

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of

**JOHN V. DOMMISSE, M.D.,**

Holder of License No. **22164**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Board Case No. MD-08A-22164-MDX

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(License Revocation)

On August 6, 2008, this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge (ALJ) Diane Mihalsky's proposed Findings of Fact and Conclusions of Law and Recommended Order. John V. Dommisse M.D., ("Respondent") appeared before the Board, special Counsel Michael W. Sillyman represented the State. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

**FINDINGS OF FACT**

1. The Arizona Medical Board ("the Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. The Board has issued License No. 22164 for the practice of allopathic medicine in the State of Arizona to Respondent John V. Dommisse, M.D.

1           3. On October 20, 2003, the Board issued a final order in case no. 03F-22164-  
2 MDX against Dr. Dommissé's license to practice allopathic medicine in the State of  
3 Arizona.<sup>1</sup> As a result of Dr. Dommissé's appeal to superior court, on January 17, 2006  
4  
5

6 <sup>1</sup> The Board's order contained additional information on Dr. Dommissé's background and  
7 credentials, as follows:

8           3. Respondent received his formal medical training at the  
9 University of Cape Town Medical School in South Africa, graduating  
10 in 1965.

11           4. Respondent completed a general practice residency in  
12 Bridgeport, Connecticut, in 1967, at Bridgeport General Hospital.

13           5. Respondent obtained Canadian board certification in  
14 psychiatry in 1976, after completion of a residency-training in adult,  
15 adolescent and geriatric psychiatry at the University of Toronto's  
16 Clarke Institute of Psychiatry.

17           6. Respondent holds medical licenses in South Africa, Ontario,  
18 Canada, Virginia, Connecticut and Arizona.

19           7. Following his residency in Toronto, Respondent became a  
20 faculty member at the University of Toronto and headed the Toronto  
21 Western Hospital Psychiatry Day Hospital Program.

22           8. In approximately 1978, Respondent relocated to  
23 Portsmouth, Virginia where he practiced psychiatry as the Director  
24 of Out Patient Services at the Maryview Community Mental Health  
25 Center attached to Maryview General Hospital.

          9. After two years, Respondent entered private practice in  
Portsmouth, Virginia in psychiatry.

          10. Respondent began practicing "nutritional and metabolic"  
medicine while in Virginia. He did not undertake any formal study or  
training in nutritional and metabolic medicine. Rather, he engaged  
in self-study primarily by locating and reviewing articles from  
various sources. His self-study on these topics took place from the  
mid-1970s to the present.

          11. Over the period of time while he was practicing in Virginia,  
Respondent started using nutritional and metabolic methods in  
reference to his psychiatric practice.

1 the Board issued an amended final order against Dr. Dommissé's license. In the  
2 amended order, the Board concluded that Dr. Dommissé had violated applicable statutes  
3 and rendered care that was below the standard for allopathic physicians in Arizona by  
4 diagnosing and treating patients without performing a physical examination of them;  
5 diagnosing patients with various conditions, including systemic candidiasis,  
6 hypothyroidism, macrocytosis, and diabetes, without appropriate supporting symptoms or  
7 test results; prescribing excessive thyroid hormone replacement medications, which  
8 resulted in some patients developing iatrogenic or physician-caused hyperthyroidism;  
9 altering laboratory reference ranges to interpret normal laboratory results as abnormal;  
10 and using improper Current Procedural Terminology ("CPT") coding to bill at a higher  
11 rate.

12 4. As a result of the Board's findings in case no. 03F-22164-MDX, the Board  
13 issued a decree of censure against Dr. Dommissé and placed his license on probation for  
14 a term of five years. Among other probationary terms, Dr. Dommissé was ordered to  
15 "practice nutritional and metabolic medicine within the standards of care for allopathic  
16 physicians in the State of Arizona" and at least twice a year to be subjected to chart  
17 review by Board staff.

18 5. While Dr. Dommissé was under the Board's decree of censure and during the  
19 5-year term of probation in Case No. 03F-22164-MDX, the Board received a complaint  
20 that Dr. Dommissé improperly prescribed thyroid medication and refused to forward a  
21  
22

---

23 12. Over a period of time with self-study, Respondent's  
24 nutritional and metabolic practice evolved from a purely psychiatric  
25 practice to a more general practice treating other diseases.

13. Respondent relocated his medical practice from Virginia to  
Tucson, Arizona in 1994.

1 patient's records to another treating physician. As a result, the Board initiated case no.  
2 MD-03-1046.

3 6. Following review by outside medical consultant ("OMC") of case no. MD-03-  
4 1046, the Board determined to conduct a review of Dr. Dommissé's patient records,  
5 which resulted in case no. MD-03-1046A. The chart review of ten patients revealed  
6 multiple concerns, including documentation issues, improper interpretation of laboratory  
7 tests, inappropriately diagnosed thyroiditis, and diagnoses and treatment of medical  
8 conditions without ever performing a physical examination.

9 7. The Board initiated case no. MD-05-0086A at the suggestion of its medical  
10 director, who was reviewing a separate complaint against Dr. Dommissé. The records  
11 indicated that Dr. Dommissé had treated a patient for hypothyroidism with thyroid  
12 medication for approximately two years without actually physically seeing the patient or  
13 performing a physical examination of her.

14 8. The Board initiated case number MD-06-0925A following a patient complaint  
15 that Dr. Dommissé had over-prescribed thyroid medication.

16 9. The Board initiated case number MD-06-0937A as a compliance case relating  
17 to the Decree of Censure. The Board's review of two patient charts found that Dr.  
18 Dommissé had deviated from the standard of care for allopathic physicians in the State of  
19 Arizona by making diagnoses not supported by documentation, failing to address  
20 abnormal laboratory values, and not documenting histories or physical examinations.

21 10. The Board initiated case number MD-07-0139A as the result of a complaint  
22 regarding Dr. Dommissé's treatment of a patient for hypothyroidism.

23 11. Dr. Dommissé requested a hearing on the Board's various complaints and  
24 the Board forwarded the consolidated matters to the Office of Administrative Hearings for  
25 the scheduling of an administrative hearing. The Board issued a Complaint and Notice of



1           14. On October 16, 2003, the Board received a complaint from another physician  
2 that Dr. Dommissie improperly prescribed thyroid medication to RSH and refused to  
3 forward her records to him.

4           15. The Board assigned the complaint to OMC Kristin Hanson, MD to investigate.  
5 Dr. Hanson graduated with a medical degree from St. Louis University in 1991 and has  
6 completed residencies in internal medicine and a fellowship in endocrinology. At the time  
7 of the hearing, she was Senior Medical Director of Novo Pharmaceuticals, which  
8 manufactures drugs to treat diabetes.

9           16. At the time of the complaint, RSH was a 72-year-old female who came to Dr.  
10 Dommissie on complaints of osteoarthritis, bronchial asthma, and osteoporosis.

11           17. Dr. Hanson reviewed RSH's medical records. She testified that, between  
12 1998 and 2003, Dr. Dommissie treated RSH with thyroid hormone replacement without  
13 demonstrating the presence of thyroid disease.

14           18. Dr. Hanson testified that, during Dr. Dommissie's treatment of RSH, he placed  
15 her on a thyroid hormone dose that led to an over-replacement of thyroid hormone with  
16 subsequent Thyroid-Stimulating Hormone ("TSH"), free Triiodothyronin ("T3") and free T4  
17 in the hyperthyroid range.

18           19. Dr. Dommissie treated RSH over a five-year period without a single entry in  
19 the medical records that he had conducted a physical examination of her.

20           20. Over the course of Dr. Dommissie's treatment of RSH, he treated and billed  
21 her without documentation of a chief complaint, a history, a physical examination, a  
22 review of past medical history, a review of medication, a review of systems, or an  
23 assessment or plan.

1           21. Following a request for RSH's medical records by another physician with a  
2 signed medical release form from RSH, Dr. Dommissie contacted RSH and convinced her  
3 to withdraw her release and request and then refused to forward the medical records.

4           22. Dr. Hanson testified that Dr. Dommissie provided hormone replacement  
5 therapy to RSH to unacceptable levels for estrogen replacement and then failed to refer  
6 her to a gynecologist despite a number of encounters where the patient complained of  
7 symptoms and signs of estrogen excess and abnormal uterine bleeding.

8           23. A handwritten note in Dr. Dommissie's file for RSH indicates that, on June 29,  
9 1998, she called to request an emergency appointment because she was very  
10 concerned, because after beginning hormone replacement, she had started having  
11 periods. She had one from June 14 to June 22, 1998 and had started again on June 28,  
12 1998. A second note indicated that, later on June 29, 1998, RSH called again and  
13 informed Dr. Dommissie that she was about to go on a 10-day vacation and wished to  
14 have the bleeding resolved before her departure. These two notations were the only  
15 records about this matter referred to in the hearing.

16           24. Dr. Dommissie's "Subsequent Detailed Nutritional Metabolic Management  
17 (30)" note dated January 20, 1999, notes that RSH "had to quit the bi-estrogens for one  
18 day a week because of spotting, which took care of that problem and now she will try it  
19 again."

20           25. A typewritten note dated September 22, 1999 stated that RSH "had called to  
21 tell you she went to the ER yesterday for a circulation problem in both arms. The doctor  
22 said the thyroid lab report showed hyperactivity, so told her to drop the Levoxyl and that's  
23 what she did. She asked: Do you have another opinion on this situation?" Dr. Dommissie  
24 had written on the note, stating that he disagreed with the doctor because "I bet he only  
25 did a TSH."

1           26. RSH's file includes a note dated November 16, 2001 that, "[s]ince my HRT  
2 prescriptions were refilled (early this year) I have been spotting on almost a constant flow  
3 (never fills a Kotex pad)."

4           27. A note dated August 20, 2003 states that RSH was cancelling her September  
5 2, 2003 appointment because "she has to see what else happens, as she's going to be  
6 scheduled for major surgery (hip replacement or another hip replacement)."

7           28. A note dated September 18, 2003 states that RSH "said you were going to  
8 give her the names of some surgeons who would work with her because of the thyroid.  
9 She was rejected a Mayo because of that."

10           29. RSH's file also contains a typed message from RSH dated October 14, 2003,  
11 that "she needs to speak without re: the uproar with Dr. Lending. She wants to be sure  
12 you understand what her position is – with you/against Dr. Lending."

13           30. Dr. Dommissie's file for RSH includes a letter "to whom it may concern," dated  
14 January 24, 2004 from RSH and her husband. The letter states that RSH went to see  
15 Robert Lending, MD, after being told by an acquaintance that he was an "excellent  
16 diagnostician." RSH and her husband went to an appointment with Dr. Lending, but were  
17 not pleased when "[u]pon hearing Dr. Dommissie's name he began aggressively  
18 questioning her thyroid treatment and began carrying on about the condition of her  
19 thyroid (which was, and is fine)." After the appointment, "Dr. Dommissie . . . questioned  
20 Dr. Lending's request and called [RSH] personally to get her permission." The letter  
21 concluded that these events had "caused a lot of distress" for RSH; she "had no idea that  
22 the visit to Dr. Lending would result in so much turmoil."

