I Certify that this is a true and correct copy of the document on file with the State of Washington, Departme of Health, Adjudicative Clerk Office.

19 day of Sept, 2006

Signature, Authorized Representative

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Charles Momah, MD
Docket No.: 03-01-A-1015MD
Document: Final Order

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

The following information has been withheld:

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

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

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

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

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of **CHARLES MOMAH, MD** License No. MD00030669 Respondent.	**Docket No. 03-01-A-1015MD** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER**

The Medical Quality Assurance Commission ('Commission'), by and through Michael L. Farrell, Department of Health Staff Attorney, and Respondent, Charles Momah, MD, represented by counsel, John C. Versnel, III, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

1.1 Respondent is licensed to practice as a physician and surgeon in the state of Washington.

1.2 On June 17, 2003, the Commission issued the original Statement of Charges in Docket No. 03-01-A-1015MD. The charges have been amended, and on August 13, 2004 the Commission issued the 4th Amended Statement of Charges against Respondent. The Order on Summary Suspension dated September 10, 2003 summarily suspended Respondent's license to practice medicine and Respondent did not contest the summary suspension.

1.3 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(1), -.180(4), -.180(13), -.180(20), -.180(24).

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

1.5 Respondent understands that if the allegations are proven at a hearing, the Commission has the authority to impose sanctions pursuant to RCW 18.130.160.

1.6 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.7 Respondent waives the opportunity for a hearing on the Statement of Charges provided that the Commission accepts this Agreed Order.

1.8 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.9 Respondent understands that this Agreed Order is not binding unless and until it is signed and accepted by theCommission.

1.10 If the Commission accepts this Agreed Order, it is subject to the federal reporting requirements pursuant to Section 1128E of the Social Security Act and 45 CFR Part 61, RCW 18.130.110 and any other applicable interstate/national reporting requirements. It is a public document and will be available on the Department of Health web site.

1.11 If the Commission rejects this Agreed Order, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order presentation.

Section 2: FINDINGS OF FACT

Without admitting the allegations herein, and specifically denying any criminal conduct, the Respondent acknowledges the following allegations and, for the purposes of this proceeding only, does not dispute them.

2.1 Charles Momah, MD, Respondent, was issued a license to practice as a physician and surgeon by the state of Washington in March 1993. Respondent's license is currently active and suspended, subject to the Order on Summary Suspension dated September 10, 2003.

2.2 In May 2001, Respondent filled out a re-credentialing application form with a healthcare provider network. The form contained an attestation clause signed by Respondent, certifying all of the answers on the application are complete, accurate and current. The application contained information that was knowingly false.

2.3 On or about May 2001, Respondent saw Patient One, a 21 –year-old female, and in July 2001 performed a diagnostic laparoscopy and hysteroscopy for abnormal uterine bleeding. Patient One's primary care provider had opined she had irritable bowel syndrome. Patient One had episodic health insurance coverage (mostly Medicaid) during her treatment time with the Respondent and by September of 2002,

owed him over eight thousand dollars. Respondent prescribed narcotics for Patient One during this time including morphine tablets.

2.4 In July of 2002, Respondent noted Patient One was pregnant. Patient One delivered that infant in November of 2002.

2.5 Patient One returned to Respondent's care in February of 2003. Respondent performed seven transvaginal ultrasounds on Patient One from February 2, 2003 through July 30, 2003. Respondent prescribed Percocet and Xanax for her pelvic pain and indicated she had ruptured ovarian cysts. Respondent's records state that he was discussing her "drug addiction problem" with her but continued to prescribe Percocet and Xanax.

2.6 In April of 2003, Respondent's progress notes indicate that he referred Patient One to Swedish Hospital for inpatient treatment of her addiction. However, Respondent continued to prescribe Percocet and Xanax. Respondent also provided Patient One with his cell phone number in case she needed him.

2.7 Respondent saw Patient One on June 30, 2003, and again prescribed Percocet.

2.8 On July 7, 2003, Respondent saw Patient One and according to his progress notes engaged in a detailed discussion about her "drug addiction and drug seeking behavior." The note also indicates that Respondent told Patient One to seek another provider.

2.9 On July 30, 2003, Respondent saw Patient One again for pelvic pain, performed a transvaginal pelvic ultrasound and endometrial biopsy, and ordered blood work. He also gave her another prescription for Percocet.

2.10 August 12, 2003, Patient One called Respondent telling him that she was having more abdominal pain and needed contraception. He told her to come to the office at 6 p.m. When Patient One saw Respondent she told him she wanted emergency contraception because she had unprotected intercourse with her boyfriend on August 11. Respondent gave Patient One prescriptions for Percocet, Valium, and four birth control pills. He then had her change into an exam gown. Respondent did a transvaginal ultrasound and then began a manual exam. Patient One felt Respondent massage her clitoris and recognized that the pelvic exam was not proceeding normally.

2.11 Respondent pulled down his pants and underwear and got on top of Patient One. He placed his penis inside her. When Patient One asked Respondent what he was doing, he said, "You know you want it." Patient One told Respondent to stop and get off. The assault lasted about ten minutes until Respondent ejaculated. Respondent then got off of Patient One, pulled up his pants, told her to come into his office, and left the room.

2.12 Patient One wiped off Respondent's semen with her panties and got dressed. After putting her clothes back on, she met with Respondent in his office. Respondent threatened Patient One that if she reported the event to the police, he would reveal her history of narcotic dependence and her child would be taken away from her.

2.13 In April 2001, Respondent evaluated Patient Two, age 36, for treatment of irregular and painful menses. Patient Two delivered her fourth baby in February 2001 by cesarean section (c-section). During the pregnancy, cervical cerclage was performed to prevent prematurity. After delivery, there were complications of endometritis and abdominal wound cellulitis.

2.14 On April 23, 2001, Respondent performed surgery for a diagnostic laparoscopy and hysteroscopy on Patient Two. Respondent did not obtain and review the patient's prior medical records from her other providers. Respondent did not evaluate any other organ systems as a possible source of the patient's pain. Complications of the surgery were uterine perforation treated by placement of Surgicil. Other complications were increased vaginal bleeding and pelvic pain. Respondent performed surgery on Patient Two only two months after the patient had a c-section, which also entailed excessive bleeding. There were no acceptable indications for hysteroscopy presented; on the contrary, hysteroscopy was contraindicated in this patient. No certified ultrasound examinations were recorded.

2.15 On May 17, 2001, Respondent scheduled a laparoscopy and hysterectomy on Patient Two for indications of enlarged uterus and adenomyosis. Respondent failed to prepare for the surgery by reviewing the patient's records from her c-section. Vaginal hysterectomy for this patient was contraindicated because of the combination of recent cesarean section, post partum endometritis, abdominal wound infection, and recent uterine perforation by hysteroscopy. Respondent did not provide sufficient information for this patient to form an informed consent to the surgery Respondent proposed.

2.16 During the last surgery on May 17, 2001, Respondent failed to identify the source of Patient Two's complicating excessive bleeding and did not effectively stop it prior to the end of the operation. Blood replacement was inadequate during the immediate postoperative period. Later, shock from blood loss developed. Hospital staff initiated life-saving emergency measures during a period when the Respondent could not be reached. Respondent's actions delayed the Patient's return to surgery and needlessly exposed her to the risk of exsanguination.

2.17 Pathology results failed to confirm Respondent's justification for the hysterectomy on Patient Two, which showed the patient's uterus was not enlarged. Respondent did not dictate his operative report for five days, and did not dictate his discharge summary for twenty-one days. Respondent discharged Patient Two from the hospital while she still had a temperature of 102F.

2.18 Patient Three was a 46-year-old woman with complaints of abdominal pain. Respondent performed a total abdominal hysterectomy, lysis of adhesions, and bi-lateral salpingo-oophorectomy on Patient Three on May 19, 2001, only two months after she had her ruptured appendix removed on March 13, 2001. The patient had not had time to fully resolve the inflammatory process from the ruptured appendix. Respondent's notes from the March procedure noted a left ovarian cyst, but his notes from the May procedure puts the cyst on the right side. Pathological results did not confirm Respondent's basis for diagnosing this patient with an enlarged uterus.

2.19 Patient Three visited the emergency room soon after her surgery because she developed wound infection and superficial dehiscence. Respondent did not acknowledge the seriousness of the wound, despite the fact that the patient had post-operative follow-up care to attend the wound for several weeks.

2.20 Patient Four was a 23-year-old woman who had a c-section in 1997. Respondent had been her physician for several years when he saw Patient Four in July 2000 for complaints of abdominal pain and bleeding. Respondent recommended and performed a laparoscopy, lysis of adhesions, hysteroscopy, and D&C on or about July 21, 2000. Patient Four lacked clear indications for hysteroscopy based only on a history of pelvic pain and irregular bleeding.

2.21 Patient Four arrived at the hospital at 0555 hours on April [redacted] 2001 for delivery of her baby for a possible vaginal birth after cesarean (VBAC). The patient began to have difficulty soon after her arrival. Respondent was called and paged, but he did not arrive at the hospital to attend the patient until 1204 hours. Respondent then left the hospital while his patient was in imminent labor. In the absence of GBS test results before the patient's due date, Respondent ordered Ampicillin; Penicillin allergy was listed in the chart.

2.22 In July 2001 Patient Four returned to the hospital for a laparoscopy and hysteroscopy. Pathological results failed to confirm Respondent's indications for these procedures. There is no record that Respondent fully informed Patient Four of the possible complications of the procedure. Respondent did not rule out other pathology including malignancy, pelvic infection, organic disease, complications from her two c-sections, or other causes. The time interval between the patient's pregnancy and her complaints was too short to justify surgical evaluation.

2.23 Patient Five, age 23 was the Respondent's patient for five years, beginning in 1997. Her two cesarean sections were in 1997 and 1999, with a bilateral tubal ligation in February 1999 at age 21. Afterward, she complained of persistent right lower abdominal pain. Respondent listed endometriosis as the cause of her pelvic pain. Endometrial biopsy was normal. In August 2000, Respondent diagnosed her with an enlarged uterus and recommended a laparoscopy and hysteroscopy. There was no indication for a diagnostic hysteroscopy; the Respondent's efforts to treat the patient's condition medically were inadequate.

2.24 Patient Five returned on September 28, 2000 for a D&C, hysteroscopy and laparoscopy. After the procedure, Patient Five continued to have pain. Respondent recommended a hysterectomy, despite a lack of evidence to support the recommendation. Respondent's diagnosis was pelvic pain and abnormal uterine bleeding, but there was little history concerning the bleeding other than she was amenorrheic.

2.25 Vaginal hysterectomy on Patient Five was very difficult. This could have been predicted on the basis of the risk factors listed. During the first night in hospital, Patent Five was returned to the operating room to stop bleeding and to receive four units

of blood replacement. No evidence of endometriosis was found and the uterus was not as large as suspected. Respondent stated that he met with the patient and her husband to discuss a hysterectomy, but there is no record of this meeting in the chart.

2.26 Patient Six, age 22, was diagnosed with a twin pregnancy in October 2000. She had been seeing Respondent for fertility treatment. She had a history of miscarriages. During one of her admissions for preterm labor, ultrasound noted the twin pregnancy to be monoamniotic and monochorionic. This finding classified her as high risk. Respondent should have referred this patient to a hospital with a perinatology service and Level III nursery.

2.27 On February [redacted] 2001, Patient Six presented to Labor and Delivery at approximately 2000 hours in pre-term labor and complaining of chest tightness. Respondent should have attended this patient as soon as it was apparent she was in labor. Respondent delayed his one visit until 1000 hours February [redacted] 2001. Respondent should have promptly referred her to a tertiary care center for specialized management.

2.28 Patient Seven, age 24, was Respondent's patient beginning in 1999. She presented with symptoms of heavy menstrual bleeding and abdominal pain. The patient was started on Clomid at the very first visit without clear documentation of the indication. Respondent initially recommended both a laparoscopy and a hysteroscopy. There was little, if any, indication for a laparoscopy and none for a hysteroscopy. Respondent did not follow or monitor the patient while she was taking Clomid.

2.29 Patient Seven went to Respondent's office in September 2002 for a scheduled laparoscopy and hysteroscopy. She became concerned about conditions in Respondent's office and declined to proceed with the procedures. The Respondent attempted to coerce Patient Seven to have the surgery by telling her she could not get pregnant unless she had a laparoscopic procedure performed. The patient left before the surgery was started. Respondent put the patient at risk of harm by attempting to carry out a laparoscopy and hysteroscopy in an uncertified office surgical facility with inadequate facilities and equipment and at a time when he did not have hospital privileges or a transfer agreement with a hospital.

2.30 Patient Eight, age 19, began medical care with Respondent at age 16, in December 2000 for contraceptives. She was only four months post-partum. Respondent

prescribed 150 mg Depo-Provera, which most likely lead to irregular bleeding and some pain. In March 2001 Respondent performed a D&C and hysteroscopy without any indication of an intrauterine mass. The laparoscopy was also not indicated in this patient, only seven months post-partum and only sixteen years old.

