STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Jason Adam Dreyer
Master Case No.: M2020-990
Statement of Charges

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

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

The following information has been withheld:

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

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

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

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

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY

In the Matter of	**No. M2020-990**
JASON ADAM DREYER Credential No. DO.OP.60323732 Respondent	**STATEMENT OF CHARGES**

The executive director of the Board of Osteopathic Medicine and Surgery (Board), on designation by the Board, makes the allegations below, which are supported by the evidence contained in case no. 2019-3611. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On February 12, 2013, the State of Washington issued Respondent a credential to practice as an osteopathic physician and surgeon. Respondent's credential is currently active.

1.2 On or about August 2014 through January 2017, while performing spine surgeries on Patients A through G at Providence St. Mary's in Walla Walla, Washington, Respondent practiced below medical standards of care by performing extensive spine surgeries without clear medical indications. Specifically, Respondent overstated the Patients' diagnosis of "dynamic instability" to justify spinal fusion surgeries, overstated treatments performed during spine surgeries, and inadequately charted in Patients' records, as evidenced by the following allegations.

1.3 On or about September 15, 2016, Respondent performed spinal fusion surgery on Patient A. Patient A was a sixty-six (66) year old male with complaints of low back pain for approximately six (6) years and reports of rapidly worsening symptoms. After examining the patient and reviewing patient radiographic reports preoperatively, Respondent diagnosed Patient A with lumbar spondylolisthesis, spondylosis of L (Lumbar) 3 through S (Sacral)1 and spinal stenosis of L3-S1. Respondent recommended and performed spinal fusion surgery, specifically Extreme Lateral Interbody Fusion (XLIF) of L 3-5 and Transforaminal Lumbar Interbody Fusion (TLIF) of L5 through S1. However, radiographic imagery only indicated lumbar

spondylosis without conclusive spondylolisthesis. The accepted surgical medical standard of care for a diagnosis of lumbar spondylosis would be to perform a less invasive decompression surgery, not the more invasive spinal fusion surgery.

1.4 On or about July 29, 2015, Respondent performed spine fusion (TLIF L4-S1) surgery on Patient B. Patient B was a forty-seven (47) year old female with complaints of back and leg pain that began in 2014 after Patient B fell down approximately seven (7) steps of stairs. Respondent's preoperative notes state that symptoms worsened from onset and rated as severe and continuous. Respondent diagnosed Patient B with spondylosis and stenosis L4-S1 and recommended spine fusion surgery (TLIF L4-S1.) However, Patient B's radiographic imagery showed only very minor disc abnormalities with minimal to no spinal stenosis. Further, Respondent's surgical notes state that a laminectomy was performed for the purpose of decompression, but post-operative radiographic imagery indicated that the laminectomy was only performed at the fusion surgical site, indicating that procedure was not performed for the purpose of decompression. Performing spine surgery on a patient with minor disc abnormalities minimal spinal stenosis is not within the medical standard of care.

1.5 On or about August 11, 2014, Respondent performed spine surgery (TLIF L3-S1) on Patient C. Patient C was a thirty-four (34) year old male with back and leg pain for approximately 6 (six) years. Patient C described back and leg pain as an "aching sensation." Respondent's preoperative notes diagnoses included spondylolisthesis, spondylosis, and stenosis with recommended multi-level surgery. However, the preoperative radiographic imaging only indicated a very mild disease, indicating a disc bulge with possible impingement of S1 nerve and mild degenerative disc and facet changes at L3-5. Performing invasive multi-level surgery on a patient with minor spine abnormalities and is not within the medical standard of care.

1.6 On or about August 25, 2016, Respondent performed spinal fusion surgery (L2-3) on Patient D. Patient D was a fifty-five (55) year old male with complaints of lower back pain and right leg numbness from a work-related lifting injury sustained in December 2015. Respondent's preoperative diagnoses included spondylolisthesis at L2-3 and spinal stenosis at L2-3 with recommendation for a L2-3 spinal fusion. However, a preoperative MRI completed on or about April 20, 2016, did

not support a diagnosis of either spondylolisthesis or stenosis, noting only multilevel degenerative changes with no instability. During a postoperative visit, Respondent charted that the patient continued to have pain on both sides of his legs. On or about January 3, 2017, Respondent performed a decompression laminectomy at L3-S2. Operative notes for this procedure state that Patient D did not have instability at L5-S1 during intraoperative testing. Performing spinal fusion surgery without evidence of instability is not within the medical standard of care.

1.7 On or about February 25th and July 30th, 2015, Respondent performed spinal fusion surgeries on Patient E. Patient E was a forty-eight (48) year old male with complaints of back and leg pain for approximately seven (7) months prior to his initial presentation.

A. Respondent's preoperative diagnoses for the first surgery on 1/25/2015 included spondylosis L4-5, L5-S1 and stenosis L4-5, L5-S1, noting "dynamic instability" of the spine. The first surgery performed was a Level 3 Anterior Cervical Discectomy and Fusion (ACDF), laminectomies at L5-S1and a facetectomy at the L4-5 level on the right side. However, preoperative radiographic imagery indicated only disc degeneration and narrowing at L5-S1 with no spinal stenosis noted. Further, postoperative imaging dated February 25, 2015 shows no evidence of a facetectomy procedure.

B. On or about July 30, 2015, Respondent performed an C4-7 ACDF (Anterior Cervical Discectomy and Fusion) surgery on Patient E. Respondent's preoperative diagnoses included cervical kyphosis, spondylosis and stenosis. However, preoperative radiographic imaging did not support this diagnosis.

C. Performing multiple cervical spine surgeries on a patient without clear indication of instability is not within the medical standard of care.

1.8 On or about November 6, 2014, Respondent performed cervical spine surgery (2 Level ACDF) on Patient F. Patient F was a forty-one (41) year old female with complaints of neck and arm pain and weakness that started after a slip and fall accident in December 2013. Preoperatively, the patient was diagnosed with a disc

bulge at C6-7 and with a C6 and C7 radiculopathy. However, preoperative radiographic imaging indicated only a small central disc bulge at C6-7 with no stenosis or instability. Performing cervical spine surgery on a patient without a clear indication of instability is not within the standard of care.

1.9 On or about September 24, 2015, Respondent performed spinal surgery on Patient G. Patient G was a forty-three (43) year old female, morbidly obese, with complaints of low back pain and left thigh numbness for approximately five (5) years, and with symptoms worsening over the past three (3) months. Respondent diagnoses included spondylolisthesis at L4-5 and spondylosis at L5-S1 with recommended lumbar surgery (Level 2 ACDF). However, preoperative radiographic imaging did not indicate any instability or any significant pathology. Performing lumbar surgery on a morbidly obese patient without clear indications of instability or pathology is not within the medical standard of care.

1.10 Respondent's charting for Patient A-G was inadequate, with a demonstrated pattern of "cut and paste" template language in patients' charts.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), and (13), which provide in part:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;
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> …
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of

a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

…

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

… .

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

3. NOTICE TO RESPONDENT

The charges in this document affect the public health and safety. The executive director of the Board directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline pursuant to RCW 18.130.180 and the imposition of sanctions under RCW 18.130.160.

DATED: March 5, 2021

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE
AND SURGERY

RENEE FULLERTON
EXECUTIVE DIRECTOR

ROBERT W. FERGUSON
ATTORNEY GENERAL

KRISTIN G. BREWER, WSBA #38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

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

Patient A: [redacted]

Patient B:

Patient C:

Patient D:

Patient E:

Patient F:

Patient G: