WASHINGTON
Medical Commission

Licensing. Accountability. Leadership.

Business Meeting
October 11, 2024

FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

DISCLAIMER: THE BELOW HEARING SCHEDULE IS SUBJECT TO CHANGE.

Hearing Date	Respondent	Case No.	Location
October 2024			
October 15-16	Shibley, Eric, MD	M2018-443	Virtual
November 2024			
November 18-20	Hammel, James F., MD	M2023-493	TBD
December 2024			
December 6	O'Neill, Jay, PA	M2024-231	TBD
January 2025			
January 14-17	Benson, David, MD	M2022-721	TBD
January 24	Smith, Steven, MD	M2022-722	TBD
February 2025			
February 10-13	Jackson, Ricky, MD	M2022-491	TBD

Information on how to observe a hearing can be obtained from the Adjudicative Clerk Office, (206) 391-5193.

2024 Meeting Schedule

WASHINGTON
Medical Commission
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Date & Time	Location	Meeting Type
January 4 **10 am – 11 am**	Virtual	Policy Committee
January 11 **8:30 am – 5 pm**	Virtual	Case Disposition Personal Appearances
January 19 **9am – 11 am**	Virtual	Business
March 7 **8:30 am – 5 pm**	Hilton Garden Inn Olympia 2101 Henderson Park Lane SE Olympia, WA 98501	Case Disposition Personal Appearances
March 21 **10 am – 11 am**	Virtual	Policy: Interested Parties
April 11 **10 am – 11 am**	Virtual	Policy Committee
April 26 **9 am – 11 am**	Virtual	Business
May 2, 2024 **8:30 am – 5 pm**	Hilton Garden Inn Olympia 2101 Henderson Park Lane SE Olympia, WA 98501	Case Disposition Personal Appearances
June 6 **10 am – 11 am**	Virtual	Policy: Interested Parties
June 13 **8:30 am – 5 pm**	Hilton Garden Inn Olympia 2101 Henderson Park Lane SE Olympia, WA 98501	Case Disposition Personal Appearances
June 27 **4 pm – 5 pm**	Virtual	Policy Committee
July 11 **8:30 am – 5 pm**	Virtual	Case Disposition Personal Appearances
July 19 **9 am – 11 am**	Virtual	Business
September 5 **10 am – 11 am**	Virtual	Policy: Interested Parties
September 12 **8:30 am – 5 pm**	Capital Event Center 6005 Tyee Drive SW Tumwater, WA 98512	Case Disposition Personal Appearances

Updated: June 5, 2024

Date & Time	Location	Meeting Type
September 26 **4 pm – 5 pm**	Virtual	Policy Committee
October 4 **8:00 am – 5 pm**	Radisson Seattle Airport 18118 International Blvd. Seattle, WA 98188	Commissioner Retreat
October 11 **9 am – 11 am**	Virtual	Business
November 14 **8 am – 5 pm**	Virtual	Case Disposition Personal Appearances
December 5 **10 am – 11 am**	Virtual	Policy: Interested Parties

Updated: June 5, 2024

2025 Meeting Schedule

January

S	M	T	W	T	F	S
			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
26	27	28	29	30	31	

1	New Years Day	Holiday – Offices Closed	
2	Policy Committee	4 pm	Virtual
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
10	Committees/Workgroups	8:30 am	Virtual
10	Business	9:30 am	Virtual
10	Lunch & Learn	Noon	Virtual
20	Martin Luther King Day	Holiday – Offices Closed	
30	Policy: Interested Parties	10 am	Virtual

February

S	M	T	W	T	F	S
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2	3	4	5	6	7	8
9	10	11	12	13	14	15
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17	President's Day	Holiday – Offices Closed	
27	Policy Committee	4 pm	Virtual

March

S	M	T	W	T	F	S
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16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

9	Personal Appearances	8:30 am	Hybrid Location: TBD
9	Case Disposition	10:45 am	
10	Committees/Workgroups	8:30 am	
10	Business	9:30 am	
10	Lunch & Learn	Noon	
27	Policy: Interested Parties	10 am	Virtual

2025 Meeting Schedule

April

S	M	T	W	T	F	S
		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	26
27	28	29	30			

Date	Meeting	Time	Location
17	Commissioner Retreat	8 am	Hilton Seattle Airport 17620 Intl. Blvd.
18	SMART Training	8:30 am	
24	Policy Committee	4 pm	Virtual

May

S	M	T	W	T	F	S
				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	26	27	28	29	30	31

Date	Meeting	Time	Location
8	Personal Appearances	8:30 am	Hybrid Location: TBD
8	Case Disposition	10:45 am	
9	Committees/Workgroups	8:30 am	
9	Business	9:30 am	
9	Lunch & Learn	Noon	
26	Memorial Day	Holiday – Offices Closed	

June

S	M	T	W	T	F	S
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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Date	Meeting	Time	Location
19	Juneteenth	Holiday – Offices Closed	
26	Policy: Interested Parties	10 am	Virtual

July

S	M	T	W	T	F	S
		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	26
27	28	29	30	31		

Date	Meeting	Time	Location
4	Independence Day	Holiday – Offices Closed	
10	Personal Appearances	8:30 am	Virtual
10	Case Disposition	10:45 am	Virtual
24	Policy Committee	4 pm	Virtual

2025 Meeting Schedule

August

S	M	T	W	T	F	S
					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	26	27	28	29	30
31						

21	Personal Appearances	8:30 am	Hybrid Location: TBD
21	Case Disposition	10:45 am	
22	Committees/Workgroups	8:30 am	
22	Business	9:30 am	
22	Lunch & Learn	Noon	

September

S	M	T	W	T	F	S
	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	26	27
28	29	30				

1	Labor Day	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

October

S	M	T	W	T	F	S
			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
26	27	28	29	30	31	

2	Personal Appearances	8:30 am	Virtual
2	Case Disposition	10:45 am	Virtual
30	Policy Committee	4 pm	Virtual

2025 Meeting Schedule

November

S	M	T	W	T	F	S
						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	26	27	28	29
30						

11	Veterans Day	Holiday – Offices Closed	
20	Personal Appearances	8:30 am	Hybrid Location: TBD
20	Case Disposition	10:30 am	
21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	
27	Thanksgiving Day	Holiday – Offices Closed	
28	Native American Heritage Day	Holiday – Offices Closed	

December

S	M	T	W	T	F	S
	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	26	27
28	29	30	31			

25	Christmas	Holiday – Offices Closed

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) Spring Conference	TBA (Usually last week of April)	TBA
Washington State Medical Association (WSMA) Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA (Usually October)	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	TBA (Usually 2nd Week of January)	TBA
Federation of State Medical Boards (FSMB) Annual Conference	April 25-26, 2025	Seattle, WA
CLEAR Annual Conference	TBA (Usually mid-September)	TBA
FSMB Board Attorneys Workshop	Tentative: November 6-7	TBA

Business Meeting Agenda
October 11, 2024

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Department of Health, Washington Medical Commission (WMC) meetings. This agenda is subject to change. The Business Meeting will begin at 9:00 am on October 11, 2024, until all agenda items are complete. The WMC will take public comment at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Virtual via Teams Webinar: Registration links can be found below.
Commissioners and staff will attend this meeting virtually.
Physical location: Department of Health, 111 Israel Rd SE, TC2 Rm 166, Tumwater, WA

Time	Friday – October 11, 2024
Open Session	
9:00 am	Business Meeting

Register for this meeting at: WMC Rules Hearings & Business Meeting

1.0 Chair Calls the Meeting to Order

2.0 Public Comment

The public will have the opportunity to provide comments. If you wish to speak, please use the Raise Hand function, and you will be called upon. Keep your comments brief, and when the Chair opens the floor, state your name and, if applicable, the organization you represent. If you would prefer to submit written comments, send them to amelia.boyd@wmc.wa.gov by October 4, 2024. ***Please do not use this public comment period to address disciplinary cases or issues that the WMC is currently covering in its rulemaking or policy efforts. If you wish to comment on rules currently under development, to ensure your comments are considered as part of rulemaking, visit our "Rules in Progress" page and select the specific rule from the "Current Rules in Progress" table. We also welcome you to attend and comment at our rulemaking workshops and hearings. The schedule for these meetings can be found on our "Rules in Progress page. For feedback on WMC policies, guidelines, or interpretive statements, you may email medical.policy@wmc.wa.gov or provide verbal comments at one of the upcoming Policy: Interested Parties or Policy Committee meetings. You can find the schedule for these meetings on the Policy Meetings page. Disclaimer: The WMC accepts written comment into the record as a normal course of the Business Meeting. On a case-by-case basis, the WMC will, at its sole discretion, grant a request to verbally read a comment into the record. Comments containing profanity, discriminatory language, ad hominem attacks on Commissioners or staff, threats of violence, or discussion of active cases or litigation before or involving the WMC will not be read. The comment will still be included in the packet for consideration and awareness.***

2.1 The Chair will call for comments from the public.

3.0 Chair Report

4.0 Consent Agenda

Items listed here are considered routine agency matters and are approved by a single motion without separate discussion. If separate discussion is desired, that item will be removed from the Consent Agenda and placed on the regular Business Agenda. — Action

4.1 Agenda – Approval of the October 11, 2024 Business Meeting agenda. — Pages 9-12

4.2 Minutes – Approval of the July 19, 2024 Business Meeting minutes. — Pages 13-23

Open Sessions

Rules Hearings

9:15 am Military Spouse Temporary Permits

Register for this meeting at: WMC Rules Hearings & Business Meeting

Hearing Notice

Agenda	Presented By:	Page(s)
Housekeeping	Amelia Boyd	
Hearing opened by Presiding Officer	Karen Domino	
• Introduction		
• Call for questions regarding the rule or hearing process		
• Call for testimony from the public and interested parties regarding proposed language		
• Call for written comments		None received
• Commissioners discuss comments and proposed language		
• Vote		
CR-102 document	CR-102	24-28
Hearing closed by Presiding Officer		

9:45 am General Provisions for Opioid Prescribing

Register for this meeting at: WMC Rules Hearings & Business Meeting

This hearing will begin at 9:45 am or once the previous hearing is concluded, whichever is later.

Hearing Notice

Agenda	Presented By:	Page(s)
Housekeeping	Amelia Boyd	
Hearing opened by Presiding Officer	Karen Domino	
• Introduction		
• Call for questions regarding the rule or hearing process		
• Call for testimony from the public and interested parties regarding proposed language		
• Call for written comments		29-57
• Commissioners discuss comments and proposed language		
• Vote		
CR-102 document	CR-102	58-64
Hearing closed by Presiding Officer		

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Break **10 minutes**

Business Meeting Resumes

Open Session

5.0 New Business

5.1 **2026 Meeting Dates** — Action Pages

Presentation of the proposed 2026 meeting dates.

6.0 Old Business

6.1 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the WMC's committees and workgroups. Written reports begin on page 69. See page 71 for a list of committees and workgroups.

6.2 **Rulemaking Activities** — Update

Rules Progress Report provided on page 73.

Amelia Boyd, Program Manager, will request the following:

- Initiate CR-103 permanent rulemaking to formalize the rules approved through expedited rulemaking (CR-105) concerning physician assistant collaborative practice under ESHB 2041. The CR-105 was filed as WSR #24-15-055. — Action Pages 75-86
- Initiate the CR-103 permanent rulemaking to formalize the rules approved through expedited rulemaking (CR-105) removing references to osteopathic physician assistants. The CR-105 was filed as WSR #24-15-054. — Action Pages 87-89

7.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on September 26, 2024. Recording available here. The agenda was as follows: — Report/Action

7.1 **Proposed Policy: Processing Complaints Against Medical Students, Residents, and Fellows** — Pages 90-91

The Committee recommended approval for DOH Secretary review.

This proposed policy was previously a procedure, which can be found on the WMC's website: Complaints against students, residents, fellows WMC (wa.gov)

7.2 **Proposed Policy: Commissioner and Pro Tem Recusal Policy to Address Conflicts of Interest** — Pages 92-97

The Committee recommended approval for DOH Secretary review.

7.3 **Guidance Document: Medical Directors: Roles Duties and Responsibilities (GUI2020-02)** — Pages 98-99

This document was up for its four-year review. The Committee recommended reaffirming as written.

7.4 **Proposed Interpretive Statement: "Qualified Physician" Under Optometry Law** — Pages 100-101

The Committee recommended approval for DOH Secretary review.

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The following items were deferred at the July 19, 2024, Business meeting. These items were discussed at the Policy Committee meeting held on June 27, 2024.

7.5 **Proposed Policy: Artificial/Assistive/Augmented Intelligence (AI)** — Pages 102-109
The Committee recommended approving this document for DOH Secretary review.
Comment from the Washington State Hospital Association (WSHA) — Page 110

7.6 **Policy:** Telemedicine, POL2021-02 — Memo on page 111
The Committee recommended rescinding this policy.

8.0 Member Reports

The Chair will call for reports from Commission members.

9.0 Staff Member Reports

The Chair will call for further reports from staff. — Written reports on pages 112-125

10.0 AAG Report

Heather Carter, AAG, may provide a report.

11.0 Adjournment of Business Meeting

Informational

Hearing Schedule	Page 2
2024 Meeting Schedule	Pages 3-4
2025 Meeting Schedule	Pages 5-8
2024 Medical Malpractice Annual Report	Pages 126-185

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Business Meeting Minutes
July 19, 2024

Virtual Meeting via Teams Webinar
Link to recording: https://youtu.be/s1V1Ix4zLFg?si=4qCZo__HVi3dHqrW

Commission Members

Michael Bailey, Public Member
Christine Blake, Public Member – Absent
Toni Borlas, Public Member – Absent
Daniel Cabrera, MD
Po-Shen Chang, MD
Jimmy Chung, MD
Diana Currie, MD
Karen Domino, MD, Chair
Arlene Dorrough, PA-C
Anjali D'Souza, MD
Harlan Gallinger, MD – Absent
April Jaeger, MD
Jamie Koop, Public Member – Absent
Ed Lopez, PA-C, Officer-at-Large
Sarah Lyle, MD
Terry Murphy, MD, Vice Chair
Elisha Mvundura, MD – Absent
Robert Pullen, Public Member – Absent
Scott Rodgers, JD, Public Member – Absent
Claire Trescott, MD
Richard Wohns, MD – Absent

WMC Staff in Attendance

Colleen Balatbat, Staff Attorney
Jennifer Batey, Legal Support Staff Manager
Amelia Boyd, Program Manager
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Carmen Challender, Health Services Consultant
Marisa Courtney, Licensing Manager
Joel DeFazio, Staff Attorney
Kelly Elder, Staff Attorney
Gina Fino, Director of Compliance
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
Mike Hively, Director of Operations & Informatics
Jenelle Houser, Investigator
Ken Imes, Information Liaison
Kyle Karinen, Executive Director
Shelley Kilmer-Ready, Legal Assistant
Mike Kramer, Compliance Officer
Lisa Krynicki, Staff Attorney
Stephanie Mason, PR & Legislative Liaison
Micah Matthews, Deputy Executive Director
Joe Mihelich, Health Services Coordinator
Lynne Miller, Paralegal
Fatima Mirza, Program Case Manager
Taylor Bacharach-Nixon, Administrative Assistant
Freda Pace, Director of Investigations
Stormie Redden, Legal Assistant
Chris Waterman, Complaint Intake Manager
Trisha Wolf, Staff Attorney
Mahi Zeru, Equity & Social Justice Manager

Others in Attendance

Marlon Basco-Rodillas, Dept. of Health (DOH)
Rose Bigham, Washington Patients in Intractable Pain (WaPIP)
Amy Brackenbury
Katherine Burton
Heather Carter, Assistant Attorney General
Jennifer Davies
Thomas Fain
Renee Fullerton
Kat Haz
Maria Higginbotham
Cyndi Hoenhous, WaPIP
Linda Jezzard

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Others in Attendance continued

Katerina LaMarche, Washington State Hospital Association (WSHA)
Carolyn Logue, Washington Academy of Anesthesiologist Assistants
Martha Mioni
Hillary Norris, Washington State Medical Association (WSMA)
Susan Olson
Diana Opong
Shannon

1.0 Call to Order

Karen Domino, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to order at 9:08 a.m. on July 19, 2024.

2.0 Public Comment

Susan Olsen, a chronic pain patient, provided comments in support of the rule petition concerning opioid prescribing, which the Commissioners considered under item 7.2 of this meeting, emphasizing the importance of individualized pain management. She expressed gratitude for their supportive medical team but shared fears about inadequate pain control, especially recalling a difficult experience at a teaching hospital. She stressed the need for clear guidelines for future providers and highlighted the importance of not having a predetermined morphine equivalent number that may not suit every patient. She believes clarifying these guidelines will improve patient care and reduce stress for those undergoing medical procedures.

Cyndi Hoenhous, co-chair of Washington Patients in Intractable Pain (WaPIP), discussed the group's activities and outlined their goals. Ms. Hoenhous also advocated for access to appropriate pain care for those living with intractable pain in Washington. She highlighted the gap between well-intentioned policies and the real-life experiences of patients, emphasizing the negative impacts and barriers those policies can create. She called for representation in discussions and actions related to opioid policy, sharing that many patients feel disenfranchised. She criticized the focus on reducing opioid prescriptions and other metrics, arguing that it has led to a lack of individualized pain care. She questioned the current restrictions and patient outcomes, urging the need for data to examine the deterioration of pain care and to support provides. She proposed forming a workgroup to address these issues and return to a system of individualized care based on patient outcomes.

Katherine Burton, a chronic pain patient, expressed increasing difficulty in obtaining adequate pain medication each month, even with a supportive doctor and pharmacy. She mentioned the uncertainty regarding medication coverage and supply. She supported Maria Higginbotham's petition concerning opioid prescribing, which the Commissioners considered under item 7.2 of this meeting, to clarify that there is no maximum morphine equivalent dose in Washington State and to oppose unnecessary forced tapers, advocating for exemptions for rare diseases and chronic pain. She highlighted that many chronic pain conditions, including their own, are degenerative and progressive, which may require an increase in medication rather than a taper. She also noted that many alternative treatment modalities are not covered by insurance and are thus unaffordable for many patients.

Jennifer Davies, a chronic pain patient, described their experience with transverse myelitis as a manifestation of systemic lupus, highlighting the lengthy and painful process of obtaining a diagnosis, particularly for women. She explained that systemic lupus is a criteria-based diagnosis, often leading to delayed recognition and treatment. She shared her personal journey with various

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treatments, including biologics and chemotherapy, and expressed concern over the difficulty in finding pain specialists due to fears of disciplinary action among doctors. She emphasized the need for proper pain management and criticized misinformation and disinformation about opioid therapies, particularly the notion that they are ineffective for autoimmune disorders. She supported Maria Higginbotham's petitions and expressed frustration with the current state of medical practice, which she felt is negatively affecting patients needing pain relief and other off-label treatments.

Maria Higginbotham provided comments in addition to the information she provided in her rule petition, which the Commissioners considered under item 7.2 of this meeting. She shared her experience with systemic lupus and transverse myelitis, highlighting the lengthy and challenging process of obtaining a diagnosis, particularly for women. She discussed various treatments she underwent, including biologics and chemotherapy, and expressed concern over the difficulties in accessing pain management due to doctors' fear of disciplinary action. She criticized misinformation about the efficacy of opioids for autoimmune disorders. She expressed frustration with the current state of medical practice and its impact on patients needing pain relief and other treatments.

Kat Haz provided comments in support of the rule petition concerning opioid prescribing, which the Commissioners considered under item 7.2 of this meeting, emphasizing the need for more inclusive language in petitions related to chronic pain, noting that 70% of chronic pain patients are women, yet clinical trials did not include women until the 1990s. She highlighted her experience with Ehlers-Danlos syndrome, a multi-symptom disease causing severe pain and conditions like adhesive arachnoiditis, and complex regional pain syndrome, which is highly painful and nicknamed "suicide disease." Ms. Haz serves as the Director of Communication, Law, and Public Policy for the American Pain and Disability Foundation, where she has worked on legislation and public policy. She stressed that her experiences reflect the broader struggles of chronic pain patients, who often no longer receive proper treatment. Ms. Haz welcomed recent discussions about exempting certain conditions from tapering but found the language vague. She cited data showing the harmful effects of involuntary tapers, including increased emergency visits, injuries, mental health crises, and suicides. She urged policymakers to listen to stakeholders and take further action to protect chronic pain patients.

Douglas Stamp, PA-C, practicing pain medicine at Peninsula Pain Clinic in Silverdale, Washington, supports adding "rare diseases" to the exemption for Sickle Cell Disease in opioid guidelines. He believes this inclusion is important as many rare diseases require chronic opioid pain management. He also calls for additional clarification from the WMC on the criteria for patients who should not be tapered off opioids, suggesting that language from the CDC supporting stable legacy patients should be included in the WMC guidelines.

Brenda Williams stated she supports the recent changes to WAC 246-918-870, including the exemption for sickle cell patients, and emphasized that biological testing should not be punitive and that not all chronic pain patients should be tapered off their prescriptions. She called for further reduction in restrictions and complications for chronic pain patients. She supports the rule petition concerning opioid prescribing, which the Commissioners considered under item 7.2 of this meeting, and emphasized the following:

- Clarifying that Washington State does not have a maximum MME (morphine milligram equivalent) limit.

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- Addressing forced tapering, with a request to add that any forced taper or reduction in medication for compliant patients is a violation of state law and below the standard of care.
- Expanding the exemption for sickle cell disease to include all rare diseases affecting over 30 million Americans.
- Adding an exemption for chronic pain patients.

Martha Mioni provided comments in support of the rule petition concerning opioid prescribing, which the Commissioners considered under item 7.2 of this meeting. She shared that she is currently being forcibly tapered from pain medication, which is having a devastating impact on her life. Ms. Mioni has been a model patient since a work-related injury in 2000, which caused her L5-S1 rupture. The tapering not only affects her but also impacts her role as a caretaker for her husband, who has had a kidney transplant and is legally blind.

3.0 Chair Report

Dr. Domino asked new Commissioner, Dr. Daniel Cabrera, to introduce himself. Dr. Cabrera stated he works in internal medicine primarily as a hospitalist at Harborview Medical Center and has been there for over 12 years.

Dr. Domino provided a report on her attendance at the Federation of State Medical Boards (FSMB) meeting in June, which focused on alternative licensing models for internationally trained physicians. She highlighted the significant role these physicians play in addressing gaps in healthcare, especially in rural areas and specialties like family practice and anesthesiology. Dr. Domino noted that Washington State is making good progress in this area. She mentioned the absence of the American Board of Medical Specialists at the meeting, which complicates board certification for internationally trained doctors and can affect their ability to bill for services. She commended Mr. Micah Matthews and the international physician group for their efforts in addressing these challenges.

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Agenda for July 19, 2024.

4.2 Minutes from the April 26, 2024, Business Meeting

Motion*:* The Chair entertained a motion to approve the Consent Agenda. The motion was seconded and approved unanimously.

5.0 Commissioner Training

5.1 Open Public Meetings Act

Heather Carter, Assistant Attorney General (AAG), provided training regarding the Open Public Meetings Act (OPMA).

6.0 New Business

6.1 Appointment to the Interstate Medical Licensure Compact Commission

Kyle Karinen, Executive Director, shared that he has been representing the WMC on the Interstate Medical Licensure Compact (IMLC) since Melanie retired last year. This role involves attending two major meetings each year—one virtual and one in person—and performing about two hours of work per month. Mr. Karinen has been handling this

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responsibility and is willing to continue but requested a vote to formalize his role.

***Motion**:* The Chair entertained a motion to approve Mr. Karinen's continued representation of the WMC on the IMLC. The motion was seconded and approved unanimously.

6.2 Appointment to the Physician Assistant Licensure Compact Commission

Mr. Karinen discussed the development of a new Physician Assistant (PA) Compact, which, like the IMLC for MDs and DOs, will establish a commission to manage licensing and reciprocity issues for physician assistants. He noted that the PA Compact is in its initial stages, unlike the more established IMLC. Mr. Karinen, along with Micah Matthews, Deputy Executive Director, recommended Marisa Courtney, Licensing Manager, to represent Washington on the PA Compact Commission. They believe Ms. Courtney is well-suited for the role due to her understanding of licensing statutes and her current availability.

***Motion**:* The Chair entertained a motion to approve Ms. Courtney to represent Washington on the PA Compact. The motion was seconded and approved unanimously.

6.3 Grant funding Process for IMG Assistance Programs Process

Mr. Matthews explained that the packet before the Commissioners outlines a process for disbursing grants, as directed by Senate Bill 6551 from 2020. This process, mapped out in coordination with the Department of Health (DOH), involves using their grant disbursement procedures but includes additional steps for clarity on the WMC's role. The request is for the Commissioners to approve this process, although the specific selection criteria for grants will be developed later. The grants are intended to support various activities, such as subsidizing clinical experiences or funding advocacy groups, once appropriated by the legislature. The approval needed now is for the process itself, not the criteria.

***Motion**:* The Chair entertained a motion to approve this process. The motion was seconded and approved unanimously.

6.4 2025 Legislation Request

Mr. Matthews provided an overview of the legislative process and current political outlook. He explained that the Commission needs to approve legislative proposals before development begins, which includes working with stakeholders and developing language. The proposals are then submitted to the governor's office as Agency Request Legislation, with updates expected in December or January.

He outlined the process for five items needing approval and three items for information. The information items come from the International Medical Graduate (IMG) work group and will be reviewed by the governor's office before potentially going to the legislature.

Mr. Matthews also discussed the political context, noting that federal issues and upcoming elections could influence state-level legislative priorities. He mentioned budgetary concerns, including a directive from the governor's office to avoid new programs and potential revenue shortfalls from upcoming initiatives. This context might affect the feasibility of the IMG work group's proposals.

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1. Uniform Disciplinary Act Technical Amendment
   Mr. Matthews explained that when a new profession is established, it should be referenced in the Uniform Disciplinary Act and added to the professions list in RCW 18.130.040. This includes updates like those for the Uniform Telehealth Act, which refers to this section. However, the Interstate Medical Licensure Compact is not currently listed, causing a discrepancy. The proposed fix aims to ensure that the compact statutes, including those for the PA Compact, are properly included and referenced.

   ***Motion**:* The Chair entertained a motion to approve this request. The motion was seconded and approved unanimously.

2. Non-Disciplinary License Yield
   Mr. Matthews explained this is a historical request from the Commission to establish a process for individuals to voluntarily return their licenses without disciplinary implications. Currently, the only way to relinquish a license involves a Stipulation to Informal Disposition (STID) or agreed order, which can negatively impact one's career record. The proposed process would allow licensees to surrender their licenses if they are not under investigation or disciplinary action, thereby returning the license as a property right. This initiative aims to provide a more graceful exit option. Additionally, even if a license expires, the Commission retains authority and may investigate complaints related to it, but this proposal specifically targets non-disciplinary cases.

   Mr. Karinen discussed the issue of licensed professionals facing physical or cognitive challenges that affect their ability to practice safely but who prefer to avoid the stigma of formal disciplinary actions. He emphasized the need for a respectful and non-litigious process for these individuals, allowing them to retire gracefully while removing themselves from the Commission's jurisdiction without formal proceedings.

   ***Motion**:* The Chair entertained a motion to approve this request. The motion was seconded and approved unanimously.

3. Locums Limited License
   Mr. Matthews explained that the "locums limited license" is designed to expedite the licensing process for locum tenens professionals based on reduced initial documentation. This idea, inspired by military spouse licensure expediting laws, would allow for a provisional license to be issued while pending documentation is completed. The license would be contingent on the later submission of acceptable documentation, with an agreement that failure to meet the requirements could result in license revocation. This proposal, supported by the Washington Association of Medical Staff Specialists, aims to streamline the onboarding process for locum tenens professionals and address feedback from stakeholders and the licensing unit. This may also be a way to attract border state Locums placements.

   ***Motion**:* The Chair entertained a motion to approve this request. The motion was seconded and approved unanimously.

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4. WMC Authority Related to Medical Examiners
Mr. Matthews addressed ongoing issues with complaints related to medical examiners. Historically, the Commission faced challenges due to ambiguities in the Uniform Disciplinary Act, particularly around its authority over complaints involving deceased individuals. While the Commission cannot alter determinations of cause or manner of death, complaints persist, and there have even been hearings on such issues.

The proposal aims to clarify authority by removing it from the Medical Commission. Instead, determinations of cause or manner of death would be handled through the court system, potentially with a special master (a medical examiner with expertise) appointed by the judge. This proposal was previously drafted but stalled due to political changes, and recent complaints suggest it's still a relevant issue.

***Motion**:* The Chair entertained a motion to approve this request. The motion was seconded and approved unanimously.

5. Public Records Act Exemption-Licensee Demographic Data
Mr. Matthews discussed a proposed change to the Public Records Act concerning the handling of licensee information. He expressed skepticism about its success but strong support for its intent. The proposal aims to address safety concerns related to the release of sensitive information, particularly demographic data and medical records, which can be misused or combined with other data to compromise privacy.

Key points include:

Historical Context: The Public Records Act from the 1970s promotes transparency but doesn't account for modern data risks.

Current Issues: There's a concern about the release of demographic information and how it might be combined with other data, leading to privacy risks.

Proposed Changes:
- A prohibition on releasing licensee demographics and medical records.
- Ensuring that medical records, which are not generated by the Commission but are acquired second-hand, are not released through the Public Records Act.

Alternative Solutions: Data sharing agreements are suggested as a safer method for handling and evaluating data requests.

Mr. Matthews acknowledged that this proposal goes against existing state policy and might face opposition but emphasized the need for such a discussion due to current data security concerns.

***Motion**:* The Chair entertained a motion to approve this request. The motion was seconded and approved unanimously.

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The following items were informational.

Mr. Matthews discussed proposed changes and initiatives related to the licensing and integration of International Medical Graduates (IMGs) into the medical system. Key points were:

Clinical Experience License Updates:
- Eliminate Washington State Residency Requirement: The 12-month residency requirement for the clinical experience license will be removed.
- Remove Step 3 Requirement: Align with the ECFMG process, allowing IMGs to take Step 3 after matching into a residency.
- Extend License Validity: Increase the license duration from 4 to 8 years to accommodate remediation and residency transition.

Residency and Transition Programs:
- Innovation Waiver Request: A request will be made for an innovation waiver from the NRMP to allow state-based funding for up to 5,000 residency positions. This will support a transition year under the clinical experience license, leading to a traditional residency.
- Dedicated IMG Residency Positions: Propose state-funded residency positions outside of the traditional match system.

Apprenticeship Pathway:
- Four-Year Supervised Practice: Implement a pathway where IMGs complete four years of supervised practice under the clinical experience license, culminating in board certification and eligibility for hospital credentialing and insurance billing.

Abbreviated Evaluation Process:
- For Exceptionally Qualified IMGs: Propose a shorter, 6-8 week supervised evaluation for highly qualified IMGs.

Recognition of Canadian Medical Schools:
- Upcoming Changes: With the LCME ending dual accreditation of Canadian medical schools in 2025, propose recognizing Canadian medical schools and exams as equivalent to U.S. standards.

These initiatives aim to streamline the licensing process, enhance integration opportunities for IMGs, and adapt to evolving needs in medical workforce planning.

6.5 2025 Meeting Dates

Mr. Karinen presented the proposed meeting dates for 2025 and requested approval.

***Motion**:* The Chair entertained a motion to approve the 2025 proposed meeting dates. The motion was seconded and approved unanimously.

7.0 Old Business

6.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet. There were no additional reports.

6.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. In addition to the written report, Ms. Boyd made the following requests:

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- Initiate standard rulemaking regarding the comments received as part of the Commission's current rulemaking regarding opioid prescribing: WSR #23-17-094. Ms. Boyd that this rulemaking has already been the subject of significant public comment. The focus of this rulemaking is quite narrow, but the volume of feedback received prompted the Commissioners to decide, during the last workshop, to request initiating rulemaking based on these comments. These comments are included in the packet for review. Ms. Boyd requested the Commissioners approve this rulemaking request.

  ***Motion**:* The Chair entertained a motion to initiate standard rulemaking. The motion was seconded and approved unanimously.

  The Commissioners deliberated on whether to pursue a broad or narrowly focused approach for the rulemaking.

  ***Motion**:* The Chair entertained a motion to make this rulemaking encompass all the opioid prescribing sections of WAC for both the MDs and PAs. The motion was seconded and approved unanimously.

- Initiate CR-102 – General Provisions for Opioid Prescribing and Tapering for Physicians and Physician Assistants. The CR-101 was filed on August 16, 2023, as WSR #23-17-094.

  Ms. Boyd explained that the Commission already has rulemaking underway for this, and a hearing was held at the last Commission meeting. During that hearing, there were concerns about the removal of some previously established language. We have reinstated that language and now need to schedule another rulemaking hearing, which will take place in October. Ms. Boyd's request was to file a supplemental CR-102 to amend the existing rulemaking process. This CR-102 will include the updated language, which was outlined in the packet, and will require biological specimen testing. If approved, the hearing is tentatively scheduled for October to finalize these changes and make the revised language permanent.

  ***Motion**:* The Chair entertained a motion to initiate the next step in the rulemaking process, the CR-102 or Proposed Rules. The motion was seconded and approved unanimously.

- Rulemaking Petition – RE: Opioid Prescribing from Maria Higginbotham

  Ms. Boyd presented the petition, explaining that it concerns the opioid prescribing sections in both the MD and PA rules. She further noted that if the Commissioners would like to approve initiating rulemaking based on this petition, they can incorporate it into the rulemaking they approved earlier this meeting.

  ***Motion**:* The Chair entertained a motion to initiate rulemaking on this petition and incorporate it into the rulemaking approved earlier in the meeting. The motion was seconded and approved unanimously.

8.0 Policy Committee Report

In the absence of Christine Blake, Public Member, Policy Committee Chair, Dr. Domino reported on the items discussed at the Policy Committee meeting held on June 27, 2024. The agenda was as follows:

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Procedure: Processing Complaints Against Medical Students, Residents, and Fellows
Proposed Policy: Commissioner and Pro Tem Recusal Policy to Address Conflicts of Interest
Proposed Policy: Artificial/Assistive/Augmented Intelligence (AI)
Policy: Telemedicine, POL2021-02

In the interest of time, the preceding four items were deferred to the next Business meeting, which will be held October 11, 2024.

Proposed Policy: Clinical Experience Assessment
Dr. Domino asked Mr. Matthews to report on this item. Mr. Matthews clarified that the entrustment scale was developed by the International Medical Graduate Work Group. This scale, intended for collaborative use, had been sent to the Secretary's office for review about a year ago but was delayed in returning. It has now returned with the Secretary's recommended amendments, some of which were accepted while others conflicted with the original scale. The tool, as presented, is intended for use with the supervised practice of clinical experience license orders. It is recommended that supervisors use it quarterly to track skill improvement and document the clinical activities of the licensee for program directors.

> ***Motion:*** The Chair entertained a motion to approve the document as presented. The motion was seconded and approved unanimously.

9.0 Member Reports

No member reports were provided.

10.0 Staff Reports

The reports below are in addition to the written reports that were included in the meeting packet.

Mr. Karinen noted that Christine Blake, Public Member, and Ed Lopez, PA-Cm are working with the FSMB on their education committee for the annual meeting, which brings notable recognition to the Commission. He thanked them for their service and reminded everyone that next year's annual meeting will be in Seattle. As the host state, it’s beneficial to have such visibility for the Commission.

11.0 AAG Report

Heather Carter, AAG, had nothing to report.

12.0 Leadership Elections

12.1 Restatement of Nominating Committee Report
Dr. Jimmy Chung, Committee Chair, restated the nominations for the following leadership positions:

- Chair – Dr. Karen Domino
- Vice Chair – Dr. Terry Murphy
- Officer-at-Large – Ed Lopez, PA-C

12.2 Nominations From the Floor
Dr. Chung called for nominations for all positions from the panel of Commissioners. No other nominations were provided.

12.3 Elections of Leadership
Dr. Chung stated the slate of candidates were elected by acclamation.

13.0 Adjournment

The Chair called the meeting adjourned at 11:28 am.

Submitted by

Amelia Boyd, Program Manager

Karen Domino, MD, Chair
Washington Medical Commission

Approved October 11, 2024

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WSR 24-18-041
PROPOSED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed August 27, 2024, 9:06 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 23-19-029.

Title of Rule and Other Identifying Information: Military spouse temporary practice permits; WAC 246-918-076 (physician assistants) and 246-919-397 (physicians) How to obtain a temporary practice permit—Military spouse proposed updates to incorporate RCW 18.340.020.

Hearing Location(s): On October 11, 2024, at 9:15 a.m., virtual. Register for this virtual meeting to be held via Teams https://tinyurl.com/ycxn37ve; or in person at the Department of Health, 111 Israel Road S.E., Room 166, Tumwater, WA 98501. To join the Washington medical commission's (WMC) rules interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

Date of Intended Adoption: October 11, 2024.

Submit Written Comments to: Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, email https://fortress.wa.gov/doh/policyreview/, beginning on the date and time of this filing, by October 4, 2024 at 11:59 p.m.

Assistance for Persons with Disabilities: Contact Amelia Boyd, program manager, phone 1-800-525-0127, TTY 711, email medical.rules@wmc.wa.gov, by October 4, 2024.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WMC is amending WAC 246-918-076 and 246-919-397 to align with the provisions of 2SHB 1009 (chapter 165, Laws of 2023), also known as the Military Spouse Employment Act, codified under RCW 18.340.020. These amendments are intended to streamline the permit process for military spouses, ensuring consistency with the new state legislation and improving overall clarity and efficiency in the application process.

The proposed language clarifies the requirements, emphasizes the expedited nature of the license process, aligns the terminology by changing "permit" to "license" in accordance with the bill, refines the terminology, removes outdated requirements, and updates the definitions.

The anticipated effects of the proposed language include:

- Clearer requirements will reduce confusion for applicants and ensure a smoother application process.
- Emphasizing the expedited nature of the license process will likely lead to quicker approval times, benefiting military spouses needing timely access to employment.
- Aligning the terminology with the bill by changing "permit" to "license" will create consistency and reduce potential misunderstandings.
- Refining terminology and removing outdated requirements will ensure the regulations are up-to-date and relevant.
- Updated definitions will provide greater precision and accuracy in interpreting the rules, ensuring they are correctly applied to eligible individuals.

Reasons Supporting Proposal: By clarifying the requirements, the proposal ensures that applicants understand the necessary steps, re-

ducing errors and rejections in the application process. Aligning the terminology by changing "permit" to "license" creates consistency with the legislative language, enhancing legal coherence and interpretation. Refining terminology and removing outdated requirements keep the regulations current and relevant, ensuring they meet present-day standards and needs. Updating definitions provides clearer guidelines for eligibility and application, ensuring that the rules are applied accurately and effectively to all relevant parties.

Statutory Authority for Adoption: RCW 18.71.017 and 18.130.050.

Statute Being Implemented: 2SHB 1009 (chapter 165, Laws of 2023), codified under RCW 18.340.020.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: WMC, governmental.

Name of Agency Personnel Responsible for Drafting: Amelia Boyd, 111 Israel Road S.E., Tumwater, WA 98501, 360-918-6336; Implementation and Enforcement: Kyle Karinen, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-4810.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rules are exempt from a cost-benefit analysis under RCW 34.05.328 (5)(b)(iii) because the proposed rules incorporate the military spouse licensure requirements from RCW 18.340.020.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The proposed rules only impact individual licenses, not small businesses.

Scope of exemption for rule proposal:

Is fully exempt.

August 26, 2024
Kyle Karinen
Executive Director
Washington Medical Commission

OTS-5594.1

AMENDATORY SECTION (Amending WSR 17-18-097, filed 9/6/17, effective 10/7/17)

WAC 246-918-076 How to obtain ((~~a~~)) an expedited temporary ((~~practice permit~~)) license—Military spouse. A military spouse ((~~or state registered domestic partner of a military person~~)) may receive ((~~a~~)) an expedited temporary ((~~practice permit~~)) license while completing any specific additional requirements that are not related to training or practice standards for physician assistants under the following conditions.

(1) ((~~A~~)) An expedited temporary ((~~practice permit~~)) license may be issued to an applicant who is a military spouse ((~~or state registered domestic partner of a military person~~)) and:

(a) Is moving to Washington as a result of the military person's transfer to the state of Washington;

(b) ((~~Left employment in another state to accompany the military person to Washington;~~

~~(c)~~)) Holds an unrestricted, active license in another state or United States territory that ((~~has~~)) the commission currently deems to have substantially equivalent licensing standards for a physician assistant ((~~to those~~)) in the state of Washington; and

((~~(d)~~)) (c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body ((~~of the~~)) in any other state or ((~~states~~)) United States territory in which the applicant holds a license.

(2) ((~~A~~)) An expedited temporary ((~~practice permit~~)) license grants the ((~~individual~~)) applicant the full scope of practice for the physician assistant.

(3) ((~~A~~)) An expedited temporary practice ((~~permit~~)) license expires when any one of the following occurs:

(a) ((~~The~~)) A full or limited license is ((~~granted~~)) issued to the applicant;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the expedited temporary ((~~practice permit~~)) license; or

(c) One hundred eighty days after the expedited temporary ((~~practice permit~~)) license is issued.

(4) To receive ((~~a~~)) an expedited temporary ((~~practice permit~~)) license, the applicant must:

(a) ((~~Submit to the commission the necessary application, fee(s), fingerprint card if required, and documentation for the license;~~

~~(b) Attest on the application that the applicant left employment in another state to accompany the military person;~~

~~(c)~~)) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for physician assistants;

((~~(d) Provide verification of having an active unrestricted license in the same profession from another state that has substantially equivalent licensing standards as a physician assistant in Washington;~~

~~(e)~~)) (b) Submit a written request for a temporary practice permit; and

(c) Submit a copy of the military person's orders and a copy of one of the following:

(i) The military-issued identification card showing the military person's information and the applicant's relationship to the military person;

(ii) A marriage license; or

(iii) A state registered domestic partnership((~~; and~~

~~(f) Submit a written request for a temporary practice permit~~)).

(5) For the purposes of this section the following definitions shall apply:

(a) "Military spouse" ((~~means the husband, wife,~~)) is someone married to or in a registered domestic ((~~partner of~~)) partnership with a military person((~~.~~)) who is serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States; and

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

OTS-5595.1

AMENDATORY SECTION (Amending WSR 20-22-003, filed 10/21/20, effective 11/21/20)

WAC 246-919-397 How to obtain ((a)) an expedited temporary ((practice permit)) license—Military spouse. A military spouse ((or state registered domestic partner of a military person)) may receive ((a)) an expedited temporary ((practice permit)) license while completing any specific additional requirements that are not related to training or practice standards for physicians under the following conditions.

(1) ((A)) An expedited temporary ((practice permit)) license may be issued to an applicant who is a military spouse ((or state registered domestic partner of a military person)) and:

(a) Is moving to Washington as a result of the military person's transfer to the state of Washington;

(b) ((Left employment in another state to accompany the military person to Washington;

(c))) Holds an unrestricted, active license in another state or United States territory that ((has)) the commission currently deems to have substantially equivalent licensing standards for a physician ((to those)) in the state of Washington; and

(((d))) (c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body ((of the)) in any other state or ((states)) United States territory in which the applicant holds a license.

(2) ((A)) An expedited temporary ((practice permit)) license grants the ((individual)) applicant the full scope of practice for the physician.

(3) ((A)) An expedited temporary ((practice permit)) license expires when any one of the following occurs:

(a) ((The)) A full or limited license is ((granted)) issued to the applicant;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the expedited temporary ((practice permit)) license; or

(c) One hundred eighty days after the expedited temporary ((practice permit)) license is issued.

(4) To receive ((a)) an expedited temporary ((practice permit)) license, the applicant must:

(a) ((Submit to the commission the necessary application, fee(s), fingerprint card if required, and documentation for the license;

(b) Attest on the application that the applicant left employment in another state to accompany the military person;

(c))) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for physicians;

(((d) Provide verification of having an active unrestricted license in the same profession from another state that has substantially equivalent licensing standards for physicians in Washington;

(e))) (b) Submit a written request for a temporary practice permit; and

(c) Submit a copy of the military person's orders and a copy of one of the following:

(i) The military-issued identification card showing the military person's information and the applicant's relationship to the military person;

(ii) A marriage license; or

(iii) Documentation of a state registered domestic partnership.

((~~(f) Submit a written request for a temporary practice permit.~~))

(5) For the purposes of this section the following definitions shall apply:

(a) "Military spouse" ((~~means the husband, wife,~~)) is someone married to or in a registered domestic ((~~partner of~~)) partnership with a military person((~~.~~)) who is serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States; and

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

General provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants. WSR #24-18-091.
Rule comments 1-36 were posted to https://fortress.wa.gov/doh/policyreview/ and retrieved October 7, 2024 at 2:33 pm.

#	Comment
1	Gilbert Wilson I have stiff personal syndrome (SPS), with chronic progressive inflammatory demyelinating polyneuropathy or CIDP. There's no pain clinic capable or qualified to treat or understand this very rare disease. 'You should do extensive PT' - not recommended for this disease. 'You should have a tinge machine or a tinge implant system' - this would exacerbate the condition, causing muscle contractions everywhere. MS Contin has been used for decades and (according to the CDC) less than .001% of chronic pain patients become addicted to their medication. Unless the statistics have changed in the last 25 years since I took pharmacology courses to become an Addictive Studies professional. Drop the crisis/epidemic causes with doctors and prescription opioids - it doesn't exist! You are causing an epidemic of suicides as a result of pain patients not being treated or under treated. I utilize medications that are the standard treatment for my disease - should I be declined pain medications because of my disease? Because I am! SPS can break bones, cause muscles and tendons to tear and rupture blood vessels and arteries, causing sudden death. I have been refused opioid medication to treat my chronic pain. Because of state laws and the fear of prosecution of my physicians. I am 'unlawfully' diagnosed as 'opioid dependent', and subjected to constant drug testing, which is very expensive and time consuming, though understandable. I am NOT treated as a patient with chronic pain issues related to my SPS and CIDP, I'm treated like a criminal. Having worked for several years in different addiction recovery centers, I can say with confidence that they were treated with more respect, consideration and compassion than I have been while being forced to attend pain clinics. From the moment you walk in the doors of a pain clinic, you are subjected to a drug test, without having done any behavior to warrant testing. You are immediately considered an opioid dependent drug addict and NOT a patient with a progressive and incurable, painful disease. I'm a former officer in the US Coast Guard and a FAS licensed airframe mechanic since 1984. I hold an Associate Degree in Applied Sciences in Human Services addictive studies and a BA in Social Work. Please stop this insanity and suffering!
2	Valorie Hawk I support Maria Higginbothams petition. I was hit by a truck, which caused a four car accident, while working for Congress nearly 3 decades ago. I sustained multiple injuries and worked with physical therapists for over a decade. I have Syringomyelia, a progressive, inoperable cyst/tumor inside the spinal cord, which causes a lot of intense pain, sensory impairment, weakness, numbness, temperature changes and disability. I also have Thoracic Outlet Syndrome, Osteoporosis, Osteoarthritis, sciatica, scoliosis, a badly twisted pelvis, cluster headaches, arthritis, cardiac issues and multiple damaged disks, immune system irregularities, pinched nerves and neurological issues, which impacts every single aspect of my life. I've had a couple of falls and MV accidents over the years, that have caused a worsening of my medical issues. I've been to over 250 medical practitioners, including PT, OT, Aqua PT, Chiropractors, Neurologists, Osteopaths, Acupuncture, trial failed pain pump, electro current therapy, cognitive behavioral therapy, various injections, medical cannabis, Ketamine, Kratom, lotions and potions and nearly everything, short of voodoo! I've found that the majority of the chronically ill pain patients I know also have a laundry list of injuries and ailments and have tried nearly every type of treatment that is available to them before trying pain medicine. Anti opioid physician zealots from the UW gaslit our legislature into passing the first anti pain patient law in the country in 2011, sending many of us to pain management clinics. When the 2016 CDC

	Guidelines were issued many of us were abruptly 'tapered' or cut off and a lot of doctors stopped prescribing, left medicine, retired prematurely or switched to other careers. When the Seattle Pain Center was shut down in 2017 it left nearly 25K of us without pain management and it caused immense suffering, several suicides and an unknown number of deaths. Many of us in the pain community are genetically hyper metabolizers of medication, requiring higher doses and more quantity to reach a similar effect to typical metabolizers. Thus, dictating a MME limit does not stand up to scientific scrutiny or work for each individual patient's healthcare needs. The powers that be tried to make policy by lumping patients in with addicts, which only caused more suffering, stigma and hardship for legitimate pain patients. The DEA slashing production every single year since about 2017 causes more medication shortages each year. During 2023 there's been even more shortages across the country and there has been times that pharmacies are completely out, so patients receive nothing or a lot less than their prescription mandates. This summer I received none of my main pain medication one month and half another month. The stress, sickness and withdrawals, on top of the intractable pain, that's these shortages cause is very dangerous, in many ways. Policymakers tried a simple solution to 'fix' addiction, which has only caused more harm, pain, suffering and deaths. The CDC research shows that less than .001% of pain patients addict to their medications, as addiction is caused by genetics, unresolved childhood trauma and socioeconomic factors. Most pain patients I know, myself included, do NOT want to take medication or want to chase a high, we just want enough pain relief to be able to take a shower, cook a meal, get groceries or to rejoin life or work. For most of us, our receptors are so filled with pain signals that a 'high' just doesn't happen. People with addictions want to escape life, while pain patients want to take part in life. It's bad enough to be ill, injured, sick, etc., but to have to fight for rights to life saving medications and healthcare constantly takes an enormous toll on an individual, their family and loved ones. Would diabetics have insulin banned because others abused it - it's ludicrous to even consider! From doctors quitting or being afraid of repercussions to prescribe, to pharmacist's judgement, to medicine shortages, it really makes life more challenging for the most impaired and vulnerable members of our communities. The suicide rate is skyrocketing and it'll likely continue to increase drastically, as more practitioners refuse to help their patients. When palliative care and hospice patients aren't having their pain treated appropriately (if at all) in one of the most advanced countries in the world, it's pretty terrifying. It's dire that pain practitioners and patients be part of the policy making process, instead of having addiction professionals, who may have a financial incentive, be the main voice for stakeholders.
3	Michael Huntley I am 57 years old and live in Spokane, Washington. I have been on opiate pain medication since suffering a traumatic lower limb injury in 2005. My injury left me with a debilitating chronic pain condition that is life long. Back in the days before the current "opiod crisis" I was able to continue working my excellent high paying job, providing for my family, with the help of 360mg oxycontin daily. It didn't start out that high, of course. Although I wasn't opiod naive, I had taken them so infrequently prior to my injury that I had little tolerance. Unfortunately, when Washington state implemented its current guidelines a few years ago, it turned my life upside-down. I am now on permanent disability, and spend every day (and night) in excruciating pain. I currently receive 24mg hydromorphone daily (roughly 96mg morphine equivalent). Just because my dosage was drastically reduced, it doesn't mean my tolerance did. So now I am left in a situation where I have to pick and choose when I want pain relief, and just suffer through the rest of the time. My quality of life is horrible, the only thing that keeps me from committing suicide is the fact that it would make the people who love me suffer.

	Please don't let anyone who doesn't know what it's like to go through life like this make decisions that dictate what my doctor and I have to do. Please leave it up to him and I.
4	Debra A Nolan All restrictions in opioid prescribing should be between doctor and patient. My body my choice applies to ANY healthcare condition and chronic pain from diseases or injuries are a healthcare condition. All the rules and regulations that the CDC put out were based on debunked information and the cdc has admitted they have caused undue harm to chronic pain patients. In America true patriotism is admitting if you have made a mistake and taking all measures to correct them. Involving the DEA in health care is a mistake. Medicine is not a direct science and every patient is different. So any limits on MME are junk science because no two metabolism are the same. If the DEA were educated and licen in the medical field they would realize thus. All doctors that have been jailed for treating chronic pain patients should be immediately released as they went by their training and the individual patient needs not a chart or graph of a special interest group. Anything less than the above does not set America apart as being the home of the free and the land of the brave. Over 3.5 trillion dollars have been spent on the war on drugs and yet people are dying from illicit drugs every day while the DEA goes after doctors and patients. Bring common sense back. You all have the power to see the data and see for yourself the harm that has been caused to people in pain. Also the harm done to people that are being tricked into buying tainted drugs d to addiction. If the DEA was attending to the business of the illegal cartel, instead of licensed educated doctors that each state requires a level of professionalism to give these doctors these licenses, then out streets would not be full of people dying from illegal drugs. Suicides among chronic pain patients are up over 500%. Whose hands are these patients blood on? No one can endure 24/7 pain but due to politics this is what is being done to CPP. Yet it has cost lives not saved any lives. It is time for a change. It is time for empathy and compassion to be shown to the most vulnerable in America. Please remove ALL of these deadly restrictions on opioid prescribing as the data proves that prescription opioids were never nor are now the cause of the overdose crises. Yet the data also proves these restrictions are killing Americans
5	Tamera Lynn Stewart As the Director of the P3Alliance, I am speaking on behalf of the 967 people within our organization who have actively engaged with or stayed informed about the Washington Medical Commission’s actions on opioid prescribing. It is critical that the Commission include exceptionally clear and concise language in the regulations. Prescribers must be directed to prioritize the health and quality of life of each individual patient rather than being driven by fear of unclear guidelines and communications. Without this clarity, doctors are left with the impression that their licenses and practices are at greater risk if they continue prescribing opioids at individualized levels. They should never have the fear that providing good care to their patients would come at the cost of their own livelihood. This fear can lead to catastrophic consequences, including rushed decisions to taper all patients to an undefined MME or to stop prescribing altogether. I urge the Commission to address the following specific points in their regulations: 1. WAC 246-918: We partially support the recent changes, such as adding an exemption for sickle cell patients and stating that biological testing should not be used in a punitive way. Additionally, it's crucial to make it clear that not all chronic pain patients need to have their prescriptions tapered, as it has continually led to worse outcomes for certain subsets of these patients. Our only objection is that it stops shy of what we know will be required to right this ship and save lives. 2. No maximum MME in Washington State: Clearly state in

	the regulations that Washington does not have a maximum MME (Morphine Milligram Equivalent) limit, ensuring prescribers can provide care tailored to individual patient needs. 3. Address forced tapering: Please continue to work with P3 and others to ensure it is clear that setting a maximum for all patients or requiring all patients to be on a specific regimen is below the standard of care and always has been. In addition, we feel it is imperative to craft a rule with concise language to protect patients from unnecessary harm due to changes in MME calculations. 4. Exempt chronic pain patients: Include an exemption for chronic pain patients, especially those with incurable, progressive diseases that cause severe pain. 5. Exempt all rare diseases: Since the regulations already provide an exemption for sickle cell disease (one of 10,000 rare diseases), extend this exemption to ALL rare diseases, as identified by NORD, affecting over 30 million Americans. Including these clear directives will not only protect patients but also provide prescribers with the confidence to continue offering necessary, compassionate care without the fear of violating vague guidelines.
6	Brenda Williams As a parent, watching your chronically ill daughter suffer on a daily basis is one of the most difficult things in life. Without her daily opiod medication she is in excruciating pain and barely able to move. Her daily prescription helps lower her pain to a more bearable level. She has tried several other medications and therapies, but none of them worked at giving her a baseline level of relief. I have experienced how hard it is for her sometimes to get her monthly pain medication at the pharmacy. She is often looked upon as a drug addict, by an unknowing pharamcist who doesn't know what her condition is, and who is only looking to get the medication for fun. More than once she has had to switch pharmacies because they change which manufacturer they use. She has had severe allergic reactions to more than one manufacturer and the dyes or fillers used in the making of their particular pill. While I understand that there are drug users and abusers, it is imperative that rules/laws/regulations need to keep in mind that there is a large percentage of the chronically ill population that need/use opiod medications carefully and correctly just to survive. Please keep that population in mind when making changes.
7	Debra Nolan Chronic pain is a health care condition. The doctor patient relationship should be a sacred space. Any other health condition is ruled and regulated by the government? Let doctor treat their patients based on the fact they see the patient they have the patients medical history. To make any health care rules without this information is ludicrous because that is why the state has rigid education and licensing guidelines before a doctor can have a practice. It looks as if the state doesn't trust their rigid licensing requirements to go above and beyond to control the doctor patient relationship. Let doctors treat the patient based on the individual patient. Some patients may not need opioids. Some may need extremely high doses. Only that physician can determine that based on the doctor patient relationship. There are too many cooks stirring the pot and it is killing chronic pain patients and many doctors are being targeted by the DEA because of government over reach. It needs to stop. If the state doesn't trust the doctor to do the right thing as far as prescribing then either do not give them a medical license or remove it. Don't expect them to go through all the training and licensing requirements then try to punish them for doing their jobs. As a nation we can do better for people in chronic pain. Now these draconian measures are killing these patients.

8	Maria Higginbotham First I want to acknowledge the WMC for the hard work they have put into addressing the issues facing chronic pain patients in our state. By changing the current rules we can perhaps get back to a system where patients are treated as individuals with different issues and not all lumped into one category. According to the CDC the misapplication or use of inappropriate policies and being inflexible on opioid dosage and duration, discontinuing or dismissing patients from a practice, tapering stable patients has caused significant patient harm AMA President Gerald E. Harmon, MD, said in a press release. “The nation’s drug overdose and death epidemic has never just been about prescription opioids,” Harmon said patients need policymakers, health insurance plans, national pharmacy chains and other stakeholders to shift focus and help physicians remove barriers to evidence-based care. I have filed a petition asking for clarification on 3 issues. TAPERING Add the following language: Not all chronic pain patients should or must have their prescription opioid medications reduced, tapered, cut, or otherwise decreased. If a patient is stable on opioid therapy and has been compliant with their treatment plan: any such reductions are a violation of State policy, and destabilizing the patient, by decreasing their medication, is below the standard of care and a violation of state law. Treatment plans should not be altered or changed unless a violation occurs. b) This change is needed because: Physicians fear regulatory scrutiny. Abandoned or undertreated pain patients are often forced to suffer agonizing pain. Destabilizing these patients often forces patients to choose to seek relief illicitly, using dangerous and deadly street drugs. Due to psychological distress tapering creates a mental health crisis of being abandoned. many have overdosed or committed suicide. In the event of a violation of a treatment contract, the treating practitioner should investigate to determine whether a purported violation is accurate and assess its severity level. The investigation should always include a face-to-face meeting with the patient to discuss potential violations, and, as appropriate, to remediate them c) The effect of this rule change will be: To define the standard of care and stop unnecessary patient harm. WAC 246-919-850 WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. MME DEFINE NO MAXIMUM MME I am requesting the following change: Add the following language: Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioids, shall not be predetermined by specific morphine miligram equivalent MME (MED) guidelines. Neither the State of Washington nor federal law require dose, strength, quantity, or duration limitations on prescription opioids. In addition, Washington does not have an "upper limit" for opioid prescribing. b) This change is needed because: Many physicians and medical personnel are unaware that there is NOT a maximum MME dose in Washington State. The 2016 CDC Opioid Prescribing Guidelines have been misapplied and have caused direct harm to the pain community. If a patient is stable and has been compliant with their treatment plan then forcing tapers of stable patients to a specific MME aka MED, is a violation of the state law and below the standard of care. Abruptly tapering or discontinuing opioids may cause serious patient harms including severe withdrawal symptoms, uncontrolled pain, psychological distress, and in rare instances, suicide. ADD EXEMPTIONS RARE DISEASES/CHRONIC PAIN Add Exemption for Rare Diseases and Chronic Pain. Patients who have rare disease, as defined by the National Organization for Rare Disorders (NORD) and/or indicated by the Rare Disease Databases of the National Institutes of Health (NIH) are Exempt from these guidelines and/or policies. b) This change is needed because: According to the NIH there are over 10,000 rare diseases affecting more than 03 milion US citizens of which 90% are without treatment. A rare disease is a disease or

	condition that affects less than 200,000 people in the United States. Many are life threatening and most do not have treatments. c) The effect of this rule change will be: Adding Rare Disease as an Exemption ensures that ALL Americans suffering from Rare Diseases receive adequate pain treatment. Sickle Cell Disease is but 1 of 10,000 rare diseases that cause intractable pain. Many patients search for 8-10 years for a diagnosis. According to the NIH, misdiagnoses delay specialty care. Often these delays cause the disease to progress uncontrollably and to increase in severity, especially in terms of persistent and worsening chronic pain
9	Kate Burton For multiple years now, approximately 95% of opioid overdose deaths have been attributed to illegal, gang-manufactured fentanyl. Less than 3% of accidental overdoses have even included legally prescribed opioids. Imposing further limitations on legal pain medications - even incrementally - exacerbates the problems people with chronic pain (or surgery, or cancer) with medically documented conditions and diseases deal with while attempting to access their life-saving medications. Overall, these restrictions help little to none in reducing the supply of illegal opioids nor the rate of overdose death- but they do result in immense difficulties for patients and their families merely trina to survive their own sufferina. Sadly, suicide can be the result. The American Medical Society and the Medical Society of Interventional Pain Physicians both have made public statements about the misleading comments made by the CDC about opioid medications. Furthermore, nationwide news stories about international illicit fentanyl have made it very clear that we do not have a legal prescription opioid problem in our country, we have an illicit fentanyl problem invading our country. I urge you to not only abstain from further medication restrictions, but to also retract previous controls. Thank you for your consideration, Kate Burton
10	Vicki Sulfaro Hello my name is Vicki Sulfaro and I'm an intractable pain patient in washington state. I support the petitions submitted by Maria Higgingbothom. I've been in severe pain since 2000 when i was involved in a severe MVA. I was stopped and a young man from my kids high school hit me at over 50 mph I've had multiple surgeries which has stabilized my spine but it hasn't the pain until i was put on opioids to help ease the severe pain after trying multiple treatments. I'm also a rapid metabalizer verified by a DNA test that proved i was. My Meds only lasted a bit until i was put on extended relief with a immediate release for breakthrough pain. In 2009 i was forced into pain management as my dr retired and his replacement refused to treat my pain. I was immediately told i needed to be reduced because they were told i was on to high a dose. Since 2009 i have been reduced 90% . Before i was reduced i was able to work go on trips go to concerts etc. Now im pretty much stuck in my chair and all because i was reduced by 90 percent. I have no quality of life. I can't do things with my family. Sadly Life is just passing me by. I've never had any issue with my meds i don't abuse them it just makes my pain .Bearable. Thank you for taking the time to read this and for all your doing to try and help so many victims who are suffering so badly. You are Appreciated Best wishes and thank you again Vicki sulfaro
11	Anonymous I am a caregiver for a patient who has struggled with pain for over 20 years. Although she is always in pain, she's the strongest person I know. She has survived so many procedures, surgeries. About 10 years ago her doctor all of a sudden said she had to be tapered. She was before the taper, able to go for short walks, help do minor chores around the house and do minor shopping. When she was tapered, she was reduced to a life in bed watching the world pass her by. She didn't do anything wrong. Doctor said because the CDC

	changed the rules and he was receiving letters from the Washington medical commission that his prescription numbers were high? He is a pain management doctor?? Heart doctors write prescriptions for hearts, every specialist treats their specialty with medication, why are pain doctors being constantly attacked for treating patients who have painful rare diseases? Things need to change. I support Maris Higginbotham's petitions, we need EXEMPTIONS for Chronic Pain/Rare Diseases, we need doctors to STOP tapering and using some false MME they say I'd in Washington law as a reason!!
12	Cherie A Sandretzky I am a retired Critical Care RN and also a Chronic Pain Patient (CPP) due to a work injury. I'm able to see both sides to this opioid hysteria we are enduring. First, I want to offer answers instead of giving you a long sob story of what I have been through. You will see enough of these. Now to begin, we need to make sure everyone understands the difference between being an addict and someone dependent on medications, there are vast differences. Working in the hospital setting, I assure you that every provider is able to tell the difference between someone drug seeking versus someone in real pain. The addict will do terrible things to themselves for drugs. They pop their shoulders out, saw off part of their finger, go through the sharps containers looking for drugs (which we never dispose of meds that way) they lie, manipulate and have amazing stories, all to get some type of medication. They have a nomenclature that when they say certain things like "I can only take dilaudid" etc. We know what their plan is and are quick to stop it. Now when someone comes in with Chronic Pain, you can tell by their vital signs, their demeanor and their history that they are suffering. Providers are smart and can distinguish the difference. However, with this opioid hysteria vilifying the CPP and the blatant lies coming from the CDC, backed up by the DEA and the DOJ. People are suffering worse than hundreds of years ago. A CPP will sign a pain contract and follow it perfectly. They never ask for more medicine, never run out, never "lose" their medicine, never sell it. They come in for pill counts, Urinalysis, lab tests and are so appreciative to be able to have a semi-normal life when medicated appropriately. CPP are not complicit in this enormous problem of overdoses. It is the illicit Fentanyl coming over the borders. We know the CDC in 2016 grouped the pain patients into the group of drug overdoses, when in reality, only 1 out of 100 CPPs suffered overdoses and usually it was with other substances, so essentially they were part of the addicts group. Presently, people are dying by their own hands, because they cannot receive any help. The Providers are frightened they will become one of the thousands of providers that are in jail, prosecuted by the DOJ and not able to call for any expert witnesses, Prison all for helping their patients to be pain free or close to it.. The problem has now crossed over from not just the CPP, it has now affected the Acute Pain Patient; (APP), people that have severe trauma, like a head-on collision, surgeries such as Open Heart, where they crack your chest open, strip your leg veins out, stop your heart, are being given IV Tylenol. People crying from Cancer, are given ibuprofen. This is seriously brutal, harmful and morally wrong to do this to our patients, to those in pain whether chronic or acute. The pendulum has swung too far over and needs to head back to helping and not harming our people. My last hospitalization, where I had two long grueling spinal surgeries. I was offered a lavender sachet, a bed of ice, and then music therapy. None of those touched the pain of having my entire spine rebuilt with 28-4 inch screws drilled into my vertebra, two 28 inch rods attached to my spine and a cage put in to stabilize it all. I seriously asked for a shot of whiskey and a stick to bite onto. It has become worse than a war-zone, casualties screaming and begging for death. I have heard, seen and witnessed this as an RN and as a patient. Yes, there are always a few bad providers, in it for money making, as in any arena. Those are the ones that need to be stopped, along with those crossing the border and bringing illicit drugs into our

	country. So in an effort to help the overdose deaths and also be compassionate to the CPP. the APP. and even our pets (yes veterinarians are jumping on the bandwagon of denying pain medication to our pets). We need to have a plan and have as many demographic people as we can, to figure out how to help our patients, our providers, and the addicts that do need help. We need to have available help for the addict, I cannot tell you how many times a young person would come into the ER and ask for help, they wanted off drugs, only to be told there was no help, but here's a list of numbers to call, so good luck getting a bed and getting off drugs, beds they are months out. So they go back to doing street drugs and often dying from hot doses of illicit drugs, not pain medicines. We need to educate our Providers that pain medicine is okay to give, we need to have parameters, policies and procedures to ascertain whether a person is in need of pain relief or drug seeking. As stated earlier, we know, and are able to stop the drug seekers. However, our hands are now tied because we are frightened of losing our licenses, careers, our security, our homes, etc. because the DOJ is out to nab anyone they can. and why? We know that this whole opioid hysteria was created for money, Dr. Kolody, of the CDC, has huge amounts of stock in the Suboxone industry. The lawsuits against the Sackler family and other medicine makers are huge. Our state has already received millions in lawsuit activity. We need to stop making this about money and make it about taking care of our people whether chronic pain or acute pain, this hysteria needs to stop. We need to protect our providers. We also need to let patients have the right for medication that allows them to survive, to have a semi-normal life. Let patients and providers Not be afraid or be vilified by others, such as the pharmacists, hospitals, the CDC, incompetent or fraudulent providers, young providers being taught the wrong way to approach pain, scandalous companies making a buck with alternative therapies for pain, and the attorneys. We need to have parameters and I mean GOOD parameters set up for medication. The MME the CDC has recommended is ridiculous and not even appropriate. We need to have the providers, experts in pain, the patients and qualified persons input. Unless you are a healthcare provider, you should not be in the business of tampering with the care of patients. We are educated and adept at our care. Yes, in the 1980s we sent every ER patient home with a 4 pack of pain pills, a prescription for a month's worth of pain meds and that pendulum was too far over. Yes we need to look into having appropriate measures taken to help the CPP, the APP, the addict, to protect our providers, the pharmacists, the people that need help. It starts here, I urge you all to look up "The Doctor Patient Forum" for information about this entire mess. Claudia Merandi is a huge proponent of the pain community. She has laws passed in Rhode Island that protect the providers and the patients. It works, if we can all work together to solve this. I am willing to attend and have input for any panels regarding setting up good parameters, policies and procedures that our state can provide in helping our good citizens. Thank you for your time and consideration in this matter. You are greatly appreciated.
13	Jan Shoop I am Jan Shoop...I live with tremendous, intractable chronic pain. I have Ankalosing Spondylitis...a genetic disease of the joints and vertebrae. I have Adhesive Arachnoiditis..I have severe Degenerative Disc disease, osteoarthritis and 'Back Failure Syndrome'. I have had both my knees and hips replaced plus some smaller joints in my hands and feet. And to top it off I was diagnosed with Parkinsons Disease two years ago. Until recently I believed l was alone in my suffering but, I have since met these wonderful people l am here with today that have brought me courage and strength. My heart is broken that they are also suffering with pain. In 1980 I came to Washington to become a paramedic as at the time this is where the best paramedics were trained. I saved lives for a living. After many back injuries I retired and went to Respiratory Therapy school. I worked in the Intensive Care Unit at Tacoma General

	Hospital until I could no longer stand upright. I was forced to retire again. They performed a nine hour surgery on my back which was a complete failure. I now have rods and screws floating in my body not attatched to anything as my vertebrae are disintegrating. I have been to many doctors for this and none will touch me. I have been on numerous narcotics which have been unsuccessful in relieving my pain. Then my doctor put me on the Fentanyl 100mcg transdermal patch which has literally saved my life. My life is back. I am now able to walk my dog. I am able to get out of bed…I can prepare food for myself. I have good friends and l am now able to function in society. I feed the homeless, I counsel the lonely and the disenfranchised, I bring communion to the sick. Without this medication I would be nothing…my life would be over..Even with the Fentanyl patch I am never without pain… If I were able I would still be working. I have three Associate degrees and a Bachelor's in Psychology. My mind is strong…my body weak. I am truly blessed that I have the life that l live now. I want to do as much as l can for as long as l can. Without this Fentanyl patch I would be finished! I saved lives for a living..please save mine and the lives of those that suffer in pain. Let us not forget how fragile we all are. *** Jan Shoop passed away in 2022, after a tremendous battle with pain, injuries and incurable conditions
14	Travis J Noble I am tired of seeing my Mom suffer from her medications being tapered down. This is unreasonable and hurting her and other patients. I can't imagine having the surgeries and the pain she suffers from everyday. This whole opioid problem is NOT from opioids, it is from illicit drugs. We need to protect those in pain, like my Mom, who has chronic pain. Or from people getting hurt and needing help. No one is helping because they are afraid they will lose their license and jobs. Even our pets are suffering, do you really think that the drugs they give my 10 lb dog will do anything to a grown adult? Ridiculous isn't it. Please stop this insanity of the MME that is only recommended, it is not a law! Let the Doctors do their job and stay out of the medical business. I am tired of hearing my mom cry in the bedroom from untreatable pain, because her doctor is worried about being put in prison like Dr. Bill Bauer. Or believe the lies the CDC has said about the MMEs and how they need to be such a nominal amount it won't help. Or how about how Suboxone, Buponepherine, Subutex, etc. are pain medicines. No they are not, all they do is rot your teeth and create a med that is impossible to withdraw from. I hear it is worse than Heroid to stop. It is all about the lawsuits and the way for people to get money. It is a travesty that this faction of society has to suffer for companies to make millions. How do people, how do YOU sleep at night knowing people are killing themselves because they cannot get any relief from pain. Whether long term pain or short term pain. It all hurts!
15	Shannon Russell I completely support Maria Higginbothams petition and am grateful the commission is finally seeing how pain patients have been unfairly treated with bias. We don't want to live these lives, to be diseased and suffering in pain. We'd much rather be normal people, able to raise our children and be involved in their lives instead of being forced to stay behind and not be involved. Not be able to go to events or have quality of life I've been on pain management since 2007 but have dealt with pain for most of my adult life. Prior to 2016 when all the rules changed and our government became our doctors boss everything was good. Not perfect but at least I felt listened to and heard. I didn't feel like my husband had to go to every appointment and advocate for me. Since 2016 I've been yelled at by my doctor because I didn't want to stop taking something that was working for me. I've had 2 doctors retire. One of them abruptly and only gave me a month supply to find another doctor. When searching for a new pain management doctor the only ones out there will only do surgeries or injections but those are for everyone. I've had my pharmacy that I had all my scripts filled at tell me they will no

	longer fill my scripts for pain . There is more fear than freedom to do the right thing for pain management patients. I don't understand stopping a medication that is doing its job to have a surgery that might help. I have many things that my body is going through that cause me pain. I also have many tools in my tool box to help me live a normal or semi normal life from pain medication (high dosage of opioids), chiropractic and massage therapy. They all work together and most I have to pay out of pocket cause insurance doesn't cover alternative care. The rules done by the cdc in 2016 have destroyed my quality of life that I have been fighting to preserve since I was 27 yrs old. I don't fit into the box and I definitely don't think because your a female victim of child abuse that it automatically means your going to become an addict. My struggles with our medical hasn't been easy and I'm one of the lucky ones.
16	Denice LaCoste Erikson I support Maria's Bill. I support any bill that helps chronic pain patients and their physicians. I'm tired. We're all tired. Chronic pain patients are treated like we have leprosy when we walk into a doctors office. I myself have been completely and abruptly cut off pain medication, after 28 years of correct use, or force tapered 4 times in the last 8 years. We tired. We're in pain. We are your daughters, mother's, brothers, etc, and we need protection for ourselves and our physicians who prescribe. My husband is Retired Military, a Veteran, and his brothers are denied proper pain control. His wife, myself, has been left bedbound. This undertreatment, mistreatment, an no treatment for pain has got to stop!
17	Martha Mioni Favors I totally support Maria Higginbotham's statement for the Chronic Pain Patient (CPP). I have been a CPP for over 20 years after rupturing L5-S1 at work on February 14, 2000. I had disc removal surgery which left me with scar tissue, nerve damage, and severe right leg sciatica. I have also developed other chronic pain issues. I take opiates to help me cope with my severe pain and for a quality of life. Because of the pain medication I am also able to be my husband's (James) caretaker who is now legally blind. He also has had diabetes for close to 40 years, a kidney transplant recipient, and a huge fall risk. If I didn't have access to these life saving medications, I couldn't function along with someone else having to take care of my husband!!! I have been a CPP at Peninsula Pain Clinic (PPC) in Silverdale, WA, for over 20 years. I have been the model patient, passed every urine test, and have been on the same dosage of long acting Oxycontin, 40 mg. 3 times a day, and short acting Oxycodone, 15 mg. 3 times a day (165 mg. total) for many, many years. Once the correct dosage was figured out I have never asked for an increase. Recently PPC is starting to forcibly taper every one of their patients down to 120 MME out of fear. Once tapered down to that amount I will not be able to function and will no longer be able to be my husband's caretaker. I am now needlessly suffering. I ask myself why, why, why!!! If you are afraid I will overdose, I certainly think after taking opiates for over 20 years I would have done so by now!!! Please Washington State!!! Please make it possible for the pain medication prescriber be able to do their job, prescribe the amount their patients need without fear, and let them practice, "DO NO HARM!!!"
18	Lucinda Poisel I totally support the petition filed by Maria Higginbotham regarding tapering rules. Forced tapering by the system has left me in 24/7 pain. Pain consumes my quality of life, my mobility which in turn affects my marriage, my family,friends,everything. Please consider all the unheard cries for HELP! Thank you.

19	Gina Drosdak Gillespie I want to thank the Commission for updating and amending the opioid guidelines. I am 69 years old and have suffered from disabling conditions since my 30s. I moved to WA State in 2020. My former doctor in PA said he could treat me for 6 months. Sadly, I needed more time than this. I had tried to make an appointment with almost 20 doctors--each one saying they do not accept patients on pain medication. I wish I had saved the list of how many offices I had called before I finally found a doctor who accepted me. I currently have 4 loose screws in my cervical hardware, one very close to the vertebral artery and one very close to a nerve root. I also have nerve compression and stenosis in my cervical spine. I have 4 bulging discs in my lower back, stenosis, spondylolisthesis, and nerve root narrowing. I have extensive arthritis throughout my body. Almost all of these conditions have been known for millennia as causing quite severe pain. I am very fortunate that Belbuca (buprenorphine) and Tramadol keep me functioning, although there are 1-3 days a month that I need something a bit stronger like Oxycodone. However, I can't get that extra help anymore. Currently, over 3,000 medical professionals are sitting in prison for doing nothing more than treating pain patients with compassion. They were not running "pill mills" or selling them, etc. Something must be done to protect both doctors and pain patients. It saddens me that what's happening now is due to the CDC's Opioid Guidelines--a guideline influenced primarily by anti-opioid zealots with a conflict of interest. Most of these anti-opioid zealots never treated a pain patient in their life and they make more money testifying against medical professionals than they do in their practices. I sent an email message to Amelia Boyd with links to information showing the CDC acted in bad faith based on junk science. I do hope all Commission members were sent this message and I hope all members look at the links. You can only make just decisions if presented with facts. Too many people are suffering today--many are terminal cancer patients and veterans. Pain patient suicides have skyrocketed after they've been force-tapered or cut off cold turkey from pain medication that enabled them to function--and even work--on a daily basis. Statistics say at some point, either you or a loved one will deal with a debilitating condition. Would you be comfortable watching your spouse, parent, or child writhe in pain--and no one will help to ease the pain? This is happening in WA State right now. I urge all Commission members to thoroughly research this important subject. I hope the links I provided in my email message to Amelia help facilitate your efforts. Thank you for allowing me to share my situation and the concerns I have for the dire situation pain patients are in today.
20	Damon Sandretzky I would like to tell you what I have witnessed regarding my wife and her experiences over the last 17 years as a Chronic Pain Patient (CPP). First, she was an RN working in the ICU and the ER and got hurt on the job and has had 9 back surgeries and every type of therapy, medicine, and different physicians imaginable. Finally after 12 years, the pain clinic said they could do nothing more for her and released her to her Primary Physician with instructions to continue on with the present pain medications they recommended. She was able to do physical things to a degree. I watched her suffer silently, often going into the restroom to cry. She has always been a trouper and had the best attitude. With her team of her Physician, Physical therapist, medication team, etc. She was able to participate in events. Then in 2020, she had to have two more surgeries because the rods broke in her back and her upper back collapsed. She was basically bed ridden at this time, with pain levels above 10/10.. Unfortunately, this is about the time that PROP and other entities decided it was the CPPs that were creating all the deaths from overdoses and they should all be taken off any medications. When in reality, the deaths have been from illicit drugs like Fentanyl. The CDC was combining deaths from illicit drug

	overdoses along with information about prescription medicine, focusing on the CPPs. Basically they were adding all the overdoses together. With what little research done on the subject, only 1% of those deaths were of a CPP. The rest of the deaths were from illicit street drugs brought into the country. But somehow the CPPs were villified and blamed for the overdose deaths. Drugs brought into our country is the main cause, a situation that is now highlighted in our nightly news. When in 2020, my wife was in the hospital, after her surgeries, No patients were given any pain management. the entire surgical floor sounded like a Civil War field hospital. People were literally screaming in pain, begging for some help. Do you know what they were offered? Lavender corsages, smell therapy to help the pain of being fileted open. Next, ice beds, yes, laying on a bed of ice for hours and days, somehow it was supposed to alleviate that pain of having 4 inch screws driven into your vertebrae with a drill and hammer. Next those poor people suffering from complex surgeries were offered music therapy. Yep nothing like old time rock and roll to stop that pain from having your abdomen ripped open and sewn back up. My wife, a CPP, was in a wonderful program that allowed her to be semi pain free. When the hospital and the doctors there heard this, they immediately pegged her as a problem, a drug seeker, and created a hostile environment for her. I, as her advocate, asked to speak to her caretakers there. Before I could get help, my wife's neophyte nurse complained that I was intruding and making it hard for her to work because I was advocating for my wife's pain. I was then kicked out and trespassed from the hospital. All because I was trying to help my wife not scream in pain from having a 25 inch incision on her back and her entire spine rebuilt from pelvis to neck. The distress we both went through was unnecessary and I feel in violation of "Do No Harm" and utilizing pain as a measure of how well a patient is doing. Today, my wife has had her pain medication reduced to what supposedly is the MME the CDC recommended. Which she is grateful for. I cannot believe that those without a medical degree working in the DOJ, DEA, CDC, etc. can require rules and parameters regarding a person's health and care. My wife is now housebound and tries her best, but I see her suffering in pain, not able to hold her new grandbabies or do simple things like go for a drive or out to dinner. It is just too painful for her to do normal things anymore. If she was prescribed the correct amount of medication, I believe her life would take on a better quality. I guess what really gripes me the most, is the reasons behind these "recommendations" set forth by the CDC, and followed up by the DOJ and the DEA. It is all about money. Lawsuits abound with every state, federal and persons suing the opioid makers. Certain CDC personnel have vested interest in Suboxone stock and it has certainly been pushed as the new pain medication. If anyone disagrees with the CDC, they are investigated and now over 3000 healthcare providers are in jail because of skewed tactics and investigations regarding pain medications. My wife is in a group called The Doctor Patient Forum (DPF), the stories from people losing their pain programs, of being given a letter saying they have 30 days to find a new provider. Or that the new policy the hospital or clinic have started is no pain medicine for anyone, or people are forced to have procedures like epidural steroid injections or pain stimulator placed,or worse, being given medications like Suboxone, Trazodone, or Haldol for pain is actually malpractice and not up to the standards of care. It has become so bad that even Veternarians will not prescribe pets pain medicine after trauma or surgery! Seriously, how much pain medicine could my 10 lb poodle get for comfort, not enough fora 200 lb man. Seriously such a sad situation. How sad that ERs, the place where people go for urgent care, have signs posted saying they will not give anything for pain to patients that are seriously suffering. There are no providers available nowadays for CPP and now this opioid hysteria has trickled down to the Acute Pain Patients (APP). People suffering from traumas, people having lengthy surgeries like Open-heart or kidney transplants are given IV tylenol. So now not only CPPs suffer, but if you break a bone, you will now be penalized

	and be made to suffer from pain that could easily be reduced. People are seriously suffering from these archaic lies. You will not become addicted after one pill. Otherwise we would all be alcoholics and drug addicts. Again the difference of addiction versus dependence is an important lesson for us all. This is a horrible travesty and needs to be addressed. We need to separate the CPP and the drug addicts. Studies show that only 1% of CPP die from overdoses and most likely they do it on purpose due to their pain not being controlled. The people dying are the illicit Fentanyl users and those thinking they are safe and get a hot dose of Fentanyl. We need better help for addicts, we need empathy for the CPPs like my wife. We need policies and procedures for hospital APPs to be treated for pain. We need to stop this pendulum from its vast swing to paranoia. Please let's rethink this whole Opioid Hysteria and start helping patients, both CPP and APP. Some day each one of us will need help in some form of eliminating pain, whether one time or a lifetime. Please listen to those that suffer.
21	Monte Erickson I'm a retired veteran. My wife has chronic pain and we need the Washington state Medical Board to rewrite Prescription Guidelines for Chronic Pain patients and their doctors. Doctors are afraid to write prescriptions to treat their patients. The patients are in pain and have a reduced quality of life. Guidelines also need to be separated between chronic pain patients and drug addiction.
22	Pamela Beall My 76 year old mom was force tapered down from her proper pain management several years ago and is continually suffering because of it. She has rheumatoid arthritis with six degenerative discs in her lower back, bone on bone knees, fibromyalgia and osteoporosis. The four options her pain management doctor gives her is 1) physical therapy (Which she does and it causes her more pain) 2) Pain relief with FDA approved full agonist opioids (To which she is on the bare minimum first tier 5 of hydrocodone) 3) spinal steroid injections which are not FDA approved, high risk and low reward or 4) spinal disc surgery for which she is a very poor candidate and would probably never get a surgeon to take her case. So this leads us back to 1 and 2 Without appropriate and effective FDA approved pain relief from an FDA approved full agonist opioid she will continue to lose her mobility because she cannot move as much (PT) and therefore she loses muscle which loses mobility and we get on this vicious cycle. I want to remind everybody reading that every single one of us is one accident, one illness away from needing pain relief. She only wants some comfort in her golden years so she can enjoy her family, including great grandkids. We need to do better for our elderly and any chronic pain patient! There is a huge difference between dependence and addiction. She has always taken exactly what she is prescribed and is dependant on the pain relief to LIVE and MOVE! Is a diabetic type one dependant on insulin or addicted to it? Huge difference! Life should not be lived in agony in a civilized society. Consider that those in high level pain cannot advocate for themselves, cannot sleep well or take care of themselves appropriately unless supported by their Drs with all available means! My Mom could be your Mom or wife or sister. Please consider the bigger picture in evaluating " protocols". We have learned how far reaching and devestating the 2016 opioid "guidelines" have wreaked. A 900% increase in overdoses! The exact opposite of it's intentions. Patients in pain, some turning to street drugs or suicide to escape their pain is the result of harsh, forced tapering and fear mongering . We must protect Drs and patients. Drs are scared to prescribe for fear of prosecution! It's time to admit the mistakes of 2016 guidelines (I know they were updated in 2022 but systems haven't adapted to them either!) and allow and encourage Drs to TREAT THEIR PATIENTS appropriately again! Thank you for your attention to this matter

23	Garrett Beyer My father had his pain medicine reduced and could not live with the pain, he committed suicide, therefore I support the petition filed by Maria Higginbotham Hello, My name is Garrett Beyer and the primary reason for me writing this letter today is an attempt to give a voice to the many disabled American citizens that, with the debilitating disorders they have leaves them struggling to do normal daily tasks, let alone attempt to debate with Congress the impacts, of the new restrictive regulations on pain medications and fears of future actions that only focus on addicts and seems to completely disregard the needs of people that live in excruciating pain on a daily basis and have no other option but to depend on opioid medication for relief. Their only chance for mobility to be able to to live as normal life as possible, and without often can leave them without any other chance of relief but to take their own life... ? My Dad was one of those unfortunate people that after his doctor retired left him unable to find a new doctor to take over his treatment due to all of the doctors in his small Idaho town too afraid of the new regulations to take him as a pain patient. After several back and femur surgeries from a logging accident it left him in unbearable pain without his medication. Unable? to work, pay his bills, or even be able to play with his grand children. I guess he felt abandoned by his doctor and decided his only chance for relief was through the barrel of his 44 magnum. ? I guess my main question is why are the lives of people like my dad and many other good people that have no other choice but to take these medications less important than people with drug addiction that have every choice not to take them?? To add insult to injury, I have inherited my dad's bone and spine disorder. After several spine surgeries that included 3 discectomys and laminectomys, I now rely on opioid medications in order to walk without the shooting, burning pain from my back to my toes. Although the doctors and surgeons I have are amazing, it still leaves me rather terrified that future regulations or the loss access to caring doctors could one day force me to the same fate as my dad. ? I'm not saying that the epidemic of heroin addicts misusing prescription opioids isn't a major problem, but there has to be better ways to tackle this issue without completely throwing good, caring doctors and legitimate chronic pain patients under the bus.Thank you for your time and consideration. Garrett Beyer
24	Sarah Tompkins My name is Sarah Tompkins and I ask for the following changes. As a chronic pain patient, I've experienced doctors pushing for tapering despite understanding chronic pain patients diagnosis or medical treatment. Chronic pain patients must not be automatically tapered and must be a part of their own healthcare team having their voices weigh as much as their providers. Add the following language: Not all chronic pain patients should or must have their prescription opioid medications reduced, tapered, cut, or otherwise decreased. If a patient is stable on opioid therapy and has been compliant with their treatment plan: any such reductions are a violation of State policy, and destabilizing the patient, by decreasing their medication, is below the standard of care and a violation of state law. Treatment plans should not be altered or changed unless a violation occurs b) This change is needed because: Physicians fear regulatory scrutiny. Abandoned or undertreated pain patients are often forced to suffer agonizing pain. Destabilizing these patients often forces patients to choose to seek relief illicitly, using dangerous and deadly street drugs. Due to psychological distress, tapering creates a mental health crisis of being abandoned, many have overdosed or committed suicide. In the event of a violation of a treatment contract, the treating practitioner should investigate to determine whether a purported violation is accurate and assess its severity level. The investigation should always include a face-to-face meeting with the patient to discuss potential violations, and, as appropriate, to remediate them c) The effect of this rule change will be: To define the standard of care and stop

	unnecessary patient harm. WAC 246-919-850 WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. According to the CDC the misapplication or use of inappropriate policies and being inflexible on opioid dosage and duration, discontinuing or dismissing patients from a practice, tapering stable patients has caused significant patient harm d) The rule is not clearly or simply stated: There is no upper MME/MED limit or ceiling limit in Washington State or federal law. Washington State does not have an upper limit for opioid prescribing. The rules call for a consult with Pain Management at 120 MME
25	Cathie Waite My story is long and sad. I want to say first that I wholeheartedly support the petitions filed by Maria Higginbotham. I have both been force tapered by physicians almost costing me my life as well as physicians stating they had to prescribe a specific MME. My loved ones have watched me suffer to the point of almost dying, this is not how medical care should be in this country. My Dr retired in 2020 and I was referred to another. That Dr told me she refused to see me as long as I was on opiates. After my daughter complained for me I was sent to the chief of the clinic (A very well known clinic). The chief immediately started force tapering me. Her goal was to get me to 10 mme from 150 mme. Naturally I wasn't happy so I found another Dr., an internal medicine Dr. She wouldn't treated me for a year and encouraged me to try buprenorphine. She kept me at my level for a year and it was inadequate. After being pushed into tapering down from OxyContin to be at a level low enough to start buprenorphine. After the taper down she started me on the patches and they destroyed my skin and it took almost two months to heal. So, she took me off of the patch and put me in sublingual starting at the lowest dose, tapering me up to the highest dose. It NEVER worked for my pain and I was concerned about the tooth decay it could cause. So then she tapered me up to the highest dose of 24 mgs. It failed miserably. At this point also, I had been in withdrawal for around 6 months off and on. It was awful. I told her I didn't want to take it anymore and I wanted back on what had helped me. My Dr had their pharmacist making the decisions of how to taper. I told both of them that it didn't work and I was suffering. So, They started tapering me off of the buprenorphine and as soon as I was off of it they abandoned me and left me with nothing. It was beyond cruel in how they dealt with it. I had a very severe infection called cdiff as well as my normal pain at this point. At one point the pharmacist told me that she wanted me back on the buprenorphine. I asked her why put me on something that doesn't work for pain? She couldn't answer. I was still experiencing withdrawal when I was taken off of the buprenorphine. I called the Dr office because I was miserable. She wouldn't see me. She told her staff that I couldn't be in withdrawals bc I was at such a low dose and refused to help me with the withdrawal symptoms. They both refused to talk to me about it. I was blind sided by being taken off of what was helping. I had been on the same dosage of opiates since 1996 with no complications. With all of this I became suicidal and couldn't get out of bed because of the withdrawal and the rebound pain. The pain was unbearable add she just abandoned me so she didn't have to deal with it. I went 2 months with nothing before I found a Dr at a pain clinic that was not only willing to treat me but over time put me back on the dose I had been on before these Drs started tapering me. Thank goodness for him. He saved my life because I was very close to suicide. I have been with my pain provider for awhile now, around two years. At this pain clinic I have to go monthly and I have to test every other month and then sometimes at random. I'm grateful to have my life and that I didn't give up. We need individualized care back in this state

26	Meagan Remund To Whom It May Concern: It took me 10 years of hit and miss therapies and medications to get both my severe, chronic pain under control and my mental health stabilized, so that my life was livable. In January of 2017, my pain doctor, who I have been with since 2012, cut my meds by ¾ in a 2 month time frame, as well as gave me an ultimatum to stop 3 of my main psychiatric medications or they would stop treating me at all. So, without contacting my psychiatrist or requesting those records to see the testing I've done that shows my need for those medications, they forced me off my psych medications and they weren't even the prescribing doctors. I've since been dealing with major withdrawals, suicidal thoughts, chronic fatigue, insomnia and intense pain. I have never gone to an ER because I know the way I will be treated and it will be a waste of time and money, not to mention an unnecessary addition to my anger and frustration. My quality of life has diminished almost completely. I'm 39 and cannot bathe without help, cannot fix myself food, and I need help getting to the bathroom. I have 2 kids and am married to an army sergeant who is gone for training missions most the time. The clinic I go to has always required a monthly urinalysis screen and I've never asked for early refills or failed a drug test. They used to fill a script for 30 days with 28 day appointments, now it's exactly 28 day fills and still 28 day appointments. One of my medications is so expensive (a generic at $3000 a month) that most pharmacies don't carry it or won't fill it because my insurance won't reimburse them the full amount and it's always at least 2 days or more to get it filled, and still I get just 28 days. They tell me their clinical practices are following the law, but that is simply not true. I've been in contact with the WA state DOH licensing commissioner and the DOH lawyer, both of who have also told me their practices are NOT based on any current laws and they see the unethical and dangerous practices this clinic is participating in. There's no longer any trust between patient and doctor, because they would rather lie or gaslight us, than take a chance on losing their licenses. My only recourse is to file a complaint, which the DOH lawyer says I have a solid, actionable case for but I would be kicked out of the clinic with no one to take over my care. Plus, I'd be blacklisted and would have an even more difficult time trying to find another provider. The wrong people are being punished for the wrong things. This war on pain patients isn't going to curb the deaths or OD's from street drugs, in fact you can already see what a wash in terms of human lives this has become with the increase in suicides and heroin overdoses. We didn't ask to be held prisoner by our broken bodies, we would rather not have to go to the doctor every month and we would rather not take medications every single day, but what other options are there or chance do we have at living a somewhat productive life we can be proud to call ours? Like with prohibition, they are doing it with pain medications and trying to regulate human behavior with more laws, without any regard to the people who take their medications safely and as prescribed. It's a case in point definition of insanity; doing the same thing over and over expecting different results. Fentanyl and Heroin use will continue to climb and ODs and suicides will continue to rapidly increase.
27	Suzanne Helms WAC 246 (-918): I have a MSc in biochemistry and a BSc MT (ASCP). My thoughts on the WMC and the exemptions/recommendations: The support for recent changes does not go far enough for rare or painful, progressive disease exemptions. The addition of an exemption for sickle cell patients, cancer, and pallation, is a step in the right direction. However, it is far better to exempt *all* intractable pain-causing disease patients - aka rare/incurable/painful, progressive diseases (which naturally includes sickle cell, serious cancers, and pallation). It should be noted simply, "If the benefit of opioids outweighs the risks

	in treatment, such as, improvements in a patient's ability to perform independent activities of daily living, ability to work vs. not, etc., then it is better to keep a patient on their treatment plan." Given how few patients are on a long-term opioid treatment plan, this wording provides the medical team with the clarity needed to continue treatment for those that otherwise will not recieve a continuity of care. With an overall opioid prescribing at very low rates, it is not necessary to taper the chronic pain patients that are left. Not all chronic, intractable pain patients require medication tapers, and exemptions will prevent destabilizing these patients medically if tapered from their treatment, especially if performed inaccurately. As a result of the remaining chronic pain patients having difficulty finding and remaining on their treatment regimen; chronic, intractable pain patients require the same exemptions as sickle cell, cancer care, and pallation. In addition, there is no MME (morphine milligram equivalents) maximum limit in WA, or by the FDA, but rather, levels where practitioners already monitor patients more carefully. Therefore, if a patient is following their treatment plan as recommended, then forced tapering, or reducing pain-relieving medication(s), should be a violation of state law; as well as considered below the standard of care. Biological testing should not be used as a punitive measure. Low-quality drug screens should not be used or recommended for medication adherence. If the testing is for point of care 10 panel antigen-based tests, then these tests are considered low quality. These urine screening tests are not designed for medication adherence. They only screen for illicit drugs, and not very well. 10 panel UDS (Urine Drug Screen) antigen tests have several false negative and false positive rates. Using a result from one of these tests, without GC-MS validation, should be considered below the standard of care, and medical abandonment if used to dismiss a patient, based on false negatives… For example, one research paper on antigen tests researched the morphine test, which is a metabolite antigen found in every US-marketed UDS antigen test. They found "all currently marketed opiate immunoassays use antibodies raised solely against morphine" (Krasowski MD, Pizon AF, et. al. Using molecular similarity to highlight the challenges of routine immunoassay-based drug of abuse/toxicology screening in emergency medicine. BMC Emerg Med. 2009 Apr 28;9:5. doi: 10.1186/1471-227X-9-5. PMID: 19400959; PMCID: PMC2688477) but, the results had a varied sensitivity to morphine itself; at antigen concentrations greater than equivalent doses taken by many patients due to low-dose opioid prescribing. There is an inability of these tests to react with non-morphine medication metabolites: "2 of 8 [of the researched UDS] marketed assays being essentially insensitive to oxycodone and 3 additional assays only producing cross-reactivity equal to 300 ng/mL morphine at oxycodone concentrations of 16,000 ng/mL or greater…For oxycodone, only 3 of 7 marketed assays have sensitivities to oxycodone sufficient to readily detect daily use of 20 mg oral oxycodone. Exact urine concentrations of oxymorphone following either oxymorphone or oxycodone administration have not been reported in the literature but are likely to be well below the assay sensitivities due to the extensive metabolism of oxymorphone prior to renal excretion." The paper further reports, "Marketed opiate assays do not cross-react with the mixed opiate agonist-antagonist buprenorphine (Tanimoto similarity to morphine = 0.783) (Additional file 1). Commonly used non-opiate opioid drugs (e.g., fentanyl, meperidine, methadone, propoxyphene) generally have low structural similarity to morphine (Tanimoto [test] similarity range = 0.407 – 0.522) and either do not cross-react, or do so only at extremely high concentrations, with opiate screening immunoassays." Meaning, the tests are not specific enough to detect medication adherence, especially given the metabolism rates of patients and the poor quality of the antigen metabolites used for these tests. Issues with marketed urine antigen tests and medication adherence vs. the ability to detect results, with just non-morphine alone, should be reason enough to not use biological testing for medication adherence testing. It would be wise to remove

	recommendations for biological testing, but rather, review confirmation by GCMS if medication adherence is in question. There are many/rare disease without known cures, other than the patient's current treatment plan. This subset of the population is roughly 30 million Americans. This means, every large Thanksgiving dinner gathering has 1 of these Americans at the dinner table. Each family - yours and mine. Maybe they are the ones that cannot make it to dinner, but they have a place in our homes and hearts. We can treat and serve the interest of these patients, their physicians, and insurers; exemptions need to exist for chronic, intractable pain; remove nuanced tapering, MME ceilings, and punitive biological testing recommendations. Thank you.
28	Lisa J Bruna PhD I am writing this testimonial to express my extreme concern regarding trends in opiate prescribing in the US, as well as the state of Washington. I have a chronic pain condition that has left me disabled and significantly reduces my quality of life. I have ovarian cysts, chronic migraines, fibroids, endometriosis and fibromyalgia. I also struggle with serious depression and anxiety. I have tried to hold off on taking opiates to control my pain for as long as I could. I do not currently take them, but I do fear that I will need them in the future. However, I am terrified that should I need them, doctors will fear prescribing. The worst part, for me, is that I potentially have a hiatal hernia that needs surgery to be fixed; my stomach may very well be pushing up into my diaphragm and I am scared to do anything about it. I am scared because I do not believe that I will receive appropriate pain management if I do have any kind of procedure performed. Fibromyalgia is in part a disease of central nervous system sensitization, which means that because of my body already over interprets pain signals, I often feel as if I HAVE just had surgery when all I have done is go to the grocery store. But more terrifying to me, is the idea that I may have pain in the region of the surgery for the rest of my life if I do not receive adequate pain relief. However, I do not think that my plight is anything compared to the intractable pain patients who are suffering NOW due to unnecessary and irresponsible restrictions on opiate medications. Over the past few months I have been hearing more and more about how doctors are intimidated by the CDC Guidelines and by stories of DEA raids, are leaving pain practices and/or abandoning their patients. As a member of several large online communities made up of intractable pain patients, I am alarmed by how frequently I am hearing that responsible, medically compliant pain patients, who have been utilizing opiates successfully, sometimes for decades, are being told that they will no longer be prescribed the medication that makes living their lives possible. People who have never abused, sold or misused their medications are being abruptly abandoned, without a realistic taper schedule or an alternative medication that works. Tragically, I know that in some cases these patients are left without recourse, other than suicide. I know that the suicide rate among intractable pain patients is skyrocketing, even if it isn't being documented as such. If our government doesn't act now to support intractable pain patients, to enact reasonable pain medication prescribing policies that recognizes the rights of responsible citizens to have their pain managed. I fear an epidemic of suicide is on the horizon. The World Health Organization (WHO), the United Nation's health department, so to speak, has declared pain management to be a human right (WHO, 2012). Denying pain management, when it's legitimately needed, is a human rights violation. As the restrictions on opioid prescribing becomes stricter and stricter, it is not the addict who suffers, but the legitimate pain patient. It is the job of our government to protect its citizen's rights and their lives. It cannot do that if it unnecessarily restricts access to pain control. Please keep this in mind, as you consider your course of action. Thank you for your attention to this very important matter.

29	Yvonne Helmick Although I agree with the changes the commission is currently making to the opioid prescribing rules I believe more needs to be done. I am 80 years old and have just recently begun to understand what living with pain is like. I have a 63 year old daughter who has been living with horrific pain for 23 years. Just last year she was finally diagnosed with a rare disease called Ehlers Danlos Syndrome. This disease destroys the connective tissue in the body. She has endured over 50 surgeries, 14 on her spine. Nothing can help her but pain medication allows her to have some quality of life. Over the last few years I have seen the result of her being forced tapering of over 50% of her medication due to the 2016 CDC opioid guidelines. This is not how vulnerable patients should be treated. Watching someone you love suffer needlessly is heartbreaking. I agree and support Maria Higginbotham petition Specifically 1) Make it VERY clear in the rules that Washington State does NOT have a maximum MME 2) Address forced tapering. Please add to the rule “if a patient is compliant with their treatment plan, then any forced taper or reduction in medication is a violation of state law and below the standard of care" 3) ???Since the WMC is adding an Exemption for Sickle Cell Patients, 1 of 10,000 rare diseases, l am asking that they add an Exemption for ALL Rare Diseases which affect over 30 million Americans 4) Add an Exemption for Chronic Pain Patients, patients with diseases and medical conditions that are incurable and are progressive and aggressively causing destruction to the body resulting in intractable pain
30	Lindri As a person who suffers from chronic pain, and has for 7 years, I’d like to comment that CP sufferers are paying the price for the DEA narrative, the skewed CDC data, the threat of the PMP and all of the gate keepers from top down. I have a medical condition…..A debilitating, agonizing medical condition. Receiving medical care just as any other person with a condition should not be punished because my disease is politically and socially unpopular. Lying in bed, suffering past ‘level 10’ every day all day under treated does not allow me the luxury of brushing teeth, taking a shower, and anything else above those on Maslow’s Hierarchy . If my pain surpasses the amount that I’m prescribed and I’m honest about how I’ve had to survive, I get punished….we all get punished…..I’m out. Stress is pain’s best friend. We are encouraged to utilize mindfulness, meditation and we all want access to non-pharmaceutical interventions, I.e acupuncture, chiropractics, naturopathy, diet, movement …. However, as a population we are grossly under treated, or not treated at all. How, then can we access these alternatives. We are offered pain psychology, but we can’t get out of bed. Relying solely on opiate therapy, or no treatment is wholly irresponsible. However, in order to reduce our stress, access other options that help us begin to heal, and possibly provide us with an exit strategy. … That was my hope…WE NEED TO BE ADEQUATELY TREATED. .I have 2 systemic diseases that cause pain and 5 spinal injuries. One of my best therapies is simply movement, fresh air and finding some kind of meaning to my life. BUT FIRST, I NEED TO BE ADEQUATELY TREATED…not struggling from refill to refill. Emerging research shows that pain management is enhanced by adding non-pharmaceutical interventions….BUT FIRST I NEED TO BE ADEQUATELY TREATED….for however long it takes. Just like depression or diabetes, I need a dose review when my disease flares or progresses and without my doctor limited by the threat of losing their license. I trust my doctor to make the appropriate assessment. I JUST NEED MEDICAL CARE. The WMC uses language that states that “Patients have the right to reasonable pain management”. Lets define “reasonable” and make it reasonable. Pain cause mental and physical stress…stress causes pain. It’s a vicious cycle perpetuated by the very people who are under treating us, or not treating us. The state current milieu then becomes counter

	productive. These draconian 'guidelines' set forth by the CDC, the overreach of the DEA are what drives patients to high risk behaviors - going to the streets, asking friends and in too many cases, suicide. Please act on our behalf. I would love each of you to spend a few days in my body....Then you would understand the urgency. We are dying.
31	Alisha Briggs Hello, my name is Alisha and I have been paralyzed since 2012. At the age of 22. I have been on pain medication since. Which allows me to tolerate the agony that I have suffered since. I suffer with daily debilitating pain that never get better and is resistance to all other kinds of pain relief treatment but full agonists opioid medication. I was given 210 miligram equivalent daily before the limit of 120 miligram law was passed in washington state. I was on this dose for 12 years without any issues. I was stable, happy, and as healthy as possible. I have been forced tapered since this law was passed and I can't get any help. No one will let me have the dose that I need to handle this very intense pain. The doctor's are afraid to help me because of their 120 miligram limit. I went to two different pain specialist and was told that they wound not give me what I need because of the risks to them personally even though I'm documented and compliant on my pain contracts. I have been suffering through a endless Taber to 120. I have lost half of my functions due to this taper. I have troubles sleeping and staying active because I have to fight more pain with less medication. I would ask you to remove this limit of 120 mme on doctors in washington state. My life is harder now and I just want to be able to shower and sleep and play with my dog and work part time. I need more medication to improve my life. I have tried acupuncture, aspirin and all insaids. I have done many sessions of physical therapy. I am permanently damaged and deserve the treatment that works. Which is oxycodone. I have had my medication cut in half over 5 years. I have been suffering in silence because I can't get anyone to help me. I want to live as full as a life as possible but that has become impossible without more medication and compassion from the legislative government of Washington State. Please consider the most at risk people in the state. The diabled and those in intractable daily constant pain for which there is no cure but only comfort measures. We need more latitude and compassionate care in prescription amounts allowed. Doctors need protection from prosecution for helping us to live. I ask you to think of those who need your help and have been hurt by these limits. We need protection and to be helped. I'm so tired of fighting this alone. I ask that you talk to pain patients that are without help that must have fill opioids to survive their terrible medical conditions. These people fight everyday for simple things. To cook a meal, to catch the bus, to take a shower and for many to have dignity and any control over their lives. These prescription limits are harmful and make getting medication very difficult. Please think about us when you look into this matter. We need to have representation and compassionate care. We need doctors to be able to treat us. Please Call me if you have questions. Thank you for your time-Alisha
32	George Briggs I am a sixty eight year old man and I suffer from pain every day. I worked hard physical labor during my life and I have had diabetes for decades. These things have left me with neck, shoulder, back Leg, hand and feet pain. I have requested pain treatment from numerous doctors, both specialists and general practitioners. I have been universally denied any real treatment.I have been offered lyirica and recommended nsaids. Lyrica is ineffective and the amounts of nsaids I would need is dangerous. Aspirin is the only one that works but I can not use large amounts without intestinal bleeding. I don't want to be high all day every day on cannabis or drunk on liquor. I don't believe my mind can deal with marajuna or my liver with alcohol. Mindfulness is a deceit. My pain is real and I can't

	think it away. When I have said I am suffering from pain I have been told that opiates don't work or told that the Doctor doesn't treat pain or just plain ignored. I can't speak for these Doctors directly but I can infer that they are afraid to treat me. I believe from my experience that the State has come between me and these Doctors and that the risk is to large for them to treat me for pain. This leaves me suffering with very few options. Doctors need to be left alone to treat me and those suffering from pain like me. Thanks for letting me offer my opinions,
33	Brynn emery I support Maria Higginbotham's petition regarding chronic pain patients who since 2016 CDC guidelines have not been able to access appropriate pain treatment. We have seen family members suffer from untreated pain, and the anxiety they endure every month when they see their pain doctor fearing they might be "fired" from treatment or tapered to a lower dose and left to suffer. Please change the rules so doctors cannot taper patients who have done nothing wrong, and please notify doctors that Washington State doesn't have a MME limit. Thousands of Washington's most vulnerable citizens are suffering, forced to choose between a life in agonizing pain, go to street drugs or commit suicides. Regards Brynn Higginbotham Sent from my iPhone
34	Viola Von Lindern Ive been a chronic pain patient since 2009. Due to the severe degenerative pain in my spine and neck I became unable to continue working even with Ada accomodations in 2014. At that time I filed for disability through the Social Security Administration. At the time I had documentation from 2 primary care doctors, an occupational doctor, a psychiatrist (who made statements regarding my worsening depression etc) and a neurosurgeon. I was approved for full permanent disability in early 2015. I am assuming all medical professionals are aware how difficult it is for anyone to be determined disabled under SSA guidelines and specific conditions. I am a chronic pain patient who is now suffering due to physician's who are no longer willing to prescribe pain medicine that I need to get out of bed every day and have any quality of life. My provider from 2014-2021 who was with me through becoming disabled and prescribed pain medicine at a level where I could still enjoy being alive sadly took an early retirement in 2021. Although in her Dr notes in my last after visit summary states I followed all rules of the pain contract with zero aberrations and at a non-escalating steady mme of 120 the entire 7 years, no doctor at Valley medical would continue my contract and completely turned their backs on me as far as caring for my pain. Valley medical no longer allows their physicians to prescribe opioids. I was sent to Anesis pain clinic in Renton who gaslight me and sneakily tapered me down without my knowledge or consent until the newest Dr came in and took everyone in the clinic off pain medication and forced injections and Suboxone as the only treatments they would provide. I had severe reactions to the Suboxone and even after explaining and requesting changes for months I realized there was no longer care available for me there either. I've been demoralized, treated like a drug abuser, accused of misuse and considered suicide several times since my primary care provider retired in 2021. Knowing how much proof and documentation required to establish your disability for the SSA to consider you disabled enough to receive disability income, I believe it should be illegal for a physician or physicians assistant to force taper, reduce MME and/or deny opioids to anyone with proof of SSDI. Doctors should NOT be afraid of prosecution if they prescribe opioid medication at sufficient levels to alleviate the pain of patients with PROVEN disabilities. I request that you sincerely consider adding to the rule changes that allow patients on SSDI who have already legally proven their disability to be treated the same as you're rule changes for sickle cell disease, as long as their disability is due to a condition or disease that

	causes chronic bodily pain. I concur with the rule changes, however, I also stand with Maria Higginbotham from Washington Pain Advocacy group and her petitions for the additional changes needed that not only affect me but thousands of others in our state.
35	Jennifer Lynn Davies Thank you for the opportunity to express my own journey with intractable pain, As a chronic pain patient living with systemic lupus erythematosus (SLE) and central nervous system involvement, I urge you to protect access to opioid therapy for intractable pain patients. Many patients living in pain are women with autoimmune disorders. Lupus affects, usually, women and women of color. Thus, there are persistent gender and racial disparities. Many live in severe pain and are gaslight by physicians who think that they are drug seekers. This perception is WRONG and needs to change guided by government. My personal experience with transverse myelitis as presentation of lupus, a debilitating and painful condition, has shown me the crucial role opioid therapy plays in improving quality of life. For 16 years, opioids have been a vital part of my treatment, enabling me to: - Care for my children during their formative years - Support my mother with Crohn's disease and dementia (2014-2022) - Maintain a semblance of normalcy despite chronic pain The data supports our community: overdose rates among intractable pain patients are negligible. I implore you to distinguish between prescription opioid therapy for chronic pain and the illicit opioid crisis. Many patients fear speaking out, lest they lose access to essential pain management. I urge you to consider our voices and protect our right to pain abatement. I support Maria Higginbotham's petition and request that you: 1. Preserve access to opioid therapy for intractable pain patients. 2. Differentiate between chronic pain management and addiction. 3. Address the stigma surrounding prescription opioid use. 4. Understand that pain management providers fear disciplinary action, thus do not want to prescribe opioids at all. Leaving folks to ingest high doses of Tylenol without considering the nuances of the individual patient. Tylenol for lupus patients who have kidney and liver damage should NOT be prescribed this drug over an opioid. 5. Physicians need to be supported by having the state ensure that they will not be prosecuted for helping their patients live a better quality of life. It seems government has gone too far, and the damage will take years to correct. 6. It is import to note that the CDC exaggerated overdoses by over 50%, and conflated patients with legal prescriptions with addicts and illicit drugs. Knee-jerk assumptions have zero place in governing or in public policy. Physicians need protection, and patients need access to pain abatement. Furthermore, I emphasize that: - Intractable pain patients are not the driving force behind the opioid epidemic. - Restrictive policies harm legitimate patients, exacerbating suffering. - Balanced, evidence-based approaches prioritize patient well-being. Thank you for considering our plight. I apologize for the delayed response, as I've recently undergone a total hip replacement." Please feel free to contact me with any questions or my testimony. Thank you very much Jennifer Davies