2.31 Patient Eight returned to see Respondent for prenatal care with her second pregnancy. Respondent did not have hospital privileges and did not arrange for continuity of care of this very young patient. Respondent did not have any formal or informal arrangement with a physician or midwife to perform the hospital care. There was no coordination of the patient's care or transfer of records.

2.32 Patient Nine, age 30, sought care with Respondent for pregnancy and delivery. The patient believed her pregnancy was high risk. Respondent put this patient at risk because he did not have hospital privileges or an arrangement with a practitioner to perform the delivery. Respondent did not inform the patient that he could not take care of her in the case of complications requiring hospitalization or for final delivery. Respondent performed medically unnecessary ultrasounds on the patient that did not benefit the patient.

2.33 Respondent did not respect Patient Nine's privacy when she was dressing. He attempted to engage her in a social relationship by calling her without medical basis and asking her to join him for lunch.

2.34 Patient Ten, age 40, began medical care with Respondent in 1994 for pelvic pain and fertility treatment. Over the period 1996 to 2003, Respondent performed seven laparoscopies and two laparotomies, all of them medically unnecessary and not for the benefit of the patient. Respondent performed ultrasounds that were medically unnecessary.

2.35 Respondent performed pelvic exams on Patient Ten that included sexualized touching of the Patient's clitoris and vagina. Respondent used a transvaginal ultrasound to sexually stimulate the patient. He asked the patient permission to insert his penis in her during the course of a medical exam. Respondent's intent to sexualize the patient's exams was demonstrated by his sexual comments during the exam, sexually caressing the patient's breasts, kissing her, calls to the patient's home between visits for dates, and offering to exchange narcotic drugs for sexual contact.

2.36 Patient Eleven, age 46, first saw Respondent in 1997 for pregnancy and delivery and later for pelvic pain. In 1998, Patient Eleven [redacted] continued seeing him as a patient. Although Respondent diagnosed the patient with ovarian cysts, the repetitive ultrasounds Respondent performed on Patient Eleven were medically unnecessary to monitor or treat this condition. Respondent performed laparoscopies in November of 2000 and March of 2001. The March 2001 laparoscopy was not medically indicated so soon after the one Respondent had performed in November 2000.

2.37 Respondent failed to take necessary diagnostic steps for Patient Eleven's headaches and visual disturbances. Appropriate diagnostic steps would include an MRI or CT scan to ascertain the cause of the patient's condition and treat it correctly. Respondent did not record evidence that he counseled the patient about the side effects of bromocriptine medication that he prescribed for her elevated pituitary hormone levels.

2.38 In 1998, Respondent started to make sexual comments to Patient Eleven. After hearing about her marital problems he told her, "We can do it," (meaning we can have sex) and, "I can make you feel good." On one occasion, Respondent asked Patient Eleven to [redacted] Respondent then sent the [redacted] employees home. Respondent called Patient Eleven into his office. He grabbed her arm and said, "You know you wanted it and I can make you feel good. Nobody needs to know about this." Respondent exposed his penis and pushed Patient Eleven's head down trying to get her to perform oral sex. Respondent pushed his penis into her mouth and after some minutes ejaculated. Respondent then told Patient Eleven to go into the operating room. Respondent told Patient Eleven to take her clothes off and get onto the table. When Patient Eleven got onto the table, Respondent had intercourse with her. Respondent told her that if she told anyone he would see that her child would be taken away, and that no one would believe her because she was receiving prescription narcotics. Respondent told Patient Eleven he had written in her patient chart that she was a "drug seeker" and that no one would believe her.

2.39 Patient Twelve, age 32, began seeing Respondent in 1996 for routine gynecological care. Respondent performed medically unnecessary laparoscopies, ultrasounds, and hysteroscopies without any benefit to the patient. Patient Twelve had a

left oophorectomy performed in Respondent's uncertified office operating room in July 2003. Respondent did not have hospital privileges at the time, therefore Respondent could not admit this patient or provide continuity of care if there were complications in surgery or later during the recovery period. Respondent's operating room lacked the facilities and equipment required to perform the surgical procedures he performed on Patient Twelve safely.

2.40 Respondent prescribed narcotic pain medications for Patient Twelve's pelvic pain from at least 1998. After learning the patient was obtaining narcotics from other providers, Respondent continued to prescribe narcotics for the patient.

2.41 Patient Thirteen, age 39, began seeing Respondent for fertility treatments and gynecological care. Respondent performed ultrasounds while she was pregnant that were not medically necessary. Respondent performed a laparoscopy in January 2003, that was not medically necessary.