23           31. Dr. Hanson testified that the standard of care for the diagnosis and  
24 management of a patient who is believed to have hypothyroidism is to perform a  
25 thorough history and physical examination, including a thyroid examination, in addition to



1 the measurement of a high sensitivity TSH level and other related testing deemed  
2 necessary. Dr. Dommissie deviated from this standard.

3 32. Dr. Hanson testified that the standard of care for the treatment of a patient  
4 diagnosed with hypothyroidism, based on symptoms plus an abnormal TSH, is to place  
5 her on Levothyroxine and to adjust the dose to obtain a TSH within the normal range of  
6 0.3 and 3.0 acceptable levels. Dr. Dommissie deviated from this standard.

7 33. Dr. Hanson testified that the standard of care requires a physician to refer a  
8 patient on estrogen replacement therapy who is experiencing abnormal uterine bleeding  
9 to a gynecologist for further evaluation. Dr. Dommissie deviated from this standard.

10 34. Dr. Hanson testified that Dr. Dommissie also deviated from the standard of  
11 care by placing RSH on supplemental estrogen leading to unacceptable levels of  
12 estrogen replacement in a post-menopausal woman. The only reason to prescribe  
13 estrogen replacement therapy would be to relieve hot flashes, vaginal dryness, and other  
14 symptoms for a patient going through menopause.

15 35. Dr. Hanson testified that the claimed bone density improvement that Dr.  
16 Dommissie noted in RSH's chart was "spurious." Fractured vertebra can cause bone  
17 density scans to show improvement in scores.

18 36. Dr. Hanson testified that Arizona statute requires allopathic physicians to  
19 provide patient records upon receipt of a signed authorization or release.<sup>2</sup> They are not  
20 allowed to contact the patient to ask them to reconsider the release.

---

21  
22 <sup>2</sup> A.R.S. § 32-1401(27)(r) includes among the definitions of "unprofessional conduct"  
23 "[f]ailing to make patient medical records in the physician's possession promptly available  
24 to a physician assistant, a nurse practitioner, a person licensed pursuant to this chapter  
25 or a podiatrist, chiropractor, naturopathic physician, osteopathic physician or  
homeopathic physician . . . on receipt of proper authorization to do so from the patient . . .  
." This statutory subsection was not charged in the Board's complaint and notice of  
hearing.



- 1 c. a disclaimer form since Dr. Dommissse does not do routine physical examination,  
2 only focused examination when indicated, described *infra* at Finding of Fact No.  
3 209;
- 4 d. notes in the margin of the intake sheet and a one- to two-page report of presenting  
5 problem, medication, food and drug history, and systemic review; and
- 6 e. provisional diagnoses and recommendations with the first recommendation almost  
7 routinely being "Several vitamin, mineral, special thyroid and other blood tests to  
8 find the causes or other aggravating factors in these conditions" (this  
9 recommendation is referred to below as "the standard recommendation").

10 41. Dr. Dommissse then orders a large number of laboratory studies that almost  
11 routinely include CBC, chemistry panel, lipid panel, thyroid panel, including anti-TPO  
12 autoantibodies, vitamin B-12, vitamin D, vitamin E, IGF-1 (growth hormone), amino acid  
13 profile, basic food panel, numerous metals, candida antibodies, Mycoplasma antibodies,  
14 and NK function. Other studies are also frequently ordered including testosterone,  
15 estradiol, progesterone, osteocalcin, and free insulin levels.

16 42. Dr. Dommissse made many notations and prescriptions on the lab sheets and  
17 sometimes on the initial encounter dictation sheet.

18 43. Dr. Dommissse did not record a progress-follow-up note on any of the ten  
19 charts inspected.

20 44. Dr. Dommissse did not record a physical examination, even focused, on any of  
21 the ten charts at any point in his care of the patient.

22 45. Dr. Scheerer provided an overview of his review at the hearing. Dr.  
23 Dommissse's charts were exceedingly difficult to follow. The SOAP format, which stands  
24 for the patient's Subjective complaint, the physician's Objective findings, the physician's  
25 Assessment or impressions or conclusion, and a Plan of treatment, is standard for every

1 allopathic physician's records of every office visit. Dr. Dommissé's charts do not include  
2 any of the SOAP elements. A subsequent physician would have to spend hours  
3 analyzing Dr. Dommissé's charts to have any idea what he did to treat the patient's  
4 complaints with what outcome. The results of treatment were especially hard to  
5 ascertain, since Dr. Dommissé did not perform physical examinations. The laboratory  
6 results were in no order. Dr. Dommissé made comments on lab sheets that were hard to  
7 follow. Dr. Scheerer could not determine Dr. Dommissé's thoughts on patient care from  
8 visit to visit.

9 ***Patient JTK***

10 46. At the time of treatment, JTK was a 32-year-old male who came to Dr.  
11 Dommissé for a thyroid check. The intake sheet was dated February 12, 2004 and the  
12 first encounter is September 10, 2004. JTK complained of anxiety, sinus congestion, and  
13 depression.

14 47. Dr. Dommissé made no notation of a physical examination but listed eight  
15 provision/working diagnoses, including thyroiditis, anxiety disorder, memory disturbance,  
16 insomnia without sleep apnea, dry skin, sinusitis, common migraine, immune deficiency,  
17 and major depressive disorder, recurrent episode, partial remission.

18 48. Dr. Scheerer testified that most of Dr. Dommissé's diagnoses of JTK were  
19 probably psychiatric rather than physical or medical.

20 49. In addition to the standard recommendation, Dr. Dommissé listed the  
21 following recommendations on the patient's chart: (a) Seroquel 25 mg tablet, one-fourth  
22 or one-half or one after supper daily for anxiety; (b) Guaifenesin 600 mg tablets two every  
23 4 to 6 hours as needed; and (2) to analyze blood tests in about 2½ weeks. Dr.  
24 Dommissé listed JTK's prognosis as "[p]robably very good. The use of Seroquel in a  
25 nutritional practice is a wonderful solution to anxiety as it is not habit-forming and the

1 tardive dyskinesia does not occur in nutritional medical practices, and I have even  
2 reversed it in full-blown cases, so I am not concerned about that at all. Whatever we find  
3 in the blood work and correct will probably help him also, possibly even his main  
4 conditions.”

5 50. The laboratory sections of the charge include various testing results with  
6 notations that “[s]ome of the ranges listed . . . are those established by the ordering  
7 physician and are given at his or her request.” There is also a notation under NK cell  
8 function without viability that part of this test has been developed by Tiburon Diagnostic  
9 Laboratory and has not been cleared or approved by the FDA and that the FDA has  
10 determined that such clearance or approval is unnecessary.

11 51. Dr. Scheerer testified that he did not know the basis of Dr. Dommissé’s  
12 diagnosis of JTK with immune deficiency. The NK cell test was not approved by the  
13 FDA.

14 52. The chart also contains encounter forms (billing sheets) dated September 24,  
15 2004, October 21, 2004, November 4 and 9, 2004, December 6, 2004, and January 13,  
16 2005. There are no comprehensive written or typed office visit notes for these  
17 encounters. Dr. Dommissé wrote short notes in the margin of the dictated form of  
18 September 10, 2004.

19 53. At the back of the chart are copies of prescriptions written by Dr. Dommissé.  
20 Some are scratched out with notations made.

21 54. Dr. Scheerer testified that the standard of care in the treatment of this patient  
22 for thyroid problems includes a physical examination and a written or typed office visit  
23 note for every office visit and the ordering of laboratory tests that are appropriate for the  
24 differential diagnoses. In addition, an allopathic physician must be fully knowledgeable  
25 regarding the medications he prescribes.



1           59. Although there is no indication of a physical examination, the initial encounter  
2 form is dated November 9, 2004, and a two-page typed report sets forth the presenting  
3 problem, medication, food and drug history, and a systemic review following by a list of  
4 seventeen provisional/working diagnoses including: migraine, memory disturbance,  
5 multiple chemical sensitivities, chronic fatigue, anxiety, dizziness, food allergies,  
6 constipation, fibroid uterus, enuresis, insomnia, dry skin, cold intolerance, hyperlipidemia,  
7 hypoglycemia, candida overgrowth, and immune deficiency.

8           60. Dr. Dommissé followed his provisional/working diagnoses with the standard  
9 recommendation and the following additional recommendations: (a) obtain previous lab  
10 reports; (b) appointment in two weeks to review blood test results; and (c) Seroquel 25  
11 mg tablet, one-quarter after supper daily.

12           61. There is an encounter form dated November 19, 2004, and a second office  
13 visit form dated December 3, 2004, although there is no dictated or written office visit  
14 report in the record for these dates. The December 3, 2004, encounter form lists seven  
15 diagnoses including thyroiditis and vitamin B12 deficiency.

16           62. There are copies of three prescriptions in the back of the chart: Seroquel 25  
17 mg, one fourth tablet per day, #25 refillable X3; Cortef 20 mg, one-half tablet q.a.m., one  
18 forth tablet q.p.m., #75 refillable X3; and super methyl B-12, 10 mg injection X1 at Swan  
19 Clinic.

20           63. Dr. Scheerer testified that the standard of care for the treatment of JMG  
21 includes a physical examination and complete medical history, typed or written notes for  
22 every office visit, and appropriate clinical follow up to observe drug side effects.

23           64. Dr. Scheerer testified that, based on the record, Dr. Dommissé deviated from  
24 the standard of care in the treatment of JMG by:  
25

- 1 a. failing to conduct a physical examination on the patient's initial visit or any  
2 subsequent visit as evidenced by the absence of any indication of a complete  
3 history and physical examination;
- 4 b. failing to maintain a typed or written note for every office visit in the patient's file;
- 5 c. failing to perform a physician examination to rule out early onset of possible  
6 tardive dyskinesia related to the use of Seroquel; and failing to follow up with  
7 appropriate clinical review for observation of drug side effects.

8 65. Dr. Scheerer testified that Dr. Dommissé's deviations from the standard of  
9 care in treatment of JMG resulted in increased risk of missed diagnoses, since no  
10 physical examination were performed of JMG. In addition, JMG risked increased delay in  
11 the diagnosis of drug side effects since no physical examination was done, i.e., failure to  
12 rule out early onset of tardive dyskinesia.

13 ***Patient TLS***

14 66. At the time of treatment, TLS was a 40-year-old schizophrenic woman being  
15 treated with several medications, including Synthroid, according to the phone intake  
16 sheet dated November 1, 2004, based on history provided by the patient's mother.

17 67. A copy of a prescription dated November 2, 2004 for Celexa 40 mg, #30 with  
18 5 refills is contained in the patient's record.

19 68. The patient's record shows a two-page dictated note regarding history and a  
20 list of seventeen provisional/working diagnoses, including thyroiditis, major depression,  
21 menometrorrhagia, social phobia, abnormal weight gain, gastritis, memory disturbance,  
22 chronic fatigue, hypersomnia with sleep apnea, dry skin, low sex drive, palpitation,  
23 hyperlipidemia, hypoglycemia, candida overgrowth, generalized anxiety and muscle  
24 cramps. In addition to the standard recommendation, Dr. Dommissé made the following  
25 additional recommendation for TLS: (a) continuation of Celexa 40 mg and reduction of



1 frequency of Geodon; (b) a note that the patient signed a Medicare private contract; and  
2 (c) instructions for the patient to return in two and a half to three weeks.

3         69. Under prognosis in the patient's record, Dr. Dommissie wrote "Uncertain but  
4 hopeful because she has never had a complete blood panel and we may find significant  
5 deficiencies to account for many of her symptoms, even the psychotic ones . . . ."

6         70. The laboratory test results for December 1, 2004 contain considerable  
7 handwritten notes in which, among other notations, show an interpretation of low iron  
8 reading of 41 as "lack of mobilizing, not deficiency" and interpretation of an elevated  
9 candida IgG as "chronic overgrowth."

10         71. A second encounter form is dated December 3, 2004. There is no typed or  
11 written note and no indication of a physical examination. The diagnoses include  
12 thyroiditis, as well as vitamin B-12 deficiency and systemic candidiasis. There are fifteen  
13 diagnoses on the encounter sheet.

14         72. Dr. Scheerer testified that systemic candidiasis is an unusual diagnosis that  
15 is not support by TLS' medical records. There are all kinds of common candidiolitis, such  
16 as oral and vaginal. Systemic candidiasis is relatively rare and usually requires  
17 hospitalization and treatment with antibiotics. Dr. Dommissie did not treat TLS for  
18 systemic candidiasis.

19         73. A January 24, 2005 encounter form lists twenty diagnoses. There are no  
20 typed or written notes for the encounter on January 24, 2005 or for a previous encounter  
21 on December 7, 2004 and no indication of a physical examination.

22         74. Dr. Scheerer opined that the standard of care in the treatment of TLS  
23 required that initial office encounters include a history and physical examination;  
24 differential diagnoses that reasonably relate to the history and physical examination data;  
25 proper interpretation of laboratory results; a physical examination of the thyroid prior to

1 treatment of a patient diagnosed with thyroid disease. Dr. Scheerer admitted at hearing  
2 that, for a psychiatric patient who has run out of previously prescribed psychotropic  
3 medication, the standard of care may allow an emergency prescription prior to formation  
4 of a formal doctor-patient relationship to maintain and prevent deterioration in the  
5 patient's condition.

6 75. Dr. Scheerer opined that Dr. Dommissé deviated from the standard of care in  
7 his treatment of TLS by:

- 8 a. not conducting a complete physical examination of the patient;
- 9 b. failure to maintain office visit notes in the chart for patient visits on December 3,  
10 2004 and January 24, 2005;
- 11 c. misdiagnosing vitamin B-12 deficiency, misinterpreting the significance of a low  
12 iron level without further workup and misinterpreting the significance of an  
13 elevated candida IgG antibody titer; and
- 14 d. diagnosing and treating thyroiditis when there was no record on the chart of any  
15 examination of TLS' thyroid gland.

16 76. Dr. Scheerer opined that, by not conducting a physical examination, including  
17 a thyroid examination, Dr. Dommissé placed TLS at increased risk for misdiagnosis and  
18 treatment. By misinterpreting the significance of a low iron level without further workup  
19 and the significance of an elevated IgG antibody titer, Dr. Dommissé placed TLS at  
20 increased risk of misdiagnosis and treatment. By misdiagnosing TLS with a Vitamin B-12  
21 deficiency when there was no supportive clinical evidence, Dr. Dommissé may have  
22 increased TLS' anxiety, which was troubling because TLS was known to be anxious even  
23 before any misdiagnosis. Dr. Scheerer admitted at hearing that, because Vitamin B-12 is  
24 water soluble, any excess due to Dr. Dommissé's injections would not have harmed TLS.

25 ***Patient DLR***

1           77. At the time of treatment, DLR was a 66-year-old female with a long history of  
2 hyperthyroidism, which had been treated by surgery, radioactive iodine, and a second  
3 surgery, according to the phone intake sheet dated September 21, 2004.

4           78. The initial encounter form is dated October 15, 2004 and is accompanied by  
5 a 2½ -page dictation consisting of history and twenty eight provisional diagnoses. There  
6 is no indication of a physical examination. In addition to the standard recommendation,  
7 Dr. Dommissie recommended vitamin K-1 and appointment two and a half to three weeks.

8           79. A second encounter form is dated October 25, 2004. Dr. Dommissie noted  
9 three severe deficiencies—thyroid, vitamin B-12 and the amino acid arginine.

10           80. Dr. Scheerer testified that DLR was already on thyroid medication and had an  
11 elevated TSH. Her B-12 level was 569, which is normal. Dr. Dommissie put DLR on  
12 Armour Thyroid medication and increased her dosage to 60 mg/day.

13           81. An encounter form dated November 12, 2004 shows fourteen diagnoses,  
14 including vitamin B-12 deficiency and systemic candidiasis. There is no typed or written  
15 office visit note.

16           82. The last encounter form is dated January 11, 2005 and contains  
17 approximately twenty-five diagnoses, including systemic candidiasis and vitamin B-12  
18 deficiency. There is no indication of a physical examination.

19           83. Dr. Scheerer opined that the standard of care in the treatment of DLR  
20 required a history and physical examination; a typed or written note accompanying every  
21 office visit; accurate interpretation of laboratory test results; differential diagnoses that  
22 relate reasonably to the data obtained in the history and physical examination of the  
23 patient; and examination of the thyroid gland in the treatment of a patient with thyroid  
24 disease.  
25



1           89. In additional to the standard recommendation, Dr. Dommissie recommended  
2 that DFS be treated by making an appointment in three weeks.

3           90. In DFS' chart for August 13, 2004 are copies of laboratory results from  
4 Carondelet St. Mary's Hospital dated June 2003 and from Tiburon Diagnostic Laboratory  
5 dated August 17, 2004.

6           91. Dr. Dommissie wrote on the laboratory report for September 1, 2004 that  
7 DFS' "anemia is probably [due] to mycoplasma chronic infection, lo[w] testosterone, lo[w]  
8 zinc and hi[gh] candida."

9           92. The second encounter form for patient DFS is dated September 3, 2004, and  
10 records eleven diagnoses including systemic candidiasis and chronic mycoplasma  
11 pneumonitis. There is no written office note and no apparent physical examination.

12           93. Dr. Scheerer testified that Dr. Dommissie's diagnosis of mycoplasma  
13 infection as based on a single titer of DFS' blood. The infection is like tuberculosis; once  
14 a patient is exposed, evidence remains in the blood. The infection could have been old  
15 and resolved or new and active. Dr. Dommissie did not perform any test, such as a chest  
16 x-ray, to confirm his diagnosis of mycoplasma chronic pneumonitis infection. Such a test  
17 is routine.

18           94. Dr. Scheerer testified that patients having systemic candidiasis are usually  
19 severely ill and have been hospitalized. Dr. Dommissie did not treat DFS for systemic  
20 candidiasis.

21           95. An encounter form dated November 5, 2004 shows 22 diagnoses and no  
22 typewritten office note or physical examination.

23           96. The final encounter form is dated December 2, 2004, and lists twelve  
24 diagnoses including systemic candidiasis and mycoplasma pneumonitis. There is no  
25 written or typed office visit note and no indication of a physical examination.

1           97. Dr. Scheerer testified that Dr. Dommissé diagnosed DFS as suffering from  
2 systemic candidiasis based solely on antibody titers, not a blood culture. This was not  
3 appropriate. In addition, systemic candidiasis would have required hospitalization and  
4 treatment with antibiotics, which was not done.

5           98. Dr. Scheerer testified that Dr. Dommissé also treated DFS with  
6 hydrocortisone, which was inappropriate without a workup, repeating the blood test, and  
7 performing a TSH test. Dr. Dommissé's diagnosis of hypoadrenaline is one of the most  
8 serious things around; he should have done a further workup.

9           99. Dr. Scheerer opined that the standard of care in the treatment of DFS  
10 required, at a minimum, a history and physical examination; typed or written notes for  
11 every office visit; and differential diagnoses reasonably related to information obtained in  
12 the history and physical examination of the patient.

13           100. Dr. Scheerer opined that Dr. Dommissé deviated from the standard of care in  
14 his treatment of DFS by:

- 15           a. failing to perform a physical examination;
  - 16           b. failing to have written or typed office visit notes for the dates of September 3,  
17           2004, November 5, 2004, and December 2, 2004;
  - 18           c. misinterpreting the significance of an elevated candida IgG antibody titer in his  
19           diagnosis of systemic candidiasis;
  - 20           d. diagnosis of mycoplasma pneumonitis without performing a physical examination  
21           or chest x-ray based, apparently, on the basis of an elevated mycoplasma IgG  
22           antibody titer;
  - 23           e. treating DFS with a low free cortisol level with hydrocortisone without further  
24           workup; and
- 25

1 f. prematurely or inaccurately interpreting the significance of the patient's anemia  
2 and not recommending further workup.

3 101. Dr. Scheerer opined that Dr. Dommissse's deviations from the standard of  
4 care placed DFS at increased risk of side effects from prescribed hydrocortisone which  
5 may not have been indicated. There was also potential delay in diagnosis of anemia and  
6 low free cortisol and possible harm to DFS based on misdiagnoses.

7 ***Patient AMcH***

8 102. At the time of treatment, patient AMcH was a 23-year-old male with a  
9 bipolar disorder. His family provided historical data according to the phone intake form  
10 dated July 7, 2004 and the first encounter was on August 23, 2004. There is a two-page  
11 dictated report consisting of history followed by a list of thirteen provisional/working  
12 diagnoses, including bipolar-2 disorder, abnormal weight gain, memory disturbance,  
13 chronic fatigue, muscle spasms, insomnia without sleep apnea, classical migraine,  
14 dyslipidemia, vitamin B-12 deficiency, hypoglycemia, thyroiditis, acne, and hypersomnia.  
15 The diagnoses are followed by the standard recommendation and notation of an  
16 appointment in three weeks. There is no indication of a physical examination.

17 103. The chart contains a laboratory report from Baptist Medical Center dated  
18 July 31, 2003, with a vitamin B-12 level of 531 with a normal range of 210-705. Next to  
19 that is a notation of 600-2000.