36	Charlotte Hughes My daughter was injured at the age of 15. I have watched her suffer for almost 31 years with CRPS and so many related diagnoses. For a while, once drs started actually feeling free to treat pain, she was able to function and enjoy a bit of life. Then the CDC weighed in on the issue, without thinking of chronic pain patients. CPP's were not the cause of the drug epidemic. ILLEGAL drugs are!! But drs became scared to prescribe. And she was severely tapered, so the doctors are less scared. But she lives in fear of losing her opioids, and getting even worse. She has no life now beyond her bed. That's no way to live! I'm watching her continue to suffer more and more. It's hard for CPP's now. All hope has been removed. Only the patient and their doctor should have any say in what is needed to be used in treating them. EVERY patient is different! There is no one size fits all treatment! Changes to the laws need to be made AND COMMUNICATED to all doctors, so that rare diseases and chronic pain can be effectively treated in whatever way, and with however large a dose of opioids is necessary to keep patients somewhat comfortable. And only the patient can decide what level of pain they can live with. I know many CPP's, and not one of them expect to be pain free. They just want to be able to live a life outside their beds and home. As it is, my daughter has lost everything that any living being expects from life. There's nothing to give her hope, no joy to be found. Only worsening suffering. Please help all those suffering! There are so many out there, who are affected by pain in a very significant way. It's humane.
General provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants. WSR #24-18-091. Rule comments 37-50 were posted to https://wmc.wa.gov/rule_making_2023/physicians-and-physician-assistants-general-provision-opioid-prescribing-and and retrieved October 8, 2024 at 1:37 pm.	
37	Savanna Hello, thank you for taking the time to hopefully read my email. I have had chronic back pain for 4 years now. What I have experienced with trying to get answers and treatment through this process is beyond disturbing to me. The medical field discriminates and is down right abusive to chronic back pain. The first thing I would like to address is being forced to have procedures or refusal of treatment of any kind. If you go to a pain management in this state with chronic back pain you are automatically pushed to do spinal injections. I am going to paste below what the FDA has on the website and encourage you all to look it up for yourself. The U.S. Food and Drug Administration (FDA) is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. The injections are given to treat neck and back pain, and radiating pain in the arms and legs. We are requiring the addition of a Warning to the drug labels of injectable corticosteroids to describe these risks. Patients should discuss the benefits and risks of epidural corticosteroid injections with their health care professionals, along with the benefits and risks associated with other possible treatments. Injectable corticosteroids are commonly used to reduce swelling or inflammation. Injecting corticosteroids into the epidural space of the spine has been a widespread practice for many decades; however, the effectiveness and safety of the drugs for this use have not been established, and FDA has not approved corticosteroids for such use. We started investigating this safety issue when we became aware of medical professionals' concerns about epidural corticosteroid injections and the risk of serious neurologic adverse events.1 This concern prompted us to review cases in the FDA Adverse Event Reporting System (FAERS) database and in the medical literature (see Data Sum Now when I state this to doctors I am told this is a lie. That these injections are FDA approved. When I say we'll I don't feel comfortable and don't want to do them. I am met with aggression and am automatically treated like a drug seeker. First of all lieing to

	a patient is not right! I should be able to trust my providers and know the risks of procedures that are being pushed on me. Now let's get to the second thing that is pushed on back pain patients in this state. Cymbalta- if you do not know much about this medication I would again encourage you to do your research. It is being pushed by all your providers. Cymbalta has has hundreds of law suits filed against it. For severe withdrawal symptoms that last months. It literally causes brain zaps. There are literally rehabs to get off this medication and support groups. Again when I state this to the pain doctor I saw he got hostile. Told me that chronic pain support groups were for bitter people. Said he would never prescribe something that would cause such things. Again please do your research on this medication. Treatment for chronic back pain. When I started PT they spasmed and threw my back out so bad I was stuck hunched over couldn't move without severe pain. I called my primary care which was booking out over a month. So me not knowing what do do went to my normal urgent care where I have been taking my kids for years. The provider walked in and her exact words were why are you here what do you want me to do for you we don't give meds! I was confused I went here because I had no idea what was going on what the physical therapist had done to me and was scared. She told me to go home and wait for my primary care appointment. Within 3 days the pain got worse I couldn't shower myself my left side was going numb so I then went to the ER. Again I got a lovely greetings from a provider that started to lecture me. He told me I was not allowed to go to the ER unless I was peeing myself or could not control my bowels. Said they won't do an MRI otherwise and they don't give meds. My mother who is a nurse case Manager in DC had to fly down to help me take care of my children and bathe me while I waited for my primary care appointment. I has a person had never felt so helpless in my entire life. I learned really quick that I was no longer treated as a person but a chronic pain patient. I learned to research everything that was being pushed on me. I am going to counseling for PTSD like symptoms now anytime my pain hits a level 6. I know I will be left bed ridden screaming in pain when my back goes out. Imagine having pain as bad as labor pains for a month and just having to lay like that knowing if you take all the strength you have left to try and see a provider you will get screamed at. I don't want to be on any medication daily all medications have side effects and withdrawals Nerve meds, antidepressants, steroids, anti- inflammatory, pain meds, muscle relaxers. I should be able to have pain medication for acute flare ups and severe back pain. I have had chronic pain for Four years now I have learned to live with it and except this is what life has thrown at me. I love my life even with the things I cannot do but I want to be able to live it. I need to work remotely as I cannot stand walk or sit for more then 1-3 hours at a time. Yet I cannot get pain control to even go do in-person training to get a remote position. If I'm in a bad flare up and my kiddos have a sport tournament or dance recital I should be able to have pain control to attend the event. Those are the little things that make the struggles worth it. Yet I have to either leave earlier or go to the bathroom and cry instead of injoy seeing my kids grow. If my back goes completely out I should not be left unable to move shower for days dress myself. It's unhuman and down right wrong. I understand that pain meds when taken long term can make you think your in more pain then you actually are. I understand when taken daily they cause withdrawal just like everyother med given for chronic pain. You guys set up the rules so we are forced to have monthly injections or have to take daily meds like Lyrica or cymbalta with dangerous withdrawal there even known to cause brain damage. Instead of being able to take 5 to 10 low dose pain meds a month to manage bad days and give a better quality of life. I have now lived on aleve and Tylenol daily for 4 years do you know what that is doing to my body my stomach my liver. How can you really promote what you are doing. You are causing depression, you are causing more health issues by restricting and taken away pain medication. Thank you for listening and I really hope you create a change. I fight as my son has identical back

	issues as I do. I hope to help change things before he hits 30s and has my issues. I could never imagine my child being left to suffer as I have and pray daily things will change. Kind Regards, Savanna
38	Jeanne A Rosner Sorry if I missed it… Do these rules for PAs and MDs exclude the prescribing of a long acting opiate e.g. methadone, or a schedule iii medicine such as buprenorphine, when used in the treatment of opiate addiction in an outpatient facility that complies with the SAMHSA regulations for distribution? Otherwise in agreement. Thanks.
39	Yvonne Helmick Washington patients suffering from rare diseases and medical conditions that cause intractable pain have suffered tremendous harms because physicians fear legal retribution for treating pain patients. Patients have been abandoned or forced tapered and unable to find new practitioners willing to treat them. Many pain patients feel they only have few choices, to live suffering in pain with no quality of life, to move to countries that treat pain, go to the streets and obtain dangerous street drugs or commit suicide. Obviously the best choice is that patients are treated with empathy and compassion and remain under the watchful eye of physicians who treat them.
40	Anonymous Why is it we have to suffer due to the ones choosing to take a medication not subscribed to them by their physician? Your cutting off legit pain patients causing them to commit suicide because they have no quality of life left or forcing them to live in extreme pain! The 90MME is rediculious! The limit and milligram should be up to the physician that actually spent years upon years in college to learn how to safely prescribe. You try an go above an beyond protecting the criminal choosing to take things not prescribed at the expense of legit pain patients, when did their life become so much more valuable than ours?? Your sanctioning physicians for doing their jobs.
41	Maria 5 yrs ago The Human Rights Watch team did a year long investigation into how badly pain patients are being treated (mistreated) in this country. This mistreatment has only gotten worse since that report. This country's current overdose crisis is due to illicit and illegal drugs. Prescribing long ago stopped being the problem, yet politicians and the media keep feeding the false narrative. Physicians are afraid to treat patients, they face being arrested and prosecuted. Many have quit practicing, others have closed their clinics. Large health organizations forbid their "employees " (physicians) from doing their job, which is to "do no harm" So patients are left to suffer agonizing pain, facing limited choices, suffer, commit suicide, move to another country or go to the streets and likely die from laced illicit drugs. When do patients right's become important again? We definitely need to provide services to those suffering from addiction, but this can be done without causing harm to patients, who by no choice of their own, suffer from diseases and conditions that cause pain America is a great country, but it can do better, treat patients fairly
42	Isaac T Arnett Jr Recently, my clinic had me sign a waiver agreeing that I am ok with being cut off from opioid meds, without notice and informed me that withdrawal is not life threatening. Frightening, that they would even mention such a thing. My pharmacy will not fill my full prescription and makes me pickup every 2 weeks instead every 28 days. 28 days is the standard, so I have the extra costs of transportation along with having to make the extra time. Even my Dr. askes me what is up with my pharmacist. The contract I am

	required to sign looks like something that a felony prisoner being released on parole would have to sign. It includes that "I must get better". That is odd due to people my age don't get better with a degenerative disease. I don't think anyone gets better with degenerative spinal stenosis. In a nutshell, I am treated like a criminal and undertreated for pain and my treatment is not individualized. An example for that is take meds as needed with a daily limit. Instead, it is take 1 every 4 hours. a lot of the criminalizing of pain patients comes from NARX scoring. I recently had to purchase needles for intramuscular injection of hydrocortisone, due to having Addison's Disease. I did notice a difference in treatment at my pain clinic and at my pharmacy right after that. I had to go to a different pharmacy to get the meds and the needles and that because my regular pharmacy told me they couldn't get what I needed. Using more than one pharmacy goes against a person. The reason doesn't matter. Having injectables goes against a person. Living in pain 24/7/365 goes against a person. People living with chronic pain are treated like criminals..., and what looks to me like lab rats in some sci-fi experiment.
43	Kate Burton – **Duplicate to comment #9** For multiple years now, approximately 95% of opioid overdose deaths have been attributed to illegal, gang-manufactured fentanyl. Less than 3% of accidental overdoses have even included legally prescribed opioids. Imposing further limitations on legal pain medications - even incrementally - exacerbates the problems people with chronic pain (or surgery, or cancer) with medically documented conditions and diseases deal with while attempting to access their life-saving medications. Overall, these restrictions help little to none in reducing the supply of illegal opioids nor the rate of overdose death- but they do result in immense difficulties for patients and their families merely trina to survive their own sufferina. Sadly, suicide can be the result. The American Medical Society and the Medical Society of Interventional Pain Physicians both have made public statements about the misleading comments made by the CDC about opioid medications. Furthermore, nationwide news stories about international illicit fentanyl have made it very clear that we do not have a legal prescription opioid problem in our country, we have an illicit fentanyl problem invading our country. I urge you to not only abstain from further medication restrictions, but to also retract previous controls. Thank you for your consideration, Kate Burton
44	Brenda Williams – **Duplicate to comment #6** As a parent, watching your chronically ill daughter suffer on a daily basis is one of the most difficult things in life. Without her daily opiod medication she is in excruciating pain and barely able to move. Her daily prescription helps lower her pain to a more bearable level. She has tried several other medications and therapies, but none of them worked at giving her a baseline level of relief. I have experienced how hard it is for her sometimes to get her monthly pain medication at the pharmacy. She is often looked upon as a drug addict, by an unknowing pharamcist who doesn't know what her condition is, and who is only looking to get the medication for fun. More than once she has had to switch pharmacies because they change which manufacturer they use. She has had severe allergic reactions to more than one manufacturer and the dyes or fillers used in the making of their particular pill. While I understand that there are drug users and abusers, it is imperative that rules/laws/regulations need to keep in mind that there is a large percentage of the chronically ill population that need/use opiod medications carefully and correctly just to survive. Please keep that population in mind when making changes.

45	Maria Higginbotham (same commentor as #8) I applaud the efforts the WMC is making to ensure Washington patients suffering in pain receive adequate and accessible pain treatment. Since the 2016 CDC Opioid Prescribing Guidelines were issued many state medical boards, physicians, hospitals, insurance companies and pharmacies have implemented policy's based on a "guideline" that have adversely impacted patients suffering in pain. Many physicians have forcibly tapered patients, many have stopped treating pain patients and others have just quit practicing. This has left millions of pain patients without care and forced them to choose between a life in agony, alternatives such as street drugs and or suicide. The WMC's Adding an Exclusion for Sickle Cell patients is an important step forward to ensuring those who suffer pain from a rare disease have their pain treated effectively. I would like to mention that according to the CDC, Sickle Cell Disease affects approximately 100,000 Americans. I would like the Commission to consider adding one additional Exemption. Rare Diseases. According to the FDA, there are over 7,000 rare diseases affecting more than 30 million people in the United States, many of these diseases are life threatening and most do not have treatment. According to the Orphan Drug Act, the definition of a rare disease is a disease or condition that affects less than 200,000 people in the United States. Most rare diseases do not have FDA approved treatments I would like to ask how the WMC will ensure that physicians acknowledge these changes? Again I respect the work done by WMC to untangle the issues brought forth by the 2016 cdc opioid guidelines. Every person will suffer pain sometime in their life. Pain does not discriminate Regards Maria Higginbotham
46	Katherine Burton With your latest statement on force tampering, it appears that you are attempting to do right by pain, patients and doctors in explaining the ramifications. However, at several clinics, Force Tapering is still a problem. Also, Individualized care may be ordered, but is frequently not given. It must remain clear that the undertreatment of pain is a departure from the standard of care. How the WMC will ensure that physicians acknowledge this? Secondly, adding an exemption for Sickle cell Disease was admirable— I would like to encourage the WMC to go one step further and add all Rare Diseases. Accordingly to the FDA, there are 7,000 dare diseases affecting over 30 million patients with no FDA-approved treatment. It is therefore even more important in these cases that adequate pain treatment remains accessible with as few limitations as possible. Thank you.
47	Vicki Sulfaro (same commentor as #10) Im a intractable pain patient suffering from severe non stop pain daily. Since the CDC "guidelines" I've been reduced 90% of my pain meds. Medicine that allows me to function. I've had multiple treatments and surgeries to try and get relief from the non stop pain i suffer caused by a MVA in 2000. I suffered severe permanent damage to my spine. I do not abuse my meds never have. My doctor isn't allowed to treat my pain to the point im able to work. My injuries were further impacted by a surgeon who refused to listen when i told him what was going on. I can't walk far nor can i stand for any length of time because i suffer from severe nerve damage. I understand that there is a crisis caused by illegal drugs and it's horrible but there is also another crises people suffering needlessly because our Drs aren't allowed to do their job. They took a oath to do no harm but them not being able to adequately treat their patients pain has caused millions to suffer some dying from heart attack and strokes and others not being able to live in the agony caused by the severe restrictions take their own lives. Im asking you please do what's right and don't make it harder for pain patients to receive life saving medicine

48	Gina Robertshaw – **Duplicate to comment #19** I want to thank the Commission for updating and amending the opioid guidelines. I am 69 years old and have suffered from disabling conditions since my 30s. I moved to WA State in 2020. My former doctor in PA said he could treat me for 6 months. Sadly, I needed more time than this. I had tried to make an appointment with almost 20 doctors--each one saying they do not accept patients on pain medication. I wish I had saved the list of how many offices I had called before I finally found a doctor who accepted me. I currently have 4 loose screws in my cervical hardware, one very close to the vertebral artery and one very close to a nerve root. I also have nerve compression and stenosis in my cervical spine. I have 4 bulging discs in my lower back, stenosis, spondylolisthesis, and nerve root narrowing. I have extensive arthritis throughout my body. Almost all of these conditions have been known for millennia as causing quite severe pain. I am very fortunate that Belbuca (buprenorphine) and Tramadol keep me functioning, although there are 1-3 days a month that I need something a bit stronger like Oxycodone. However, I can't get that extra help anymore. Currently, over 3,000 medical professionals are sitting in prison for doing nothing more than treating pain patients with compassion. They were not running "pill mills" or selling them, etc. Something must be done to protect both doctors and pain patients. It saddens me that what's happening now is due to the CDC's Opioid Guidelines--a guideline influenced primarily by anti-opioid zealots with a conflict of interest. Most of these anti-opioid zealots never treated a pain patient in their life and they make more money testifying against medical professionals than they do in their practices. I sent an email message to Amelia Boyd with links to information showing the CDC acted in bad faith based on junk science. I do hope all Commission members were sent this message and I hope all members look at the links. You can only make just decisions if presented with facts. Too many people are suffering today--many are terminal cancer patients and veterans. Pain patient suicides have skyrocketed after they've been force-tapered or cut off cold turkey from pain medication that enabled them to function--and even work--on a daily basis. Statistics say at some point, either you or a loved one will deal with a debilitating condition. Would you be comfortable watching your spouse, parent, or child writhe in pain--and no one will help to ease the pain? This is happening in WA State right now. I urge all Commission members to thoroughly research this important subject. I hope the links I provided in my email message to Amelia help facilitate your efforts. Thank you for allowing me to share my situation and the concerns I have for the dire situation pain patients are in today.
49	Shannon Russell – **Very similar comment to #15** (same commentor as #15) I've been on pain management since 2007 but have dealt with pain for most of my adult life. Prior to 2016 when all the rules changed and our government became our doctors boss everything was good. Not perfect but at least I felt listened to and heard. I didn't feel like my husband had to go to every appointment and advocate for me. Since 2016 I've been yelled at by my doctor cause I didn't want to stop taking something that was working for me. I've had 2 doctors retire. One of them abruptly and only gave me a month supply to find another doctor. When searching for a new pain management doctor the only ones out there will only do surgeries or injections but those are for everyone. I've had my pharmacy that I had all my scripts filled at tell me they will no longer fill my scripts for pain . There is more fear than freedom to do the right thing for pain management patients. I don't understand stopping a medication that is doing its job to have a surgery that might help. I have many things that my body is going through that cause me pain. I also have many tools in my tool box to help me live a normal or semi normal life from pain medication (high dosage of opioids), chiropractic and massage therapy. They all work together and most I have to pay out of pocket cause insurance doesn't cover alternative care. The

	rules done by the cdc in 2016 have destroyed my quality of life that I have been fighting to preserve since I was 27 yrs old. I don’t fit into the box and I definitely don’t think because your a female victim of child abuse that it automatically means your going to become an addict. My struggles with our medical hasn’t been easy and I’m one of the lucky ones.
50	Denice LaCoste – **Duplicate to comment #16** I support Maria's Bill. I support any bill that helps chronic pain patients and their physicians. I'm tired. We're all tired. Chronic pain patients are treated like we have leprosy when we walk into a doctors office. I myself have been completely and abruptly cut off pain medication, after 28 years of correct use, or force tapered 4 times in the last 8 years. We tired. We're in pain. We are your daughters, mother's, brothers, etc, and we need protection for ourselves and our physicians who prescribe. My husband is Retired Military, a Veteran, and his brothers are denied proper pain control. His wife, myself, has been left bedbound. This undertreatment, mistreatment, an no treatment for pain has got to stop!

WSR 24-18-091
PROPOSED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed August 30, 2024, 2:24 p.m.]

Supplemental notice to WSR 24-07-106.

Preproposal statement of inquiry was filed as WSR 23-17-094.

Title of Rule and Other Identifying Information: General provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants. The Washington medical commission (commission) is proposing amendments to the commission's opioid prescribing rules to exclude patients with sickle cell disease, to clarify tapering considerations and, in this supplemental, to clarify the use of biological specimen testing. The proposed rules amend WAC 246-918-801 Exclusions, 246-918-870 Periodic review—Chronic pain, and 246-918-900 Tapering considerations—Chronic pain for physician assistants, as well as WAC 246-919-851 Exclusions, 246-919-920 Periodic review—Chronic pain, and 246-919-950 Tapering considerations—Chronic pain for allopathic physicians.

Hearing Location(s): On October 11, 2024, at 9:45 a.m., virtually. Register for this virtual meeting to be held via Microsoft Teams webinar https://tinyurl.com/ycxn37ve; or in person at the Department of Health, 111 Israel Road S.E., Room 166, Tumwater, WA 98501. To join the commission's rules interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

Date of Intended Adoption: October 11, 2024.

Submit Written Comments to: Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, email https://fortress.wa.gov/doh/policyreview/, medical.rules@wmc.wa.gov, beginning on the date and time of this filing, by October 4, 2024, at 11:59 p.m.

Assistance for Persons with Disabilities: Contact Amelia Boyd, program manager, phone 1-800-525-0127, TTY 711, email doh.information@doh.wa.gov, by October 4, 2024.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: On November 3, 2022, the Center for Disease Control and Prevention (CDC) released the Clinical Practice Guideline for Prescribing Opioids for Chronic Pain (https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html) (Guideline). This guideline updated the CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016 (2016 Guideline). Since the release of the 2016 guideline, new evidence has emerged on the benefits and risks of prescription opioids for both acute and chronic pain as compared to nonopioid treatments, dosing strategies, opioid dose dependent effects, risk mitigation strategies, and opioid tapering and discontinuation. The update expands the 2016 guideline to provide evidence-based recommendations for prescribing opioid pain medication for acute, subacute, and chronic pain for outpatients aged ≥18 years, excluding pain management related to sickle cell disease, cancer-related pain treatment, palliative care, and end-of-life care. This update leverages new data to expand content on prescription opioids for acute and subacute pain throughout the recommendations.

RCW 18.71.800 and 18.71A.800 directs the commission to consider the guidelines from the CDC when developing opioid prescribing rules. As such, when the new guideline was released in 2022, the commission

contracted with Gregory Terman, MD, to do a comprehensive comparison of the commission's opioid prescribing rules covering physicians (WAC 246-919-850 through 246-919-990) and physician assistants (WAC 246-918-800 through 246-918-835) to the guideline. Dr. Terman is a former pro tempore commissioner of the commission, as well as a professor of anesthesiology and pain medicine at the University of Washington in Seattle. Dr. Terman was asked to recommend changes to the commission's opioid prescribing rules based on the differences found between the commission's opioid prescribing rules and the guideline. Dr. Terman provided the commission with a report, titled "Comparing and Contrasting the 2022 CDC Opioid Prescribing Guideline and the 2019 Washington State Prescribing Rules" (report). Based on the recommendations in the report, the commission is proposing amending the rules as follows:

(1) Exempting patients with sickle cell disease;

(2) Stating in rule that not all chronic pain patients need to be tapered off opioids;

(3) Stating in rule that decisions regarding patient treatment should not be based solely on one aberrant biological specimen test; and

(4) As a result of the previous public rules hearing, reinstating language requiring biological testing at certain intervals for chronic pain patients.

Reasons Supporting Proposal: The commission is proposing rules based on the following recommendations from Dr Terman's report:

(1) Exempting patients with sickle cell disease: The guideline exempts sickle cell disease along with cancer and patients receiving palliative or end-of-life care and states that these patients "can be at risk for inadequate pain treatment." The commission's rules already exclude patients with cancer and the provision of palliative, hospice, or other end-of-life care because those patients typically need a different level of care than a patient with chronic pain that is not related to cancer, palliative, or end-of-life care.

(2) Stating in rule that not all chronic pain patients need to be tapered off opioids: Since their opioid rules were updated in 2018, the commission has seen a number of complaints from chronic pain patients who have been tapered too rapidly or their opioid regimen has been discontinued completely. The department of health released a statement on September 20, 2019, that spoke to this issue:

"Neither the Washington State opioid prescribing rules nor the CDC opioid prescribing guideline support rapidly tapering or discontinuing opioids for patients on existing opioid doses exceeding 90 mg MME per day under most circumstances. Abruptly tapering or discontinuing opioids in a patient who is physically dependent may cause serious patient harms including severe withdrawal symptoms, uncontrolled pain, psychological distress, and in rare instances, suicide."

In the Report, Dr. Terman notes: "The CDC states that one of the primary reasons for updating the rules, was 'misapplication of the 2016 CDC Opioid Prescribing Guideline (66), benefits and risks of different tapering strategies and rapid tapering associated with patient harm (68, 71–73), challenges in patient access to opioids (6), patient abandonment and abrupt discontinuation of opioids (71)' (page 4). In perhaps the clearest example of the CDC attempting to avoid inflexible interpretations of this version of the Guideline, CDC removed all specific doses and durations from all 12 of the 2022 recommendations – relegating the same doses seen in the 2016 recommendations (based largely on the same data) to the supporting text. The rules (commis-

sion's rules) attempted to avoid dose-focused inflexibility of care by reassuring prescribers that the 'commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration" (WAC 246-919-850). Whether this has been successful in avoiding opioid treatment related patient stigma, abandonment and inappropriate discontinuation of opioids is a matter of discussion beyond the scope of this document but the desire to avoid these patient punishments is clearly a similarity between the CDC and the Rules." The commission believes that including in the rule a statement that tapering is not always necessary would be beneficial for achieving this objective.

(3) Stating in rule that decisions regarding patient treatment should not be based solely on one aberrant biological specimen test: In the Report, Dr. Terman highlights that both the commission's rules and the guideline recognize biological specimen testing, such as urine toxicology testing, as an effective risk mitigation strategy for subacute and chronic opioid prescribing. He goes on to say that the guideline describes the correct utilization of biological specimen testing involves applying it universally to prevent bias, emphasizing discussions over punishment for unexpected results, and integrating results into broader clinical assessments to formulate action plans following unexpected outcomes. The commission's rules do not address how to handle an unexpected result. Additionally, the commission has received reports that physicians and physician assistants have stopped prescribing opioids and, in some cases, dismissed patients solely based on a single abnormal biological specimen test. This abrupt change in a patient's care greatly raises the risk of patient harm. By providing some guidance in rule regarding biological specimen testing, the commission is working toward reducing patient harm.

RCW 18.71.800 and 18.71A.800 require that the commission consider the Agency Medical Directors Group (AMDG) and CDC guidelines when adopting rules regarding opioid prescribing. The proposed rules implement the statute's goals and objectives by:

(1) Revising the established rules to be consistent with the CDC's guideline; and

(2) Supporting the overarching goals of RCW 18.71.015 by protecting and promoting public health, safety, and welfare.

On April 26, 2024, a rule hearing was held, during which concerns were raised about the proposed removal of "biological testing" from subsection (1) of both the Periodic review—Chronic pain sections: WAC 246-918-870 and 246-919-920. Due to these concerns, a follow-up workshop was held on June 4, 2024. At this workshop, interested parties, staff and commissioners worked together to refine the draft language. The revised proposal now includes "biological testing" once again, necessitating this supplemental proposal.

Statutory Authority for Adoption: RCW 18.71.017, 18.71.800, 18.71A.800, and 18.130.050.

Statute Being Implemented: RCW 18.71.800 and 18.71A.800.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington medical commission, governmental.

Name of Agency Personnel Responsible for Drafting: Amelia Boyd, 111 Israel Road S.E., Tumwater, WA 98501, 360-918-6336; Implementation and Enforcement: Kyle Karinen, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-4810.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, TTY 711, email medical.rules@wmc.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The proposed rules do not impact businesses, they only impact providers.

Scope of exemption for rule proposal:

Is fully exempt.

August 29, 2024
Kyle S. Karinen
Executive Director
Washington Medical Commission

OTS-5085.2

AMENDATORY SECTION (Amending WSR 22-22-039, filed 10/25/22, effective 11/25/22)

WAC 246-918-801 Exclusions. WAC 246-918-800 through 246-918-935 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The treatment of patients with sickle cell disease;

(3) The provision of palliative, hospice, or other end-of-life care;

(((3))) (4) The provision of procedural medications;

(((4))) (5) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010; or

(e) Residential treatment facilities as defined in RCW 71.12.455; or

(((5))) (6) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection (((4))) (5) of this section.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-918-870 Periodic review—Chronic pain. (1) The physician assistant shall periodically review the course of treatment for

chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-918-935, must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the physician assistant's discretion.

(2) During the periodic review, the physician assistant shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, and quality of life have improved, diminished, or are maintained; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician assistant's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and

(c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-918-935 and subsection (1) of this section.

(4) If the patient violates the terms of the agreement, the violation and the physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

(5) Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physician assistants should not dismiss patients from care on the basis of a biological specimen test result alone.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-918-900 Tapering considerations—Chronic pain. Not all chronic pain patients will need their opioid prescriptions tapered. Relying on medical decision making and patient-centered treatment, the physician assistant shall consider tapering or referral for a substance use disorder evaluation when:

(1) The patient requests;

(2) The patient experiences a deterioration in function or pain;

(3) The patient is noncompliant with the written agreement;

(4) Other treatment modalities are indicated;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event or overdose;

(7) There is unauthorized escalation of doses; or

(8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

OTS-5086.2

AMENDATORY SECTION (Amending WSR 22-22-039, filed 10/25/22, effective 11/25/22)

WAC 246-919-851 Exclusions. WAC 246-919-850 through 246-919-985 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The treatment of patients with sickle cell disease;

(3) The provision of palliative, hospice, or other end-of-life care;

((~~(3)~~)) (4) The provision of procedural medications;

((~~(4)~~)) (5) The treatment of patients who have been admitted to any of the following facilities for more than 24 hours:

(a) Acute care hospitals licensed under chapter 70.41 RCW;

(b) Psychiatric hospitals licensed under chapter 71.12 RCW;

(c) Nursing homes licensed under chapter 18.51 RCW and nursing facilities as defined in WAC 388-97-0001;

(d) Long-term acute care hospitals as defined in RCW 74.60.010; or

(e) Residential treatment facilities as defined in RCW 71.12.455; or

((~~(5)~~)) (6) The treatment of patients in residential habilitation centers as defined in WAC 388-825-089 when the patient has been transferred directly from a facility listed in subsection ((~~(4)~~)) (5) of this section.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-919-920 Periodic review—Chronic pain. (1) The physician shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-919-985, must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the physician's discretion.

(2) During the periodic review, the physician shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, and quality of life have improved, diminished, or are maintained; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards or maintenance of treatment objectives and compliance with the treatment plan.

(3) Periodic patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools or patient report from reliable patients to document either maintenance or change in function and pain control; and

(c) Review of the Washington state PMP at a frequency determined by the patient's risk category in accordance with the provisions of WAC 246-919-985 and subsection (1) of this section.

(4) If the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

(5) Biological specimen testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Physicians should not dismiss patients from care on the basis of a biological specimen test result alone.

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-919-950 Tapering considerations—Chronic pain. Not all chronic pain patients will need their opioid prescriptions tapered. Relying on medical decision making and patient-centered treatment, the physician shall consider tapering or referral for a substance use disorder evaluation when:

(1) The patient requests;

(2) The patient experiences a deterioration in function or pain;

(3) The patient is noncompliant with the written agreement;

(4) Other treatment modalities are indicated;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event or overdose;

(7) There is unauthorized escalation of doses; or

(8) The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.

2026 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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January

S	M	T	W	T	F	S
				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	26	27	28	29	30	31

Date	Meeting	Time	Location
1	New Years Day	Holiday – Offices Closed	
8	Policy Committee	4 pm	Virtual
15	Personal Appearances	8:30 am	Virtual
15	Case Disposition	10:45 am	Virtual
16	Committees/Workgroups	8:30 am	Virtual
16	Business	9:30 am	Virtual
16	Lunch & Learn	Noon	Virtual
19	Martin Luther King Day	Holiday – Offices Closed	
29	Policy: Interested Parties	10 am	Virtual

February

S	M	T	W	T	F	S
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	26	27	28

Date	Meeting	Time	Location
16	President's Day	Holiday – Offices Closed	
26	Policy Committee	4 pm	Virtual

March

S	M	T	W	T	F	S
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	26	27	28
29	30	31				

Date	Meeting	Time	Location
12	Personal Appearances	8:30 am	Hybrid Location: TBD
12	Case Disposition	10:45 am	
13	Committees/Workgroups	8:30 am	
13	Business	9:30 am	
13	Lunch & Learn	Noon	
26	Policy: Interested Parties	10 am	Virtual

2026 Meeting Schedule

April

S	M	T	W	T	F	S
			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
26	27	28	29	30		

16	SMART Training	8:30 am	In person Location: TBD
17	Commissioner Retreat	8:00 am	
23	Policy Committee	4 pm	Virtual

May

S	M	T	W	T	F	S
					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	26	27	28	29	30
31						

7	Personal Appearances	8:30 am	Hybrid Location: TBD
7	Case Disposition	10:45 am	
8	Committees/Workgroups	8:30 am	
8	Business	9:30 am	
8	Lunch & Learn	Noon	
25	Memorial Day	Holiday – Offices Closed	

June

S	M	T	W	T	F	S
	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	26	27
28	29	30				

19	Juneteenth	Holiday – Offices Closed	
25	Policy: Interested Parties	10 am	Virtual

July

S	M	T	W	T	F	S
			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
26	27	28	29	30	31	

3	Independence Day (observed)	Holiday – Offices Closed	
9	Personal Appearances	8:30 am	Virtual
9	Case Disposition	10:45 am	Virtual
23	Policy Committee	4 pm	Virtual

DRAFT

2026 Meeting Schedule

August

S	M	T	W	T	F	S
						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	26	27	28	29
30	31					

20	Personal Appearances	8:30 am	Hybrid Location: TBD
20	Case Disposition	10:45 am	
21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	

September

S	M	T	W	T	F	S
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6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

7	Labor Day	Holiday – Offices Closed	
24	Policy: Interested Parties	10 am	Virtual

October

S	M	T	W	T	F	S
				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	26	27	28	29	30	31

8	Personal Appearances	8:30 am	Virtual
8	Case Disposition	10:45 am	Virtual
29	Policy Committee	4 pm	Virtual

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November

S	M	T	W	T	F	S
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	26	27	28
29	30					

11	Veterans Day	Holiday – Offices Closed	
19	Personal Appearances	8:30 am	Hybrid Location: TBD
19	Case Disposition	10:30 am	
20	Committees/Workgroups	8:30 am	
20	Business	9:30 am	
20	Lunch & Learn	Noon	
26	Thanksgiving Day	Holiday – Offices Closed	
27	Native American Heritage Day	Holiday – Offices Closed	

December

S	M	T	W	T	F	S
		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	26
27	28	29	30	31		

25	Christmas	Holiday – Offices Closed

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WASHINGTON Medical Commission
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Committee/Workgroup Reports: October 11, 2024

High Reliability Organizations Workgroup – Chair: Dr. Chung Staff: Mike Farrell
No updates to report

Healthcare Disparities Workgroup – Chair: Dr. Currie Staff: Kyle Karinen
No updates to report.

IV Hydration Treatment Workgroup – Chair: Dr. Murphy Staff: Mike Farrell/Jimi Bush
The IV hydration workgroup was formed to (1) review current roles, policies and practices in non-traditional settings that provide elective IV therapies to determine how best to address the responsibilities of an MD or PA who work with these companies; and (2) to coordinate with other Washington authorities including the Osteopathic Board, Washington Board of Nursing, and the Pharmacy Commission, to find common areas of interest on this issue. This collaboration is crucial for establishing clear guidelines and ensuring safe practices in IV hydration therapy. The IV hydration workgroup is making significant progress in addressing the complexities of IV hydration practices in non-traditional clinical settings. Jimi Bush created a research log to collect information from other states on IV hydration. A number of statements and policies were found. Using these statements from other boards, Mike Farrell is working on a draft guidance document. There is an interagency group that has formed around aesthetic treatments and a subgroup there is also examining the issue of IV hydration treatment and mobile IV services.

Finance Workgroup – Chair: Dr. Domino Staff: Kyle Karinen
The Finance Workgroup was reconstituted by Dr. Domino in July. The members are the three elected members of leadership – Dr. Domino, Dr. Murphy, PA Lopez – as well as the Immediate Past Chair, Dr. Chung. The Workgroup's charter is to provide input to myself and staff regarding the Commission's fiscal outlook. The Workgroup met in early August and along with Micah and Jimi, I provided an overview of where the Commission stands in both the short-term and long-term. In a word, the budget is in solid shape. There remain some short-term uncertainties with regard to the HELMS project and its funding. The Department has made a request to the

Legislature to address the current funding gap. In discussion with the Department, it has made clear that assessing further costs to close the funding gap to the various professions is a measure of last resort. In the event that comes to pass, the Commission's share would be just short of $840,000 under the current cost allocation formula. The Commission would fund that out of its reserves. On the long-term side, the Commission has experienced what appears to be a drop in the rate of renewals for both physicians and physician assistants. We are in the process of doing a deeper dive into what appears to be a trend that began in 2022 in order to confirm this data. It's still too early to confirm the initial numbers, but there is a potential fiscal impact over the next seven or eight years.

