>
<th>PAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Memo to File, information obtained from anonymous complainant.</td>
</tr>
<tr>
<td>02 – 03</td>
<td>Memo from DOH, Div. of Radiation Protection, report of inspection of the Bolles Clinic X-Ray Dept.</td>
</tr>
<tr>
<td>04 – 06</td>
<td>Copy of letter and inspection report sent to Dr. Bolles following Div. of Radiation Protection's inspection.</td>
</tr>
<tr>
<td>07 – 10</td>
<td>Note from Radiation Protection inspector with copy of letter and service report from the Bolles Clinic in response to corrections required.</td>
</tr>
<tr>
<td>11 – 13</td>
<td>Letter of cooperation to Dr. Bolles.</td>
</tr>
<tr>
<td>14</td>
<td>Notice of Appearance from the Attorney of Dr. Bolles.</td>
</tr>
<tr>
<td>15</td>
<td>Letter from Attorney of Dr. Bolles requesting seven day extension.</td>
</tr>
<tr>
<td>16 – 17</td>
<td>Letter statement from Dr. Bolles. Letter notes refusal to send patient records as requested in letter of cooperation.</td>
</tr>
<tr>
<td>18 – 20</td>
<td>Letter from Attorney of Dr. Bolles challenging need to provide patient records as requested in letter of cooperation.</td>
</tr>
<tr>
<td>21 – 22</td>
<td>Letter to Dr. Bolles' Attorney from Executive Director Gail Zimmerman.</td>
</tr>
<tr>
<td>23 – 24</td>
<td>Letter to Dr. Bolles' Attorney from MDB Staff Attorney G. Kelly.</td>
</tr>
<tr>
<td>25 – 37</td>
<td>Copies of repair and service invoices as provided by the Bolles Clinic.</td>
</tr>
<tr>
<td>38</td>
<td>Copy of Certificate of Registration for Radiation Machine Facility from Bolles Clinic.</td>
</tr>
</tbody>
</table>
Copy of memo to consulting radiologist, Dr. Kramer, requesting evaluation of subject radiographs. Note: Portion of this memo has been removed that did not pertain to this case.

Copy of report from consulting radiologist evaluating quality and interpretation of subject films. Note: Portion of this memo has been removed that did not pertain to this case.

Attachment A Copy of "The Law relating to Radiological Technologists" RCW 18.84 and PLS information letter.

Attachment B Copy of Kodak Exposure Guidelines prepared for the Bolles Clinic on 4-27-92.

Attachment C Patient records of Patient #1.

Attachment D Patient records of Patient #2.

Attachment E Patient records of Patient #3.

Attachment F Patient records of Patient #4.

Attachment G Patient records of Patient #5.

Attachment H Patient X-Rays.

APPENDIX F

POSSIBLE VIOLATIONS

1. RCW 18.130.180 (1), (4), (7), & (14)
APPENDIX G

ACTIVITY REPORT

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>3-19-92</td>
<td>Received anonymous complaint that the Bolles Clinic a medical assistant was operating an X-Ray machine without proper registration or certification.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>Verified with DOH, PLS, Radiologist Technician Unit that no registered or certified radiology technicians were registered.</td>
</tr>
<tr>
<td>3.</td>
<td>3-20-92</td>
<td>TC to Mike Odlaug of DOH, Radiation Protection Dept. He will inspect the Bolles Clinic and send inspection report.</td>
</tr>
<tr>
<td>4.</td>
<td>4-7-92</td>
<td>Received Radiation Protection inspection report, with multiple deficiencies noted.</td>
</tr>
<tr>
<td>5.</td>
<td>4-8-92</td>
<td>Referred to MDB Intake Coordinator for opening investigative case file.</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td>Case reviewed.</td>
</tr>
<tr>
<td>7.</td>
<td>4-13-92</td>
<td>Case assigned to J. M. Rich for investigation.</td>
</tr>
<tr>
<td>8.</td>
<td>5-1-92</td>
<td>Received copy of letter/documents from the Bolles Clinic via Radiation Protection Dept., in response to inspection report.</td>
</tr>
<tr>
<td>9.</td>
<td>5-14-92</td>
<td>Letter of Cooperation, Hand Delivered to Dr. Bolles.</td>
</tr>
<tr>
<td>10.</td>
<td>5-26-92</td>
<td>Received Notice of Appearance from Dr. Bolles' Attorney.</td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td>Received letter from Dr. Bolles' Attorney verifying request that was verbally granted for a seven day extension.</td>
</tr>
<tr>
<td>12.</td>
<td>6-8-92</td>
<td>Received letter from Attorney for Dr. Bolles. Challenges request for patient records.</td>
</tr>
</tbody>
</table>
13. 6-9-92 Received letter statement and supporting documents from Dr. Bolles. X-Rays requested also received. Dr. Bolles refuses to send patient records as requested.
Note: Letter of request for extension was dated 5-22-92 and Dr. Bolles letter statement was dated 5-19-92 but not received until 6-9-92.

14. 6-16-92 Letter to Attorney for Dr. Bolles from Executive Director Gail Zimmerman.

15. 6-26-92 Letter to Attorney for Dr. Bolles from Staff Attorney G. Kelly.

16. Received copies of patient records requested from Dr. Bolles. Patient ; not included as requested.

17. 9-1-92 Request to Dr. Kramer, for radiological evaluation of subject radiographs.

18. 9-16-92 Received report from Dr. Kramer.

19. 1-13-93 Investigative case file completed and forwarded to MDB Program Management for disposition.
The Respondent:
An alternative medicine practitioner.

The Complainant:

The Complaint:
The complainant alleges:
- by using an inappropriate laboratory test, (AMAS, Anti Malignin Antibody screening) made an inaccurate diagnosis of cancer, without any identified site of origin.
- prescribed anti-cancer therapy consisting of a "hydrogen peroxide drip" along with multiple food supplements to treat her cancer.
- referred the complainant for electrodiagnostic allergy testing.
- and that the inaccurate diagnosis of cancer caused the complainant significant psychological problems.

Case Review:
The complainant originally consulted the Respondent in March 1995 and was followed by him and a naturopath until about Dec. 1995. During that time she was treated with multiple food supplements, homeopathic drops, and had her dental amalgams removed to reduce mercury toxicity.
The complainant then presented to the Respondent in April 1996 with multiple complaints that included Rt. Chest/lung discomfort, and RUQ abdominal pain. She gave a history of similar pain previously treated with Pepcid and a family history of cancer in her mother, father and sister. Among the work-up done by the Respondent, the AMAS test was performed and reported as having elevated results of 191.

The complainant claims that the Respondent advised her that she had cancer, but the location was unknown. He proceeded to prescribe multiple food supplements for his cancer prevention protocol, and advised her as to a cancer prevention diet. This also included hydrogen peroxide IV therapy. The Respondent’s statement, prepared and submitted by his attorney,
denies that he told her she had cancer, only that she had a predisposition to cancer, given her family history and AMAS test results.

The lab reporting sheet plainly states that this is not a diagnostic test, only an indicator.

The Respondent did refer the patient for electrodiagnostic device allergy testing due to her symptoms. This is an area of concern as the Respondent has a compliance order that addresses this issue.

The complainant had significant difficulty coping with the diagnosis that she had cancer. Eventually, she consulted a number of physicians who advised her to disregard the AMAS test results, examined her and determined that she had an ulcer, but no cancer. However she has been in psychotherapy to help her overcome this incident. Her psychotherapy is documented. The Respondent denies any responsibility for having caused her any psychological difficulties. If fact, part of his statement is as follows:

"As you know, a physician takes an oath to do the best that he or she can to treat his or her patient. Patients come with many symptoms. At times these symptoms are caused by physical problems that can be uncovered by the physician. At other times symptoms are in the patient’s mind. A doctor can only do what he can do to address the physical problems that manifest. A doctor cannot treat a patient for problems that are in her mind. Here, Dr. Xxxxx never diagnosed ******** with cancer.” The statement goes on to say that if he had ignored the patient’s symptoms, family history and the AMAS test that he would have ignored his duty to the patient. “Rather, he did his best to treat the patient so that she would minimize the risk of cancer. The fact that this proper treatment allegedly caused ******** “psychological problems” is not his fault.”

Prior Cases:
Multiple, currently under Commission Order and compliance.
In the Matter of the License to Practice as a Physician and Surgeon of

LEO JOSEPH BOLLES, MD
License No. MD00004165

Respondent.

Docket No. 97-06-A-1200MD
STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND AGREE ORDER
Program No. 9C-07-0040MD

The Medical Quality Assurance Commission (Commission), by and through Michael L. Farrell, Department of Health Staff Attorney and Leo J. Bolles, MD, represented by Patrick Trudell, attorney at law, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

1.1 Leo J. Bolles, MD, Respondent was issued a license to practice as a physician and surgeon by the State of Washington in August 1952.

1.2 On May 15, 1997, the Commission issued a Statement of Charges against Respondent.

1.3 The Statement of Charges alleges that Respondent violated RCW 18.130.180(1), (4), (16) and (21).

1.4 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.5 Respondent understands that he has the right to defend himself against the allegations in the Statement of Charges by presenting evidence at a hearing.
1.6 Respondent understands that, should the State prove at a hearing the allegations in the Statement of Charges, the Commission has the power and authority to impose sanctions pursuant to RCW 18.130.160.

1.7 Respondent and the Commission agree to expedite the resolution of this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.8 Respondent waives the opportunity for a hearing on the Statement of Charges contingent upon signature and acceptance of this Agreed Order by the Commission.

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

1.10 Should this Agreed Order be signed and accepted it will be subject to the reporting requirements of RCW 18.130.110 and any applicable interstate/national reporting requirements.

1.11 Should this Agreed Order be rejected, Respondent waives any objection to the participation at hearing of all or some of the Commission members or the Health Law Judge who heard the Agreed Order presentation.

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Section 2: STIPULATED FACTS

The State and Respondent stipulate to the following facts:

2.1 On April 4, 1996, Patient One saw Respondent complaining of chest pain in her right lung area. Respondent examined Patient One and found she had a subluxation of the dorsal vertebrae at D4, 5 and 6.

2.2 Patient One told Respondent that she feared she might have cancer because her died of cancer, her died of cancer and her was dying of cancer. Respondent scheduled Patient One for an Antimalignin Antibody in Serum (AMAS) test for April 8. Patient One contends Respondent told Patient One that the test would determine whether she had cancer anywhere in her body. Patient One contends that when she asked Respondent why other physicians did not use the test, Respondent told her that the American Medical Association conceal such highly accurate tests so physicians can continue to use traditions treatments, such as chemo-therapy and radiation, and profit from those treatments.

2.3 The AMAS test was developed and is promoted by Samuel Bogoch, MD. The test measures antibodies to malignin, a substance purportedly produced by all cancer cells.

According to the literature, there is a high correlation between a positive test result (a high level of antibodies) and patients who are known to have cancer. According to the literature and according to Dr. Bogoch himself, the test is designed to show the presence of cancer in a particular patient at the time of the test; it is not designed to show a predisposition toward cancer in a particular patient.
2.4 On or about May 7, 1996, Respondent was notified that the results of the AMAS test for Patient One were positive.

2.5 Patient One contends that during a visit on or about May 9, 1996, Respondent told Patient One that there was cancer growing somewhere in her body, but that he did not know the location of the cancer.