20 104. An encounter form dated September 16, 2004 lists four diagnoses including  
21 thyroiditis and vitamin B-12 deficiency. There is no written or typed office visit report and  
22 no notation of a physical examination.

23 105. On September 23, 2004, the encounter form lists diagnoses similar to those  
24 on the September 16, 2004 encounter form. Again, there is no typed or written office visit  
25 notation and no indication of a physical examination.

1           106. The encounter form dated October 25, 2004 lists nine diagnoses, with no  
2 written or typed office visit and no indication of a physical examination although the  
3 diagnoses include thyroiditis and vitamin B-12 deficiency.

4           107. The encounter form dated November 18, 2004 includes the diagnosis of  
5 mycoplasma pneumonitis. There is no indication of a physical examination and no  
6 mention of chest x-ray results. The diagnosis appears to be based on a comment on the  
7 November 3, 2004 LabCorp report of elevated mycoplasma IgG antibody titer of 896 (0-  
8 200) but negative IGM antibody titer. A notation indicates "chr. lo-gr. Infection."

9           108. The January 10, 2005 encounter form lists eight diagnoses including  
10 mycoplasma pneumonitis, thyroiditis, acne, and vitamin B-12 deficiency. There is no  
11 dictated or written office visit note.

12           109. The back of the chart lists copies of prescriptions for Levoxyl, Cytomel and  
13 Lithobid.

14           110. Dr. Scheerer opined that Dr. Dommissie deviated from the standard of care  
15 in his treatment of AMcH by:

- 16           a. failing to perform a physical examination when treating for physical problems;
- 17           b. not making written or typed office visit notes for the encounters of September 16,  
18           2004, September 23, 2004, October 25, 2004, November 18, 2004, and January  
19           10, 2005;
- 20           c. not noting in the chart anything to suggest a diagnosis of mycoplasma pneumonitis  
21           such as supportive historical findings, an abnormality on examination or chest x-  
22           ray; and
- 23           d. misdiagnosing mycoplasma pneumonitis by misinterpreting the significance of the  
24           lab report of an antibody titer with no documented findings on physical  
25           examination or by x-ray.







1           122. At the time of treatment AS, Jr. was a 50-year-old male with a history of  
2 candida cholesterol, and hypertension, as noted on the phone-intake sheet dated  
3 October 28, 1998.

4           123. The first encounter form is dated December 3, 1998. There is a 1½-page  
5 typed report of history and systemic review followed by a list of thirteen diagnoses,  
6 including thyroiditis, systemic candidiasis, hypercholesterolemia, essential hypertension,  
7 abnormal weight gain, hepatitis, right hypochondrium pain, chronic fatigue, insomnia  
8 without sleep apnea, low sex drive, gastritis, sinusitis, and flatulence. These are followed  
9 by the standard recommendation and a notation of a return appointment in 5-6 weeks.

10           124. There is an encounter form dated December 16, 1998 with a diagnosis of  
11 and treatment for thyroiditis supported by laboratory tests from Sonora Quest  
12 Laboratories LLC of a positive anti-TPO antibody, free T4, Free T3, and a high TSH.

13           125. An encounter form dated January 15, 1999 has a one-half page dictation  
14 with diagnoses of thyroiditis, growth hormone deficiency, testosterone deficiency and low  
15 WBC.

16           126. The encounter form dated February 5, 1999 shows five diagnoses including  
17 thyroiditis but no indication of a physical examination.

18           127. The encounter form dated February 16, 1999 has a half-page dictation of  
19 history but no indication of a physical examination. The diagnoses are immune  
20 deficiency, auto-immune thyroiditis, mineral deficiency, vitamin E deficiency, amino acid  
21 deficiency, and toenail fungus.

22           128. Included with the March 16, 1999 encounter form is a half-page history and  
23 a list of ten diagnoses including thyroiditis, immune deficiency, hypercholesterolemia,  
24 mineral deficiency, Vitamin E overload and hepatitis but no indication of a physical  
25 examination.

1           129. The April 13, 1999 encounter form shows seven diagnoses. There is no  
2 indication of a physical examination.

3           130. On June 8, 1999 the encounter form has a one-page dictation of history and  
4 a list of ten diagnoses but no indication of a physical examination.

5           131. There are 39 encounter forms between June 22, 1999 through December 9,  
6 2004, and eight encounter forms for purchases of supplements. There are no typed or  
7 written office visit notes, no indications of physical examinations and no evidence of  
8 correlation with laboratory studies done except for brief notes written on the initial  
9 dictation of December 3, 1998. Copies of numerous prescriptions are contained in the  
10 back of the patient chart but many are scratched out or illegible.

11           132. Dr. Scheerer testified that the laboratory reports of AS, Jr. definitely showed  
12 elevated TSH.

13           133. Dr. Scheerer opined that the standard of care in the treatment of AS, Jr.  
14 required, at a minimum, a complete history and physical examination at the initial  
15 consultation; typed or written office visit reports for each office visit; laboratory results  
16 correctly interpreted; periodic examination of the patient's thyroid gland; and a medical  
17 chart constructed so that another physician could take over the patient's care in a  
18 knowledgeable manner.

19           134. Dr. Scheerer opined that Dr. Dommissie had departed from the standard of  
20 care in his treatment of AS, Jr. by:

- 21           a. not conducting or recording a physical examination;
- 22           b. not making written or typed office visit notes on 39 office visits from June 22, 1999  
23           to December 9, 2004;
- 24           c. treating for thyroid disease without a documented examination of AS, Jr.'s thyroid  
25           gland in almost fifty office visits over six years; and

1 d. making it impossible for another physician to assume the patient's care in a  
2 knowledgeable manner based upon the patient's chart.

3 135. Dr. Scheerer opined that Dr. Dommissie's deviations from the standard in  
4 his care of AS, Jr. resulted in a potential delay in diagnosis of a change in the thyroiditis  
5 condition.

6  
7  
8  
9 ***Patient BSS***

10 136. At the time of treatment BSS was a 50-year-old female whose medical  
11 problems were listed on two phone intake sheets dated April 17, 2002 as tired and on  
12 hormone replacement therapy.

13 137. The first encounter form is dated March 7, 2003. There is a two-page typed  
14 history and a list of twenty-seven provisional/working diagnoses including chronic fatigue,  
15 menopausal syndrome, fibromyalgia, dry skin, brittle nails, hair loss, memory disturbance,  
16 acne, candida overgrowth, atypical depressive disorder, autoimmune thyroiditis,  
17 abnormal weight gain, muscle spasms, panic disorder, trichotillomania, insomnia without  
18 sleep apnea, osteoarthritis, low sex drive, constipation, chronic low BP, peripheral  
19 neuropathy, common migraine, classical migraine with aura and neurological symptoms,  
20 osteopenia, hyperlipidemia, hypoglycemia/Syndrome X, and mineral toxicity. There is no  
21 indication of a physical examination.

22 138. Copies of previous laboratory tests dated January 11, 2003 are in the chart.

23 139. An encounter dated April 7, 2003 has eight diagnoses including thyroiditis,  
24 despite a negative anti-TPO titer, and a vitamin B-12 deficiency, despite a level of 1,093.  
25 There is no written or typed office note and no indication of a physical examination.

1           140. An encounter form dated June 25, 2003 lists eighteen diagnoses (not all are  
2 legible). There is no written or typed office visit note and no indication of physical  
3 examination although one diagnosis is peripheral neuropathy.

4           141. BSS' record shows encounter forms for office visits dated July 17, 2003,  
5 September 29, 2003, October 16, 2003, January 6, 2004, February 11, 2004, April 16,  
6 2004, June 17, 2004, November 16, 2004, and December 9, 2004. There are no written  
7 or typed office visit notes or any indication of physical examinations for any of these nine  
8 office visits.

9           142. There is a bone density study dated February 11, 2004 interpreted as  
10 osteopenia based on a T-score of -1.9.

11           143. Dr. Scheerer opined that the standard of care in the treatment of BSS  
12 required, at a minimum, a complete history and physical examination; a typed or written  
13 office visit report for every office visit; accurate interpretation of laboratory results;  
14 periodic examination of the thyroid gland once treated for thyroid disease; and a medical  
15 chart constructed so another physician could take over the patient's care in a  
16 knowledgeable manner.

17           144. Dr. Scheerer opined that Dr. Dommissse deviated from the standard of care  
18 in the treatment of BSS by:

- 19           a. not performing a physical examination;
- 20           b. not including a written or typed note for each office visit, except for the office visit  
21           of March 2, 2003;
- 22           c. making a diagnosis of thyroiditis and treating thyroiditis without doing a physical  
23           examination, imaging study or positive anti-TPO antibody titer;
- 24           d. making a diagnosis of vitamin B-12 deficiency when the level obtained was greater  
25           than 1000;

- 1 e. diagnosing thyroiditis rather than hypothyroidism and treating BSS without any  
2 physical examination of her thyroid gland over a period of more than 20 months;  
3 and  
4 f. making it very difficult, if not impossible, for another physician to assume BSS'  
5 care in a knowledgeable manner based on the information available in the chart.

6 145. Dr. Scheerer testified that Dr. Dommissé's deviations from the standard in  
7 his care of BSS may have resulted in possible mistreatment for thyroiditis and Vitamin B-  
8 12 deficiency. By not examining BSS, Dr. Dommissé exposed BSS to the risk of a  
9 potential misdiagnosis or delay in diagnosis and by treating thyroiditis, Dr. Dommissé  
10 may have added or worsened the BSS' osteopenia.

11 ***Patient EML***

12 146. At the time of treatment, EML was a 68-year-old female with a history of  
13 fibromyalgia and hypothyroidism, according to the phone intake sheet dated September  
14 15, 2000.

15 147. The first encounter form is dated November 1, 2000. There is a two page  
16 typed report consisting of history and a list of sixteen provisional/working diagnoses,  
17 including autoimmune thyroiditis, chronic fatigue, fibromyalgia, dysphagia, sinusitis,  
18 muscle spasms, dry skin, brittle nails, menopausal syndrome, constipation, cold  
19 intolerance, migraine, hoarseness, atypical depression, tachycardia, and weight loss.

20 148. The diagnoses are followed by the standard recommendation and: (a) a  
21 note to increase Cytomel 12.5 mcg from one daily to b.i.d.; and (b) a notation that Dr.  
22 Dommissé will analyze the thyroid tests in one to two weeks and see the patient in follow  
23 up in two months.

1           149. The second encounter form is dated November 10, 2000, with the number  
2 one diagnosis of thyroiditis related to a review of laboratory test results. There is no  
3 written or typed office note and no indication of a physical examination.

4           150. The encounter form dated January 18, 2001 lists seven diagnoses, the first  
5 being thyroiditis. There is no written or typed office note and no indication of a physical  
6 examination.

7           151. On March 15, 2001, there is an encounter form noting twelve diagnoses,  
8 listing thyroiditis as number one. There is no written or typed office note and no  
9 indication of physical examination.