Committees & Workgroups

Executive Committee
Chair: Dr. Domino
Chair Elect: Dr. Murphy
Officer-at-Large: Ed Lopez, PA-C
Policy Chair: Christine Blake, PM
Immediate Past Chair: Dr. Chung
Ex Officio Member: Dr. Gallinger
Kyle Karinen
Micah Matthews
Heather Carter, AAG

Policy Committee
Christine Blake, PM, Chair (B)
Dr. Domino (B)
Ed Lopez, PA-C (B)
Dr. Lyle (A)
Scott Rodgers, PM (A)
Dr. Trescott (B)
Heather Carter, AAG
Kyle Karinen
Micah Matthews
Amelia Boyd

Newsletter Editorial Board
Dr. Currie
Dr. Chung
Dr. Wohns
Jimi Bush, Managing Editor
Micah Matthews

Legislative Subcommittee
Dr. Chung, Chair
John Maldon, PM. Pro Tem Commissioner
Christine Blake, PM
Dr. Wohns
Kyle Karinen
Micah Matthews

Finance Workgroup
Dr. Domino, WMC Chair, Workgroup Chair
Dr. Murphy, WMC Chair Elect
Kyle Karinen
Micah Matthews
Jimi Bush

Health Equity Advisory Committee
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, PM
Douglas Pullen, PM
Kyle Karinen
Mahi Zeru

Panel L
Dr. Chung, Chair
Christine Blake, PM
Arlene Dorrough, PA-C
Dr. Lyle
Dr. Wohns
Dr. Trescott
Dr. Browne, Pro Tem
John Maldon, PM, Pro Tem
Marisa Courtney,
Micah Matthews

High Reliability Workgroup
Dr. Chung, Chair
Dr. Domino
Christine Blake, PM
Dr. Jaeger
Scott Rodgers, PM
Dr. Chang
Ed Lopez, PA-C
Dr. Lyle
John Maldon, PM, Pro Tem
Kyle Karinen
Micah Matthews
Mike Farrell
Jimi Bush
Amelia Boyd

Nominating Committee 2024
Dr. Chung
Arlene Dorrough, PA-C
Dr. Jaeger

Updated: October 2, 2024

IV Hydration Treatment Workgroup
Dr. Murphy, Workgroup Chair
Dr. Jaeger
Kyle Karinen
Freda Pace
Dr. Fino
Mike Farrell
Jimi Bush
Taylor Bachrach-Nixon

CDTA Workgroup
Dr. Chung
Dr. Lyle
Ed Lopez. PA-C
Kyle Karinen
Micah Matthews
Dr. Fino
Joel DeFazio, Staff Attorney
Amelia Boyd

Anesthesiologist Assistants Rule
Dr. Domino
Dr. Currie
Dr. Chung
Micah Matthews
Marisa Courtney
Amelia Boyd
Heather Carter, AAG
Marlon Basco-Rodillas, Policy Analyst

Please note, any committee or workgroup that is doing any interested parties work or getting public input must hold open public meetings.

PM = Public Member

WMC Rules Progress Report						Projected filing dates			
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**CR-101**	**CR-102**	**CR-103**	**CR-105**
Collaborative Drug Therapy Agreements	CR-101 filed	7/22/2020	Waiting on the results of the workgroup	NA		Complete	TBD	TBD	NA
General provisions for opioid prescribing and tapering	Supplemental CR-102 filed	8/30/2024	Hearing	10/11/2024		Complete	Complete	TBD	NA
HB 1009 Military Spouse	CR-102 filed	8/27/2024	Hearing	10/11/2024	Keep BoMS updated	Complete	Complete	TBD	NA
OBS - Use of Nitrous Oxide, WAC 246-919-601	2nd workshop	10/7/2024	Workshops	In progress	Keep BoMS updated	Complete	TBD	TBD	NA
ESSB 5389 - Define Qualified Physician	CR-101 approved	10/20/2023	Submit CR-101 docs	TBD	Waiting on Board of Optometry rulemaking. Keep BoMS updated.	TBD	TBD	TBD	NA
SB 5184 - Anesthesia Assistants - New Profession	CR-101 filed	8/30/2024	Workshops	In progress		Complete	TBD	TBD	NA
2041 PA Collaborative Practice	CR-105 comment period ended	9/23/2024	Request approval for CR-103	10/11/2024	Submit CR-103 beginning of October if no substaintial comments.	NA	NA	September 2024	July 2024
Technical edits to WAC 246-919-945 and WAC 246-918-895	CR-105 comment period ended	9/23/2024	Request approval for CR-103	10/11/2024	Submit CR-103 beginning of October if no substaintial comments.	NA	NA	September 2024	July 2024

Updated: 10/4/2024

Opioid prescribing for MDs and PAs	CR-101 approved	7/19/2024	Submit CR-101 docs	November 2024	Must wait until General provisions for opioid prescribing and tapering rules are adopted to file CR-101.	Nov. 2024	TBD	TBD	NA

WSR 24-15-055
EXPEDITED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed July 16, 2024, 12:13 p.m.]

Title of Rule and Other Identifying Information: Implementation of the physician assistant collaborative practice. The Washington medical commission (commission) is proposing amendments to chapter 246-918 WAC to implement ESHB 2041 (chapter 62, Laws of 2024), which aims to establish clear guidelines and requirements for the collaboration between physician assistants (PAs) and supervising physicians. Proposed changes also include clarifying and updating terms.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: From March 2020 to October 2022, PAs were allowed to practice without a delegation agreement under the Governor's Proclamation 20-32. During this period, PAs delivered safe and efficient care, improving access to essential services statewide. Given the ongoing need for more health care providers, especially in underserved and rural areas, the legislature passed ESHB 2041 to authorize PAs to engage in a collaborative practice with physicians. This collaborative practice seeks to enhance the scope of practice for PAs, streamline processes for their practice agreements, and ensure better integration within health care teams. This will promote team-based care and enhance health care access for the state's residents.

The commission is proposing amendments to several sections of chapter 246-918 WAC, pertaining to physician assistants, to incorporate the objectives of ESHB 2041.

Reasons Supporting Proposal: To implement the legislative changes and intentions of ESHB 2041; enhance the collaborative practice framework between physician assistants and physicians; improve access to health care services, particularly in underserved and rural areas; and ensure regulatory consistency and clarity for physician assistants practicing in Washington state.

Statutory Authority for Adoption: RCW 18.71A.020, 18.130.050; and ESHB 2041 (chapter 62, Laws of 2024).

Statute Being Implemented: Chapter 18.71A RCW; ESHB 2041.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington medical commission, governmental.

Name of Agency Personnel Responsible for Drafting: Amelia Boyd, 111 Israel Road S.E., Tumwater, WA 98501, 360-918-6336; Implementation and Enforcement: Kyle Karinen, 111 Israel Road S.E., Tumwater, WA 98501, 564-233-1557.

This notice meets the following criteria to use the expedited adoption process for these rules:

Adopts or incorporates by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Content is explicitly and specifically dictated by statute.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The purpose of this rule making is to align existing rules with the changes made by ESHB 2041. The proposed amendments in this rule making are explicitly dictated by statute. Clarifying changes include replacing gender-specific terms.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Amelia Boyd, Department of Health, Washington Medical Commission, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, email amelia.boyd@wmc.wa.gov, AND RECEIVED BY September 23, 2024.

July 16, 2024
Kyle S. Karinen
Executive Director
Washington Medical Commission

OTS-5458.3

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-005 Definitions. The definitions in this section and definitions in RCW 18.71A.010 apply throughout this chapter unless the context clearly requires otherwise:

(1) "Collaboration agreement" means a written agreement that describes the manner in which the physician assistant is supervised by or collaborates with at least one physician and that is signed by the physician assistant and one or more physicians or the physician assistant's employer.

(2) "Commission" means the Washington medical commission.

((~~(2)~~)) (3) "Commission approved program" means a physician assistant program accredited by the committee on allied health education and accreditation (CAHEA); the commission on accreditation of allied health education programs (CAAHEP); the accreditation review committee on education for the physician assistant (ARC-PA); or other substantially equivalent organization(s) approved by the commission.

((~~(3)~~)) (4) "Employer" means the scope appropriate clinician, such as a medical director, who is authorized to enter into the collaboration agreement with a physician assistant on behalf of the facility, group, clinic, or other organization that employs the physician assistant.

(5) "NCCPA" means National Commission on Certification of Physician Assistants.

((~~(4) "Osteopathic physician" means an individual licensed under chapter 18.57 RCW.~~

~~(5)~~)) (6) "Participating physician" means a physician that supervises or collaborates with a physician assistant pursuant to a collaboration agreement.

(7) "Physician" means an individual licensed under chapter 18.57, 18.71, or 18.71B RCW.

((~~(6)~~)) (8) "Physician assistant" means a person who is licensed under chapter 18.71A RCW by the commission to practice medicine ((~~to a limited extent only under the supervision of a physician or osteopathic physician~~)) according to a collaboration agreement with one or more participating physicians.

(a) "Certified physician assistant" means an individual who has successfully completed an accredited and commission approved physician assistant program and has passed the initial national boards examination administered by the National Commission on Certification of Physician Assistants (NCCPA).

(b) "Noncertified physician assistant" means an individual who:

(i) Successfully completed an accredited and commission approved physician assistant program, is eligible for the NCCPA examination, and was licensed in Washington state prior to July 1, 1999;

(ii) Is qualified based on work experience and education and was licensed prior to July 1, 1989;

(iii) Graduated from an international medical school and was licensed prior to July 1, 1989; or

(iv) Holds an interim permit issued pursuant to RCW 18.71A.020(1).

(c) "Physician assistant-surgical assistant" means an individual who was licensed under chapter 18.71A RCW as a physician assistant between September 30, 1989, and December 31, 1989, to function in a limited extent as authorized in WAC 246-918-250 and 246-918-260.

((~~(7)~~)) (9) "Practice agreement" means a mutually agreed upon plan, as detailed in WAC 246-918-055, between a supervising physician and physician assistant, which describes the manner and extent to which the physician assistant will practice and be supervised.

((~~(8)~~)) (10) "Supervising physician" means any physician or osteopathic physician identified in a practice agreement as providing primary clinical and administrative oversight for a physician assistant.

((~~(9) "Alternate physician" means any physician or osteopathic physician who provides clinical oversight of a physician assistant in place of or in addition to the supervising physician.~~))

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-035 Prescriptions. ((~~(1)~~)) A physician assistant may prescribe, order, administer, and dispense legend drugs and Schedule II, III, IV, or V controlled substances consistent with the scope of practice ((~~in an approved practice agreement filed with the commission~~)) provided:

((~~(a)~~)) (1) The physician assistant has an active DEA registration; and

((~~(b)~~)) (2) All prescriptions comply with state and federal prescription regulations.

((~~(2) If a supervising physician's prescribing privileges have been limited by state or federal actions, the physician assistant will~~

~~be similarly limited in their prescribing privileges, unless otherwise authorized in writing by the commission.~~))

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-055 Collaboration and practice agreements. (1) A practice agreement must meet the requirements in RCW 18.71A.120.

(2) A physician assistant ((~~may have more than one supervising physician if the practice agreement is entered into with a group of physicians and the language of the practice agreement designates the supervising physicians.~~

~~(3) Pursuant to a practice agreement,~~)) practicing under a practice agreement that was entered into before July 1, 2025, may continue to practice under the practice agreement until the physician assistant enters into a collaboration agreement, as defined in RCW 18.71A.010. A physician assistant specified in this section shall enter into a collaboration agreement by either the renewal date of their license or July 1, 2025, whichever is later.

(3) A physician assistant may administer anesthesia, except the types of anesthesia described in subsection (4) of this section, without the personal presence of a ((~~supervising~~)) participating physician.

(4) Administration of general anesthesia or intrathecal anesthesia may be performed by a physician assistant with adequate education and training under direct supervision of a supervising anesthesiologist. Adequate education and training for administration of general or intrathecal anesthesia is defined as:

(a) Completion of an accredited anesthesiologist assistant program; or

(b) Performance of general or intrathecal anesthesia clinical duties pursuant to a valid practice agreement prior to September 22, 2021.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-075 Background check—Temporary practice permit. The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

A temporary practice permit that is issued by the commission is valid for six months. A one-time extension of six months may be gran-

ted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician assistant during the time period specified on the permit. The temporary practice permit is a license to practice medicine as a physician assistant provided that the temporary practice permit holder has a ((~~practice~~)) collaboration agreement ((~~on file with the commission~~)) with a participating physician.

(3) The commission issues a license after it receives the national background check report if the report is negative and the applicant otherwise meets the requirements for a license.

(4) The temporary practice permit is no longer valid after the license is issued or the application for a full license is denied.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-080 Physician assistant—Requirements for licensure. (1) Except for a physician assistant licensed prior to July 1, 1999, individuals applying to the commission for licensure as a physician assistant must have graduated from an accredited commission approved physician assistant program and successfully passed the NCCPA examination.

(2) An applicant for licensure as a physician assistant must submit to the commission:

(a) A completed application on forms provided by the commission;

(b) Proof the applicant has completed an accredited commission approved physician assistant program and successfully passed the NCCPA examination;

(c) All applicable fees as specified in WAC 246-918-990; and

(d) Other information required by the commission.

(3) The commission will only consider complete applications with all supporting documents for licensure.

(4) ((~~A physician assistant may not begin practicing without first filing a practice agreement with the commission.~~

~~(5)~~)) A physician assistant licensed under chapter 18.57A RCW prior to July 1, 2021, renewing their license on or after July 1, 2021, must do so with the commission. Individuals licensed under chapter 18.57A RCW and renewing their license after July 1, 2021, will follow the renewal schedule set forth in WAC 246-918-171. The commission shall issue a physician assistant license to the individuals described in this subsection without requiring full application or reapplication, but may require additional information from the renewing physician assistant.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-105 Practice limitations due to participating physician disciplinary action. (1) To the extent a supervising, but not a collaborating, physician's prescribing privileges have been limited by any state or federal authority, either involuntarily or by the physi-

cian's agreement to such limitation, the physician assistant will be similarly limited in their prescribing privileges, unless otherwise authorized in writing by the commission.

(2) The physician assistant shall notify their supervising physician whenever the physician assistant is the subject of an investigation or disciplinary action by the commission. The commission may notify the supervising physician or other supervising physicians of such matters as appropriate.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-125 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this rule, laser, light, radiofrequency, and plasma devices (hereafter LLRP devices) are medical devices that:

(a) Use a laser, noncoherent light, intense pulsed light, radiofrequency, or plasma to topically penetrate skin and alter human tissue; and

(b) Are classified by the federal Food and Drug Administration as prescription devices.

(2) Because an LLRP device penetrates and alters human tissue, the use of an LLRP device is the practice of medicine under RCW 18.71.011. The use of an LLRP device can result in complications such as visual impairment, blindness, inflammation, burns, scarring, hypopigmentation and hyperpigmentation.

(3) Use of medical devices using any form of energy to penetrate or alter human tissue for a purpose other than the purpose set forth in subsection (1) of this section constitutes surgery and is outside the scope of this section.

PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) A physician assistant must be appropriately trained in the physics, safety and techniques of using LLRP devices prior to using such a device, and must remain competent for as long as the device is used.

(5) A physician assistant may use an LLRP device so long as it is with the consent of ((~~the supervising~~)) a participating physician((~~, it is in compliance with the practice agreement on file with the commission,~~)) and it is in accordance with standard medical practice.

(6) Prior to authorizing treatment with an LLRP device, a physician assistant must take a history, perform an appropriate physical examination, make an appropriate diagnosis, recommend appropriate treatment, obtain the patient's informed consent (including informing the patient that a nonphysician may operate the device), provide instructions for emergency and follow-up care, and prepare an appropriate medical record.

PHYSICIAN ASSISTANT DELEGATION OF LLRP TREATMENT

(7) A physician assistant who meets the above requirements may delegate an LLRP device procedure to a properly trained and licensed professional, whose licensure and scope of practice allow the use of an LLRP device provided all the following conditions are met:

(a) The treatment in no way involves surgery as that term is understood in the practice of medicine;

(b) Such delegated use falls within the supervised professional's lawful scope of practice;

(c) The LLRP device is not used on the globe of the eye; and

(d) The supervised professional has appropriate training in, at a minimum, application techniques of each LLRP device, cutaneous medicine, indications and contraindications for such procedures, preprocedural and postprocedural care, potential complications and infectious disease control involved with each treatment.

(e) The delegating physician assistant has written office protocol for the supervised professional to follow in using the LLRP device. A written office protocol must include at a minimum the following:

(i) The identity of the individual physician assistant authorized to use the device and responsible for the delegation of the procedure;

(ii) A statement of the activities, decision criteria, and plan the supervised professional must follow when performing procedures delegated pursuant to this rule;

(iii) Selection criteria to screen patients for the appropriateness of treatments;

(iv) Identification of devices and settings to be used for patients who meet selection criteria;

(v) Methods by which the specified device is to be operated and maintained;

(vi) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(vii) A statement of the activities, decision criteria, and plan the supervised professional shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician assistant concerning specific decisions made. Documentation shall be recorded after each procedure, and may be performed on the patient's record or medical chart.

(f) The physician assistant is responsible for ensuring that the supervised professional uses the LLRP device only in accordance with the written office protocol, and does not exercise independent medical judgment when using the device.

(g) The physician assistant shall be on the immediate premises during any use of an LLRP device and be able to treat complications, provide consultation, or resolve problems, if indicated.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-126 Nonsurgical medical cosmetic procedures. (1) The purpose of this rule is to establish the duties and responsibilities of a physician assistant who injects medication or substances for cosmetic purposes or uses prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfiguration, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011.

(2) This section does not apply to:

(a) Surgery;

(b) The use of prescription lasers, noncoherent light, intense pulsed light, radiofrequency, or plasma as applied to the skin; this is covered in WAC 246-919-605 and 246-918-125;

(c) The practice of a profession by a licensed health care professional under methods or means within the scope of practice permitted by such license;

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

(3) Definitions. These definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Nonsurgical medical cosmetic procedure" means a procedure or treatment that involves the injection of a medication or substance for cosmetic purposes, or the use of a prescription device for cosmetic purposes. Laser, light, radiofrequency and plasma devices that are used to topically penetrate the skin are devices used for cosmetic purposes, but are excluded under subsection (2)(b) of this section, and are covered by WAC 246-919-605 and 246-918-125.

(b) "Prescription device" means a device that the federal Food and Drug Administration has designated as a prescription device, and can be sold only to persons with prescriptive authority in the state in which they reside.

PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) ((~~A physician assistant may perform a nonsurgical medical cosmetic procedure only after the commission approves a practice plan permitting the physician assistant to perform such procedures. A~~)) For a physician assistant to perform a nonsurgical medical cosmetic procedure, the physician assistant must ensure that ((~~the supervising~~)) their participating physician is in full compliance with WAC 246-919-606.

(5) A physician assistant may not perform a nonsurgical cosmetic procedure unless their ((~~supervising~~)) participating physician is fully and appropriately trained to perform that same procedure.

(6) Prior to performing a nonsurgical medical cosmetic procedure, a physician assistant must have appropriate training in, at a minimum:

(a) Techniques for each procedure;

(b) Cutaneous medicine;

(c) Indications and contraindications for each procedure;

(d) Preprocedural and postprocedural care;

(e) Recognition and acute management of potential complications that may result from the procedure; and

(f) Infectious disease control involved with each treatment.

(7) The physician assistant must keep a record of their training in the office and available for review upon request by a patient or a representative of the commission.

(8) Prior to performing a nonsurgical medical cosmetic procedure, either the physician assistant or the delegating physician must:

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent including disclosing the credentials of the person who will perform the procedure;

(f) Provide instructions for emergency and follow-up care; and

(g) Prepare an appropriate medical record.

(9) The physician assistant must ensure that there is a written office protocol for performing the nonsurgical medical cosmetic proce-

dure. A written office protocol must include, at a minimum, the following:

(a) A statement of the activities, decision criteria, and plan the physician assistant must follow when performing procedures under this rule;

(b) Selection criteria to screen patients for the appropriateness of treatment;

(c) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(d) A statement of the activities, decision criteria, and plan the physician assistant must follow if performing a procedure delegated by a physician pursuant to WAC 246-919-606, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

(10) A physician assistant may not delegate the performance of a nonsurgical medical cosmetic procedure to another individual.

(11) A physician assistant may perform a nonsurgical medical cosmetic procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is used, so long as the physician assistant's supervising physician is on-site during the entire procedure.

(12) A physician assistant must ensure that each treatment is documented in the patient's medical record.

(13) A physician assistant may not sell or give a prescription device to an individual who does not possess prescriptive authority in the state in which the individual resides or practices.

(14) A physician assistant must ensure that all equipment used for procedures covered by this section is inspected, calibrated, and certified as safe according to the manufacturer's specifications.

(15) A physician assistant must participate in a quality assurance program required of the supervising or sponsoring physician under WAC 246-919-606.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-130 Physician assistant identification. (1) A physician assistant must clearly identify ((~~himself or herself~~)) themself as a physician assistant and must appropriately display on their person identification as a physician assistant.

(2) A physician assistant must not present ((~~himself or herself~~)) themself in any manner which would tend to mislead the public as to their title.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-175 Retired active license. (1) To obtain a retired active license a physician assistant must comply with chapter 246-12 WAC, excluding WAC 246-12-120 (2)(c) and (d).

(2) ((~~A physician assistant with a retired active license must have a practice agreement on file with the commission in order to~~

~~practice except when serving as a "covered volunteer emergency worker" as defined in RCW 38.52.180 (5)(a) and engaged in authorized emergency management activities or serving under chapter 70.15 RCW.~~

~~(3)~~)) A physician assistant with a retired active license may not receive compensation for health care services.

((~~(4)~~)) (3) A physician assistant with a retired active license may practice under the following conditions:

(a) In emergent circumstances calling for immediate action; or

(b) Intermittent circumstances on a part-time or full-time nonpermanent basis.

((~~(5)~~)) (4) A retired active license expires every two years on the license holder's birthday. Retired active credential renewal fees are accepted no sooner than ((~~ninety~~)) 90 days prior to the expiration date.

((~~(6)~~)) (5) A physician assistant with a retired active license shall report ((~~one hundred~~)) 100 hours of continuing education at every renewal.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-260 Physician assistant-surgical assistant (PASA)—Use and supervision. The following section applies to the physician assistant-surgical assistant (PASA) who is not eligible to take the NCCPA certification exam.

(1) Responsibility of PASA. The PASA is responsible for performing only those tasks authorized by ((~~the supervising~~)) their participating physician(s) and within the scope of PASA practice described in WAC 246-918-250. The PASA is responsible for ensuring their compliance with the rules regulating PASA practice and failure to comply may constitute grounds for disciplinary action.

(2) Limitations, geographic. No PASA may be used in a place geographically separated from the institution in which the PASA and ((~~the supervising~~)) their participating physician are authorized to practice.

(3) Responsibility of supervising physician(s). Each PASA shall perform those tasks they are authorized to perform only under the supervision and control of the supervising physician(s). Such supervision and control may not be construed to necessarily require the personal presence of ((~~the supervising~~)) their participating physician at the place where the services are rendered. It is the responsibility of ((~~the supervising~~)) their participating physician(s) to ensure that:

(a) The operating surgeon in each case directly supervises and reviews the work of the PASA. Such supervision and review shall include remaining in the surgical suite until the surgical procedure is complete;

(b) The PASA shall wear identification as a "physician assistant-surgical assistant" or "PASA." In all written documents and other communication modalities pertaining to their professional activities as a PASA, the PASA shall clearly denominate their profession as a "physician assistant-surgical assistant" or "PASA";

(c) The PASA is not presented in any manner which would tend to mislead the public as to their title.

AMENDATORY SECTION (Amending WSR 21-22-043, filed 10/27/21, effective 11/27/21)

WAC 246-918-410 Sexual misconduct. (1) The following definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician assistant-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to ((~~a number of~~)) several factors, including the nature, extent and context of the professional relationship between the physician assistant and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Physician assistant" means a person licensed to practice as a physician assistant under chapter 18.71A RCW.

(c) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.

(2) A physician assistant shall not engage in sexual misconduct with a current patient or a key third party. A physician assistant engages in sexual misconduct when ((~~he or she engages~~)) they engage in the following behaviors with a patient or key third party:

(a) Sexual intercourse or genital to genital contact;

(b) Oral to genital contact;

(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

(f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;

(g) Not allowing a patient the privacy to dress or undress;

(h) Encouraging the patient to masturbate in the presence of the physician assistant or masturbation by the physician assistant while the patient is present;

(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;

(j) Soliciting a date;

(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the physician assistant.

(3) A physician assistant shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the physician assistant:

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the physician assistant's personal or sexual needs.

(4) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.

(5) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

(a) Documentation of formal termination;
(b) Transfer of the patient's care to another health care provider;
(c) The length of time that has passed;
(d) The length of time of the professional relationship;
(e) The extent to which the patient has confided personal or private information to the physician assistant;
(f) The nature of the patient's health problem;
(g) The degree of emotional dependence and vulnerability.
(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.
(7) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.
(8) A violation of any provision of this rule shall constitute grounds for disciplinary action.

AMENDATORY SECTION (Amending WSR 06-03-028, filed 1/9/06, effective 2/9/06)

WAC 246-918-420 Abuse. (1) A physician assistant commits unprofessional conduct if the physician assistant abuses a patient. A physician assistant abuses a patient when ((~~he or she~~)) they:
(a) Make((~~s~~)) statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;
(b) Remove((~~s~~)) a patient's clothing or gown without consent;
(c) Fail((~~s~~)) to treat an unconscious or deceased patient's body or property respectfully; or
(d) Engage((~~s~~)) in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.
(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

WSR 24-15-054
EXPEDITED RULES
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed July 16, 2024, 12:12 p.m.]

Title of Rule and Other Identifying Information: Removing references to osteopathic physician assistants. The Washington medical commission (commission) is proposing amendments to WAC 246-918-895 and 246-919-945, Pain management specialist—Chronic pain, to align rule language with currently accepted language.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: In 2020, the legislature passed SHB 2378 Concerning physician assistants. This bill eliminated the profession of osteopathic physician assistant and placed all physician assistants under the authority of the commission. As a result of this bill, chapter 246-854 WAC, which pertained to osteopathic physician assistants, was repealed.

In both WAC 246-918-895 and 246-919-945, the commission references a section to the now-repealed chapter 246-854 WAC. Additionally, these sections reference both allopathic and osteopathic physician assistants. The commission intends to remove the references to chapter 246-854 WAC and to allopathic and osteopathic physician assistants.

Reasons Supporting Proposal: With the repeal of chapter 246-854 WAC and the elimination of classifying physician assistants as either allopathic or osteopathic, WAC 246-918-895 and 246-919-945 need to be updated to align rule language with currently accepted language.

Statutory Authority for Adoption: RCW 18.71.017 and SHB 2378 (chapter 80, Laws of 2020).

Statute Being Implemented: RCW 18.71.017.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington medical commission, governmental.

Name of Agency Personnel Responsible for Drafting: Amelia Boyd, 111 Israel Road S.E., Tumwater, WA 98501, 360-918-6336; Implementation and Enforcement: Kyle Karinen, 111 Israel Road S.E., Tumwater, WA 98501, 564-233-1557.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Content is explicitly and specifically dictated by statute.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The proposed amendments aligns rule language with currently accepted language without changing its effect.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Amelia Boyd, Department of Health, Washington Medical Commission, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, email amelia.boyd@wmc.wa.gov, AND RECEIVED BY September 23, 2024, at midnight.

July 16, 2024
Kyle S. Karinen
Executive Director
Washington Medical Commission

OTS-5454.4

AMENDATORY SECTION (Amending WSR 20-08-069, filed 3/26/20, effective 4/26/20)

WAC 246-918-895 Pain management specialist—Chronic pain. A pain management specialist shall meet one or more of the following qualifications:

(1) If ((~~an allopathic~~)) a physician assistant ((~~or osteopathic physician assistant~~)) must have a delegation agreement with a physician pain management specialist and meet((~~s~~)) the educational requirements and practice requirements listed below:

(a) A minimum of three years of clinical experience in a chronic pain management care setting;

(b) ((~~Credentialed in pain management by an entity approved by the commission for an allopathic physician assistant or the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant;~~

~~(c)~~)) Successful completion of a minimum of at least ((~~eighteen~~)) 18 continuing education hours in pain management during the past two years; and

((~~(d)~~)) (c) At least ((~~thirty~~)) 30 percent of the physician assistant's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.

(2) If an allopathic physician, in accordance with WAC 246-919-945.

(3) If an osteopathic physician, in accordance with WAC 246-853-750.

(4) If a dentist, in accordance with WAC 246-817-965.

(5) If a podiatric physician, in accordance with WAC 246-922-750.

(6) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

OTS-5453.1

AMENDATORY SECTION (Amending WSR 18-23-061, filed 11/16/18, effective 1/1/19)

WAC 246-919-945 Pain management specialist—Chronic pain. A pain management specialist shall meet one or more of the following qualifications:

(1) If an allopathic physician or osteopathic physician:

(a) Is board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, neurology, rheumatology, or anesthesiology;

(b) Has a subspecialty certificate in pain medicine by an ABMS-approved board;

(c) Has a certification of added qualification in pain management by the AOA;

(d) Is credentialed in pain management by an entity approved by the commission for an allopathic physician or the Washington state board of osteopathic medicine and surgery for an osteopathic physician;

(e) Has a minimum of three years of clinical experience in a chronic pain management care setting; and

(i) Has successful completion of a minimum of at least ((~~eighteen~~)) 18 continuing education hours in pain management during the past two years for an allopathic physician or three years for an osteopathic physician; and

(ii) Has at least ((~~thirty~~)) 30 percent of the allopathic physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) If ((~~an allopathic~~)) a physician assistant, in accordance with WAC 246-918-895.

(3) ((~~If an osteopathic physician assistant, in accordance with WAC 246-854-330.~~

~~(4)~~)) If a dentist, in accordance with WAC 246-817-965.

((~~(5)~~)) (4) If a podiatric physician, in accordance with WAC 246-922-750.

((~~(6)~~)) (5) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

Policy

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Title:	Complaints Against Students, Residents, and Fellows		POL202x-0x
References:			
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	medical.commission@wmc.wa.gov
Supersedes:			
Effective Date:			
Approved By:	,Chair		

Policy Statement

In carrying out its disciplinary role to protect the public, the Washington Medical Commission (Commission) receives complaints[1] against students and physicians during their post-graduate training. Because of the highly supervised environment in which students, resident physicians (residents), and fellows are practicing medicine, the Commission establishes the following policy on how complaints against Physician Assistant (PA), Anesthesiologist Assistant (AA), and allopathic Medical Students, Residents, and Fellows are considered. For students and residents on whom the Commission receives a complaint, the Commission will, with some exceptions, refer the complaint back to Program Directors, Deans, and supervising physicians for correction. Complaints filed against Fellows, due to their increased training, will progress through the standard process established in law and Commission rule, unless circumstances of the complaint require additional consideration. This policy is enacted to further the goals of non-punitive educational systems and provide necessary grace to trainees on their journey to full scope practice.

Referring Student Complaints

PA, AA, and MD students are generally in the early stages of learning and practicing medicine, have little control over their practice conditions, and are being monitored in a highly structured, supervised environment. While the Commission may receive complaints against PA, AA, or MD students, the Commission recognizes that training Program directors and Deans are generally better equipped to address standard of care concerns in an educational setting than the Commission. Complaints received by the Commission regarding actions outside of the training program related to the practice of medicine or not, may be investigated under the authority of RCW 18.71.230 and the investigatory and discipline process

[1] For the purpose of this procedure, the term "complaint" includes a mandatory report under RCW 18.130.070 and 18.130.080.

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authorized under RCW 18.130. Examples of actions outside of a program of interest to the Commission include but are not limited to boundary violations, sexual misconduct, diversion, or criminal convictions.

Complaints against Residents

Under authority of RCW 18.71.030(9), residents are legally permitted to practice medicine in a training program sponsored by a college or university or a hospital in this state, pursuant to their duties as a trainee. Postgraduate clinical training programs generally require each of their residents to initially obtain a limited license which permits them to practice medicine in connection with their duties in the residency program, though many residents seek full physician and surgeon licensure as soon as they meet eligibility requirements which include the successful completion of two years of postgraduate training.

A limited license does not authorize a resident to engage in any practice of medicine outside of their residency program, but full licensure does. The Commission recognizes that residents practicing medicine *within* their program with or without a limited license have little control over their practice environment which, by design, provides ongoing learning opportunities with continuous evaluation and feedback processes to cultivate the skills necessary to be a competent physician. Attending physicians and Program Directors are responsible for training their residents on the standard of care and professional conduct involving the practice of medicine. Due to established supervisory roles within training programs, a residency Program Director, or alternatively an attending physician, graduate medical education officer, or hospital employer, may be in a better position than the Commission to manage practice concerns involving one of their residents. While the Commission generally refers standard of care issues to residency Program Directors, there are some exceptions.

- *Unprofessional Conduct.* A resident with or without a limited license is not shielded from being investigated or disciplined for unprofessional conduct. At times, a resident's supervising attending physician, or their Program Director, may also be investigated or disciplined by the Commission if, on a case-by-case basis, the Commission determines such action is necessary to protect the public. Further, the Commission may discipline a resident with a limited license for a finding of unprofessional conduct under authority of RCW 18.71.230 and a resident with a full license under authority of the Uniform Disciplinary Act RCW 18.130.

- *Health Condition Impairment.* Whether fully licensed as a physician and surgeon or not, if the Commission receives a complaint that that a resident is impaired or potentially impaired as the result of a health condition, the Commission may open an investigation and consider making a simultaneous referral to the Washington Physician Health Program (WPHP).

Complaints against Fellows

The Commission typically processes complaints against fellows holding a limited license in a manner similar to processing complaints on fully licensed licensees. The Commission may consider training status involving standard of care issues, especially those involving procedures being developed as a part of their fellowship training, in determining whether to investigate a complaint or impose discipline.

Policy

Title:	Commissioner and Pro Tem Recusal Policy to Address Conflicts of Interest		POL202x-0x
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	medical.commission@wmc.wa.gov
Supersedes:	NA		
Effective Date:			
Approved By:	,Chair		

Introduction

Administrative proceedings are to be free from the impression that a participating member pre-judged the matter at hand. In *Washington Med. Disciplinary Bd. v. Johnston*, the Supreme Court of Washington opined, "Under the appearance of fairness doctrine, proceedings before a quasi-judicial tribunal are valid only if a reasonably prudent and disinterested observer would conclude that all parties obtained a fair, impartial, and neutral hearing." [1]

Similarly, the Washington State Executive Ethics Board has issued advisory opinions regarding the Ethics in Public Service Act, Chapter 42.52 of the Revised Code of Washington (RCW), and its application to Boards/Commissions. That guidance has remained grounded in the basic concept that public servants are not to be decision-makers involving matters that personally benefit them. Advisory Opinion number 96-09 includes that boards and commissions may require members to disclose their interests and abstain from voting or attempting to influence votes when there is a conflict of interest.[2]

In compliance with the advisory opinion, the Washington Medical Commission (Commission) Code of Conduct states that commissioners will, "recuse themselves and proactively disclose when there is a real or potential conflict of interest, or the appearance of such a conflict." This code of conduct aligns with the Federation of State Medical Boards (FSMB) recommendation that boards adopt a conflict of interest policy. Such a policy should include that no board member shall participate in the deliberation, making of any decision, or taking of any action affecting the member's own personal, professional, or pecuniary interest, or that of a known relative or of a business or professional associate.

[1] *Matter of Johnston, 99 Wash. 2d 466, 478, 663 P.2d 457, 464 (1983).*
[2] Advisory Opinion on Disclosure Requirements for Boards and Commissions, Number 96-09, approved May 20, 1996, reviewed May 5, 2021, available at https://ethics.wa.gov/sites/default/files/public/AO%2096-09.pdf (Accessed April 8, 2024)

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The Commission is committed to preventing bias from unjustly influencing Commission activities. The purpose of this policy is to prevent biases from unjustly impacting licensing, investigations, policy-making, and disciplinary matters.

Case Management Team Meetings

Case Management Team (CMT) meetings include at least three Commissioners who access complaints and determine whether to authorize an investigation. To further prevent bias from impacting Commission activities, staff redact the allopathic physicians (MD) or physician assistants (PA) identifying information including, but not limited to, name, gender or gender identity, and race.

Case Disposition Meetings

Case Disposition meetings involve a panel of Commissioners who hear presentations of cases that have the investigation completed. Each case is presented by a Reviewing Commission Member (RCM) who does not state the identifying details of the MD or PA, including, but not limited to, name, gender or gender identity, and race as part of their presentation. The panel then decides whether to authorize discipline or close the case for each instance.

While these redactions and exclusions are aimed at preventing bias and ensuring fairness, they may inadvertently obscure a Commissioner's immediate recognition of a conflict of interest. The redactions and limited information particularly impede the identification of reasons for recusal during both CMT and Case Disposition meetings. However, once a Commissioner or the Commission's Executive Director becomes aware of a potential conflict of interest involving a Commissioner, this recusal policy offers guidance on proceeding to uphold impartiality and fairness.