2.6 During this visit, Respondent put Patient One on a cancer protocol, which included a special diet, various enzymes, food supplements, and colloidal minerals.

2.7 During this visit, Patient One asked Respondent where she could buy the items listed in paragraph 1.11. Respondent told her she could purchase these items at the front desk of his office. He also told her that they are expensive, but that if she became a distributor of the products, she could buy them wholesale. Patient One went to the front desk and was given a form to fill out to become a distributor. She noticed that at the bottom of the form was Respondent’s name listed as the sponsor of her distributorship.

2.8 On or about May 13, 1996, Respondent put Patient One on RC11, an anti-cancer herb mixture.

2.9 On or about May 15, 1996, Respondent put Patient One on Essiac tea, an anti-cancer herb mixture.

2.10 During one of the visits in May, Respondent also told Patient One to join a cancer-survivors group.

2.11 On May 21, 1996, Patient One went to see her obstetrician-gynecologist, Dr. , MD. Dr. examined Patient One and found no evidence of cancer. Dr. referred Patient One to an oncologist,
2.12 In early June 1996, Dr. examined Patient One and found no evidence of cancer.

Section 3: CONCLUSIONS OF LAW

The State 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 For the purpose of this proceeding only, the above facts constitute unprofessional conduct in violation of RCW 18.130.180(1), (4), (16), and (21).

3.3 The above violations are grounds for the imposition of sanctions under RCW 18.130.160.

Section 4: AGREED ORDER

Based on the preceding Stipulated Facts and Conclusions of Law, Respondent agrees to entry of the following Order:

4.1 Respondent wishes to retire from the practice of medicine on October 31, 1998. Respondent agrees not to practice medicine after October 31, 1998, and to send his license to the Department of Health within seven days of that date.

4.2 For the duration of his practice of medicine, Respondent agrees not to use the AMAS test. Respondent also agrees that before selling, as part of a multi-level marketing program, a patient vitamin supplements, enzymes, colloidal minerals, or other substances recommended by Respondent, he agrees to provide the patient with a written statement that (1) states whether Respondent profits from the sale of such substances, (2) provides a list of at least one
alternative facility at which to obtain the substances, and (3) states the patient will not be 
treated differently if the patient chooses not to purchase the substances from Respondent.

4.3 Respondent shall assume all costs of complying with this Order.

4.4 If Respondent violates any provision of this Order in any respect, the Commission, may 
take further action against Respondent’s license.

4.5 This Agreed Order will be subject to the reporting requirements of RCW 18.130.110 
and all interstate reporting requirements, including, but not limited to, the National Practitioner 
Data Bank, 45 CFR 60.

4.6 This Agreed Order is not binding on Respondent or the Commission unless accepted 
by the Commission.

4.7 This Agreed Order shall become effective ten (10) days from the date the Order is 
signed by the Commission chair, or upon service of the Order on the Respondent, whichever 
date is sooner.

//
//
//
I, Leo J. Bolles, MD, Respondent, certify that I have read this Stipulated Findings of Fact, Conclusions of Law and Agreed Order in its entirety; that my counsel of record, if any, 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 Stipulated Findings of Fact, Conclusions of Law and Agreed Order, I understand that I will receive a signed copy.

Leo J. Bolles, MD
Respondent

5-1-98
Date

Patrick A. Trudell WSBA # 11363
Attorney for Respondent

5/20/98
Date
Section 5: ORDER

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

DATED this 27th day of ____________ January, 1998.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Panel Chair

Presented by:

Michael L. Farrell WSBA # 16022
Department of Health Staff Attorney

April 17, 1998

Date
In the Matter of the License to Practice as a Physician of

LEO JOSEPH BOLLES, MD License No. MD00004165

Respondent.

Program No. 96-07-0040MD

STATEMENT OF CHARGES

The Program Manager, on designation by the Commission, makes the allegations below.

Any patients referred to in this Statement of Charges are identified in an attached Confidential Schedule.

Section 1: ALLEGED FACTS

1.1 Leo J. Bolles, MD, Respondent, was issued a license to practice medicine and surgery by the State of Washington in August 1952. Respondent’s license is subject to order number 86-04-0162MD; 91-05-0236MD; 91-07-0155MD; 92-03-0014MD; 92-04-0027MD dated December 15, 1995.

1.2 On March 2, 1988, the Medical Disciplinary Board issued a statement of charges against Respondent alleging, in effect, Respondent misdiagnosed a patient as having adrenal insufficiency and hypothyroidism when there were no medical indications supporting those diagnoses, and subsequently treated the patient for these conditions.
1.3 On February 15, 1989, following a hearing, the Board issued Findings of Fact, Conclusions of Law, and Order placing restrictions on Respondent’s prescribing or treating of patients with possible adrenal or thyroid problems.

1.4 On February 17, 1995, the Medical Quality Assurance Commission, successor in interest to the Board, issued a statement of charges against Respondent alleging, in effect, Respondent (a) failed to comply with the Order of February 15, 1989, (b) violated federal and state law concerning the use of parenteral drugs and injections containing adrenal cortical extract, and the use of two devices, (c) prescribed thyroid medication and adrenal cortical extract in a non-therapeutic manner to several patients, and (d) used poor technique in developing and washing x-ray films.

1.5 On December 15, 1995, Respondent and the Commission entered into Stipulated Findings of Fact, Conclusions of Law and Agreed Order which, among other things, further restricted Respondent’s treatment of patients with possible adrenal gland or thyroid gland problems.

1.6 On April 4, 1996, Patient One saw Respondent complaining of chest pain in her right lung area. Respondent examined Patient One and found she had a subluxation of the dorsal vertebrae at D4, 5 and 6.