10          152. The encounter form dated May 15, 2001 lists seven diagnoses with immune  
11 deficiency as number one and thyroiditis as number two. There is no written or typed  
12 office note and no indication of a physical examination.

13          153. There are eighteen encounter sheets from August 7, 2001 through  
14 December 3, 2004, which list variable and numerous diagnoses. There are no typed or  
15 written notes of any of these visits and no indication of any physical examination.

16          154. Dr. Scheerer opined that the standard of care in treatment of EML required,  
17 at a minimum, a complete history and physical examination; a typed or written office note  
18 for every office visit; correct interpretation of laboratory results; periodic physical  
19 examination of the patient's thyroid gland; and a medical chart constructed so that  
20 another physician could take over the patient's care in a knowledgeable manner.

21          155. Dr. Scheerer opined that Dr. Dommissie deviated from the standard in his  
22 treatment of EML by:

23           a. not including a physical examination;

24           b. not including typed or written office notes for twenty-two office visits between  
25           November 10, 2000 and December 2, 2001;



- 1 c. listing several diagnoses on November 1, 2000 that do not relate to data in the  
2 recorded history and without conducting physical examinations;
- 3 d. diagnosing immune deficiency based on a test that is not FDA approved and  
4 which, in part, was developed at Tiburon Diagnostic laboratory and without  
5 checking more routine factors such as IgG1-5 levels;
- 6 e. failing to examine EML's thyroid gland after diagnosing her with thyroid disease on  
7 any occasion in twenty-two office visits over four years; and
- 8 f. making it impossible for another physician to assume care of EML in a  
9 knowledgeable manner based on information in the chart.

10 156. Dr. Scheerer opined that Dr. Dommissse's deviations from the standard of  
11 care exposed EML to risk of possible mistreatment for immune deficiency and that his  
12 failure to take a complete history or to perform a physical examination, Dr. Dommissse  
13 exposed EML to risk of misdiagnosis.

14 157. Dr. Scheerer opined that, by failing to examine EML's thyroid gland, Dr.  
15 Dommissse placed her at increased risk for delay in diagnosis of a change in her thyroid  
16 disease.

17 **Case No. MD-05-0086A**

18 ***Patient LB***

19 158. The Board opened an investigation into Dr. Dommissse's treatment of LB  
20 because the records reviewed in another case suggested that Dr. Dommissse treated the  
21 patient for approximately two years without ever physically seeing her or performing an  
22 evaluation.

23 159. At the time of treatment by Dr. Dommissse, LB was a 29-year-old female  
24 who had been diagnosed in 1996 with Chronic Fatigue Syndrome. LB's symptoms had  
25 worsened and she claimed to be homebound as a result of her condition.

1           160. The Board assigned LB's case to OMC Miriam Anand, MD. Dr. Anand  
2 graduated from George Washington Medical School in 1998 and completed a residency  
3 and fellowship in internal medicine. She has been in private practice as an allergist for  
4 five years.

5           161. LB requested that Dr. Dommissse handle her care over the phone so she  
6 would not have to travel to his office. Dr. Dommissse agreed and was to review LB's  
7 extensive records. However, LB could not afford for Dr. Dommissse to review the records  
8 for longer than 30 minutes.

9           162. On May 15, 2001, Dr. Dommissse dictated a letter outlining LB's history  
10 based on his telephone conversation with her and his brief review of her medical records.  
11 He later diagnosed LB with autoimmune thyroiditis, mineral toxicity, chronic fatigue, low  
12 adrenal res [sic] and chronic hypotension, among other diagnoses.

13           163. Dr. Dommissse's diagnosis of hypothyroidism was the result of blood tests  
14 he ordered on June 6, 2001, which showed LB's TSH was slightly high at 4.48 and her  
15 T3 was borderline at 2.3.

16           164. On June 18, 2001, Dr. Dommissse instructed LB to continue taking her  
17 thyroid hormone despite her complaints of increased fatigue and weakness and did not  
18 repeat the laboratory tests.

19           165. On November 1, 2005, LB's TSH level was 0.02 and, according to her  
20 medical records, Dr. Dommissse did not consider whether she had been over-replaced  
21 with thyroid medication.

22           166. Dr. Dommissse diagnosed LB with aluminum toxicity and performed  
23 chelation therapy without documenting informed consent.

24           167. Dr. Anand testified that the standard of care when a patient complains of  
25 excessive fatigue is to complete a thorough history and physical examination to check for

1 low thyroid function. The examination should include visual inspection and palpation of  
2 the thyroid gland for enlargement, inspection of the skin and hair and assessment of  
3 neurological reflexes. Dr. Domnisse deviated from the standard of care in failing to  
4 perform a physical examination of LB.

5 168. Dr. Anand testified that the standard of care when a patient complains of  
6 excessive fatigue also includes performing laboratory studies to rule out thyroid disease  
7 and to rule out other causes of fatigue such as anemia. Dr. Domnisse deviated from the  
8 standard of care in Diagnosing LB with hypothyroidism based on insufficient history, no  
9 supporting physical examination findings, and on borderline laboratory results that were  
10 not repeated.

11 169. Dr. Anand testified that the standard of care in providing patients with  
12 medication is to prescribe only when indicated. Dr. Domnisse deviated from this  
13 standard by continuing to treat LB with thyroid medication after she complained of  
14 symptoms and after receiving laboratory results that indicated LB was receiving too much  
15 thyroid hormone.

16 170. Dr. Anand testified that Dr. Domnisse's deviations from the standard of  
17 care may have resulting in LB experiencing increased weakness and fatigue from  
18 excessive thyroid replacement. His treatment of LB with excess thyroid hormone put her  
19 at risk for potentially life-threatening arrhythmias and osteoporosis.

20 ***Patient JJ***

21 171. The Board opened an investigation into Dr. Domnisse's treatment of  
22 patient JJ following her complaint that he had over prescribed thyroid medication.

23 172. At the time of treatment by Dr. Domnisse, patient JJ was a 64-year-old  
24 female with a 30-year history of hypothyroidism who was taking daily thyroid replacement  
25 medication.

1 173. JJ's primary concerns were to avoid type 2 diabetes, a recent increase in  
2 blood pressure, cholesterol issues, weight issues, and her thyroid.

3 174. On November 29, 2004, Dr. Dommissse took a history review of systems  
4 and listed several diagnoses including auto immune thyroiditis. He performed no  
5 documented physical examination.

6 175. Dr. Dommissse ordered numerous laboratory tests and instructed the patient  
7 to take Armour Thyroid.

8 176. JJ's complaint was assigned for investigation to Kelly Sems, MD, who is  
9 now employed the Board's Chief Medical Consultant. Previously, she was one of the  
10 Board's staff medical consultants.

11 177. Dr. Sems completed 3-year residencies in internal medicine and  
12 rheumatology. She practiced rheumatology in Iowa before becoming employed by the  
13 Board.

14 178. Dr. Sems testified that JJ's medical chart showed encounter forms for  
15 January 18, 2005, August 1, 2005, April 21, 2006, July 19, 2006, August 4, 2006, and  
16 August 6, 2006. None of records were in the typical SOAP format. Dr. Dommissse's  
17 records were extremely hard to understand, because information on the amount of  
18 prescribed drugs, symptoms, observed effects of prescribed drugs, and changes to the  
19 treatment plan were all in different parts of the file. The only treatment note that clearly  
20 provided Dr. Dommissse's thought processes was the November 29, 2004 "Initial complex  
21 Nutritional-Metabolic Evaluation/Counseling." This form had three handwritten columns  
22 of notes dated 6-20-05, 3-13-06, and 6-14-06 that appeared to modify the  
23 "provisional/working diagnoses."

24 179. In September 2006, JJ's records indicate that she called Dr. Dommissse's  
25 office to report heart palpitations, anxiety, and dizziness. Dr. Sems testified that these

1 were symptoms of possible thyroid medication over-replacement. Such over-  
2 replacement could also affect the heart and decrease bone density.

3 180. The records show Dr. Dommissie advised JJ that her symptoms were due to  
4 Metformin, which JJ was taking for diabetes. Dr. Sems testified Metformin has not been  
5 shown to cause palpitations, anxiety, or dizziness. Dr. Dommissie did not consider  
6 thyroid over-replacement. As a factor in mitigation, Dr. Sems noted that Dr. Dommissie  
7 did advise JJ to stop taking thyroid replacement medication.

8 181. Dr. Sems testified that the standard of care requires a physician to provide  
9 adequate care to a patient with hypothyroidism on replacement medicine with routine  
10 office visits at least twice a year with an interval history and physician examination,  
11 monitoring of hypothyroidism at least once a year with laboratory tests such as TSH and  
12 appropriate adjustments of medications as needed. Dr. Dommissie did not meet this  
13 standard.

14 **Case No. 06-0937A**

15 182. In connection with the Board Order dated October 20, 2003 and after the  
16 Board issued its amended order on January 18, 2006, two patient charts of Dr.  
17 Dommissie were randomly reviewed. Board consultant Dr. Sems reviewed the charts and  
18 testified at hearing concerning her opinion of the adequacy of the charts and treatment  
19 reflected therein.

20 ***Patient MPJ***

21 183. The medical records for patient MPJ included an encounter form from  
22 February 3, 2006, an appointment card for MPJ's next appointment, laboratory results  
23 and scripts which are crossed out for Levoxyl, K Phos and KCl.

24 184. The encounter form has several ICD-9 codes circled for the medical  
25 diagnoses including the following: enzyme deficiency, food allergies, autoimmune

1 thyroiditis, vitamin E deficiency, mineral deficiency, amino acid deficiency,  
2 hypophosphatemia, low potassium and immune deficiency.

3 185. There is no documented history or physical examination or medication list  
4 or documentation of counseling.

5 186. The laboratory results showed an abnormal laboratory value for TSH of  
6 0.02 (0.30-2.50 normal). Dr. Domnisse did not address this abnormality in the patient's  
7 records.

8 187. Although Dr. Domnisse diagnosed the patient with thyroiditis, there was no  
9 antibody test for autoimmune thyroiditis in the laboratory work.

10 188. Although Dr. Domnisse diagnosed MPJ with Vitamin E deficiency, the  
11 Vitamin E levels fell within the normal range.

12 189. Dr. Sems testified that the standard of care requires a physician to address  
13 abnormal laboratory values such as a TSH of .02 (0.30-2.50).

14 190. Dr. Sems testified that the standard of care requires a physician who makes  
15 a diagnosis to substantiate the diagnosis with supporting and corresponding history,  
16 physical examination, and laboratory work.

17 191. Dr. Sems testified that, although it did not appear that MPJ was actually  
18 harmed by Dr. Domnisse's failure to address the abnormal TSH level, potential harm  
19 could have resulted from the effects of a persistent hyperthyroid state. Making an  
20 incorrect diagnosis potentially subjected MPJ to treatments that were not required and  
21 could have delayed proper diagnosis and treatment.