This policy is intended to provide guidance for Commissioner and Pro Tem appointees[3] in mitigating conflicts of interest that could compromise the integrity of Commission proceedings.

Legal Authority

United States Constitution

The 14th Amendment of the United States Constitution,[4] provides due process protection for individuals in the U.S., not just practitioners, to protect against biased, unjust governmental adjudications. The United States Supreme Court has clarified that due process protects against a likelihood of decision-maker bias from impacting a fair adjudication,[5] and these protections have been further enhanced through Washington state laws.

[3] To avoid redundancy, the term "Commissioner" henceforth includes a Commissioner or a Pro Tem appointee.

[4] Available at https://www.archives.gov/milestone-documents/14th-amendment (Accessed May 14, 2024)

[5] "Not only is a biased decisionmaker constitutionally unacceptable, but 'our system of law has always endeavored to prevent even the probability of unfairness.' Where there is merely a general predilection toward a given result which does not prevent the agency members from deciding the particular case fairly, however, there is no deprivation of due process." *Matter of Johnston*, 99 Wash. 2d 466, 475, 663 P.2d 457, 462 (1983) (quoting *In re Murchison*, 349 U.S. 133, 136 (1955)).

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Revised Code of Washington

In Washington, commissioners are considered "state officers", and as such are bound by the Ethics in Public Service Act, chapter 42.52 RCW. Pertinent sections of this statute include the following:

RCW 42.52.020 Activities incompatible with public duties.

No state officer or state employee may have an interest, financial or otherwise, direct or indirect, or engage in a business or transaction or professional activity, or incur an obligation of any nature, that is in conflict with the proper discharge of the state officer's or state employee's official duties.

RCW 42.52.030 Financial interests in transactions.

(1) No state officer or state employee, except as provided in subsection (2) of this section, may be beneficially interested, directly or indirectly, in a contract, sale, lease, purchase, or grant that may be made by, through, or is under the supervision of the officer or employee, in whole or in part, or accept, directly or indirectly, any compensation, gratuity, or reward from any other person beneficially interested in the contract, sale, lease, purchase, or grant.

RCW 42.52.160 Use of persons, money, or property for private gain.

(1) No state officer or state employee may employ or use any person, money, or property under the officer's or employee's official control or direction, or in his or her official custody, for the private benefit or gain of the officer, employee, or another.

RCW 42.52.903 Serving on board, committee, or commission not prevented.

Nothing in this chapter shall be interpreted to prevent a member of a board, committee, advisory commission, or other body required or permitted by statute to be appointed from any identifiable group or interest, from serving on such body in accordance with the intent of the legislature in establishing such body.

Guidance on Transparency Involving a Conflict of Interest and Recusal

There must be transparency in the handling of conflicts of interests involving Commission matters. To prevent a conflict of interest involving public duties from compromising fairness, the Commission recognizes that specific prohibitions in chapter 42.52 RCW must be read in conjunction with the exception specified in RCW 42.52.903 and, in limited circumstances, that conflicts of interest may occasionally be unavoidable. A commissioner's employer or affiliated health systems may not, in and of themselves, create a conflict of interest necessitating

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recusal; however, when any of these affiliations, or others, create a scenario in which that a commissioner may financially, personally, or professionally benefit, or be harmed, that does necessitate recusal.

The Commission adopts the following guidance:

- Commissioners are responsible for handling conflicts of interest with full transparency at all times and for recusing themselves from cases as soon as reasonably possible if they recognize a conflict of interest that may compromise fairness, impartiality, or the appearance of impartiality;
- No commissioner may be beneficially interested, directly or indirectly, in a decision in which they are involved;
- No commissioner may participate, in their official capacity, in a transaction involving the state with a partnership, association, corporation, firm or other entity of which the commissioner is an officer, agent, employee or member, or in which the commissioner owns a beneficial interest;
- A commissioner is encouraged to announce their potential conflict of interest and recuse themselves as soon as they first recognize the potential conflict, and if there is a true conflict they should leave the room or call and not participate in any discussion involving the matter to avoid impartiality or the appearance of impartiality; and
- A commissioner must abstain from any discussion or vote taken by the Commission involving an action (including contracting, rulemaking, or policy decisions) or transaction with any entity with which the commissioner may benefit or be harmed (financially, personally, or professionally), and if a commissioner abstains from voting because of such involvement, such commissioner shall announce for the record their reason for their abstention.

Procedure for Commissioner Recusal[6]

Internal Process Among Commissioners

To ensure fundamental fairness, a commissioner should notify the Panel Chair and the Executive Director of any concerns they have regarding any commissioner's, including but not limited to their own, inability to be impartial. Disqualification processes and standards are

[6] This recusal procedure was heavily influenced by Texas Administrative Code, Rule Section 187.42, with quotation marks omitted, with modifications which incorporate Washington state law and ethics board guidance to ensure impartiality and to protect the public.

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addressed in the Administrative Procedure Act, specifically in RCW 34.05.425[7], in addition to the Model Procedural Rules for Boards, specifically in WAC 246-11-230[8].

Standards for Recusal

A commissioner should exercise sound discretion in choosing whether to be recused from participation and voting regarding any matter. A commissioner should choose to be recused if they:

- Have a direct financial interest or relationship with any matter, party, or witness that would give the appearance of a conflict of interest;
- Have a current or past relationship* within the third degree of affinity with any party or witness; or
- Determine that they have knowledge of information that is not in the administrative record of a contested case and that they cannot set aside that knowledge and fairly and impartially consider the matter based solely on the administrative record.

Once a commissioner believes there may be a conflict of interest that has the potential to cause impartiality, or an appearance of impartiality, the first step is for the commissioner who recognizes that conflict to alert the Commission Executive Director, or their designee. Then, in consultation with the Commission Executive Director, or their designee, there will be a discussion with the commissioner with the potential conflict, if possible, to make a clear determination of the following: (1) "must" recuse, (2) "should" recuse, or (3) "unnecessary" to recuse. The determination will err on the side of recusal. If a conflict is recognized late, it will be addressed as soon as reasonably possible.

The fact that a commissioner participated in another matter regarding a respondent, applicant, attorney, or matter may not by itself mandate the commissioner's recusal from other matters. If a Commissioner is familiar with a respondent or applicant due to serving on a panel or serving as a reviewing commission member, that alone is generally not sufficient to warrant recusal. However, in the event that prior involvement may potentially prejudice the rights of any party to a fair proceeding, the presiding officer (presiding Commissioner or health law judge) may cure any such prejudice by an instruction to Commissioners or members of the hearing panel to not consider the statement during the course of the proceeding or during deliberations or discussion related to the proceeding.

[7] "(3) Any individual serving or designated to serve alone or with others as presiding officer is subject to disqualification for bias, prejudice, interest, or any other cause provided in this chapter or for which a judge is disqualified. (4) Any party may petition for the disqualification of an individual promptly after receipt of notice indicating that the individual will preside or, if later, promptly upon discovering facts establishing grounds for disqualification. (5) The individual whose disqualification is requested shall determine whether to grant the petition, stating facts and reasons for the determination. (6) When the presiding officer is an administrative law judge, the provisions of this section regarding disqualification for cause are in addition to the motion of prejudice available under RCW 34.12.050. (7) If a substitute is required for an individual who becomes unavailable as a result of disqualification or any other reason, the substitute must be appointed by the appropriate appointing authority. (8) Any action taken by a duly appointed substitute for an unavailable individual is as effective as if taken by the unavailable individual." RCW 34.05.425.

[8] "(4) Any party may move to disqualify the presiding officer, or a member of the board hearing the matter, as provided in RCW 34.05.425(3)." WAC 246-11-230.

However, if the Commissioner has prior knowledge of a situation from having served as a hospital quality assurance reviewer or as an expert or fact witness or attorney of record on a civil case involving the respondent or applicant, recusal is warranted.

In summary, Commissioners must recuse themselves if there is a conflict of interest and should recuse if there is an appearance of a conflict of interest. Commissioners are expected to use reasonable judgment and should discuss the possible conflict of interest with the Commission's Executive Director, or their designee, and err on the side of recusal.

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Guidance Document

WASHINGTON Medical Commission
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Medical Directors: Roles, Duties and Responsibilities

Introduction

Serving as a medical director may be more challenging than most practitioners[1] realize and come with certain responsibilities that, if not well-understood, could bring a practitioner to the attention of the Washington Medical Commission. A medical director can work in a wide variety of environments, including chief medical officer for a large or small medical or hospital system, a single-specialty or multi-disciplinary clinic, a long-term care facility, a medical spa, an addiction treatment facility, a telemedicine venture, or an entity seeking to gain credibility by hiring a "medical director" in some nebulous role. The Commission has reviewed complaints that practitioners failed to meet the obligations inherent in the role of a medical director. Whether this arises from simple ignorance of the laws or a reckless disregard of appropriate standards, the result can be harm to patients or a violation of state or federal law. The Commission provides this guidance document to help practitioners understand the roles, duties and responsibilities of a medical director.[2]

Guidance

While the duties will vary depending on the type of facility, and the legal relationship between the medical director and the facility, the medical director is ultimately responsible for the medical care provided and the safety of the patients. Regardless of the particular circumstances, the Commission recommends that a medical director should:

1. Prioritize staff and patient safety;
2. Understand and be familiar with the practice standards required of the particular type of practice;
3. Supervise and provide guidance to all clinical staff, whether they are employees or independent contractors;
4. Ensure that each member of the clinical staff is properly licensed, trained and acts within their legal scope of practice;
5. Coordinate care within the facility to promote teamwork and communication among the entire healthcare team;
6. Clearly communicate expectations to the clinical staff;
7. Develop and update policies, guidelines and protocols for clinical staff to ensure compliance with current practice standards, as well as federal and state regulations;
8. Ensure that the clinician staff exercise independent clinical judgment, put the patient first, and are not influenced by financial interests;

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[1] Practitioners includes physicians and physician assistants.

[2] This guideline is not intended to cover medical directors for health insurance carriers or EMS systems, which are covered by specific statutes. See RCW 48.43.540 and 18.71.212 *et seq.*

9. Respond to emergencies in a timely manner and address issues that can impact patient care;
10. Ensure that an appropriate medical record is kept for each patient, and that health care information is confidential and secure; and
11. Promote professionalism and ethical values.

By following these best practices, practitioners will reduce the likelihood of a bad outcome for patients and the likelihood of a complaint to the Commission.

The Commission advises practitioners to be wary of entering into arrangements with unlicensed persons. These relationships may entail legal risks involving aiding or abetting the unlicensed practice of medicine, the corporate practice of medicine, and violating fee-splitting, rebating or anti-kickback laws. The Commission advises practitioners considering these arrangements to seek legal counsel.

Number:	GUI2020-02
Date of Adoption:	August 21, 2020
Reaffirmed / Updated:	N/A
Supersedes:	N/A

Interpretive Statement

Title:	"Qualified Physician" Under Optometry Law		IS2024-0x
References:	Chapter 18.53 RCW; Chapter 18.71 RCW		
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	medical.commission@wmc.wa.gov
Supersedes:	n/a		
Effective Date:			
Approved By:			

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On May 9, 2023, Governor Inslee signed Enrolled Substitute Senate Bill 5389 modifying Chapter 18.53 RCW, an act regulating the practice of optometry in Washington. This new law expanded the scope of optometry to include certain advanced procedures:

> (2)(a) The practice of optometry may include the following advanced procedures:
> (i) Common complication of the lids, lashes, and lacrimal systems;
> (ii) Chalazion management, including injection and excision;
> (iii) Injections, including intramuscular injections of epinephrine and subconjunctival and subcutaneous injections of medications;
> (iv) Management of lid lesions, including intralesional injection of medications;
> (v) Preoperative and postoperative care related to these procedures;
> (vi) Use of topical and injectable anesthetics; and
> (vii) Eyelid surgery, excluding any cosmetic surgery or surgery 1 requiring the use of general anesthesia.

The new law provides that an optometrist cannot perform these advanced procedures until the Board of Optometry issued a license endorsement. The Board of Optometry will issue the license endorsement after the optometrist meets "the educational, training, and competence criteria" set forth in the new law.

To receive a license endorsement, the optometrist must successfully complete postgraduate courses as designated by the Board, successfully complete a national examination for advanced procedures, and

> (iii) Enter into an agreement with a qualified physician licensed under chapter 18.71 RCW or an osteopathic physician licensed under chapter 18.57 RCW for rapid response if complications occur during an advanced procedure.

The new law does not define the term "qualified physician licensed under chapter 18.71 RCW." Since the WMC licenses allopathic physicians under chapter 18.71 RCW, the WMC is putting forth its understanding of the term "qualified physician." It can be a challenge when laws create opportunities for collaboration between separately regulated professions. In putting forth its interpretation of the term, the WMC is undertaking its commitment to fulfill the Legislature's action and is not seeking to regulate another profession. This interpretation is intended to assist physicians who are contemplating entering into an agreement.

Being able to respond rapidly to complications from the procedures listed in the new law requires a high level of competence. The WMC interprets the term "qualified physician under chapter 18.71 RCW" in Enrolled Substitute Senate Bill 5389, Chapter 400, Laws of 2023, to mean a physician who meets each of the following criteria:

1. Holds a current license to practice as a physician and surgeon with the WMC;
2. Is not currently under an order or a stipulation to informal disposition with the WMC;
3. Holds a current and unrestricted certification from the American Board of Ophthalmology or is eligible to do so; and
4. Has a surgical suite on site or holds privileges at a local hospital.

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Policy

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

Title:	Artificial/Assistive/Augmented Intelligence (AI)		POL202x-0x
References:	WA EO 14110, 15 U.S.C. 9401(3)		
Contact:	Washington Medical Commission		
Phone:	(360) 236-2750	E-mail:	medical.policy@wmc.wa.gov
Supersedes:	NA		
Effective Date:			
Approved By:	,Chair		

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Introduction

The Washington Medical Commission (Commission) provides practitioners (physicians, physician assistants, and anesthesiologist assistants) this policy to address the use of artificial/assistive/ augmented intelligence (AI) in their delivery of health care in the state of Washington. The Commission recognizes the need for practitioners to understand how AI tools may be used safely in their practices while AI technology continues to evolve.

It is estimated that medical knowledge doubles every 73 days,[1] that 30 percent of all the data generated worldwide is estimated to be health care related.[2] AI may help to revolutionize the practice of medicine by assisting practitioners with their healthcare delivery and data integration into electronic health records.[3]

While definitions involving AI continue to evolve, Executive Order 14110 issued by the President of the United States in the fall of 2023 defined AI as follows:

> The term "artificial intelligence" or "AI" has the meaning set forth in 15 U.S.C. 9401(3): a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments. Artificial intelligence systems use machine- and human-based inputs to perceive real and virtual environments; abstract such perceptions into models through analysis in an

[1] Densen, P. Challenges and opportunities facing medical education. Trans. Am. Clin. Climatol. Assoc. 122, 48 (2011).
[2] RBC Capital Markets Episode 1: The Healthcare Data Explosion, available at https://www.rbccm.com/en/gib/healthcare/episode/the_healthcare_data_explosion (Accessed May 6, 2024).
[3] Alanazi A. Clinicians' Views on Using Artificial Intelligence in Healthcare: Opportunities, Challenges, and Beyond. Cureus. 2023 Sep 14;15(9):e45255. doi: 10.7759/cureus.45255. PMID: 37842420; PMCID: PMC10576621, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10576621/ (Accessed May 6, 2024).

automated manner; and use model inference to formulate options for information or action.[4]

Federal regulators recognize that AI has the potential to improve patient care, augment practitioner capabilities, and advance medical product development,[5] and the Commission concurs. As AI in healthcare continues to evolve, the Commission provides this summary of responsibilities, risks, benefits, and accountability considerations involving practitioners and the use of AI in their practice of medicine.

State and National Considerations

The Federation of State Medical Boards (FSMB) provided guidance in April of 2024 to state medical boards, which includes the Commission, to help ensure the safe and effective use of AI to improve patient care. The FSMB guidance document, adopted by the FSMB House of Delegates, is entitled "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," which incorporated input provided by the FSMB Ethics and Professionalism Committee. FSMB's guidance on the use of AI in the practice of medicine includes the following:

> Artificial Intelligence (AI) holds tremendous potential to aid healthcare providers in diagnosis, treatment selection, clinical documentation, and other tasks to improve quality, access, and efficiency. However, these technologies introduce risks if deployed without proper "guardrails" and understanding which may impact considerations in clinical practice as well as regulatory processes of state medical boards. By taking a proactive and standardized governance approach anchored in ethical principles, state medical boards can promote safe and effective integration of AI, in its various forms, while prioritizing patient wellbeing.[6]

As described in the FSMB guidance, multiple AI applications are already being used in healthcare "to analyze large datasets to identify patterns, classify information, and make predictions to support clinical decision-making."[7] While still evolving, AI technology is currently being used in healthcare in the following manner:

- Analyzing medical images thru computer vision systems,
- Reviewing medical records to improve communication thru interpretive services,
- Forecasting clinical trends using predictive algorithms and advanced data analytics,
- Supporting provider medical record documentation thru voice recognition, and

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[4] Executive Order 14110 "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence," Section 3(b), issued on October 30, 2023, and published in the Federal Register on November 1, 2023. Available at https://www.federalregister.gov/documents/2023/11/01/2023-24283/safe-secure-and-trustworthy-development-and-use-of-artificial-intelligence (Accessed May 6, 2024).

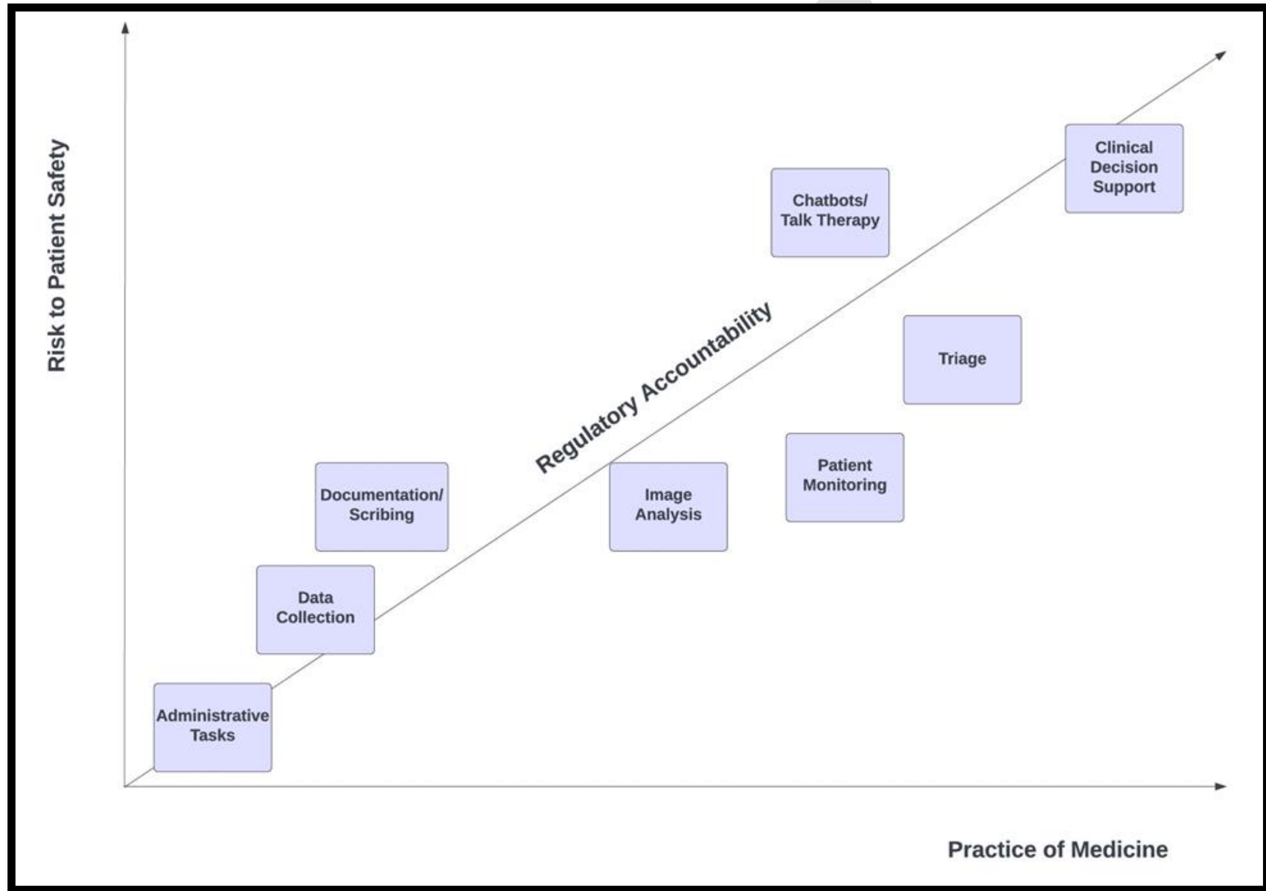
[5] Artificial Intelligence & Medical Products: How CBER, CDER, CDRH, and OCP are Working Together AI Medical Products Paper (fda.gov)

[6] "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p.1, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

[7] "Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p.3, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

- Providing patient triage and education using "Chatbots."[8]

The FSMB guidance described numerous benefits of the use of AI in the practice of medicine while also providing guidance on regulatory accountability to limit risk. The following graph visualizes how AI usage in areas of medical practice correlates with risk ratios and a corresponding need for regulatory accountability.[9]



In the state of Washington, Governor Jay Inslee on January 30, 2024, issued Executive Order 24-01 on Artificial Intelligence, and defined the following terminology:

1. "Generative AI Technology" is a technology that can create content, including text, images, audio, or video, when prompted by a user. Generative AI systems learn patterns and relationships from large amounts of data, which enables systems to

[8] "Navigation the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p. 3, available at incorporation-of-ai-into-practice.pdf (fsmb.org)
[9] "Navigation the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice," Adopted by the FSMB House of Delegates April 2024, p. 6, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

generate new content that may be similar, but not identical, to the underlying training data.

2. "High-Risk Generative AI System" means systems using generative AI technology that creates a high risk to natural persons' health and safety or fundamental rights. Examples include biometric identification, critical infrastructure, employment, health care, law enforcement, and administration of democratic processes.

Additional definitions that aide in understanding this topic are as follows:

"Artificial intelligence" means any technology that can simulate human intelligence, including but not limited to, natural language processing, training language models, reinforcement learning from human feedback and machine learning systems.

"AI-generated content" shall mean image, video, audio, print or text content that is substantially created or modified by a generative artificial intelligence system such that the use of the system materially alters the meaning or significance that a reasonable person would take away from the content.[10]

"Generative artificial intelligence system" shall mean any system, tool or platform that uses artificial intelligence to generate or substantially modify video, audio, print or text content.[11]

"Metadata" shall mean structural or descriptive information about data such as content, format, source, rights, accuracy, provenance, frequency, periodicity, granularity, publisher or responsible party, contact information, method of collection, and other descriptions.[12]

Generative AI Technology and High-Risk Generative AI Systems are being developed rapidly in the healthcare arena. AI technological advances may create educational, privacy, and use-related challenges for practitioners. As AI technology continues advancing, practitioners must ensure that their use, or their lack thereof, of AI in the practice of medicine complies with evolving standards of care involving ethics and equity, decision making, and information management.

Policy

The Commission policy relating to the incorporation and use of AI tools in the practice of medicine is grounded in the principles of mutual informed consent and autonomy of the practitioner for the purposes of clinical decisions. AI may be used as a tool in the practice of medicine by practitioners. Regardless of whether the practitioner is receiving trend analysis or algorithm treatment recommendations, the practitioner shall remain directly involved in the care of the patient with one

[10] Commonwealth of Massachusetts HD 4788. Similarly, the Commission recognizes this definition in the state of Washington.

[11] Commonwealth of Massachusetts HD 4788. Similarly, the Commission recognizes this definition in the state of Washington.

[12] Commonwealth of Massachusetts HD 4788 (applying the definition from 44 U.S.C.A. Section 3502(19)). Similarly, the Commission recognizes this definition in the state of Washington.

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exception. The practitioner may participate in quality assurance reviews of AI tools while remaining uninvolved in direct patient care so long as they stay within the guardrails of evaluating for risk, safety, bias, and effectiveness of the AI tools themselves.

However, prior to the use of AI involving a patient's care, the practitioner should understand the following:

A. Informed Consent involving Decision-Making Influences.

"Privacy means people know what they're signing up for, in plain language, and repeatedly. I believe people are smart. Some people want to share more than other people do. Ask them."– Steve Jobs

When reasonably possible, a practitioner using AI in the practice of medicine should seek to obtain informed consent from the patient, or the patient's authorized representative, in advance of using AI in their treatment and provide them with the option to receive treatment without the use of AI. However, the Commission recognizes that informed consent may not always be possible whereas at times AI is being used without the knowledge of the practitioner or beyond the control of the practitioner. The Commission also recognizes that not all practitioners will be in a position to access or understand the development, training data set biases, and design of the systems, which is acceptable.

The Commission is cognizant that as AI tools become more integrated and tested in health care workflows and as the presence of AI tools becomes commonplace in daily lives, the need or utility of informed consent for their use will likely fade. Regardless, any AI system used in the practice of medicine must be designed to prioritize the safety and well-being of individuals seeking treatment and monitored to ensure its safety and effectiveness.[13] The Commission adopts the following FSMB's guidance on AI decision-making influences*:*

"Physicians may consider AI as a decision-support tool that assists, but does not replace, clinical reasoning and discretion. Physicians should understand the AI tools they are using by being knowledgeable about their design, training data used in its development, and the outputs of the tool in order to assess reliability and identify and mitigate bias. Once the treating physician chooses to use AI, they accept responsibility for responding appropriately to the AI's recommendations. For example, if a physician chooses to follow the course of treatment provided by an AI-generated response, then they should be prepared to provide a rationale for why they made that decision. Simply implementing the recommendations of the AI without a corresponding rationale, no matter how positive the outcome may be, may not be within the standard of care. Alternatively, if the physician uses AI and then suggests a course of treatment that deviates from one delineated by AI, they should document the rationale behind the deviation and be prepared to defend the course of action should it lead to a less than optimal or harmful outcome for the patient. Generally, the reason a physician provides for disagreeing with an AI's recommendation should be because

[13] Modified wording with quotations omitted from wording within the Commonwealth of Massachusetts H.1974.

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following that recommendation would not uphold the standard of care. As with any tool, once it produces a result, the outcomes cannot be ignored; there must be documentation reflecting how it was or will be utilized by the physician in the care provided. While the expanded use of AI may benefit a physician, failure to apply human judgement to any output of AI is a violation of a physician's professional duties."

B. *Scope of Practice and the Standard of Care.* To be practicing within the practitioner's scope of practice and the standard of care using AI, a practitioner must have the expertise to assess, diagnose, and treat the patient in front of them, and, additionally, should understand the risks and benefits of using AI for the specific function(s) for which it is to be used. Put another way, if a practitioner does not have the education, training, and certification to practice in a certain scope or specialty without use of an AI tool, the practitioner may not practice outside of their scope of specialty with the use of an AI tool.

   The accepted standard of care prohibits the concept of "license renting." License renting is defined as a scenario in which, through an AI tool - regardless of if it involves unlicensed or improperly licensed personnel - access to a service is created that relies on the approval or provision of the authority of the license. Examples include but are not limited to prescriptions, medical waivers, or medical authorizations for durable medical equipment. This occurs without the due diligence of direct interaction or otherwise meeting the standard of care with the patient. These situations can utilize dynamic or pre-programmed forms, questionnaires augmented by AI dialogue or chat tools. It can also occur when personnel perform tasks outside of scope for the licensee and patients do not directly, and appropriately, interact with a licensee. Scenarios that may appear similar to this concept but are not viewed as equivalent by the WMC are institutionally designed treatment protocols for conditions such as sepsis or pneumonia or standing orders. In those situations, there is appropriate interaction with patients by the WMC licensee.

C. *Ethical and Equity Principles.* The Commission ensures the ethical and [equitable delivery of healthcare] by practitioners, whether AI is being utilized or not, to protect patient safety. The principle of justice dictates that physicians have a professional responsibility to help identify and eliminate biases, including avoiding the use of biased AI algorithms which may increase the risk of patient harm, in their practice of medicine. The Commission adopts the following FSMB's guidance involving bias:

   "AI systems encumbered by false or inaccurate information may carry a bias that can be detrimental to providers and harmful to patients. The principle of justice dictates that physicians have a professional responsibility to identify and eliminate biases in their provision of patient care, including those that may arise through biased AI algorithms. AI also poses an opportunity to expand access to care for populations historically marginalized and otherwise disadvantaged. Efforts must be made to

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ensure that all patients have equitable access to the benefits of AI and that existing disparities are not further exacerbated.”[14]

D. *Information Management Responsibilities.*

   a. Protecting Privacy. The use of AI neither decreases a practitioner's duty to protect privacy, nor alters the basic purpose of patient medical records. Practitioners are encouraged to ensure they understand the Commission's Guidance Document of Medical Records.

   b. The Commission recommends, but does not require, that practitioners practicing medicine in the state of Washington do the following involving the documentation of their AI use.

“Each generative artificial intelligence system used to create audio, video, text or print AI-generated content should include on or within such content a clean and conspicuous disclosure that meets the following criteria: (i) a clear and conspicuous notice, as appropriate for the medium of the content, that identifies the content as AI-generated content, which is to the extent technically feasible, permanent or uneasily removed by subsequent users; and (ii) metadata information that includes an identification of the content as being AI-generated content, the identity of the system, tool or platform used to create the content, and the date and time the content was created.”[15]

E. *Limitations and Education.* Practitioners are encouraged to complete continuing medical education (CME), including self-directed CME, to understand the impact of bias, in addition to limitations in research, involving underrepresented populations in health care technology applications such as AI. Prior to using a specific AI tool, the practitioner should understand limitations including but not limited to the potential for bias against populations that were not adequately represented in testing of AI tools to prevent patient harm. The Commission provides a free CME option to satisfy this guidance: (placeholder for CME course)

Conclusion

This policy seeks to ensure the responsible incorporation and use of AI tools by practitioners in the practice of medicine. AI holds promise of benefitting patients and practitioners; however, irresponsible use will raise the risk of patient harm. Practitioners are encouraged to participate in continuing medical education to gain awareness of the evolving risks, benefits, and alternatives of the use of AI technologies in healthcare. In general, honoring professional standards involving ethics, equity, informed consent, privacy, and documentation will help to minimize the risks to practitioners and the patients that they treat as this technology continues to evolve. The use of AI may raise the risk

[14] “Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice,” Adopted by the FSMB House of Delegates April 2024, p. 8, available at incorporation-of-ai-into-practice.pdf (fsmb.org)

[15] Adapted from the Commonwealth of Massachusetts HD 4788. The Commission recognizes this guidance as a best practice in the state of Washington but not a requirement.

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of patient harm and lead to potential disciplinary action by the Commission for deviations from the standard of care.

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Washington State Hospital Association

October 2, 2024

Washington Medical Commission

RE: Proposed Policy on Artificial/Assistive Intelligence (AI) and WSMA AI Principles

Delivered electronically

Dear members of the Washington Medical Commission,

On behalf of the Washington State Hospital Association (WSHA) and our more than 100 hospitals and health system members, I am writing to express WSHA's concerns with the Washington Medical Commission's (WMC) proposed policy on Artificial/Assistive Intelligence (AI).

WSHA appreciates the need to provide guardrails and ensure patient safety given the growing use of AI in healthcare. At the same time, it is important that those guardrails do not stifle innovation or prevent AI use where it is genuinely beneficial or even lifesaving.

WSHA has concerns that the WMC's potential adoption of the excerpted Federation of State Medical Board guidance on the use of AI, could do just that—stifle innovation. We are particularly concerned about the following provision, and request that this language be removed:

[…] Physicians should understand the AI tools they are using by being knowledgeable about their design, training data used in its development, and the outputs of the tool in order to assess reliability and identify and mitigate bias. Once the treating physician chooses to use AI, they accept responsibility for responding appropriately to the AI's recommendations. […]

Physicians are not technology experts, nor is it reasonable to expect them to be. Understanding how AI was developed is a realistic expectation for the technology developers, but not physicians. Moreover, the data used in training the AI systems is often difficult or impossible to access, proprietary, and in a health care environment, may include additional privacy protections. Even if a physician were to try and understand this, this information may not be available. This proposed language, and the potential liability that accompanies it, could slow or stop the use and development of AI in health care.

WSHA appreciates the need to regulate AI and ensure that it is used safely and appropriately. However, there is a fine balance between ensuring AI does not cause or perpetuate patient harm, with stifling the use of AI completely. This draft language leans too far in restricting AI use.

Thank you for the opportunity to comment.

Best,

Cara Helmer
Policy Director, Legal Affairs
carah@wsha.org

Memo

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

To: **Commissioners**

From: **Pam Kohlmeier, MD, JD**
Policy Manager

Subject: **Recommendation to Rescind the Commission's Telemedicine Policy**

The state of Washington became the first state to enact ESSB 5481, the Uniform Telemedicine Act, and this statute just recently went into effect on June 6, 2024. As such, the Commission's Telemedicine policy POL2021-02 became superseded by statutory law. Therefore, the Commission's Telemedicine policy should be rescinded.

Incidentally, that telemedicine policy has a short section at the tail end of it addressing the use of artificial intelligence (AI) in the practice of medicine. That short section was an attempt to address the bare bones regulation of this rapidly evolving tool in medicine. By rescinding the Telemedicine policy, it is timely that the Policy Committee is considering a recommendation to adopt the new Artificial Intelligence (AI) policy that is on the Policy Committee agenda today.

As the Policy Manager, I am recommending that you vote to rescind the Commission's Telemedicine Policy POL2021-02, whereas the policy is now superseded by statute.

WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

Staff Reports: October 11, 2024

Kyle Karinen, Executive Director

Budget

As mentioned in the workgroup section of the business meeting packet, Dr. Domino re-constituted the Finance Workgroup and that group met in July. Overall, the Commission remains in solid shape. To that end, the Commission has asked the Legislature for authority to add staff. There are two positions in particular that are worth noting. One position is an Ombuds role. This is largely in part to a section of the 2023 performance audit of the Commission that expressed concern about the complaint process and supporting individuals navigate the complaint, investigation, and disposition processes. Currently, this role is filled on an ad hoc basis by Complaint Intake, Investigations, Legal and Compliance, and myself and Micah depending on who is available, who is interacting with the individual, and what the questions or concerns happen to be. It simply is not an efficient or well-organized way of communicating with individuals who have contacted the Commission with questions or concerns. The second position worth noting is that we will be hiring a second full-time medical consultant. With Dr. Pam Kohlmeier's departure, it is readily apparent that we are stretched thin to respond to all manner of inquiries that range from scope of practice to policy issues to assisting staff attorneys, Commission members, and everything in between. Dr. Gina Fino does a stellar job on these types of issues (and more) but there is only so much she can do in a day. With Dr. George Heye's retirement last year, Dr. Morgan Barrett's retirement earlier this year and then Dr. Kohlmeier's, we simply need to increase the Commission's bandwidth in this regard. The grant of authority from the Legislature is by no means assured, but we have made the request.

Supplemental information available

The end of September typically brings two different reports that Commission members may find of interest.

The first is an annual report and ranking of state medical boards by the consumer advocacy group Public Citizen. We periodically receive inquiries regarding the Commission's ranking. Over the years, we have spent some time evaluating the methodology Public Citizen uses in evaluating the efficacy of state medical boards. In short, the methodology is a bit limited and does not do an adequate job of addressing the variance in state laws and procedures. Moreover, the methodology does not evaluate the rate at which the Commission investigates the complaints it receives, the amount of time investigations can take, or the resources expended in those investigations. I am highlighting the annual report here because it does occasionally attract attention from the media, other public advocacy groups, and members of the Legislature. For what it's worth, the Commission rose in the rankings from 14th to 9th in this edition.

Kyle Karinen, Executive Director continued

State Medical Boards' Enforcement Against Doctor Misconduct Appears 'Dangerously Lax' - Public Citizen

Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2021-2023 - Public Citizen

More interesting, to my mind at least, is the annual report from the Office of Insurance Commissioner to the Legislature with regard to medical malpractice insurance. Many pieces of information are fairly intuitive -- claims closed within the first year after filing had lower defense costs, for example – but there are other parts of the report that break down costs and settlements by profession and specialty. There is a wealth of information in the report and it is worth the time to review. It begins on page 126 of this packet.

Micah Matthews, Deputy Executive Director

Recurring: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Department of Health policy, requests submitted after the cutoff cannot be paid out. For specific guidance on Commissioner compensation, please refer to the WMC guideline: Compensation and Reimbursement for Commission Duties (wa.gov)

Travel, Conferences, and Presentations
I attended the CLEAR and IAMRA conferences in Baltimore, MD with a number of WMC staff and Ms. Blake in attendance. I presented on Artificial Intelligence regulatory policy, and I was named the incoming Chair of the Education and Training Committee. The IAMRA meeting was notable for its efforts on AI education but also the unveiling of the first ever WHO guidance on medical regulation.

The following week I acted as interim Chair for the inaugural meeting of the PA Compact in Washington, DC. I am pleased to announce that our own Licensing Manager, Marisa Courtney, has been elected to the inaugural Executive Committee in the role of Vice Chair. I then traveled to Spokane to attend the WSMA annual meeting for the purposes of stakeholder engagement and consultation on the resolutions proposed to the House of Delegates. None of the proposals appear to impact the WMC directly and there was a reassuring number of younger physicians and medical students who are actively engaged in the process. This is a positive change to what has been observed in the past at meetings attended by WMC.