1.7 Patient One told Respondent that she feared she might have cancer because her died of cancer, her died of cancer, and her was dying of cancer. Respondent scheduled Patient One for an Antimalignin Antibody in Serum (AMAS) test for April 8. Respondent told Patient One that the test would determine whether she had cancer anywhere in her body. When Patient One asked Respondent why other physicians did not use the test, Respondent told her that the American Medical Association conceal
such highly accurate tests so physicians can continue to use traditions treatments, such as chemotherapy and radiation, and profit from those treatments.

1.8 The AMAS test was developed and is promoted by Samuel Bogoch, MD. The test measures antibodies to malignin, a substance purportedly produced by all cancer cells. According to the literature, there is a high correlation between a positive test result (a high level of antibodies) and patients who are known to have cancer. According to the literature and according to Dr. Bogoch himself, the test is designed to show the presence of cancer in a particular patient at the time of the test; it is not designed to show a predisposition toward cancer in a particular patient.

1.9 On or about May 7, 1996, Respondent was notified that the results of the AMAS test for Patient One were positive.

1.10 During a visit on or about May 9, 1996, Respondent told Patient One that there was cancer growing somewhere in her body, but that he did not know the location of the cancer.

1.11 During this visit, Respondent put Patient One on a cancer protocol, which included a special diet, various enzymes, food supplements, and colloidal minerals.

1.12 During this visit, Patient One asked Respondent where she could buy the items listed in paragraph 1.11. Respondent told her she could purchase these items at the front desk of his office. He also told her that they are expensive, but that if she became a distributor of the products, she could buy them wholesale. Patient One went to the front desk and was given a form to fill out to become a distributor. She noticed that at the bottom of the form was Respondent's name listed as the sponsor of her distributorship.

1.13 On or about May 13, 1996, Respondent put Patient One on RC11, an anti-cancer herb mixture.
1.14 On or about May 15, 1996, Respondent put Patient One on Essiac tea, an anti-cancer herb mixture.

1.15 During one of the visits in May, Respondent also told Patient One to join a cancer-survivors group.

1.16 On May 21, 1996, Patient One went to see her obstetrician-gynecologist, MD. Dr. examined Patient One and found no evidence of cancer. Dr. referred Patient One to an oncologist,

1.17 In early June 1996, Dr. examined Patient One and found no evidence of cancer.

1.18 As a result of these events, Patient One has suffered severe emotional harm.

Section 2: ALLEGED VIOLATIONS

2.1 The violations alleged in this section constitute grounds for disciplinary action pursuant to RCW 18.130.180 and the imposition of sanctions under 18.130.160.

2.2 The facts alleged in paragraphs 1.6 through 1.18 constitute unprofessional conduct in violation of RCW 18.130.180(1) which provides in part:

The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not.

2.3 The facts alleged in paragraphs 1.6 through 1.11, and 1.13 through 1.18 constitute unprofessional conduct in violation of RCW 18.130.180(4) which provides:

Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.
2.4 The facts alleged in paragraphs 1.6 through 1.18 constitute unprofessional conduct in violation of RCW 18.130.180(16) which provides:

   Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure or service.

2.5 The facts alleged in paragraphs 1.6 through 1.18 constitute unprofessional conduct in violation of RCW 18.130.180(21) which provides:

   Violation of chapter 19.68 RCW.

RCW 19.68.030 provides in part:

   The license of any person so licensed may be revoked or suspended if he has...directly or indirectly...profited by means of a credit or other valuable consideration as a commission...in connection with the furnishing of medical...care, diagnosis or treatment or service...or for or in connection with the sale of...drugs, medication or medical supplies or any other goods.
Section 3: NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare and constitute a probability of bodily harm. The Program Manager of the Commission directs that a notice 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 pursuant to RCW 18.130.180 and the imposition of sanctions under 18.130.160.

DATED this 15th day of May, 1997.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Maryella Jansen
Program Manager

Ann F. MacMurray  WSBA # 23636
Assistant Attorney General Prosecutor
STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a 
Physician of

) Docket No. 97-06-A-1200MD*

) AMENDED STATEMENT

) OF CHARGES

) Respondent.

The Program Manager, on designation by the Commission, makes the allegations below.

Any patients referred to in this Statement of Charges are identified in an attached Confidential Schedule.

Section 1: ALLEGED FACTS

1.1 Leo J. Bolles, MD, Respondent, was issued a license to practice medicine and surgery by the State of Washington in August 1952. Respondent's license is subject to order number 86-04-0162MD; 91-05-0236MD; 91-07-0155MD; 92-03-0014MD; 92-04-0027MD dated December 15, 1995.

1.2 On March 2, 1988, the Medical Disciplinary Board issued a statement of charges against Respondent alleging, in effect, Respondent misdiagnosed a patient as having adrenal insufficiency and hypothyroidism when there were no medical indications supporting those diagnoses, and subsequently treated the patient for these conditions.
1.3 On February 15, 1989, following a hearing, the Board issued Findings of Fact, Conclusions of Law, and Order placing restrictions on Respondent's prescribing or treating of patients with possible adrenal or thyroid problems.

1.4 On February 17, 1995, the Medical Quality Assurance Commission, successor in interest to the Board, issued a statement of charges against Respondent alleging, in effect, Respondent (a) failed to comply with the Order of February 15, 1989, (b) violated federal and state law concerning the use of parenteral drugs and injections containing adrenal cortical extract, and the use of two devices, (c) prescribed thyroid medication and adrenal cortical extract in a non-therapeutic manner to several patients, and (d) used poor technique in developing and washing x-ray films.