22 ***Patient PAK***

23 192. Dr. Sems reviewed three pages of lists of "Original Provisional/Working  
24 Diagnoses" with handwritten notes/comments made by Dr. Domnisse regarding the  
25 status of the working diagnoses on different dates, a complex nutritional-metabolic

1 evaluation that lasted one hour, a follow up appointment card, and order verification for  
2 labs and lab test results containing various handwritten notes by Dr. Dommissie.

3 193. No office notes existed beyond the initial August 10, 2001 office encounter.

4 194. The only notes available were written on the 3 pages of lists of "original  
5 Provisional/Working Diagnoses" that Dr. Sems testified did not make sense.

6 195. On the March 17, 2006, encounter form, Dr. Dommissie diagnosed PAK  
7 with Macrocytosis, but Dr. Sems testified there were no symptoms or laboratory tests in  
8 the medical record to support this diagnosis.

9 196. Dr. Sems testified that PAK's medical records were inadequate and did not  
10 contain sufficient information to allow a fellow practitioner to pick up the record and  
11 provide continuity of care to PAK. The records did not contain adequate histories or  
12 examinations. Although there was a list of diagnoses, there were no outlined plans and  
13 the diagnoses rarely had supporting documentation.

14 197. Dr. Sems testified that the standard of care requires a physician who makes  
15 a diagnosis to substantiate the diagnosis with supporting and corresponding history,  
16 physical examination, and laboratory work.

17 198. Dr. Sems testified that Dr. Dommissie deviated from the standard of care in  
18 the treatment of patient PAK by failing to substantiate his diagnoses with supporting and  
19 corresponding history, physical examinations, and laboratory work. His deviation  
20 potentially subjected PAK to treatments that were not required and may have delayed  
21 proper diagnosis and treatment.

22 199. On cross-examination, Dr. Sems did not believe that the extensive blood  
23 tests that Dr. Dommissie ordered constituted a "complete organ systems examination"  
24 that under the AMA guidelines could be billed as complete physical exam.

25 **Case No. MD-07-0139A**

**Patient GVJ**

200. Another health care practitioner filed the complaint regarding patient GVJ. Dr. Dommissse had diagnosed and began treating GVJ for hypothyroidism.

201. Dr. Dommissse had altered reference ranges on Quest laboratory test to reach this diagnosis and relied on GVJ's T3 and T4 levels rather than TSH levels.

202. Dr. Dommissse prescribed 30 mg TID of Armour Thyroid to GVJ. After GVJ started taking the Armour Thyroid, he started experiencing increased anxiety and agitation.

203. The Board assigned case no. MD-07-0139A to OMC Randy J. Horwitz, MD, PhD to investigate. Dr. Horwitz is the Medical Director of the Program in Integrative Medicine and an Assistant Professor of Clinical Medicine at the University of Arizona College of Medicine. Neither the Board nor Dr. Dommissse presented Dr. Horwitz' testimony, although his two reports were admitted into evidence.

204. Dr. Horwitz prefaced his initial report by saying that he recognized Nutritional Medicine as a field of study and, although he did not agree with many of the tenets and philosophies of the practice, he understood it. He therefore restricted his "comments to the pertinent features of the complaint(s) at hand."

205. With respect to the Board's charge that Dr. Dommissse had possibly committed unprofessional conduct by altering the ranges of values that the laboratory had designated as normal, Dr. Horwitz' initial report rendered the following opinion:

In this most serious charge, I believe that the accusation was ill-stated, vague, and largely unfounded. In examining the laboratory reports in this case, it appears that Dr. Dommissse re-defined the Quest Laboratory reference range to suit his view of where the patient's value should optimally lie. This was neither a malicious nor illegal act, in that the lab results form was clearly revised by Dr. Dommissse; indeed the original lab reference range is still readable. It appears to me that Dr. Dommissse actually took the time to discuss each lab value



1 with the patient—and likely modified or discussed his opinion  
2 of the ranges in the presence of the patient. He has circled  
3 the patient's lab value, then noted his view of the optimal  
4 values (versus the reference range reported by Quest). Not  
5 only is it within his rights as a physician to do such, it should  
6 be encouraged. As a consultant, I am often called upon to  
7 explain the meaning of the patient's lab values, since they are  
8 not routinely discussed in detail with the patient by the PCP.  
9 It is a refreshing change to see this level of detail in  
10 discussing lab values.

11 I might point out that a reference range is not always  
12 equivalent to an "optimal" value for a particular lab value. In  
13 fact, the "altering" of a reference range is commonly done in  
14 Internal Medicine. . . .

15 206. With respect to the charge that Dr. Dommissie had possibly committed  
16 unprofessional conduct by using T3 and T4 levels, rather than the TSH level, to diagnose  
17 GVJ with hypothyroidism, Dr. Horwitz opined:

18 The first issue is that the diagnosis was made using a TSH  
19 blood test done by a CLIA-certified lab, Quest Laboratories.  
20 The complainant states that the patient did not have  
21 hypothyroidism based upon this test. This comes down to an  
22 argument regarding the exact lab value constituting a high  
23 TSH. I have consulted numerous authorities, and have had  
24 differing opinions. I will quote the following from an article by  
25 Douglas Ross, MD (Dept of Endocrinology, Harvard University  
School of Medicine):

"Presently there is considerable controversy as to  
the appropriate upper limit of normal for serum  
TSH. Most laboratories have used values of about  
4.5 to 5.0 mU/L. A monograph published by the  
National Academy of Clinical Biochemistry argues  
that the upper limit of normal of the euthyroid  
reference range should be reduced to 2.5 mU/L  
because 95 percent of rigorously screened  
euthyroid volunteers have serum values between  
0.4 and 2.5 mU/L [Baloch, et al. Laboratory  
medicine practice guidelines. Laboratory support

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

for the diagnosis and monitoring of thyroid disease. Thyroid 2003; 13:3]. However, a population study from Germany which excluded patients with a positive family history, goiter, nodules, or positive anti-TPO antibodies found a normal reference range of 0.3 to 3/63 mU/L [Kratzsch, et al. New reference intervals for thyrotropin and thyroid hormones based on National Academy of Clinical Biochemistry criteria and regular ultrasonography of thyroid. Clin Chem 2005; 51:1480]. The use of 2.5 mU/L as the upper limit of normal for serum TSH will increase substantially the number of patients in the United States diagnosed with subclinical hypothyroidism. Presently, controversy exists as to whether patients with serum TSH values between 5 and 10 mU/L require treatment. Until there are data demonstrating an adverse biologic significance for serum TSH values between 2.5 and 5.0 mU/L, the wisdom of labeling such patients as hypothyroid is questionable."

So, although most physicians utilize the published reference range for the TSH values, since the NACB, the Academy of the American Association for Clinical Chemistry endorses this change, there is sufficient controversy in the field to warrant careful consideration before proclaiming an "inappropriate diagnosis" violation. Dr. Dommissie is aware of this controversy, as well as the NACB opinion, so his use of this range is likely a considered opinion, rather than a neglectful or inappropriate diagnosis. With a normal FT4 and FT3, this becomes a diagnosis of subclinical hypothyroidism, the treatment of which is also controversial.

....

Nonetheless, the decision to treat subclinical hypothyroidism is also controversial. I am sometimes guided by the presence of antithyroid antibodies, but in this case, they were not ordered. Also, Dr. Dommissie recommends repeat lipid profile, perhaps in recognition of the elevation in lipids associated with hypothyroidism.

1           207. With respect to the issue of whether the 30 mg. dose of Armour Thyroid that  
2 Dr. Dommissie initially prescribed to begin treating GVJ's diagnosed hypothyroidism  
3 constituted unprofessional conduct, Dr. Horwitz opined:

4           Although I personally have found the combination of T4/T3  
5 found in Armour Thyroid provides superior replacement in  
6 terms of patient well-being and rapid equilibration of thyroid  
7 hormone levels, I favor the synthetic formulation, rather than  
8 the Armour Thyroid natural product. Many practitioners do  
9 prefer Armour, but Dr. Dommissie is **not** using the  
10 recommended 30 mg starting dose appropriately. He  
11 prescribed: 30 mg TID. Although on maintenance most  
12 patients need 90-120 mg daily, this is a high dose to start  
13 therapy, and may be problematic in someone with subclinical  
14 disease, in that there is a risk for arrhythmias if the patient  
15 becomes hyperthyroid . . . .

16 [Emphasis in original.] Dr. Horwitz proceeded to quote from the manufacturer's product  
17 information.

18           208. With respect to the issue of whether Dr. Dommissie's records for GVJ  
19 evidenced unprofessional conduct, Dr. Horwitz opined:

20           I saw no evidence to support these claims. The records were  
21 rather complete, and I believe that Dr. Dommissie believes  
22 everything he has written. Many conventional physicians  
23 disagree with the manner of his practice (Nutritional  
24 Medicine), but if we restrict our focus solely to the issue of  
25 these allegations, it becomes easier to reach conclusions.

#### **Evidence Presented in Dr. Dommissie's Defense**

26           209. Dr. Dommissie admitted that he does not perform or document complete  
27 physical examinations of patients. Instead, since 2003 he has required patients to sign a  
28 "Type of Practice Disclaimer," in which they acknowledge his explanation that he has not  
29 been trained as an endocrinologist, he was trained in psychiatry. Because Dr.  
30 Dommissie's "practice has 'morphed' into one that contains several aspects of

1 endocrinology and metabolism,” he informed patients that he does not perform full  
2 physical examinations. Patients were informed that they “need[ed] to obtain full physical  
3 examinations from your primary care, or other, physician, annually or as necessary, and  
4 provide [Dr. Dommissse] with reports of the same.”

5 210. Dr. Dommissse testified that he tells patients that he relies on others to  
6 perform physical examinations. He did not show the report of any physical examination  
7 by another health care provider that was included in the patients’ records that the Board  
8 obtained from him pursuant to subpoenae and that were admitted into evidence.

9 211. Dr. Dommissse had admitted into evidence the AMA’s CPT coding  
10 guidelines that require that, for a physician to bill at code 99205 for new patient or at code  
11 99215 for an established patient, he must perform a “general multi-system exam or  
12 complete exam of a single organ system.” Among the recognized organ systems are  
13 “hematologic/lymphatic/immunologic.” Dr. Dommissse argued that the extensive blood  
14 and other tests he orders suffice for a complete physical examination for billing and for  
15 standard-of-care purposes.