On October 3, I participated in a webinar presentation on our telemedicine policies with the Center for Connected Health Policy. The panel includes a representative with the Pacific Legal Foundation who is suing the NJ and CA Medical Boards over their telemedicine restrictions. The legal argument is practice of medicine via telemedicine is free speech and should be viewed with the strict scrutiny standard requiring no regulation while in-person care is speech incidental to conduct and should therefore be regulated. The goal appears to be to get these cases before the U.S. Supreme Court and aligns with the Institute for Justice efforts previously targeting the dietetics and nutritionist professions licensure requirements.

Micah Matthews, Deputy Executive Director continued

There will certainly be more to come from these legal efforts from ideologically aligned law groups.

In November I will present on International Medical Graduate issues in Scottsdale, AZ at the Administrators in Medicine Fall Summit. In December I will be presenting on cross state practice and licensure flexibilities to the Center for Telemedicine and e-Health Law and the American Telemedicine Association in Washington, D.C. Finally, I have been invited to speak on A.I. policy in regulation as part of a three event "National Conversation" with Canadian regulators and policy makers at a February 2025 event in Toronto, CAN.

Staffing
We are currently working on reclassifying the position that will support the Policy Committee. I anticipate we will go out for recruitment in October with onboarding occurring mid-November. I appreciate the efforts of staff and the grace extended by Ms. Blake during this transition time.

HELMS
The rush to Release 2, which is the full launch of licensing functionality, is officially classified as in the red from the perspective of schedule and scope. This means the production of the development team is not meeting projections to make the February 2025 release target. The WMC staff have repeatedly raised concerns not only with the timing of the release in light of the HELMS Lite release difficulties, but with the feasibility of such a release occurring with current resources. We anticipate more conversations with the project management team requesting scope reductions to help them accomplish this goal. I point this out to clarify that the vast majority of our requirements are statutory and therefore non-negotiable.

Budget
Please see Kyle's budget note for this cycle's update.

Legislative
I have no new updates on the status of our request legislation or decision package at this time beyond that they are under review by the Office of Financial Management.

The Washington Telehealth Collaborative will meet November 4 to consider the merits of recommending to the Legislature an addendum to the 2024 Uniform Laws Commission bill that would require the creation of a telemedicine registration for all regulated health professions except veterinarians. The WMC is on record as having concerns with this policy proposal and WSMA and WSHA each have submitted letters to the Collaborative opposing the recommendation moving forward. The concerns and opposition related to the potential for confusion in creating a new credential pathway, the cost of establishing such a pathway, and redundancy given the existence of compact pathways and our normal pathways resulting in rapid licensure.

Amelia Boyd, Program Manager

Change to AMDG Opioid Dose Calculator

In February, the Agency Medical Directors' Group (AMDG) updated the Opioid Dose Calculator. The WMC released a statement for prescribers about this change: Important Updates to the Opioid Dose Calculator and Implications for Prescribers (govdelivery.com)

Recruitment

We are seeking the following specialties to serve as Pro Tem Members:

- Urology
- Radiology
- Neurosurgery/Neurology
- General surgery
- Psychiatry
- Orthopedic surgery

If you know anyone who might be interested in serving as a Pro Tem, please have them email me directly at amelia.boyd@wmc.wa.gov.

The following position expired as of June 30, 2022, and we are awaiting word from the Governor's office staff on the new appointee:

- Public Member – Toni Borlas – not eligible for reappointment

The following positions expired as of June 30, 2022, and we are awaiting word from the Governor's office staff:

- Congressional District 10 – Richard Wohns, MD – eligible for reappointment
- Public Member – Scott Rodgers – eligible for reappointment

The following positions expired as of June 30, 2024:

- One physician representing Congressional District 6 – Claire Trescott, MD, not eligible for reappointment
- One physician representing Congressional District 8 – Harlan Gallinger, MD, eligible for reappointment
- One Physician-at-Large – Karen Domino, MD, eligible for reappointment

The application deadline for these three vacancies was March 22, 2024. The applications, along with the Commissioners' recommendations, are with the Governor.

We will have the following vacancies as of June 30, 2025:

- One physician representing Congressional District 1 – Jimmy Chung, MD, not eligible for reappointment
- One physician representing Congressional District 7 – Anjali D'Souza, MD, eligible for reappointment
- One Physician Assistant – Arlene Dorrough, PA-C, eligible for reappointment
- One Public Member – Christine Blake, eligible for reappointment

The application deadline for these four vacancies is March 31, 2025.

Mike Hively, Director of Operations and Informatics

Overview of Compulsory Records Requests

Between July 3, 2024, and October 1, 2024, the Operations and Informatics team processed five compulsory records requests. This involved the management of approximately 13,265 pages, executing 365 redactions, and withholding around 261 pages that contained protected information. The average time taken to fulfill each request was 15.1 days. Additionally, the team addressed nine litigation holds, which required a thorough review and categorization of over 4,275 records obtained through eDiscovery processes.

Digital Archiving

The following digital archiving activities were undertaken:

- Closure of 449 complaints within the BT system
- Processing of 193 medical licensing applications
- Completion of 137 A-closures, totaling 114,622 pages
- Handling of 648 physician assistant applications
- Verification of 242 medical and physician assistant applications for accuracy
- Scanning and entering 4,142 demographic census forms

Four boxes of medical applications, comprising a total of 181 files, and nine boxes of physician assistant applications, containing 673 files, were retrieved from the Records Center and converted into electronic formats. Additionally, four boxes of investigation and disciplinary records were scanned and digitized. Once archived in PDF/A format, disposition tickets were submitted for approval.

Data Requests Processed

The team processed approximately:

- 1,925 open and closed inquiries, with each inquiry potentially containing multiple requests
- 826 address changes

Demographic Activities

Demographic data management included:

- Scanning and entering approximately 3,827 census forms into the Integrated Licensing and Regulatory System (ILRS)
- Conducting 1,160 secondary census contacts
- Compiling quarterly demographic reports
- Collaborating with the Department of Health (DOH) to enhance the HELMS census
- Implementing the HELMS Survey Vista for demographic data collection and deactivating the previous Opinio survey tools

The team continues to address ad hoc demographic data requests in support of various unit requirements and to provide assistance for hardware and software inquiries. Additionally, surplus inventory tickets were submitted for IT equipment that has reached the end of its support life cycle.

Gina Fino, MD, Medical Consultant, Director of Compliance

Compliance is working on the schedule for the remaining 2024 personal appearances at the Commission's virtual meeting in November. Mike Kramer and Anthony Elders have kept all things compliance moving throughout the year, especially while I attended the CLEAR and WSMA annual meetings in September. Many thanks to them. I can't wait to apply what I've learned and foster the new relationships with other physicians and regulators from around the world (mostly Canada).

Mike Kramer has given me permission to announce that he and Seana Reichold, staff attorney at the Washington State Board of Nursing (WABON) were married on August 24, 2024. Congratulations!

For the more about other compliance work since the last update, please see Rick Glein's report below.

Rick Glein, Director of Legal Services

Staff Update:

Sara Kirschenman joined the Legal-Compliance Unit on October 1 as our newest staff attorney. Sara has been with DOH since 2011, serving as a staff attorney and then a supervising staff attorney in DOH's Office of Investigative and Legal Services before moving to the Board of Nursing in 2022. Prior to DOH, Sara was an assistant attorney general representing DSHS in juvenile dependency and termination of parental rights proceedings in superior court. Sara is a graduate of Haverford College and Seattle University School of Law. Sara brings a wealth of experience, a keen intellect, and a bit of excitement for a new adventure with the WMC.

As part of an organizational restructure, the Legal-Compliance Unit welcomed Carolynn Bradley, WMC Contracts Manager, to the team in August. The Legal team has worked closely with Carolynn over the years as she manages our expert contracts, and we are excited for the opportunity to enhance our collaboration.

Summary Actions:

In re Dorothy M. Pao, MD, Case No. M2024-614. On September 6, 2024, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Pao's medical license be suspended pending further disciplinary proceedings by the Commission. A Statement of Charges (SOC) concurrently served on Dr. Pao alleges Dr. Pao entered into a Stipulated Order with the Oregon Medical Board, surrendering her license to practice as a physician and surgeon in that jurisdiction. The Stipulated Order found that Dr. Pao engaged in unprofessional conduct that violated the Oregon Medical Practice Act, including acts of fraud or misrepresentation in the scope of Dr. Pao's practice. A hearing on the merits of the SOC has not yet been scheduled at the time of this report.

In re Alan Bunin, MD, Case No. M2024-631. A SOC was filed in September 2024 alleging Dr. Bunin entered into an Agreed Order in February 2021 (2021 Agreed Order), under Case No. M2020-713, in which he agreed to engage in a clinical competency assessment. The SOC alleges the assessment evaluators concluded that Dr. Bunin failed to demonstrate satisfactory medical knowledge or clinical judgment, and his performance was inconsistent

with safe patient care. The SOC further alleges Dr. Bunin failed to complete any recommendations made by the assessment evaluators and also failed to comply with the 2021 Agreed Order requirement to submit personal reports to the Commission. An Ex Parte Order of Summary Suspension was served concurrent to the SOC, suspending Dr. Bunin's medical license pending further disciplinary proceedings. A hearing on the merits of the SOC has not yet been scheduled at the time of this report.

In re William J. Mack, MD, Case No. M2024-613. On August 6, 2024, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Mack's medical license be suspended pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Mack alleges the Board of Healing Arts of the state of Kansas issued a Final Order (Kansas Order) suspending Dr. Mack's license to practice as a physician and surgeon in that jurisdiction. The Kansas Order found Dr. Mack failed to comply with an order compelling him to submit to and complete a full fitness to practice evaluation. An Answer to the SOC has not been timely filed, and the Commission is preparing to file a default order for the Health Law Judge's (HLJ) consideration.*

*The license holder must file a request for hearing with the disciplining authority within twenty days after being served the statement of charges. RCW 18.130.090.

Orders Resulting from SOCs:
In re Richard T. Oliver, Jr., PA, Case No. M2021-896. Agreed Order. In April 2023, the Commission filed a SOC alleging Mr. Oliver provided substandard care for eight patients who were inmates at the Department of Corrections. The SOC alleges these failures included slowness to implement evaluation and treatment of potentially life-threatening illnesses; failure to completely assess or follow up on evaluation and management of chronic medical illnesses; absence of documentation of thoughtful analysis including a plan for evaluation and treatment maximizing safety and benefit of each patient with potentially serious healthcare concerns; and prescribing medications without documenting review of potential adverse effects. In July 2024, the Commission accepted an Agreed Order in which Mr. Oliver voluntarily surrendered his physician assistant license.

In re Lokesh Tantuwaya, MD, Case No. M2021-382. Default Order of Suspension (Failure to Appear). In May 2023, the Commission filed a SOC alleging Dr. Tantuwaya entered into a 2018 Stipulated Settlement and Disciplinary Order (2018 California Order) with the Medical Board of California which placed him on probation for three years for which he has not yet been released. The SOC alleges the California Order stemmed from Dr. Tantuwaya's conviction for child endangerment and attempt to dissuade a witness from reporting a crime. The SOC further alleges Dr. Tantuwaya entered into a second Stipulated Settlement and Disciplinary Order which stemmed from a conviction for violating a protective order and placed Dr. Tantuwaya on probation for four years and prohibited him from supervising physician assistants and advanced practice nurses. The allegations further detail that Dr. Tantuwaya's California medical license was automatically suspended by operation of California law due to his 60-month incarceration after he pled guilty to conspiracy to commit honest services fraud and to receive illegal payments for health care kickbacks in violation of 18 U.S.C. §371. Dr. Tantuwaya timely filed an Answer to the SOC and requested the opportunity for settlement and/or a hearing. Dr. Tantuwaya did not appear at the scheduled

prehearing conference and the HLJ issued an Order of Default. In July 2024, a Final Order of Default was issued which indefinitely suspended** Dr. Tantuwaya's medical license.

In re David G. Knox, MD, Case No. M2024-51. Agreed Order. In February 2024, the Commission issued a SOC alleging that Dr. Knox entered into a Stipulated Order with the Oregon Medical Board and surrendered his medical license in that jurisdiction while under investigation for unprofessional conduct. The SOC further alleges the Oregon Medical Board found that Dr. Knox failed to follow the standards of practice of the American Academy of Pediatrics regarding medical cannabis, made misleading statements regarding the efficacy of medical cannabis to pediatric patients, and engaged in repeated acts of negligence. In July 2024, the Commission accepted an Agreed Order in which Dr. Knox voluntarily surrendered his medical license.

In re Wilson F. Bernales, MD, Case No. M2023-469. Final Order of Application Denial. On October 27, 2023, the Commission filed a Notice of Decision on Application denying Dr. Bernales' application for a license to practice as a physician and surgeon in the state of Washington. The Commission held a virtual hearing on May 30, 2024. A Final Order*** was issued in July 2024 which concluded that Dr. Bernales had his license to practice as a physician and surgeon revoked in New Mexico and Connecticut; suspended in Wyoming; restricted in New York, prohibiting any practice of medicine in the state; and placed on probation in Delaware and Oklahoma. The Final Order also concluded that the Virginia Board issued an order denying Dr. Bernales's application for a physician and surgeon license, finding that he had forged signatures in his license application and admitted he lied to the Virginia Board, along with the Delaware and Wyoming Boards finding that Dr. Bernales committed fraud when attempted to renew his license in their respective state, which are acts of moral turpitude and dishonesty. The Final Order ordered that Dr. Bernales' application for a license to practice as a physician and surgeon in the state of Washington be denied.

In re Kesav C. Parvataneni, MD, Case No. M2024-50. Agreed Order. In February 2024, the Commission filed a SOC alleging Dr. Parvataneni was terminated by his employer for violating policy and professional and ethical standards which led Dr. Parvataneni to voluntarily submit to a comprehensive psychosexual evaluation at his own expense. The SOC alleges the evaluation report concluded that Dr. Parvataneni is not safe to practice with reasonable skill and safety and included specific recommendations to complete prior to returning practice, noting that Dr. Parvataneni had started working to complete the evaluator's recommendations on his own volition and expense. In July 2024, the Commission accepted an Agreed Order which suspended** Dr. Parvataneni's medical license. Prior to requesting reinstatement of his license, Dr. Parvataneni must undergo a psychosexual evaluation to determine whether he can practice medicine with reasonable skill and safety, complying with all recommendations. Dr. Parvataneni is required to maintain satisfactory compliance with the Washington Physician Health Program (WPHP) monitoring contract and recommendations. Dr. Parvataneni has agreed to pay a fine of $1,000.

In re David S. Schumer, MD, Case No. M2022-991. Agreed Order. In October 2023, the Commission filed a SOC alleging substandard care of four patients during their

hospitalizations. In September 2024, the Commission accepted an Agreed Order which indefinitely restricts Dr. Schumer from providing care in an inpatient setting. Dr. Schumer must successfully complete a clinical competency assessment in order to request modification or removal of the restriction. Prior to returning to inpatient care, Dr. Schumer must obtain a pre-approved clinical inpatient supervisor. Dr. Schumer must also complete a CME on medical recordkeeping and write a paper on how he intends to apply what he learned to his practice. Dr. Schumer must pay a $2,000 fine and personally appear before the Commission.

In re Sarah L. Crandall, MD, Case No. M2023-887. Agreed Order. In January 2024, the Commission filed a SOC alleging Dr. Crandall routinely performed elective breast surgeries on poor surgical candidates with inadequate planning that resulted in unusually high instances of compromised blood supply, deformity, or necrosis of patients' breasts. In September 2024, the Commission accepted an Agreed Order which required Dr. Crandall to complete a clinical competency assessment and follow all recommendations in the assessment report. Dr. Crandall has agreed to obtain a preceptor to meet with monthly for the purpose of reviewing the quality and safety of her practice. Dr. Crandall must also complete a CME regarding plastic and reconstructive surgery of the breast and write a paper explaining the anatomy of the vascular supply to the breast and operative complications related to comorbidities. Dr. Crandall must submit personal reports to the Commission, pay a $5,000 fine, and personally appear before the Commission. Dr. Crandall may not petition to terminate the Agreed Order for at least two years.

In re Ron C. Ilg, MD, Case No. M2022-712. Final Order of Revocation. In October 2022, the Commission filed a SOC alleging Dr. Ilg pled guilty to two felony charges in federal court with the underlying pleas involving an attempt to hire a third party to injure two individuals, with one individual being a former physician colleague of Dr. Ilg. An Amended SOC filed in July 2023 alleged Dr. Ilg was convicted of the two felony charges and added that the other threatened individual was Dr. Ilg's estranged spouse. The Commission filed a Motion for Partial Summary Judgment in which it requested an order stating that there is no genuine issue of material fact and that the Commission is entitled to a judgment as a matter of law. The HLJ granted that motion, and a sanctions-only virtual hearing was held before a HLJ on August 19, 2024. A Final Order*** was issued in September 2024, which found that Dr. Ilg can never be rehabilitated and ordered Dr. Ilg's medical license be permanently revoked.

**A person whose license has been suspended under chapter 18.130 RCW may petition the disciplining authority for reinstatement. RCW 18.130.150.

***Either party may file a petition for reconsideration within ten days of service of the order. RCW 34.05.461(3); 34.05.470. A petition for judicial review must be filed and served within 30 days after service of the order. If a petition for reconsideration is filed, the 30-day period does not start until the petition is resolved. RCW 34.05.542; 34.05.470(3).

Virtual Hearings:
In re Ron C. Ilg, MD, Case No. M2022-712. A sanctions-only hearing was delegated to a HLJ and held on August 19, 2024. A Final Order was issued on September 18, 2024. The case and final decision are described above.

Rick Glein, Director of Legal Services continued

In re William Washington, MD, Case No. M2021-755. In January 2023, the Commission filed an initial SOC against Dr. Washington. In July 2024, the Commission filed a Third Amended SOC alleging Dr. Washington was found guilty of the federal crimes of wire fraud, healthcare fraud, conspiring to commit wire fraud and healthcare fraud, and conspiracy to make false statements related to healthcare matters; that Dr. Washington failed to meet the standard of care for transgender patients; that Dr. Washington provided psychiatric care beyond his expertise as a physician trained in emergency medicine; that Dr. Washington's care was substandard in the management of male hypogonadism; that Dr. Washington prescribed growth hormone without documenting growth hormone deficiency; that Dr. Washington violated the Commission's rules governing the prescribing of opioids in the treatment of pain and self-prescribed a controlled substance; that Dr. Washington failed to cooperate with Commission investigations; and that Dr. Washington violated a prior order in that his treatment and involvement with patients was in violation of the Uniform Disciplinary Act and other laws related to the practice of the profession. The Commission held a virtual hearing August 23, 2024, regarding the merits of the Third Amended SOC. A Final Order is expected to be issued by the end of November 2024.****

In re Jason Hanson, MD, Case No. M2022-208. In May 2024, the Commission filed a SOC alleging Dr. Hanson is unable to practice with reasonable skill and safety. The Commission held a virtual hearing September 3-4, 2024. A Final Order is expected to be issued by the first week of December 2024.****

In re Lisa Johnson, MD, Case No. M2023-802. In March 2024, the Commission filed a SOC alleging Dr. Johnson failed to make an appointment for or complete an evaluation as required by a January 2024 Order for Investigative Mental Examination. The Commission held a virtual hearing September 26, 2024. A Final Order is expected to be issued by the end of December 2024.****

****The HLJ has 90 days after the conclusion of the hearing to issue a decision. RCW 34.05.461.

Non-Compliance Virtual Hearing:

In re Guito C. Wingfield, MD, Case No. M2022-502. In July 2023, a Final Order was issued which required Dr. Wingfield to retain a practice monitor to conduct chart reviews for a period of one year. The practice monitor is to select ten patient charts for review each quarter and report the review findings to the Commission. In August 2024, the Commission filed a Motion for Finding of Non-Compliance with Order and the matter was placed on an HLJ's fast-track docket. In September 2024, an Order of Non-Compliance was issued, finding that Dr. Wingfield failed to comply with the terms and conditions of the Final Order by failing to retain a practice monitor and indefinitely suspended** Dr. Wingfield's medical license. Dr. Wingfield may petition for reinstatement once he has obtained a Commission-approved practice monitor.

Items of Interest:

Gina, Colleen, and Trisha, along with several other WMC colleagues, attended the 2024 CLEAR conference September 16-19 in Baltimore, MD. CLEAR is an association of

Rick Glein, Director of Legal Services continued

individuals, agencies, and organizations that comprise the international community of professional and occupational regulation. The conference content focuses on four areas of inquiry: Regulatory Administration and Governance; Compliance, Discipline, and Enforcement; Entry to Practice Standards and Continuing Competence; and Testing and Examinations. Sessions included presentations, moderated panels, and roundtable discussions.

Mike Farrell made a presentation on mandatory reporting requirements to Providence on September 9.

A huge thank you to the Legal-Compliance support staff team who successfully integrated the Owl speakerphone technology into our Case Disposition and Personal Appearances during September's meeting. We appreciate all your patience in the trial and error of modernized equipment as we master the new world of hybrid meetings.

On July 29, Rick, Mike, Gina, and Jen met virtually with newly appointed pro tem Commissioner Dr. Hutchison to provide her with an in-depth review of the Legal-Compliance Unit's processes and operations. We anticipate questions and clarifications will arise during everyone's tenure with the Commission and invite Commissioners to connect with Rick Glein on an on-going, as-needed basis.

The newly integrated Legal-Compliance Unit held an in-person all-staff meeting this summer at the Tumwater L&I building. From a rousing icebreaker of Would You Rather to a delicious spread of homemade dishes and a braised meat selection, it was a great day to reconnect with our colleagues. Kyle Karinen, who remains an honorary Legal Unit member, also made an appearance with Crumbl cookies and provided a big-picture update.

Freda Pace, Director of Investigations

Staff Update

Kayla Gregory is our newest addition to the investigative unit, filling Dr. Gina Fino's vacancy. Kayla was selected as a Clinical Health Care Investigator and joined us in September 2024. Prior to joining the commission, she was an ER nurse for 11 years, with five of them being as a travel nurse across the country. Prior to leaving bedside, she was trained and practiced as a Sexual Assault Nurse Examiner. She then switched gears from bedside and joined the Risk Management department as a Nurse Investigator and Patient Safety Officer where she developed a passion for investigating safety concerns and improving overall patient safety and satisfaction. She and her husband have two small children, and in her down time enjoys hiking, hunting, and cooking.

CMT Sign-up for 2024 & 2025

Our 2024 and 2025 CMT sign up slots are ready, awaiting your name! Please take some time to check out the new CMT calendar to find a vacant slot – there are plenty. We appreciate your continued participation in this very important process. We could not be able to do this work without you and your support!

Freda Pace, Director of Investigations continued

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, at your earliest opportunity, please promptly notify Chris Waterman at chris.waterman@wmc.wa.gov. This courtesy cancellation notice will allow Chris the opportunity to fill any last-minute vacancy needs. If you have any CMT process questions, please do not hesitate to reach out to me directly – freda.pace@wmc.wa.gov.

Jimi Bush, Director of Quality and Engagement

Commissioner Outreach

I asked Commissioners to suggest an area of concern in your community, practice, specialty or organization back in January. I have not received any responses or input to date. I would love to be able to address local concerns through CME. Please take a moment to reflect on how we can serve your colleagues and communities through personalized outreach and send Jimi any ideas you may have.

Contribute to the Newsletter Technology Corner

Beginning with the Winter edition of UPDATE! We will have a "technology corner" where we present an advancement in healthcare technology. If you have a piece of technology or a process that you think would be of interest to our readers, please let Jimi know. The winter newsletter deadline is December 3rd.

Business Practices and Productivity

It has been a busy quarter in process improvement / LEAN six sigma department. 26 Business practices and process maps were created or updated in the last quarter, including: patient impact statement and certifications, preparation of case disposition materials, onboarding commissioners, and authorizing a new case at case disposition.

Mahi Zeru, Equity and Social Justice Manager

Requesting Medical Records during CMT

To stay in alignment with WMC's values of ensuring equitable practices, when information contained in the medical record is the essential data lacking in a complaint being assessed during CMT, commissioners are advised to defer to the complainants' experience and authorize an investigation. The complainant will not be asked to submit medical records as evidence and requirement for reconsideration as it causes undue burden. The "Access to Medical Records: Addressing Inequitable Barriers" is an attachment to the weekly CMT email that explains the issues patients face when requesting medical records.

FGM/C Prevention and Response in Washington State Advisory Committee

I will join female genital mutilation/cutting (FGM/C) Prevention and Response in Washington State Advisory Committee (replacing Dr. Pam Kohlmeier). This initiative is part of the implementation of SSB 5453, Section 6, which aims to enhance statewide efforts to support FGM/C survivors and prevent future cases through strategic planning, community engagement, and education. Position is expected to conclude June 2025.

Mahi Zeru, Equity and Social Justice Manager continued

Continuing Legal Education for DOH Office of Investigative & Legal Services (OILS)
Presented WMC's Discrimination in Healthcare Policy and shared our discrimination investigation best practices with our counterparts at DOH OILS.

Marisa Courtney, Licensing Manager

Total licenses issued from = 07/11/2024-09/30/2024= 1110

Credential Type	Total Workflow Count
Physician And Surgeon Clinical Experience License	8
Physician And Surgeon Fellowship License	0
Physician And Surgeon Institution License	0
Credential Type	**Total Workflow Count**
Physician And Surgeon License	597
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	263
Physician And Surgeon Residency License	411
Physician And Surgeon Teaching Research License	3
Physician And Surgeon Temporary Permit	2
Credential Type	**Total Workflow Count**
Physician Assistant Interim Permit	17
Physician Assistant License	179
Physician Assistant Temporary Permit	0
Totals:	**1110**

Information on Renewals: July Renewals- 73.37% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	119	119
MD	1047	293	1340
MDFE	2	0	2
MDRE	224	83	307
MDTR	7	1	8
PA	197	40	237
	73.37%	**26.63%**	**100.00%**

Marisa Courtney, Licensing Manager continued

Information on Renewals: August Renewals- 68.38% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	131	131
MD	1094	391	1485
MDIN	1	0	1
MDRE	19	27	46
MDTR	6	3	9
PA	199	58	257
	68.38%	**31.62%**	**100.00%**

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

2024 medical malpractice annual report

Claims closed 2019 through 2023
October 2024

Mike Kreidler, *Insurance Commissioner*
www.insurance.wa.gov

OIC WA | 360-725-7009 | P.O. Box 40255 Olympia, WA 98504-0255

Table of contents

About this report 4

Key statistics 5
- **About the medical professional liability insurance market** 5
- **About claim data submitted by insurers and self-insurers** 6
  - Total claims 6
  - Payments to claimants 6
  - Defense costs 6
  - Method of settlement 6
  - Payments by type of medical provider 7
  - Payments and defense costs by age of claim 7
  - Regional comparisons 7
  - Allegations 7
- **About lawsuits filed and settled by attorneys** 8
  - Compensation to claimants 8
  - How lawsuits settled 8
  - Gender of claimant 8
  - Age of claimant 8
  - Regional comparisons 8

Introduction 9
- **Market analysis** 9
- **Summary data for closed claims reported by insurers and self-insurers** 10
- **Summary data for lawsuits reported by attorneys** 10
- **Closed claim and lawsuit statistics are different** 11

Market analysis 12
- **Market participants** 12
- **Loss history** 14
- **Claim reserves** 17
- **Washington state market in 2023** 18
- **National market in 2023** 19

Summary data for closed claims reported by insurers and self-insurers 21
- **Related claims** 22
- **Lawsuit status** 23
- **Method of settlement** 24
- **Size of indemnity payments** 25
- **Claim duration** 26
- **Type of reporting entity** 27
- **Injury outcome** 28
- **Type of health care organization** 30
- **Location within the facility** 31
- **Type of medical provider** 32
- **Claim allegations** 35
- **Counties** 40
- **Gender of claimant** 41
- **Age of claimant** 42

Trends 43
Summary data for lawsuits reported by attorneys 44
Method of settlement 45
Gender of claimant 46
Age of claimant 47
Counties 48
Report limitations 49
Appendices 50
Appendix A: Profitability 51
Appendix B: Reserve development 53
Appendix C: Rate filing information 56
Appendix D: 2022 NAIC profitability of medical professional liability insurance 57

About this report

Early in the 2000s, a "hard market" emerged nationally for most types of insurance. During this period, medical professional liability insurance became expensive and hard to find for many types of medical providers and facilities.

In 2006, the Washington state Legislature enacted comprehensive health care liability reform legislation (2SHB 2292) to address a number of concerns, including the cost and availability of medical professional liability insurance. This law also created reporting requirements for medical malpractice claims that are resolved and closed, with the intent to collect data to support policy decisions. The Office of the Insurance Commissioner (OIC) began publishing annual reports in 2010 that summarize the data.

This report has three sections:

1. The current condition of the medical professional liability insurance market.
2. Summary data for closed claims reported by insurers, risk retention groups and self-insurers.[1]
3. Summary data for lawsuits reported by attorneys.

[1] For simplicity, we will use the term "insurers" when referring to admitted insurers, surplus line insurers and risk retention groups.

Key statistics

This section includes premium, loss and defense cost data reported by insurers and self-insurers to the National Association of Insurance Commissioners (NAIC), closed claim data reported by insurers and self-insurers to the OIC, and lawsuit data reported by attorneys to the OIC.

About the medical professional liability insurance market

- In Washington state, the incurred loss and defense cost ratio for 2023 was 83.4%. This is similar to the 81.6% ratio for the five-year period from 2018 to 2022.
- Defense costs decreased to 17.8% of earned premium in 2023. For the five-year period from 2018 to 2022, this ratio was 19.4%.
- Direct written premiums continued to increase in 2023, reaching $241 million. This was the highest total since 2006.
- Loss development continued to be favorable overall but showed signs of flattening. For example, Physicians Insurance decreased its reserves by $61 million over its original estimates, but this is lower than the $89 million decrease in last year's report and the $111 million decrease two years ago. When insurers lower their reserves[2] for older claims, this translates to profit for the current year.
- Profitability results were mixed. The operating ratio for Physicians Insurance A Mutual Company, the admitted insurer with the largest market share in Washington state, increased from 95.2% in 2022 to 102.5% in 2023. For The Doctors Company, the admitted insurer with the second largest market share, the operating ratio decreased from 91% in 2022 to 84.8% in 2023.[3]

[2] Claim reserves are money set aside to meet future payments associated with claims incurred but not settled on a given date. If a claim reserve is too high or an investigation shows there is no legal responsibility to pay the claim, the insurer either lowers the reserve or removes the claim reserve from its books. If an insurer lowers total claim reserves for past years, this decreases incurred losses in the current year.

[3] Operating ratios measure overall profitability from underwriting and investment activities. Operating ratios are calculated using countrywide data.

About claim data submitted by insurers and self-insurers

Total claims

Insurers and self-insurers reported closing 3,043 claims between 2019 and 2023 with indemnity payments, defense costs, or both types of payments.[4] [5] Commercial insurers and risk retention groups reported 1,809 claims, while self-insured entities reported 1,234 claims.[6]

Payments to claimants

Insurers and self-insurers closed 47.2% of all claims with an indemnity payment to a claimant.

- Indemnity payments totaled $1 billion on 1,437 claims over the five-year period, or $707,889 per paid claim. For claims closed in 2023, the average indemnity payment increased to $900,549 per paid claim.
- Economic loss payments totaled $636 million, an average of $442,503 per paid claim. On average, insurers and self-insurers attributed 62.5% of each claim payment to economic loss.
- Of the claims closed with an indemnity payment, 19.3% closed with a payment of $1 million or more. These claims account for 77.2% of the total paid indemnity over the five-year period.

Defense costs

Insurers and self-insurers paid $248 million to defend 2,772 claims, an average of $89,691 per claim. The average defense cost decreased by 20.7% from 2022 to 2023, but the median defense cost increased by 14.5% over the same period.

Method of settlement

Insurers and self-insurers settled most claims with paid indemnity by negotiation between the claimant and the insurer. Of the claims with an indemnity payment, insurers and self-insurers settled 66.8% by negotiation and 28.5% by alternate dispute resolution.[7] Negotiations comprised 55.9% of the total paid indemnity, while alternate dispute resolution comprised 42.6%.

[4] This report includes claims data reported through March 24, 2024, and audited through June 11, 2024.
[5] For simplicity, this report substitutes "defense costs" for the technical phrase "defense and cost containment expenses." Defense and cost containment expenses are expenses allocated to a specific claim to defend an insured, including court costs, fees paid to defense attorneys, and fees for expert witnesses. These expenses do not include the internal costs to operate a claims department.
[6] Commercial insurers include admitted (licensed) insurers, surplus line insurers and joint underwriting associations.
[7] Alternate dispute resolutions include arbitration, mediation and private trials.

Payments by type of medical provider

Insurers and self-insurers identified the type of medical provider in 71.9% of the closed claim reports.[8] Claimants made the remaining claims against an organization, not an individual medical provider.

- Nursing resulted in the most closed claims at 260. Of these claims, 155 resulted in paid indemnity averaging $495,220.
- For physician specialties, obstetrics and gynecology accounted for the most closed claims at 189, with 101 paid claims resulting in paid indemnity averaging $1,184,577.
- Neurological surgery had the highest average paid indemnity at $2.5 million.
- Podiatry the highest average defense cost at $312,017.

Payments and defense costs by age of claim

- The longer a claim takes to be settled, the higher the paid claims tend to be. Claims closed within the first year had average paid indemnity of $234,126. Claims that took at least three years to settle had average indemnity payments of $1.2 million.
- Defense costs also increased with the age of the claim. Claims closed within the first year had average defense costs of $11,663. Claims that took at least three years had average defense costs of $180,146.

Regional comparisons

King County had the most claims (844), the highest average paid indemnity ($971,361), the highest average economic loss ($684,747), and the highest average defense cost ($126,345).

Allegations

- "Vicarious liability" was the most common allegation, with 721 claims and 285 indemnity payments averaging $725,404.
- "Improper performance" was the second-most common allegation, with 464 claims and 203 indemnity payments averaging $527,841.
- "Failure to identify fetal distress" was the allegation with the highest average paid indemnity at $3.2 million.
- "Failure to monitor" was the allegation with the highest average defense cost at $452,577.

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[8] Physician specialties, dental specialties and other types of medical providers.

About lawsuits filed and settled by attorneys

If an attorney files a lawsuit to resolve a medical malpractice incident, they should report data about the lawsuit to the OIC once the litigation is resolved.

For settlements resolved between 2019 and 2023[9]:

Compensation to claimants

Attorneys reported claimants received $131 million in total compensation on 70 claims, an average of $1.9 million per paid settlement. Attorney fees totaled $36 million, an average of $508,966 per paid settlement. On average, attorney fees were 27.3% of the total compensation paid to the claimant.

How lawsuits settled

Lawsuits settled between the parties had the highest average paid indemnity at $2.9 million, and the highest average legal expense at $669,542.

Gender of claimant

Settlements for male claimants were significantly more costly than settlements for female claimants. Average indemnity payments to male claimants were 114.2% higher than payments to female claimants, and average legal expenses were 74.2% higher.

Age of claimant

Settlements involving claimants under 21 years old had the highest average paid indemnity at $3.7 million, and the highest average legal expense at $1.3 million.

Regional comparisons

King County had the largest number of lawsuits filed, with 27 lawsuits or 36% of the statewide total. King County also had the highest average legal expense at $905,953. The “Puget Sound Metro” region (Kitsap, Pierce and Thurston counties) had the highest average paid indemnity at $3 million.

[9] This report includes data submitted on or before March 24, 2024, and audited through Sept. 9, 2024.

Introduction

Under the Revised Code of Washington (RCW) 48.140, insurers, risk retention groups (collectively "insurers") and self-insurers must submit a report to the insurance commissioner every time they close a medical malpractice claim.[10] Under RCW 7.70.140, attorneys must report aggregate settlement data from all defendants after they resolve all claims related to a medical malpractice lawsuit. This report includes data submitted by insurers, self-insurers and attorneys in summary form that protects the confidentiality of people and organizations involved in the claim or settlement process.[11]

Insurers, self-insurers and attorneys must report claim data for the prior year to the OIC by March 1 each year.[12] Attorneys' compliance with the reporting law has been low, and the insurance commissioner does not have enforcement mechanisms to improve compliance.[13] As a result, this report provides very few summary exhibits for settlement data reported by attorneys, since the data is incomplete. Most of the exhibits in this report focus on data reported by insurers and self-insurers.[14]

This report has three sections:

1. Market analysis
2. Summary data for closed claims reported by insurers and self-insurers
3. Summary data for lawsuits reported by attorneys

Market analysis

This section is an overview of the medical professional liability insurance market in Washington state and around the country that includes:

- An analysis of the profitability of the largest authorized medical malpractice insurers in Washington state.
- Information about premiums, incurred losses and defense costs for medical professional liability insurance.

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[10] A risk retention group (RRG) is an owner-controlled insurance company authorized by the Federal Risk Retention Act of 1986. An RRG provides liability insurance to members who are in similar or related business or activities. The federal act allows one state to charter an RRG and allows the RRG to engage in the business of insurance in all states. The federal act pre-empts state law in many significant ways. See RCW 48.92.030(1). For simplicity, and to protect the confidentiality of data, we include them with all other insurers in this report.
[11] RCW 48.140.040(3) says the OIC must take steps to protect the confidentiality of claim data, and RCW 48.140.060 required the OIC to adopt rules to achieve this result.
[12] See RCW 48.140.020(2) and WAC 284-24E-090.
[13] In 2010, the OIC proposed legislation, which the Legislature did not enact, that would have added enforcement mechanisms to the existing law. These bills were introduced as SB 6412 and HB 2963.
[14] RCW 48.140.050 lists information that must be provided by this report.