1.5 On December 15, 1995, Respondent and the Commission entered into Stipulated Findings of Fact, Conclusions of Law and Agreed Order which, among other things, further restricted Respondent's treatment of patients with possible adrenal gland or thyroid gland problems.

1.6 On April 4, 1996, Patient One saw Respondent complaining of chest pain in her right lung area. Respondent examined Patient One and found she had a subluxation of the dorsal vertebrae at D4, 5 and 6.

1.7 Patient One told Respondent that she feared she might have cancer because her died of cancer, her died of cancer and her was dying of cancer. Respondent scheduled Patient One for an Antimalignant Antibody in Serum (AMAS) test for April 8. Respondent told Patient One that the test would determine whether she had cancer anywhere in her body. When Patient One asked Respondent
why other physicians did not use the test, Respondent told her that the American Medical Association conceal such highly accurate tests so physicians can continue to use traditions treatments, such as chemo-therapy and radiation, and profit from those treatments.

1.8 The AMAS test was developed and is promoted by Samuel Bogoch, MD. The test measures antibodies to malignin, a substance purportedly produced by all cancer cells. According to the literature, there is a high correlation between a positive test result (a high level of antibodies) and patients who are known to have cancer. According to the literature and according to Dr. Bogoch himself, the test is designed to show the presence of cancer in a particular patient at the time of the test; it is not designed to show a predisposition toward cancer in a particular patient.

1.9 On or about May 7, 1996, Respondent was notified that the results of the AMAS test for Patient One were positive.

1.10 During a visit on or about May 9, 1996, Respondent told Patient One that there was cancer growing somewhere in her body, but that he did not know the location of the cancer.

1.11 During this visit, Respondent put Patient One on a cancer protocol, which included a special diet, various enzymes, food supplements, and colloidal minerals.

1.12 During this visit, Patient One asked Respondent where she could buy the items listed in paragraph 1.11. Respondent told her she could purchase these items at the front desk of his office. He also told her that they are expensive, but that if she became a distributor of the products, she could buy them wholesale. Patient One went to the front desk and was given a form to fill out to become a distributor. She noticed that at the bottom of the form was Respondent’s name listed as the sponsor of her distributorship.
1.13 On or about Mary 13, 1996, Respondent put Patient One on RC11, an anti-cancer herb mixture.

1.14 On or about May 15, 1996, Respondent put Patient One on Essiac tea, an anti-cancer herb mixture.

1.15 During one of the visits in May, Respondent also told Patient One to join a cancer-survivors group.

1.16 On May 21, 1996, Patient One went to see her obstetrician-gynecologist, Dr. referred Patient One to an oncologist,

1.17 In early June 1996, Dr. examined Patient One and found no evidence of cancer.

Section 2: ALLEGED VIOLATIONS

2.1 The violations alleged in this section constitute grounds for disciplinary action pursuant to RCW 18.130.180 and the imposition of sanctions under 18.130.160.

2.2 The facts alleged in paragraphs 1.6 through 1.17 constitute unprofessional conduct in violation of RCW 18.130.180 (1) which provides in part:

The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not.

2.3 The facts alleged in paragraphs 1.6 through 1.11, and 1.13 through 1.17 constitute unprofessional conduct in violation of RCW 18.130.180(4) which provides:

Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a
nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

2.4 The facts alleged in paragraphs 1.6 through 1.17 constitute unprofessional conduct in violation of RCW 18.130.180(16) which provides:

Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure or service.

2.5 The facts alleged in paragraphs 1.6 through 1.17 constitute unprofessional conduct in violation of RCW 18.130.180(21) which provides:

Violation of chapter 19.68 RCW.

RCW 19.68.030 provides in part:

The license of any person so licensed may be revoked or suspended if he has...directly or indirectly...profited by means of a credit or other valuable consideration as a commission...in connection with the furnishing of medical...care, diagnosis or treatment or service...or for or in connection with the sale of ... drugs, medication or medical supplies or any other goods.

Section 3: NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare and constitute a probability of bodily harm. The Program Manager of the Commission directs that a notice 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 pursuant to RCW 18.130.180 and the imposition of sanctions under 18.130.160.

DATED this 21st day of January, 1998.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

Maryella Jansen
Program Manager

Sharon Sullivan Eckholm
WSBA # 20866
Assistant Attorney General Prosecutor
STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
MEDICAL QUALITY ASSURANCE COMMISSION  

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

LEO JOSEPH BOLLES, M.D.  
License No. MD 4165,  
Respondent.  

Docket No. 97-06-A-1200MD  
ORDER ON RESPONDENT’S  
MOTION TO WITHDRAW  
STIPULATED FINDINGS OF FACT  
CONCLUSION OF LAW AND  
AGREED ORDER  

This matter came before Health Law Judge Arthur E. DeBusschere, Presiding  
Officer for the Medical Quality Assurance Commission (the Commission) on  
November 5, 1998, at the Sea-Tac Hilton, 17620 Pacific Avenue South, Sea-Tac,  
Washington. Members of the Commission present and considering the matter were:  
Janice Paxton, P.A.-C, Panel Chair; Hampton Irwin, M.D.; Mark Vollrath, P.A.-C.;  
Everardo Espinosa, M.D.; Marilyn Ward, Public Member; Juanita Wagner, J.D., Ph.D.,  
Public Member; Laura Roderick, M.D.; and Douglas Yoshida, M.D., J.D. Representing  
Leo J. Bolles, M.D. (the Respondent) was Rodney L. Umberger, Jr., Attorney at Law.  
Representing the Department of Health (the Department), was David Hankins,  
Assistant Attorney General. Robert Lewis, court reporter, recorded the proceedings.  

I. PROCEDURAL FINDINGS  

1.1 The Respondent was licensed as a physician and surgeon in the state of  
Washington when, on May 15, 1997, the Commission served upon the Respondent the
Statement of Charges alleging the Respondent's conduct was unprofessional as defined under provisions (1), (4), (16) and (21) of RCW 18.130.180.

1.2 The Adjudicative Clerk Office served upon the parties a Scheduling Order/Notice of Hearing scheduling dates for a prehearing conference and the hearing, as well as setting completion dates for discovery and the filing of motions and for settlement negotiations.

1.3 During a prehearing conference on February 10 and 17, 1998, the Presiding Officer granted the Respondent's request to continue the proceedings in order to have the opportunity to conduct an additional settlement conference. Paragraph 2.3, page 4, Prehearing Order No. 3.

1.4 On June 3, 1998, the Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order) in this matter was signed by the Commission.

1.5 On October 14, 1998, a Substitution of Attorneys was filed on behalf of the Respondent.

1.6 On October 14, 1998, the Respondent filed a Motion to Withdraw the Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Motion to Withdraw) and Declaration of Leo J. Bolles, M.D. in support of the Motion to Withdraw, dated October 13, 1998. Attached to the Declaration was Exhibit A and Exhibit B. Also filed were proposed orders, Alternative No. 1 and Alternative No. 2. The Respondent requested oral argument for this Motion to Withdraw.

1.7 On October 14, 1998, the Respondent filed a Motion to Shorten Time for
the Commission to hear the Respondent's Motion to Withdraw and attached a
Proposed Order Shortening Time.

1.8 On October 14, 1998, the Department filed a Response to Motion to
Shorten Time.

1.9 On October 21, 1998, the Presiding Officer heard oral argument on
Respondent's Motion to Shorten Time. The Presiding Officer denied the Respondent's
Motion to Shorten Time and ordered this matter to be placed on the Commission's
docket scheduled for November 5-6, 1998. Order Denying Motion to Shorten Time,
dated October 22, 1998.

1.10 On October 27, 1998, the Department filed a Response to Motion to
Withdraw Stipulated Findings of Fact, Conclusions of Law and Agreed Order and
attached Exhibit No.'s 1 and 2. The Department also filed a Declaration of Sharon
Sullivan Eckholm, with Attachment A, and a Declaration of Michael L. Farrell.

1.11 On November 3, 1998, the Respondent filed a Supplemental
Memorandum in Support of Motion to Withdraw Stipulated Findings of Fact,
Conclusions of Law and Agreed Order or to Stay these Proceedings. Attached to this
Memorandum was a Declaration of M.D., Declaration of Rodney L.
Umberger, Jr., along with attached Exhibit 1; and a [Proposed] Order Continuing
Hearing on Motion to Withdraw Stipulated Findings of Fact, Conclusions of Law, and
Agreed Order, and Staying Enforcement [Alternative No. 3].

1.12 During oral argument on November 5, 1998, the Respondent filed a
II. RESPONDENT'S MOTION TO WITHDRAW

2.1 In his Motion to Withdraw filed on October 14, 1998, the Respondent requested that the Commission withdraw the Agreed Order and order that the merits of the Statement of Charges filed against the Respondent be determined by an adjudicative proceeding. In the alternative, the Respondent requested that the Commission withdraw Section 4.1 of the Agreed Order and order that any sanctions imposed against the Respondent be made after an adjudicative proceeding. This section required the Respondent to cease practicing medicine on October 31, 1998, and to send his license to the Department of Health seven days later.

2.2 In the Supplemental Memorandum filed on November 3, 1998, the Respondent made a third request. He requested that the Commission continue the hearing on the Motion to Withdraw and order a stay of any enforcement of the Agreed Order. On October 16, 1998, the Respondent was unable to attend the hearing.

III. ARGUMENT OF THE PARTIES

3.1 Mr. Umberger argued that under WAC 246-11-390(11), the Respondent can withdraw a stipulated admission that was made inadvertently or as a bona fide mistake of fact and that does not unjustly prejudice the rights of the other parties. He
argued that the Respondent signed the Agreed Order as a result of a bona fide mistake of fact, in that he believed that he would be able to transition his patients to another physician prior to October 31, 1998, and in that he assumed that his patients would readily accept his decision to retire. This decision to retire precludes him from continuing to practice and care for his patients and he believes conflicts with his moral and professional obligations.

3.2 The Respondent argued that with respect to the entry of the Agreed Order, the Department of Health failed to comply with RCW 34.05.461(3). He asserted that under this statute, the Agreed Order is void, because it failed to include a statement of the available procedures and time limits for seeking reconsideration or other administrative relief. In support of this argument, the Respondent cited *Esmieu v. Schrag*, 88 Wn.2d 490, 497, 563 P.2d 203 (1977).

3.3 The Respondent also asserted that the Commission should both continue these proceedings and stay the enforcement of the Agreed Order to allow him to continue to practice medicine, because the Respondent could not attend the hearing on his motion, and requiring him to retire would adversely affect his health.

3.4 Opposing the Respondent's motion, the Department argued that under Civil Rule 60(b)(1), a party can seek relief from a judgment for reasons of “Mistakes, inadvertence, surprise, excusable neglect or irregularity in obtaining a judgment or order.” CR 60(b)(1). The Department argued that when the Respondent entered into

ORDER ON RESPONDENT'S MOTION TO WITHDRAW STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED - Page 5
the Agreed Order, he knew that his patients did not want him to retire, this factor was a major theme being expressed during prehearing activities and in settlement negotiations. This was not a mistaken belief that his patients would be upset by his retirement. Further, the Respondent's contention that he was unable to transfer his patients to another physician in six months should not be a reason to withdraw the enforcement of the Agreed Order. The six-month period was fully bargained for by the parties during the negotiations.