16 212. Dr. Dommissse had admitted into evidence a paper he authored entitled  
17 “Hypothyroidism: Sensitive Diagnosis and Optimal Treatment of All Types and Grades—  
18 A Comprehensive Hypothesis,” www.ThyroidScience 3(2):H1-13 (2008). The article cites  
19 peer-reviewed authorities and Dr. Dommissse’s own experience. The abstract of the  
20 article follows:

21 The hypothesis of this paper is that hypothyroidism (in its  
22 various forms and degrees) is often undiagnosed in its grade  
23 3 primary, secondary (pituitary), tertiary (hypothalamic) and  
24 non-thyroidal illness hypothyroidism versions; and under-  
25 treated in all versions, including its grades 1 and 2 primary  
hypothyroidism versions. The current standard and  
alternative approaches to the diagnosis and management of  
hypothyroidism, and their logical inconsistencies and

1 inadequacies, are discussed. The biggest losers in this  
2 neglectful situation are the elderly.

3 An extensive review is presented. Which is then coupled with  
4 logical argument and clinical experience to clarify the  
5 hypothesis. Methods employing the *free* thyroid hormone  
6 levels (FT<sub>4</sub> and FT<sub>3</sub>), by the accurate direct- and tracer-  
7 dialysis methods, respectively, and a lower normal range for  
8 the thyroid stimulating hormone level are described. These  
9 help optimize the newly developed diagnostic strategies.  
10 Their superiority over the standard conventional and  
11 alternative approaches are suggested by inferential argument  
12 and by the author's personal experience of his own case of  
13 post-surgical (thyroglossal cystectomy) hypothyroidism—  
14 missed by the medical profession for 36 years—and his  
15 clinical experience with 3,500 patients over a 16-year time  
16 period.

17 Diagnostic strategies and treatment methods are described  
18 which refute traditional objections to measuring the FT<sub>3</sub> serum  
19 level—at least in the case of the serum test done by the  
20 dialysis method—and to treating the varying combinations of  
21 both T<sub>4</sub> and either T<sub>3</sub> or T<sub>4</sub>/T<sub>3</sub> combination hormone  
22 preparations. The objections about aggressive thyroid  
23 treatment causing or aggravating osteoporosis and cardiac  
24 arrhythmias are found (in the author's practice) to not only be  
25 overblown, but to be entirely non-existent when corrections  
are made for certain mineral, vitamin, amino acid, and sex-  
and growth-hormonal deficiencies.

213. Dr. Dommissé testified that the Board has criticized him because one or two  
of his patients, when he attempted to maximize their T3, experienced tachycardia or  
palpitations. He testified that he adjusts the dose until he gets optimal benefit.

214. Dr. Dommissé testified that RSH had called him twice about spotting. In  
response, he had lowered her dosage of estrogen hormone replacement. She had called  
a second time, before the lowered dosage had time to take effect. If altering her dosage  
had not resolved her symptoms within a week, he would have referred her to a  
gynecologist.

1           215. Dr. Dommissé testified that the risks of excess estrogen replacement are  
2 "ridiculous." The dangers of thyroid hormone over-replacement have been "blown all out  
3 of proportion." With his prescription of thyroid replacement and estrogen replacement  
4 hormones to RSH, her bone density had shown improvement at every scan at 2-year  
5 intervals.

6           216. Dr. Dommissé testified that all the substances that he prescribes are  
7 "natural" and therefore "harmless." He placed DFS in hydrocortisone, which is identical  
8 to the naturally occurring substance. Hydrocortisone cannot be patented because it is  
9 identical to the substance that occurs naturally in the body. In contrast, internists  
10 prescribe prednisone, which increases drug companies' profits and may cause harm  
11 because it is not natural.

12           217. With respect to AMCH, Dr. Dommissé testified that his IgG titer was more  
13 than twice the normal level. His diagnosis of mycoplasma pneumonitis was of a condition  
14 that might, if left untreated, progress to "walking pneumonia." The condition definitely  
15 contributed to AMCH's complaints of chronic fatigue.

16           218. With respect to JJ, Dr. Dommissé testified that he did order her to lower her  
17 dosage of Amour Thyroid. Instead, however, she chose to go to another physician.  
18 There are other causes of tachycardia. He attempts to maximize thyroid function in his  
19 patients.

20           219. Dr. Dommissé testified that none of the tests that he orders is completely  
21 routine. He picks tests that are suited to the specific patient and reported symptoms. He  
22 usually orders a thyroid screen and tests to measure Vitamin B-12, Vitamin E, and  
23 Vitamin D. He orders a growth hormone test in elderly, frail, or middle-aged patients who  
24 request anti-aging treatments. He orders amino acid profiles for patients with symptoms  
25 of depression or another psychiatric condition. He orders basic food allergy tests for

1 patients with irritable bowel syndrome or symptoms of food allergies. He orders metal  
2 toxicity screening for aluminum and mercury in most cases. He only orders testing for  
3 copper toxicity for patients who complain of memory loss.

4 220. Dr. Dommissé testified that he only orders tests for candida for patients who  
5 complain of symptoms. Nutritional physicians use an elevated IgG antibody tier to  
6 diagnose systemic candidiasis that has not yet become symptomatic to the point of  
7 requiring hospitalization. He has definitely seen improvement of symptoms in such  
8 patients.

9 221. With respect to TLS, Dr. Dommissé testified that low thyroid can also cause  
10 heart palpitation.

11 222. Dr. Dommissé testified that it would be far more harmful to TLS to overlook  
12 a B-12 deficiency than to diagnose a condition that she might not have. Taking a lozenge  
13 for the rest of her life should reduce her anxiety.

14 223. Dr. Dommissé testified that he does not order the NK cell test routinely but  
15 only for patients he suspects of having immune deficiency disorder.

16 224. Dr. Dommissé testified that, since the 2003 hearing, he has increased  
17 focused examinations of patients, especially for blood pressure and pulse. If his records  
18 are still deficient, there had been no harm to patients. In any event, extensive blood tests  
19 will be more definitive in providing diagnoses than a physical examination.

20 225. With respect to patient JTK, Dr. Dommissé testified that nutritional  
21 physicians' patients do not get tardive dyskinesia. Although other kinds of doctors may  
22 not prescribe Seroquel for anxiety, it is not a risk for patients of nutritional physicians. He  
23 does not need to perform physical examinations of patients prescribed Seroquel,  
24 because there is no way to miss the symptoms of tardive dyskinesia. The patient begins  
25 "writhing around."

1           226. Dr. Dommissé offered into evidence 21 letters from physicians in support of  
2 him, which generally attest to the success of patients that they refer to him rather than  
3 specific practices. Dr. Dommissé also offered into evidence letters from 119 patients  
4 about their success under his treatment. The Administrative Law Judge sustained the  
5 Board's attorney's objections to admission based on hearsay and relevancy. Copies of  
6 these documents were provided to the Board's attorney and are included in the record  
7 but will not be considered further in this recommended decision.

8           227. Dr. Dommissé admitted that the better practice is to palpate the thyroid  
9 gland of patients whom he is treating for a thyroid disorder. But, since none of the  
10 patients had been harmed or had complained about his treatment, it was none of the  
11 Board's business.

12           228. Dr. Dommissé testified that an examination of the thyroid gland of a patient  
13 with thyroid disorder would only show enlargement or nodules. There is no way to write a  
14 report of such an examination.

15           229. Dr. Dommissé testified that the normal range for Vitamin B-12 in the U.S. is  
16 between 243 and 896. In Japan, the range considered to be normal is double what it is in  
17 the U.S. Japan has no incidence of Alzheimer's disease.

18           230. Dr. Dommissé argued that neither Dr. Sems, Dr. Anand, Dr. Hanson, nor  
19 Dr. Scheerer were his peers because they did not practice nutritional medicine. Only Dr.  
20 Horwitz was his peer, and Dr. Horwitz found no fault with his record-keeping and  
21 diagnostic practices.

22           231. Dr. Dommissé testified that the Board recognizes nutritional medicine as an  
23 area of specialty. It listed Nutrition as an area of interest on the 2004 and 2006 license  
24 renewal forms.

25



1           232. Dr. Dommissé testified that Nutritional physicians do not follow the SOAP  
2 format in their record-keeping. Other nutritional or complementary physicians, such as  
3 Dr. Horwitz, could understand his charts.

4           233. Dr. Dommissé testified that his patients had told him that they did not want  
5 to pay for the additional expense of having him prepare office notes in the SOAP format  
6 for each office visit. They preferred to have him spend his time focusing on treatment  
7 and care.

8           234. Dr. Dommissé testified that Nutritional physicians may not perform physical  
9 examinations, but instead rely on others to perform such examinations of their patients.

10          235. Dr. Dommissé testified that psychiatrists cannot perform detailed physical  
11 examinations. They examine patients by observing them during conversations. He  
12 performed his last physical examination approximately 41 years ago.

13          236. Dr. Dommissé testified that he practiced telemedicine and regularly treated  
14 patients from other states. He could not refuse to treat LB after her mother requested.  
15 He has experienced a 65% success rate in treating chronic fatigue patients.  
16 Conventional medicine had only a 2-6% success rate. Dr. Dommissé did not define his  
17 definition of "success" in treating chronic fatigue patients.

18          237. Dr. Dommissé testified that conventional medicine has a poor record in  
19 treating chronically ill patients.

20          238. Dr. Dommissé had testified that much of his practice focuses on treating  
21 conditions that conventional medicine has missed. Hypothyroidism is underdiagnosed in  
22 the U.S. primarily due to the sole reliance on TSH levels to diagnose it. Even if TSH  
23 levels are within normal range, more sensitive T3 or even T4 levels may show secondary,  
24 tertiary, or subclinical hypothyroidism.

25

1           239. Dr. Dommissie testified that Dr. Hanson "preferred to see his contact with  
2 RSH in a negative light." He only questioned RSH about the release because he knew  
3 that she had broken off relations with Dr. Lending, who he called a "quackbuster." RSH  
4 had confirmed that she did not want her records sent.

5           240. Dr. Dommissie's patient AS, Jr. traveled to Phoenix from Tucson to testify  
6 on his behalf. He was one of the 10 patients whose file Dr. Scheerer reviewed in the  
7 random audit.

8           241. AS, Jr. has been Dr. Dommissie's patient for approximately 10 years. When  
9 he started being seen by Dr. Dommissie, he was not required to sign a disclaimer.  
10 However, Dr. Dommissie had told him that he should have his own doctor to perform  
11 physicals.

12           242. AS, Jr. testified that Dr. Dommissie had palpated his thyroid after raising his  
13 dosage of Cytomel to raise his T3 level. Although AS, Jr. had experienced rapid  
14 heartbeat for a while, it resolved. Dr. Dommissie has never performed a physical  
15 examination of him.

16           243. AS, Jr. testified that he initially went to Dr. Dommissie because his regular  
17 doctor was not making him feel better. Every fall, he would get sick and he would stay  
18 sick with a cold all winter. He had asked his internist about his thyroid, and the internist  
19 gave him medicine, but it did not help.