2.42 Respondent provided obstetric and prenatal care to Patient Thirteen and did not inform Patient Thirteen that his hospital privileges were revoked; instead, he misrepresented his status to her. This misrepresentation put the patient at risk because he had no transfer of records or continuity of care protocol in place should the patient develop a complication or need to be admitted to the hospital.

2.43 Respondent billed insurance for an outpatient surgery on Patient Thirteen dated July 17, 2003. The patient did not have a surgery on that date, Respondent was paid for the surgery, and Respondent did not return the money paid to him.

2.44 Respondent did prenatal blood tests on Patient Thirteen and the results indicated her iron level was low. Respondent did not put her on prenatal vitamins.

2.45 Patient Fourteen, age 29, began seeing Respondent in approximately June 2001, for complaints relating to fertility and pelvic pain. Respondent performed medically unnecessary ultrasounds. Respondent performed an emergency laparoscopy in February 2003 in his uncertified office operating room. This procedure was not medically necessary, and performing the procedure in his office operating room without adequate facilities, equipment or hospital privileges put the patient at risk of harm.

2.46 Patient Fifteen, age 28, began seeing Respondent in February 2003 for pelvic pain and reversal of her tubal ligation. Respondent performed medically

unnecessary laparoscopy surgeries in February and March 2003. Patient Fifteen saw Respondent on March 30, 2003, for tubal reversal. Respondent did not have hospital privileges, and he performed this open procedure at his uncertified office operating room without appropriate facilities or equipment.

2.47 Respondent dictated two different operative reports for the March 30, 2003, surgery on Patient Fifteen. One operative report reflects the tubal repair with a laparoscopy, and the other does not mention the tubal repair. Respondent used the second operative report to obtain insurance payment for the laparoscopy procedure while also collecting $3,000 from the patient for the tubal repair which he told Patient Fifteen that her insurance would not cover. The patient paid $1000 and agreed to make payments. While the patient was in recovery, Respondent refused to allow her husband to see her until he had paid an additional $500 that was paid to the anesthetist.

2.48 Patient Fifteen became pregnant after the tubal reversal. Respondent performed medically unnecessary ultrasounds. Respondent told Patient Fifteen she might have an ectopic pregnancy. On August 28, 2003, Respondent performed open surgery in his uncertified office operating room to remove the patient's ectopic pregnancy. In addition to the risks associated with Respondent's lack of hospital admitting privileges and his inadequate operating room, this procedure put the patient in danger because there was a significant risk of bleeding, and the Respondent had no ability to give the patient blood.

2.49 Patient Sixteen, age 26, began visiting Respondent in April 2002 for treatment of irregular menstrual cycles. The patient had not been able to become pregnant and she was also seeking fertility treatment. She chose the Respondent because he was the only physician she could find who would accept her medical coupons. After several visits, Respondent began probing the patient's personal life, asking questions about her past sexual activity, and preferred sexual positions. Respondent told her he was attracted to her sexually, made unwanted comments about her private parts, and touched her breasts. Respondent called Patient Sixteen's mobile phone repeatedly and asked Patient Sixteen out on dates, which she declined.

2.50 During one of many vaginal ultrasounds Respondent performed on Patient Sixteen, he used the instrument in a manner she felt was intended to sexually stimulate

her. In May 2003, Respondent performed a pelvic exam on Patient Sixteen without a latex barrier glove, because he said he could not feel her cervix through the glove.

2.51 Patient Seventeen, age 36, began seeing Respondent in December 1999 for treatment of fibromyalgia, chronic fatigue syndrome, and ovarian cysts and fibroids which caused pain and irregular bleeding. Patient Seventeen sought out Respondent because she wanted to find a physician who would prescribe the Prozac and Phentermine she believed she needed for her fibromyalgia. The Respondent wrote those prescriptions for her at her first visit and continued to prescribe those drugs. In April 2000, the patient discussed weight control issues with Respondent. Respondent did full pelvic examinations and vaginal ultrasound examinations at every visit. Respondent never checked Patient Seventeen's blood pressure during her visits. Patient Seventeen researched other drugs when she believed that Prozac was causing her difficulties. She told Respondent she thought she should try Paxil, and Respondent wrote her a prescription for it. Respondent asked the patient intimate and irrelevant questions about her sex life and insisted that women her age must have an active sex life to avoid medical consequences. Respondent asked her to have an affair with him. She declined, and he called her at home three days later to ask if she reconsidered his offer. She declined again.