3.5 Next, the Department argued that notice of reconsideration under RCW 34.05.461(3) is not necessary when the Respondent certified in the Agreed Order that he understood the consequences of the Agreed Order, that he understood he was prepared to go to hearing, that he had a right to defend himself at a hearing, that he was waiving that right, and that he agreed to expedite the resolution of this matter by entering into an Agreed Order.

3.6 In support of its position, the Department argued that the Supreme Court has recognized that judgment entered by consent are distinct types of judgments and should be analyzed consistent with the principle that, "[t]he law favors settlements, and consequently it must also favor their finality." Haller v. Wallis, 89 Wn.2d 539, 544, 573 P.2d 1302 (1978).

IV. FINDINGS OF FACT

4.1 On November 6, 1997, the parties had a settlement conference at the Sea-Tac Hilton, Sea-Tac Washington. The parties were unable to reach a settlement

4.2 During prehearing activities and while the parties were discussing settlement, the Respondent knew that many of his patients did not want him to retire. It was expressed that numerous patients would be unhappy without the Respondent as their physician. Paragraph 18 and Attachment A, Declaration of Sharon Sullivan Eckholm, signed October 26, 1998.

4.3 On April 6, 1998, the parties entered into settlement negotiations in Spokane, Washington. During negotiations, the parties discussed the length of time needed for the Respondent to transfer his patients to another physician. The Department wanted to allow the Respondent a period of 30 to 60 days to transfer his patients. The Respondent disagreed, stating he would need a year to transfer his patients to a new physician. Paragraph 14, Declaration of Sharon Sullivan Eckholm, signed October 26, 1998.

4.4 After a short break in the meeting, the Department offered a settlement which would require the Respondent to retire in six months. Paragraph 17, Declaration of Sharon Sullivan Eckholm, signed October 26, 1998, Paragraphs 5 and 6, Declaration of Michael L. Farrell, signed October 26, 1998.

4.5 The Respondent accepted the Department's offer of settlement and signed the Agreed Order on May 1, 1998, and his attorney signed the Agreed Order.
May 20, 1998. The Commission accepted the Agreed Order on June 3, 1998. **Motion to Withdraw**, Exhibit B.

4.6 The Respondent stated that when he signed the Agreed Order, he believed, in part, that he would be able to properly transfer his patients to another physician. He also stated that he erroneously believed that his patients would support his decision to retire. The Respondent stated that he has been unsuccessful in transferring his patients to another physician. The Respondent stated that he cannot retire until he has complete assurances that his patients will be properly transferred to another physician. Paragraphs 6, 7 and 8, **Declaration of Leo J. Bolles, M.D.**, signed October 13, 1998.

4.7

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**Paragraph 4, Declaration of** __________ M.D., signed November 3, 1998. In a Supplemental Declaration, Dr. __________ stated that

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**Declaration of** __________ M.D., signed November 5, 1998.

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ORDER ON RESPONDENT'S MOTION TO WITHDRAW STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED - Page 8
V. CONCLUSIONS OF LAW

5.1 The Commission has jurisdiction over Respondent and over the subject matter herein.

5.2 The Uniform Disciplinary Act, Chapter 18.130 RCW (hereinafter referred to as the 'UDA'), governs the discipline of licensees by the Commission. RCW 18.71.019. The UDA permits the Commission to fashion appropriate remedies in disciplining the Respondent including, without limitation, imposing restrictions or limitations on the Respondent's practice. RCW 18.130.160.

5.3 Where it bears on issues presented, the agency's experience, technical competency, and specialized knowledge may be used in the evaluation of evidence. RCW 34.05.461(5).

5.4 The Respondent's contention, that under RCW 34.05.461(3), the Agreed Order was void, because it failed to include a statement of the available procedures and time limits for seeking reconsideration or other administrative relief, is incorrect. This statute, RCW 34.05.461(3), applies to the contents of a final order after there has been a hearing on the case and not to a stipulation entered into by the parties. Under RCW 18.130.160, the Respondent may enter into a stipulated disposition of the charges, "but only after a statement of the charges has been issued and the licensee has been afforded the opportunity for a hearing and has elected on the record to forego such a hearing." RCW 18.130.160. Here, the Respondent waived his opportunity for a
hearing on the Statement of Charges contingent upon signature and acceptance of the Agreed Order by the Commission. Paragraphs 1.1 through 1.11, Agreed Order.

5.5 In support of this argument, the Respondent cited Esmieu v. Schrag, 88 Wn.2d at 497. In Esmieu, the Court vacated a judgment based upon due process grounds. The trustee of the farm land did not give a ten-day written notice to the beneficiaries of a hearing on a recommendation, acceptance or rejection of a proposed exchange of farm property under the trust for apartments. The ten-day notice was part of a pretrial order. After not providing the ten-day written notice, the attorney for the trustees persuaded the court to hold an ex parte hearing on the recommended land exchange. The Supreme Court on review held that this hearing was in error and that this error was not corrected in subsequent proceedings. The Court also based their decision on the fact that the trustees, fiduciaries of the trust, had a financial interest in the apartments. This case before the Commission, however, is distinguishable from facts in Esmieu. The Respondent had counsel and fully negotiated a settlement of the charges. Following negotiations, the Respondent waived his right to a hearing and entered into an Agreed Order. The Respondent had notice of all the proceedings, was always represented by counsel, and participated fully in the proceedings to its conclusion, the signing of the Agreed Order by the parties and the Commission.

5.6 Next, the Respondent contended that under WAC 246-11-390(11), the Presiding Officer can allow him to withdraw a stipulation he made with the Department. The Respondent's contention is incorrect. WAC 246-11-390(11) allows the Presiding
Officer during the stages of an adjudicative proceeding, in particular during a
prehearing conference, to allow a party to withdraw a stipulation or admission when the
withdrawal has not prejudiced the opposing party. There was no indication that this rule
could be extended to allow the Presiding Officer to allow the Respondent to withdraw a
stipulation five months after the Agreed Order had been approved and signed by the
Commission.