20           244. AS, Jr. testified that Dr. Dommissie had discovered that he had Hashimoto's  
21 disease, which the internist had not found. Dr. Dommissie had put him on thyroid  
22 medication and amino acid. AS, Jr. testified he no longer gets sick. He no longer gets  
23 colds and flu. His cholesterol level has gone from 240 to 140-150, without medication.  
24 He feels better than he has in 10 years.

25





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

- (i) Adequate informed patient consent.
- (ii) Conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a medical peer review committee.
- (iii) Approval by the federal food and drug administration or its successor agency.  
.....
- (II) Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of the patient.  
.....
- (ss) Prescribing, dispensing or furnishing a prescription medication . . . to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . . .”

3. A.A.C. R4-16-603(18)(c)(ii) provides in relevant part as follows:

- “Departures from the Standard of Care” includes those actions or omissions that violate A.R.S. § 32-1401(27)(l), (q), or (ll).  
.....
- c. Departures Caused by Cognitive Issues Involving the Physician:  
.....
    - ii. Repetitive or egregious offenses may result in a Letter of Reprimand or a Decree of Censure with Probation. Offenses that are not, or are unlikely to be remediated, may result in Suspension or Revocation.

4. A.A.C. R4-16-604 includes among the aggravating factors considered in disciplinary actions the following:



1 Board charged Dr. Dommissé with unprofessional conduct after he diagnosed  
2 hypothyroidism based on T3 and T4 levels, rather than solely on the TSH level, Dr.  
3 Horwitz' report and Dr. Dommissé's authorities establish a good-faith controversy within the  
4 allopathic medical community regarding the appropriate diagnostic test for hypothyroidism.  
5 Because these controversies must be resolved by consensus within the allopathic medical  
6 community, the Administrative Law Judge makes no recommendation to the Board  
7 regarding Dr. Dommissé's practices in these respects in this decision, other than to  
8 recommend that such practices do not constitute unprofessional conduct in every case.

9         4. Dr. Dommissé's failure to perform a physical examination or to ensure that  
10 another appropriately trained professional performed a physical examination of any of his  
11 patients at any point in his treatment of them is far more concerning. Dr. Dommissé's  
12 "Type of Practice Disclaimer" cannot vitiate his failure. Patients of an allopathic physician  
13 are entitled to care within the applicable standard and cannot assume the risk of his  
14 unprofessional conduct.

15         5. Moreover, Dr. Dommissé did not merely give his patients nutritional  
16 supplements or dietary counseling; he gave them substances that were available only by  
17 prescription by an appropriately licensed health care provider. Dr. Dommissé admitted  
18 that he attempted to "optimize" "natural" hormones by prescribing such replacement  
19 hormones to reach higher levels than were considered safe by most allopathic  
20 practitioners. His failure to monitor the effect of such prescription by performing a  
21 physical examination or even to perform any blood tests after the initial battery placed his  
22 patients at risk and constituted unprofessional conduct. The Board's decree of censure  
23 in case no 03F-22164-MDX required such examinations.

24         6. Therefore, the Board has established that Dr. Dommissé committed  
25 unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) in his care of patients

1 RSH, JTK, JMG, TLS, DLR, DFS, AMcH, SHJ, AS, Jr., BSS, EML, JJ, MPJ, and PAK by  
2 not performing any physical examinations on them; as defined in A.R.S. § 32-1401(27)(r)  
3 in his care of patients MPJ and PAK by violating a formal order, probation, consent  
4 agreement or stipulation issued or entered into by the Board or its executive director by  
5 failing to perform physical examinations on them; and as defined by A.R.S. § 32-  
6 1401(27)(ss) in his care of patient LB by prescribing, dispensing or furnishing a  
7 prescription medication or a prescription-only device without first conducting a physical  
8 examination or previously establishing a doctor-patient relationship.

9 7. Dr. Dommissie prescribed estrogen hormone replacement to RSH, who was 72  
10 years old, post-menopausal, and had no recorded complaints to justify the prescription.  
11 Even when RSH complained of vaginal bleeding, he refused to reconsider his  
12 prescription of hormone and reduced the amount but continued the prescription, without  
13 referring her to a gynecologist. His testimony that he would have referred her to a  
14 gynecologist if her symptoms had not resolved is belied by his own records: he  
15 continued to prescribe hormone replacement and she continued to complain of vaginal  
16 bleeding. The Board has established that Dr. Dommissie committed unprofessional  
17 conduct as defined by A.R.S. § 32-1401(27)(ll) in his care of RSH.

18 8. The Board also established that Dr. Dommissie's excessive prescription of  
19 Armour Thyroid to patients RSH, LF, JJ, and GVJ caused over-replacement of thyroid  
20 hormone, causing actual or potential tachycardia, osteoporosis, weight loss, and other  
21 symptoms. The Board's decree of censure and order of probation in case no. 03F-  
22 22164-MDS addressed Dr. Dommissie's history of causing iatrogenic hyperthyroidism in  
23 his patients. The Board therefore has established that Dr. Dommissie committed  
24 unprofessional conduct as defined by A.R.S. § 32-1401(27)(j) in his treatment of LB; and,  
25 as defined by A.R.S. § 32-1401(27)(q) in his treatment of patients RSH, JJ and GVJ.



1           9. Drs. Sems, Hanson, Anand, and Scheerer all testified that they could not easily  
2 understand Dr. Dommissé's records. The Administrative Law Judge has studied Dr.  
3 Dommissé's patient records and finds that they support Drs. Sems', Hanson's, Anand's  
4 and Scheerer's opinions. The Board should reject Dr. Dommissé's argument that an  
5 allopathic physician must agree with his methods to understand his records; such an  
6 argument would preclude the flow of information and principled resolution of  
7 controversies within the profession.

8           10. RSH's case shows that, when a patient of Dr. Dommissé decides for  
9 whatever reason to seek a second opinion, if the subsequent physician does not  
10 understand or agree with Dr. Dommissé's care of the patient, his practice is to bully the  
11 patient. Instead of defending or explaining his care, Dr. Dommissé requires the patient to  
12 return to unquestioned acceptance to the tenets of his care, even if she continued to  
13 have worrisome symptoms, such as vaginal bleeding.

14           11. As RSH's case illustrates, a subsequent provider's inability to understand Dr.  
15 Dommissé's records undermines the continuity of care and could harm the patient. Dr.  
16 Horwitz' opinion to the contrary notwithstanding, the Board therefore has established that  
17 Dr. Dommissé violated A.R.S. § 32-1401(27)(e) in his records of his treatment of patients  
18 RSH, JTK, JMG, TLS, DLR, DFS, AMch, SHJ, AS, Jr., BSS, EML, LB, JJ, MPJ, and  
19 PAK, and that he violated A.R.S. § 23-1401(27)(q) in his records of treatment of patients  
20 RSH, JTK, JMG, TLS, DLR, DFS, AMch, SJH AS Jr., BSS, EML, JJ, MPJ, PAK, and  
21 GVJ.

22           12. The Board has established that Dr. Dommissé prescribed Seroquel to  
23 patients JTK and JMG without adequately explaining the risk of tardive dyskinesia. Dr.  
24 Dommissé's breezy explanation that "patients of nutritional physicians do not develop  
25 tardive dyskinesia" is not credible. The Board therefore has established that Dr.

1 Dommisse committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q) by  
2 prescribing Seroquel to patients JTK and JMG without adequately explaining the risk of  
3 tardive dyskinesia.

4 13. Dr. Dommisse diagnosed patients TLS and DFS with systemic candidiasis,  
5 DFS with hypoadrenaline, and DFS and AMcH with mycoplasma pneumonitis. The  
6 Board established that none of these patients' reported symptoms or laboratory results  
7 supported such diagnoses as they are understood by allopathic physicians. Dr.  
8 Dommisse's only defense, that nutritional physicians have their own definition of these  
9 established medical terms that does not comport with the definition of any other allopathic  
10 physician, is not established by this record. Dr. Dommisse's misdiagnoses may have  
11 caused these patients to take medication that they did not need or delayed accurate  
12 diagnoses of the cause of their reported symptoms. The Board has therefore established  
13 that Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-  
14 1401(27)(q) in his diagnoses of patients TLD, DFS, and AMcH.

15 14. Finally, the Board has established that Dr. Dommisse performed chelation  
16 therapy of patient LB without her informed consent. The Board therefore established that  
17 Dr. Dommisse committed unprofessional conduct as defined by A.R.S. § 32-  
18 1401(27)(gg).

19 15. With respect to the appropriate penalty, the consolidated charges in these  
20 matters, the Board's experts' reports and testimony, and Dr. Dommisse's testimony and  
21 conduct at the hearing leaves no doubt that the sole effect of the Board's decree of  
22 censure and order of probation in case no. 03A-22164-MDX was to make Dr. Dommisse  
23 more defiant and more committed to continuing the practices that have previously been  
24 determined to be unprofessional conduct. Although Dr. Dommisse may have  
25 contributions to make to the allopathic medical profession, under A.A.C. R4-16-

1 603(18)(c)(ii) and A.A.C. R4-16-604(6), he has repeatedly demonstrated that he cannot  
2 be regulated.

3 **ORDER**

4 Based on the foregoing, it is recommended that the Arizona Medical Board revoke  
5 License No. 22164 for the practice as an allopathic physician in the State of Arizona  
6 previously issued to Respondent John V. Dommissie, M.D. Pursuant to A.R.S. §32-  
7 1451(M) and A.R.S. § 41-1007, Respondent shall pay costs of the administrative hearing,  
8 not to exceed \$20,000.00 (twenty thousand dollars).

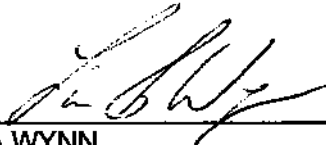
9  
10 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

11 Respondent is hereby notified that he has the right to petition for a rehearing or review.  
12 The petition for rehearing or review must be filed with the Board's Executive Director within thirty  
13 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
14 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.  
15 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
16 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)  
17 days after it is mailed to Respondent.

18 Respondent is further notified that the filing of a motion for rehearing or review is required  
19 to preserve any rights of appeal to the Superior Court.

20 DATED this 8<sup>th</sup> day of August, 2008.

21  
22 THE ARIZONA MEDICAL BOARD

23  
24 By   
25 LISA WYNN  
Executive Director

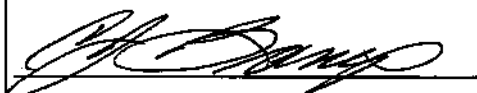


1 ORIGINAL of the foregoing filed this  
2 day of August, 2008 with:

3 Arizona Medical Board  
4 9545 East Doubletree Ranch Road  
5 Scottsdale, Arizona 85258

6 Executed copy of the foregoing  
7 mailed by U.S. Mail this  
8 day of August, 2008, to:

9 John V. Dommissie, M.D.  
10 Address of Record

11 

12 #246008

13

14

15

16

17

18

19

20

21

22

23

24

25