2.52 Patient Eighteen, age 35, began seeing Respondent in April 2002 for treatment of irregular menses and infertility. After a few visits, Respondent began flirting with the patient. He asked her to have sex with him and began unwanted fondling of her genitals and breasts during exams that seemed to the patient to be longer than necessary. Respondent required these examinations and vaginal ultrasounds at every visit. Respondent used an ultrasound instrument to sexually stimulate the patient on several visits. Patient Eighteen believed Respondent did this sexual stimulation intentionally. Respondent removed his latex barrier gloves during a pelvic exam; when the patient noticed this Respondent said, "this will only take a few minutes."

2.53 Patient Nineteen, age 25, visited Respondent November 15, 2002, to consider whether to establish pre-natal care during her pregnancy. Respondent told her that she needed to see him instead of a midwife. Respondent told her he had no hospital privileges to deliver a baby, but that he would by the time she delivered. After informing

the patient he would not do an exam because his nurse was not in the office, Respondent had Patient Nineteen disrobe and he performed a vaginal ultrasound, abdominal ultrasound, breast exam, and manual exam. The patient would have required a chaperone if she understood the extent of the exam the Respondent was going to do, but she understood a chaperone was not available.

2.54 Respondent told Patient Nineteen he could not confirm her pregnancy. She was requested to have a pregnancy test at a local hospital. Respondent called the patient's home and left a message on her answering machine with her test results, and requesting that she return to his office. A family member picked up the message off the answering machine. She had not yet informed her family that she was pregnant.

2.55 Patient Nineteen called Respondent's office soon after the first visit and informed them that she had decided not to obtain further care from Respondent. Six months later Respondent sent the patient a bill for the visit and exams. Patient Nineteen asked for a copy of her chart. Respondent's office staff informed her of his policy that charts would not be released until the bill was paid. After attempting to dispute the bill, the patient eventually paid it. Respondent's staff continued to contact the patient to schedule appointments despite her request not to do so.

2.56 The Commission conducted a practice review of the Respondent's offices, exam rooms, and practice procedures. Findings from the in-person inspection of his practice indicate that Respondent does not have staff trained to clean and sterilize instruments; does not have any backup or call coverage; does not have hospital admitting privileges at any facility; does not have qualified nursing staff attending to patients in the office; and does not have a certified or otherwise qualified ambulatory surgical center to conduct outpatient surgeries.

2.57 On or about November 16, 2005, Respondent was convicted of Rape in the Third Degree, two counts of Indecent liberties, and Rape in the Second Degree after a jury trial in King County Superior Court, Docket No. 04-1-05925-KNT. All four victims were, at the time of the criminal acts, Respondent's patients. Respondent was sentenced to twenty years in prison.

Section 3: CONCLUSIONS OF LAW

The State and Respondent agree to the entry of the following Conclusions of Law:

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

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), -.180(4), -.180(13), -.180(17), -.180(20), -.180(24).

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

Section 4: AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order:

4.1 Respondent, Charles Momah, MD, agrees that his license to practice medicine in the state of Washington is REVOKED. Respondent has no right to petition for reinstatement, to reapply for a license, or to practice pursuant to an exemption in RCW 18.71.030. Respondent further agrees that he will not return to practice or apply for a license to practice medicine in any other state or province. Respondent agrees to immediately return to the Department all copies of current credentials, if he has not already done so.

4.2 Respondent is responsible for all costs of complying with this Agreed Order.

Section 5: ACCEPTANCE

I, Charles Momah, MD, Respondent, have read, understand, and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.

CHARLES MOMAH, MD
Respondent

6/16/06
Date

John C. Versnel, III, WSBA#
Attorney for Respondent

6-16-06
Date

Section 7: ORDER

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

DATED: 06-19, 2006

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE
COMMISSION

R. H. Ruvalcaba MD
PANEL CHAIR

Presented by:

(wsba #16123) for
Michael Farrell, WSBA #16022
DEPARTMENT OF HEALTH STAFF ATTORNEY

6/16/06
Date

FOR INTERNAL USE ONLY: PROGRAM NO. 00-11-0001MD, 01-10-0029MD, 02-12-0018MD, 02-11-0019MD, 02-12-0083MD, 03-08-0025MD, 03-01-0067MD, 03-09-0066MD, 03-09-0044MD, 03-10-0044MD, 03-09-0045MD, 03-09-0018MD, 03-09-0061MD, 03-09-0067MD, 03-09-0080MD, 03-09-0096MD, 03-09-0120MD, 03-10-0106MD.