5.7 The Court's holding in Haller applies to the circumstances here. The court
in Haller examined the legal requirements of providing relief to a judgment entered by
the parties and referred to its discretion to vacate a judgment under CR 60(b)(1). In
explaining how the courts view a judgment, the Court in Haller stated:

There is an obvious difference in the view which courts take of judgments by
default and judgments by consent. In the one, the defendant has had no
representation and no hearing, whereas in the other, the moving party has,
usually with the aid of counsel, had the merits of his claim or defense examined
and has agreed upon the disposition of the controversy.

Haller 89 Wn.2d at 544 (emphasis added). In this case, there was a judgment by
consent. The Respondent had representation, had the merits of his claim and defense
examined and agreed upon the disposition of the charges. The Court in Haller further
stated what must be shown to set aside a judgment by consent:

If [the judgment] conforms to the agreement or stipulation, it cannot be changed
or altered or set aside without the consent of the parties unless it is properly
made to appear that it was obtained by fraud or mutual mistake or that consent
was not in fact given, which is practically the same thing. It will not be set aside
on the ground of surprise and excusable neglect. Neither is an error or
misapprehension of the parties, nor of their counsel, any justification for vacating
the judgment,...
Haller, 89 Wn.2d at 544 (Emphasis added), citing 3 E. Tuttle, A Treatise of the Law of Judgments SS 1352, at 2776-77 (5th ed. rev. 1925): In Haller, the Court found that the mistaken appraisal of injuries was insufficient to set aside a judgment approving settlement. Haller, 89 Wn.2d at 545-546.

5.8 In this case before the Commission, the Respondent has not shown that the Agreed Order was obtained by fraud or by mutual mistake. On April 6, 1998, the Respondent and the Department negotiated a settlement to the Statement of Charges. At issue was the length of time the Respondent needed to properly transfer his patients to another physician and to retire. The Respondent wanted a year before he had to retire and the Department wanted the Respondent to transfer his patients and retire in 30 to 60 days. To settle this dispute, the Department offered that the Agreed Order would require the Respondent to retire in six months, by October 31, 1998. Considering this offer and after consulting with his attorney, the Respondent on May 1, 1998, accepted and signed the Agreed Order. There was no mutual mistake and the Respondent fully bargained for the six-month period before he agreed to retire. Furthermore, the Respondent's assertions, that he was unable to properly transition his patients to another physician within the six-month period or that he was in error in assuming that his patients would accept his retirement, was insufficient for the Commission to withdraw the Agreed Order.

5.9 Mr. Umberger argued that enforcement of the Agreed Order should be stayed because the Respondent's health would be
adversely affected should the Commission require him to surrender his license at this
time. The Commission, which is primarily composed of physicians, is aware that
continued stress upon a patient who has could increase his chances
of
This Commission is also
cognizant of the stressful conditions under which physicians practice. Considering the
Respondent’s present health, the Commission cannot accept the argument that staying
these proceedings, and thereby allowing the Respondent to continue in his medical
practice, will help him . Likewise, the Commission cannot accept
the argument that the Respondent would be allowed to have a restful
if the Agreed Order was withdrawn and he was allowed to litigate against the
Statement of Charges and participate in a hearing.

5.10 During oral argument, the Respondent would not accept the continuance
on his motion without a stay of the proceedings which would allow him to continue his
practice of medicine. When the Respondent has
and when
he is able to attend a hearing on the matter, then he should be permitted to come
forward and to testify before the Commission to explain in his own words, his reasons in
support of the Agreed Order being withdrawn. The Commission concludes that the
Respondent failed to provide grounds for withdrawing the Agreed Order or for staying
these proceedings, and therefore, an order should be entered denying the
Respondent’s Motion to Withdraw.

ORDER ON RESPONDENT’S MOTION TO
WITHDRAW STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND AGREED - Page 13
VI. ORDER

Based upon the above, the Commission hereby ORDERS the following:

6.1 The Respondent’s request to withdraw the Agreed Order and to order that the merits of the Statement of Charges filed against the Respondent be determined by an adjudicative proceeding, is DENIED;

6.2 The Respondent’s request to withdraw Section 4.1 of the Agreed Order and order that any sanctions imposed against the Respondent would be made after an adjudicative proceeding, is DENIED; and

6.3 The Respondent’s request to continue the hearing on the Motion to Withdraw and to order a stay of the enforcement of the Agreed Order, is DENIED.

6.4 The Agreed Order in this matter, signed by the Respondent on May 1, 1998, and accepted by the Commission on June 3, 1998, remains in full force and effect.

6.5 After the Respondent recovers from his stroke and is able to attend a proceeding before the Commission, the Respondent may renew his Motion to Withdraw the Agreed Order.

DATED THIS 10 DAY OF NOVEMBER 1998.

JANICE PAXTON, P.A.-C., Panel Chair

ORDER ON RESPONDENT’S MOTION TO
WITHDRAW STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND AGREED...
DECLARATION OF SERVICE BY MAIL
I declare that today I served a copy of this document upon the following parties of record: by fax
RODNEY L. UMBERGER JR., DAVID HANKINS, AAG AND SHARON ECKHOLM, AAG by mailing a copy properly addressed with postage prepaid.

DATED AT OLYMPIA, WASHINGTON THIS 11 DAY OF NOVEMBER, 1998.

Anna Mullie
Adjudicative Clerk
cc: MARYELLA JANSEN

FOR INTERNAL USE ONLY: (Internal tracking numbers)
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