Summary data for closed claims reported by insurers and self-insurers

Insurers and self-insurers report claims with an indemnity payment and/or defense costs.[15] [16] Each closed claim report is associated with one defendant.[17] Claims can be made for a variety of allegations. People can make allegations against an organization, a medical provider or both.

Insurers and self-insurers reported three primary types of closed claim data:

1. **Defense costs:** These are expenses paid to defend claims and include expenses allocated to a specific claim, such as court costs and fees paid to defense attorneys or expert witnesses. They do not include internal costs to settle claims, such as salaries for claims staff or operating overhead for a claims department.[18]
2. **Economic damages:** Most of these amounts are estimates of the claimant's economic damages made by the insurer or self-insurer when it makes a payment to settle the claim.[19] In a few cases, a court itemized economic damages when it issued a verdict.
3. **Paid indemnity:** The amount the insurer or self-insurer paid to the claimant to resolve the claim.

Summary data for lawsuits reported by attorneys

If an attorney files a lawsuit alleging medical malpractice, the attorney must report data after the lawsuit is resolved. Many attorneys, however, do not comply with RCW 7.70.140, so data in this report is incomplete. Therefore, this section of the report is less detailed than the closed claim section.

Attorneys reported two primary types of settlement data:

1. **Total paid indemnity:** Total compensation paid by all defendants to the claimant. Indemnity payments may come from several defendants if a lawsuit named more than one party.[20]
2. **Legal expenses:** All sums paid by the claimant to the attorney, including attorney fees, expert witness fees, court costs and all other legal expenses.[21] [22]

[15] RCW 48.140.010(1) defines a claim.
[16] Under WAC 284-24D-060, if an insurer or self-insurer closes a claim without an indemnity payment or defense costs, it is not required to report the claim to the OIC.
[17] RCW 48.140.010(3) defines a closed claim.
[18] See WAC 284-24D-020(1), WAC 284-24D-330 and WAC 284-24D-340.
[19] See WAC 284-24D-350, WAC 284-24D-360, WAC 284-24D-362, WAC 284-24D-364, and WAC 284-24D-370.
[20] See WAC 284-24E-150.
[21] Attorney fees for legal representation are generally contingent fees that are payable if indemnity payments are made by one or more defendants.
[22] See RCW 7.70.140(2)(b)(v).

Closed claim and lawsuit statistics are different

One cannot compare data reported by insurers, self-insurers and risk retention groups to the data reported by attorneys because:

- Insurers, self-insurers and risk retention groups report all closed claims in which they make payments or incur expenses to defend the claim. Attorneys report data only if they filed a lawsuit against one or more defendants.
- Insurers, self-insurers and risk retention groups report data separately for each defendant. Attorneys submit one final settlement report that includes payments made by all defendants they sued.
- Insurers, self-insurers and risk retention groups are more diligent in reporting closed claim data.

Example: If an attorney sues several medical providers for their actions related to an incident with a poor medical outcome, some providers may resolve the litigation early, while others may be involved in the dispute resolution process for years. Insurers and self-insurers report claims as they resolve the claims against their customers, while an attorney waits until claims against all defendants are resolved to report the settlement.

Market analysis

This is an overview of the medical malpractice market in Washington state primarily using calendar year premium and loss data from the National Association of Insurance Commissioners (NAIC).

Market participants

The medical professional liability insurance market has three primary types of participants:

1. Admitted insurers regulated by the insurance commissioner.
2. Unregulated surplus lines insurers.
3. Risk retention groups regulated by their home state.

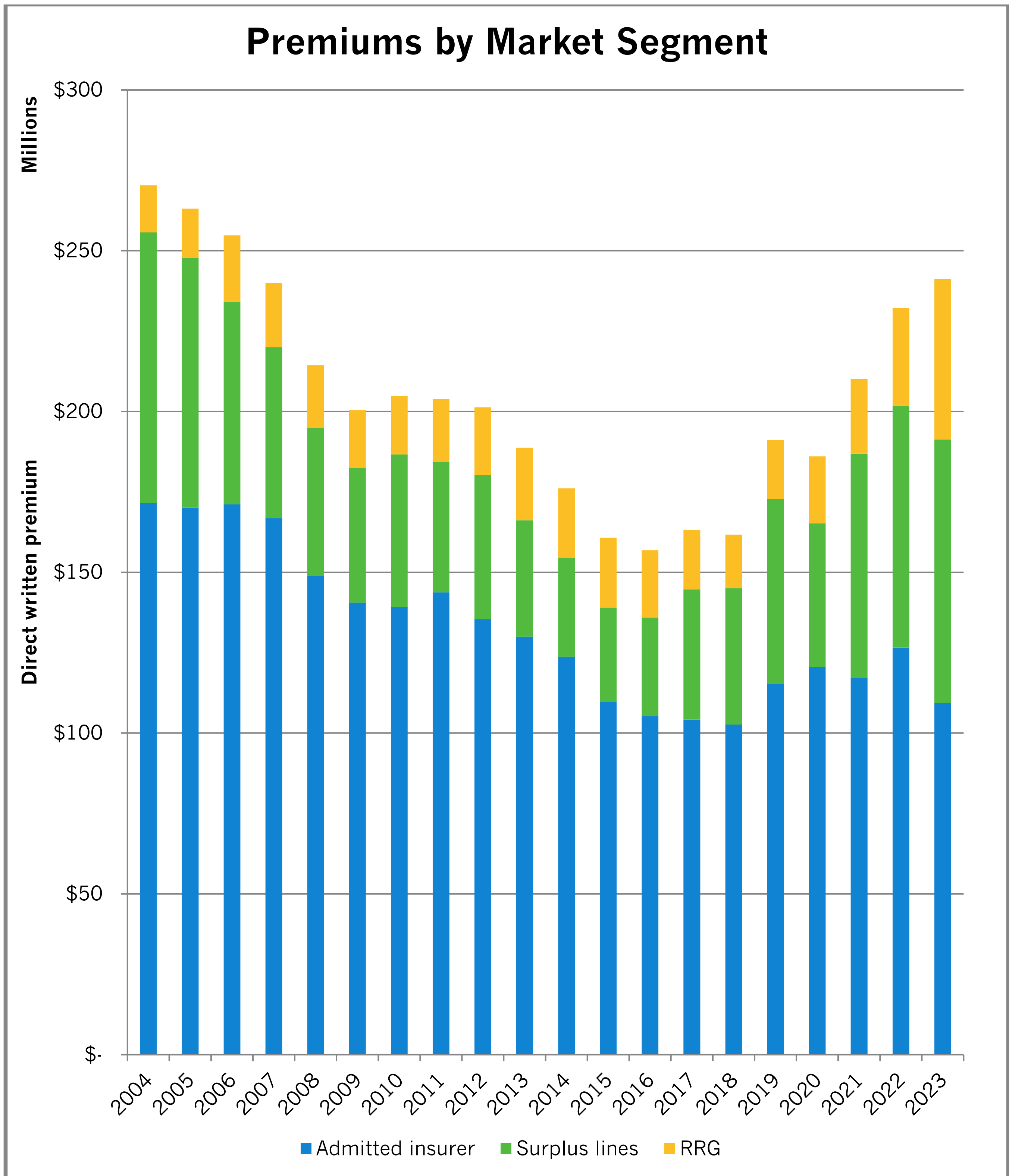
In 2000, admitted insurers wrote 95.4% of medical professional liability insurance premiums in Washington state. Physicians Insurance Group led the market with 52.7% of the admitted market share and 50.3% of the total market share.[23] In 2023, admitted insurers wrote only 45.3% of premiums, and the remainder of the market was written by surplus line insurers and risk retention groups. Physicians Insurance Group still had more than half of the admitted market share at 55%, but its share of the overall market was much lower, at 33.1%.[24]

Medical professional liability insurance has been a profitable line of business for insurers in Washington state, but profit results have been mixed in recent years. For Physicians Insurance A Mutual Company, the admitted insurer with the largest market share in Washington state, the operating ratio for 2019-2023 was 100.9%, a significant decline from its 2014-2018 ratio of 89.2%. However, for The Doctors Company, the admitted insurer with the second largest market share, this ratio improved from 98.4% to 91.3% over the same period.

[23] In 2000, Physicians Insurance Group sold insurance through three companies: Physicians Insurance A Mutual Company; Western Professional Insurance Company; and Northwest Dentists Insurance Company. Western Professional Insurance Company is no longer actively writing insurance, and a group including the ODS Companies and the Washington State Dental Association purchased Northwest Dentists Insurance Company in 2007.

[24] As of 2023, Physicians Insurance Group sells insurance through two companies: Physicians Insurance A Mutual Company, an admitted insurer domiciled in the state of Washington, and Physicians Insurance Risk Retention Group Inc., a risk retention group domiciled in the state of Vermont.

This chart shows the distribution of written premiums for each segment of the medical professional liability insurance market.



Loss history

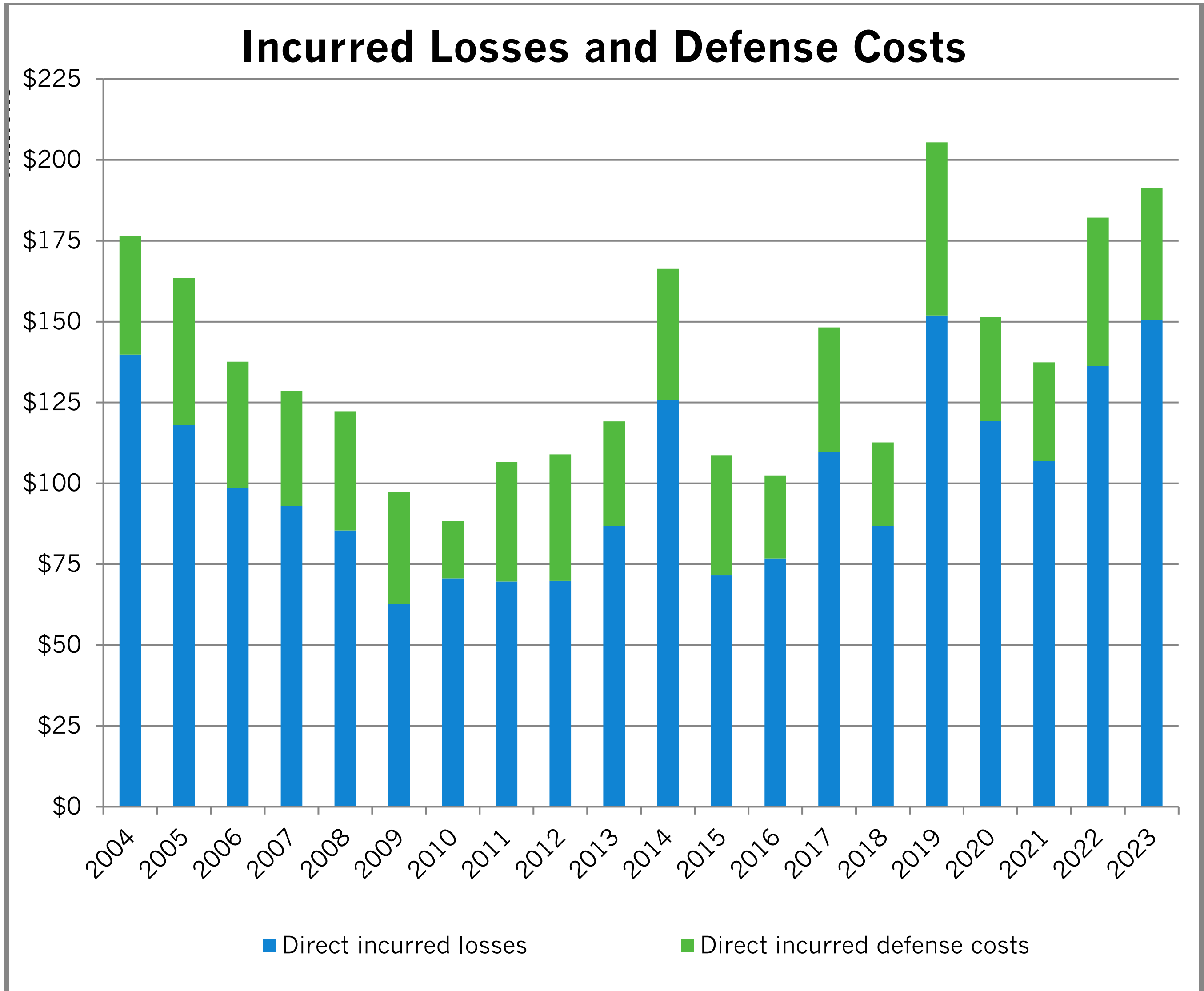
The following table shows data for the total Washington state market, which includes admitted insurers, surplus line insurers and risk retention groups. The pure loss ratio is the ratio of direct incurred losses (excluding defense costs) to direct earned premium. The defense cost ratio is the ratio of direct incurred defense costs to direct earned premium.

The overall incurred loss and defense cost ratio for medical professional liability insurance in Washington state was 83.4% in 2023, which was similar to recent years. For the five-year period from 2018 to 2022, this ratio was 81.6%.

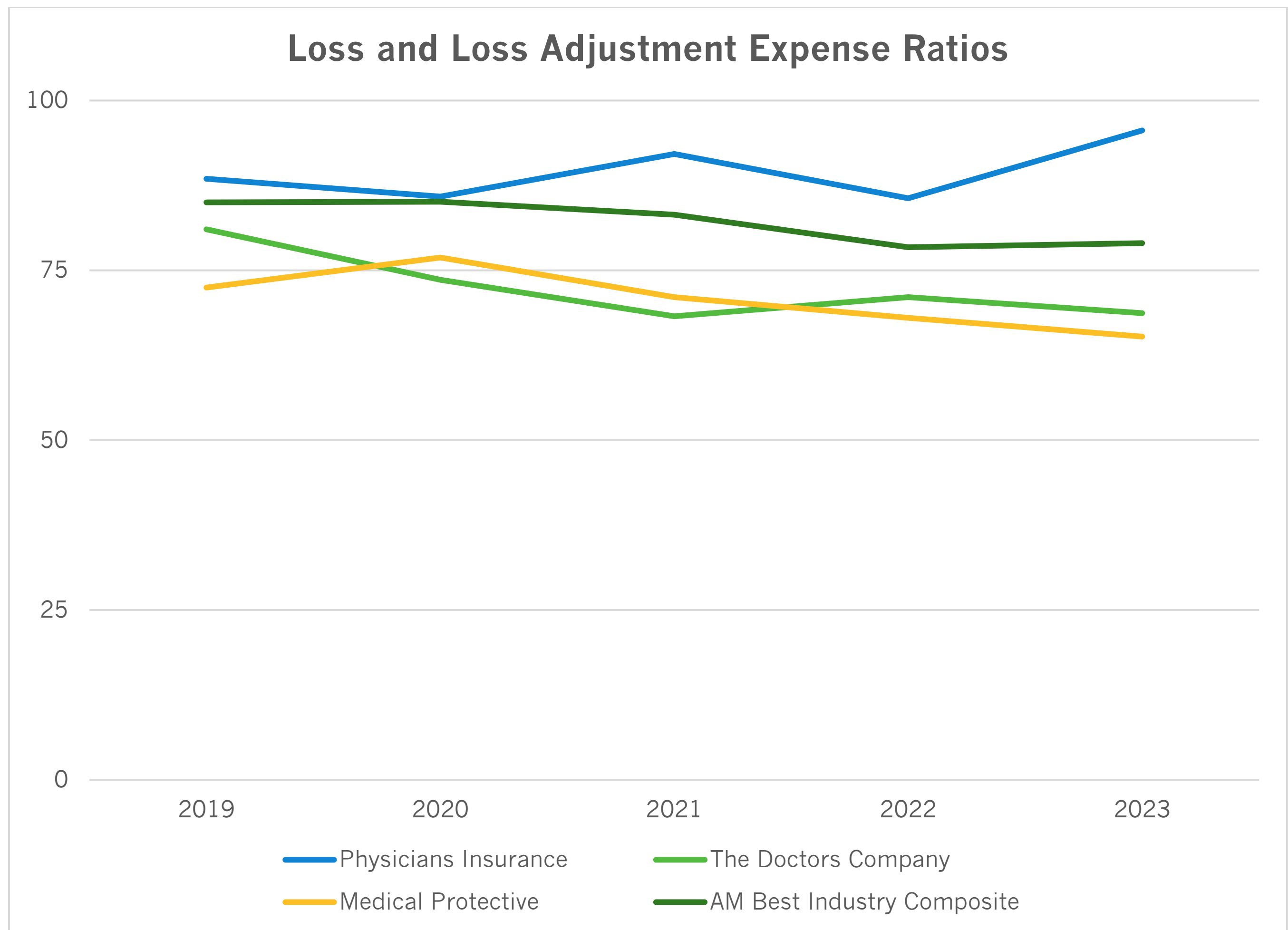
Overall Washington state medical malpractice insurance market loss experience

Year	Direct written premium	Direct earned premium	Pure loss ratio	Defense cost ratio	Incurred loss & defense cost ratio
2004	$270,352,631	$258,075,781	54.2%	14.2%	68.4%
2005	$263,090,674	$258,403,214	45.7%	17.6%	63.3%
2006	$254,759,071	$253,104,467	39.0%	15.4%	54.4%
2007	$239,959,432	$241,654,054	38.5%	14.8%	53.2%
2008	$214,357,164	$218,726,595	39.1%	16.8%	55.9%
2009	$200,445,437	$202,466,303	30.9%	17.1%	48.1%
2010	$204,786,151	$199,165,328	35.5%	8.9%	44.4%
2011	$203,869,400	$201,195,699	34.6%	18.4%	53.0%
2012	$201,288,240	$193,926,182	36.0%	20.1%	56.2%
2013	$188,761,301	$187,007,042	46.4%	17.3%	63.7%
2014	$176,091,879	$182,705,913	68.9%	22.2%	91.1%
2015	$160,752,756	$164,616,659	43.4%	22.6%	66.0%
2016	$156,825,836	$158,126,354	48.5%	16.2%	64.8%
2017	$163,187,482	$157,522,013	69.7%	24.4%	94.1%
2018	$161,729,173	$164,622,766	52.7%	15.7%	68.4%
2019	$191,108,177	$192,612,461	78.9%	27.8%	106.7%
2020	$186,040,296	$176,978,799	67.3%	18.2%	85.6%
2021	$210,111,147	$208,682,922	51.2%	14.6%	65.8%
2022	$232,144,024	$224,149,078	60.8%	20.4%	81.3%
2023	$241,201,894	$229,313,172	65.7%	17.8%	83.4%
Total	**$4,120,862,165**	**$4,073,054,802**	**49.8%**	**17.8%**	**67.6%**

This chart shows statewide industry incurred losses and defense costs by calendar year.



This chart compares loss and defense cost ratios for Physicians Insurance A Mutual Company, The Doctors Company and Medical Protective Company to industrywide data obtained from A.M. Best.[25] The Doctors Company and Medical Protective Company are two of the largest writers of medical professional liability insurance in the United States. The loss and defense cost ratio for Physicians Insurance continues to be higher than for the market overall.



[25] Best's Market Segment Report – Medical Professional Liability: Profitability Buoyed by Net Investment Income (May 1, 2024)

Claim reserves

Loss development is the change in the estimated cost of a particular group of claims between the beginning and end of a period in time. Favorable loss development means losses and defense costs decreased from the beginning to the end of the period.[26] Reserves released from prior years translate into profit for the current year.

Appendix B shows data from the 2023 annual statement for Physicians Insurance A Mutual Company.[27] The first table shows the change in incurred loss and defense cost reserves over time. The second table shows the cumulative loss development for different time periods. Overall, Physicians Insurance had favorable incurred loss development and returned some of its profits to policyholders in the form of dividends totaling $35 million from 2014 to 2020. However, since then, loss development has been less favorable, and no dividends have been paid.

Appendix B also shows loss development for The Doctors Company and Medical Protective Company. As compared to Physicians Insurance, loss development has been more favorable for both of these companies.

[26] Insurers compile the first estimate of incurred losses three months after the end of the year. Medical malpractice claims often take a long time to resolve and the first estimate of incurred losses may be very inaccurate and subject to revisions in later years. There will be changes to total incurred losses from one period to the next, as more claims are paid and the insurer revises reserves for other claims using new information. "Loss development" is the technical term for the change in incurred losses from period to period.

[27] Consolidated data from Schedule P, part 2, sections 1 and 2 for medical professional liability occurrence and claims made policies written in all states. Washington state-specific information is not available.

Washington state market in 2023

Physicians Insurance dominates the admitted medical professional liability insurance market in Washington. The Doctors Company and Medical Protective are also important participants in the market due to both their premium volume and their strong position in the national medical professional liability marketplace. Premiums written by Physicians Insurance best indicate the profitability of this type of insurance in Washington state, whereas premiums written by The Doctors Company and Medical Protective Company indicate profitability nationwide.

The following table shows direct written premiums for these companies in 2023, both in Washington state and nationwide.

Insurer direct written premiums

Insurer	Washington direct written premium	Nationwide direct written premium	WA % of Nationwide
Physicians Ins A Mutual Co	$60,128,317	$80,658,566	74.5%
Doctors Co An Interins Exch	$11,615,970	$779,926,227	1.5%
Medical Protective Co	$8,765,664	$731,483,514	1.2%

Washington state direct written premiums for the state's 10 largest admitted insurers

Admitted insurer	Washington direct written premium	Admitted market share
Physicians Ins A Mut Co	$60,128,317	55.0%
Doctors Co An Interins Exch	$11,615,970	10.6%
Medical Protective Co	$8,765,664	8.0%
American Cas Co Of Reading PA	$6,009,878	5.5%
Dentists Ins Co	$4,678,336	4.3%
Proselect Ins Co	$3,862,954	3.5%
Aspen Amer Ins Co	$2,357,102	2.2%
NCMIC Ins Co	$1,950,774	1.8%
Liberty Ins Underwriters Inc	$1,552,256	1.4%
ProAssurance Ins Co of Amer	$1,551,076	1.4%
All other admitted insurers	$6,879,370	6.3%
Total	**$109,351,697**	**100.0%**

National market in 2023

Appendix A shows the profitability for Physicians Insurance A Mutual Company, The Doctors Company and Medical Protective Company for the 10-year period ending Dec. 31, 2023, using two ratios:

- The operating ratio, which is the combined ratio minus the net investment income ratio.[28] [29]
- The combined ratio, which is the sum of the expense ratio, loss ratio, and dividend ratio.[30] [31] [32]

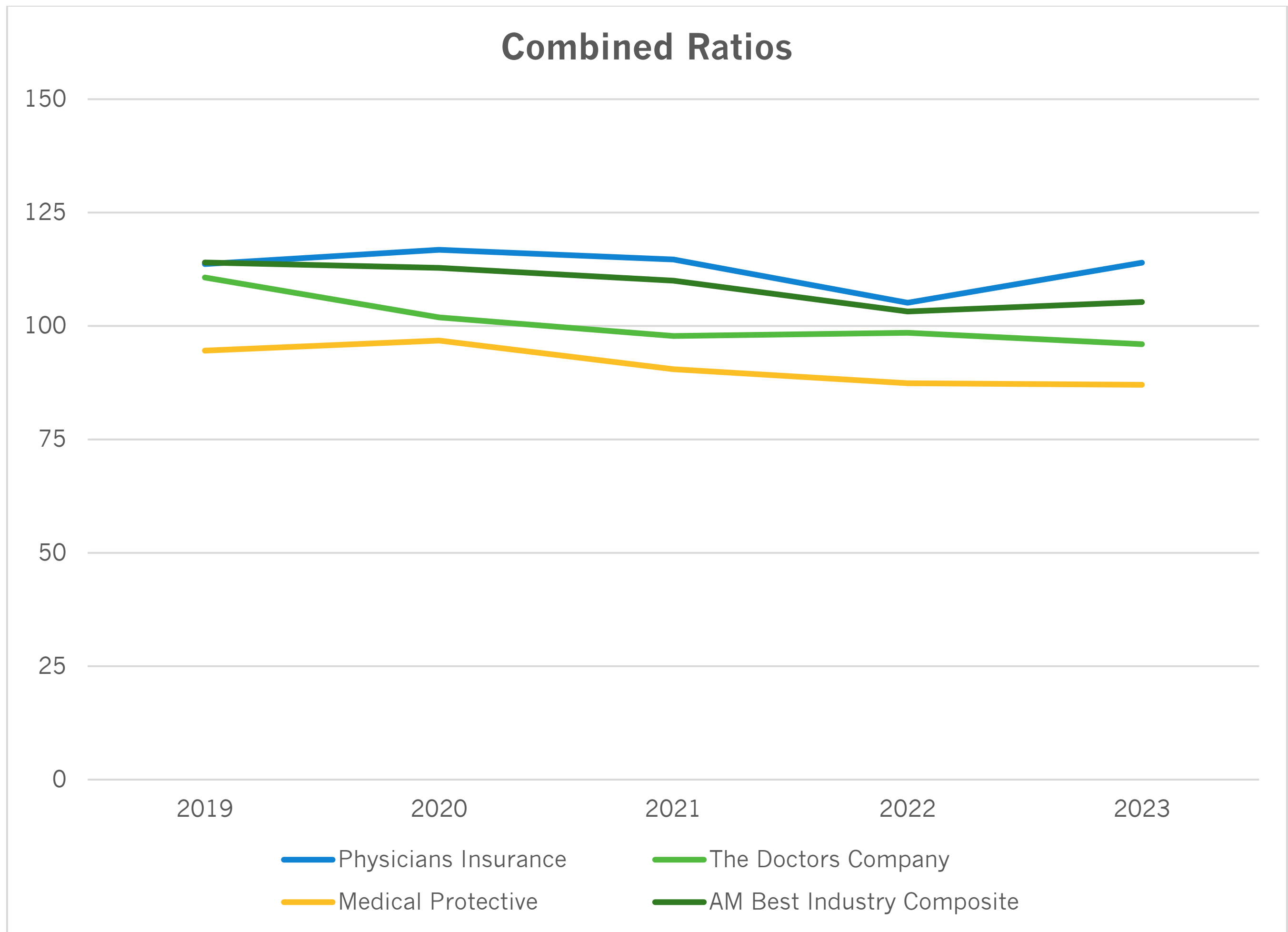
The following table summarizes overall profitability by operating ratios.[33] Following a significant improvement in 2022, the operating ratio for Physicians Insurance A Mutual Company increased to 102.5% in 2023. Meanwhile, The Doctors Company posted an operating ratio under 100% for the seventh consecutive year. Of the three companies, Medical Protective Company continues to have the lowest operating ratio.

Operating ratios by company

Year	Physicians Insurance	Doctors Company	Medical Protective
2014	85.7%	102.7%	128.5%
2015	89.5%	98.1%	37.2%
2016	90.6%	101.6%	49.3%
2017	88.7%	93.6%	46.7%
2018	90.8%	95.7%	47.9%
2019	96.0%	99.3%	48.8%
2020	105.5%	94.1%	60.9%
2021	105.1%	89.9%	57.3%
2022	95.2%	91.0%	56.1%
2023	102.5%	84.8%	53.1%

[28] The operating ratio measures a company's overall operational profitability from underwriting and investment activities. If an operating ratio is below 100%, the company is making a profit from its underwriting and investment activities.
[29] The net investment income ratio is calculated by dividing net investment income by net earned premiums.
[30] The expense ratio is calculated by dividing incurred underwriting expenses by net written premiums.
[31] The loss ratio is calculated by dividing losses and defense costs by net earned premiums.
[32] The dividend ratio is calculated by dividing policyholder dividends by net earned premiums.
[33] Loss portfolio transfers between Medical Protective and its affiliates distorted its operating ratios in 2014 and 2015.

This chart compares combined ratios from Physicians Insurance, The Doctors Company and Medical Protective Company to cumulative data obtained from A.M. Best.[34] [35]



[34] Best's Market Segment Report – Medical Professional Liability: Profitability Buoyed by Net Investment Income (May 1, 2024)

[35] The combined ratio measures how well an insurance company is performing in its daily operations. A ratio below 100% means the company is making an underwriting profit. A company can make an operating profit if the combined ratio is above 100%, because the ratio does not include investment income.

Summary data for closed claims reported by insurers and self-insurers

Overall summary of closed claim data by year closed

Item	2019	2020	2021	2022	2023
Claims closed	667	604	563	638	571
Claims paid	305	264	279	309	280
Paid indemnity	$188,833,420	$156,600,864	$152,441,343	$267,207,399	$252,153,696
Average indemnity payment	$619,126	$593,185	$546,385	$864,749	$900,549
Median indemnity payment	$125,000	$125,000	$150,000	$250,000	$262,500
Economic loss	$139,127,976	$96,830,671	$75,258,105	$171,142,844	$153,517,041
Average economic loss	$456,157	$366,783	$269,742	$553,860	$548,275
Median economic loss	$75,000	$65,000	$75,000	$130,138	$107,463
Claims with defense costs	597	557	500	587	531
Defense costs	$44,859,170	$54,922,741	$34,377,900	$66,658,698	$47,804,824
Average defense cost	$75,141	$98,605	$68,756	$113,558	$90,028
Median defense cost	$23,130	$17,341	$23,450	$30,373	$34,778

From 2019 to 2023, insurers and self-insurers paid $1 billion on 1,437 claims, or $707,889 per paid claim.[36] Following a significant increase in 2022, the average indemnity payment continued to trend upward in 2023, reaching $900,549.

The total economic loss was $636 million, or $442,503 per paid claim. On average, insurers and self-insurers attributed 62.5% of indemnity payments to economic loss. The average economic loss decreased by 1% from 2022 to 2023, while the median economic loss decreased by 17.4%.

Claims reported by insurers and self-insurers included defense costs 91.1% of the time. Insurers and self-insurers paid $249 million to defend 2,772 claims, or an average defense cost of $89,691. The average defense cost decreased by 20.7% from 2022 to 2023, but the median defense cost increased by 14.5% over the same period.

[36] These amounts differ from what we reported in prior reports, because reporting entities can edit their data. For example, a reporting entity can re-open a claim, make additional payments and edit the report to show it closed a year later than earlier reported.

Related claims

Insurers and self-insurers identified medical incidents for which they defended more than one claim. This happens if a claimant alleges more than one medical provider or facility is responsible for their injury and the insurer covers both parties.

From 2008[37] to 2023, insurers and self-insurers reported 1,622 multiclaim incidents. 53% of the multiclaim incidents resulted in indemnity payments. The aggregate average indemnity payment per incident was $751,568, which is 106.3% higher than the average per-claim indemnity payment for the same period.

Often, related claims from a single incident are resolved at different times, so there can be a lag between the insurer's or self-insurer's first claim report related to an incident and its final report that closes the series of related claims. This means average indemnity payments at the incident level will increase over time as additional claims related to previously reported incidents are resolved.

[37] Because claims related to the same incident can be closed on different dates, this discussion of incident-level information uses all available closed claim data, which insurers started reporting to the OIC in 2008. The remainder of our analysis of closed claim data uses information related to claims closed between 2019 and 2023.

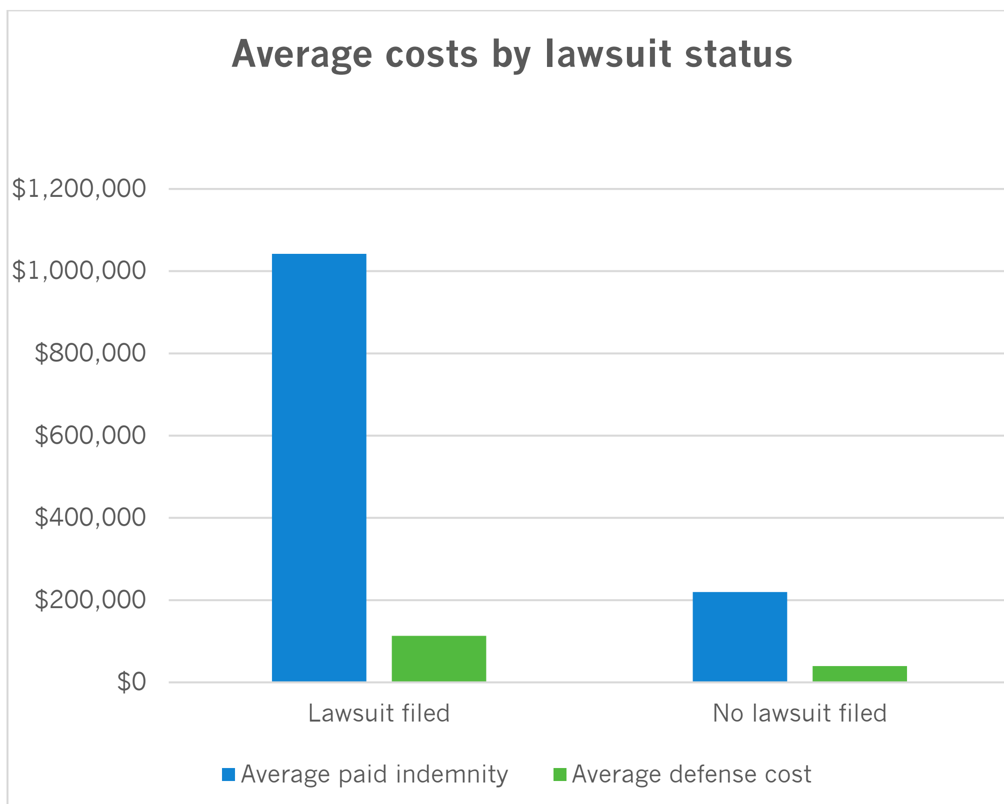
Lawsuit status

This table summarizes litigation data.[38]

Closed claim data by lawsuit status

Lawsuit status	Claims closed	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Lawsuit filed	1,906	853	$1,042,064	1,889	$113,145
No lawsuit filed	1,137	584	$219,788	883	$39,516
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**

Of the 3,043 claims reported, claimants filed lawsuits 62.6% of the time. Insurers and self-insurers incurred defense costs in 99.1% of the claims in which the plaintiff filed a lawsuit. Lawsuits resulted in indemnity payments 44.8% of the time, whereas 51.4% of claims without litigation resulted in indemnity payments.



[38] These amounts are not comparable to lawsuit settlement data reported by attorneys. Insurers and self-insurers report data for each defendant. Attorneys submit one settlement report that includes payments made by all defendants named in the lawsuit.

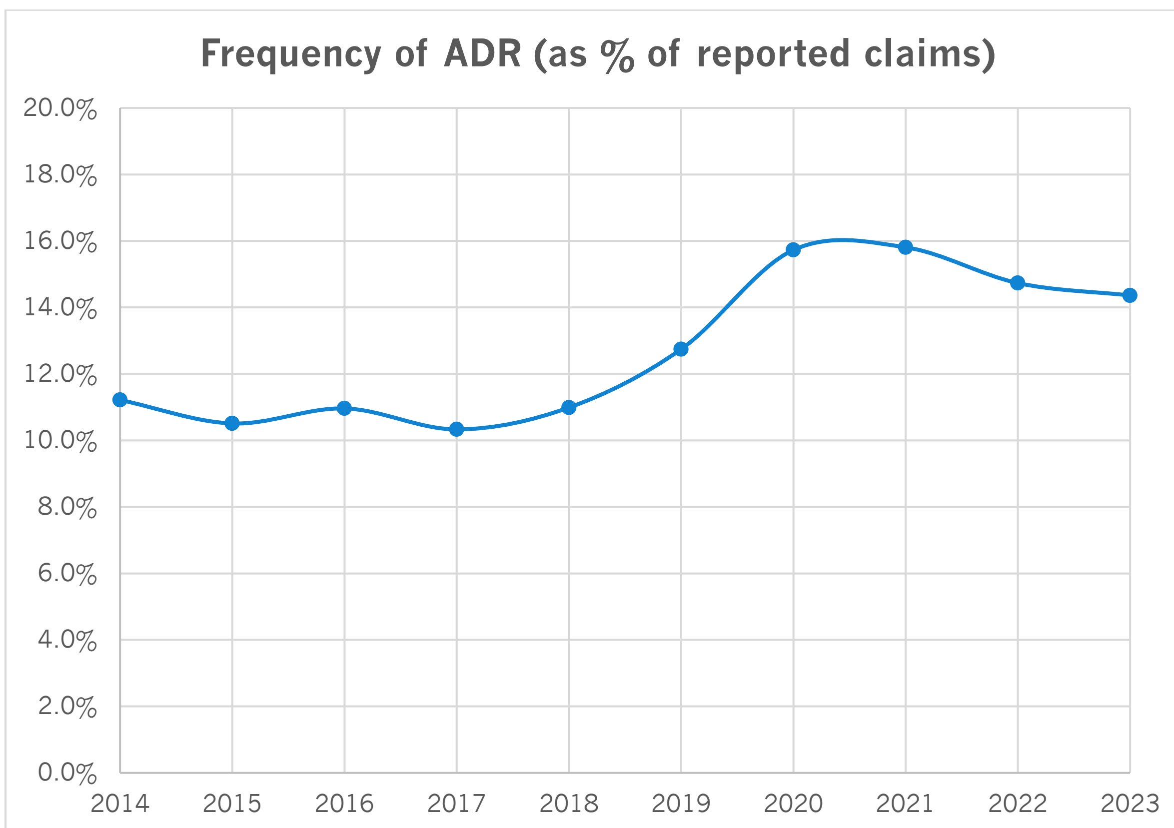
Method of settlement

Closed claim data by settlement method

Method of settlement	Claims closed	Claims paid	Average paid indemnity	Claims with defense costs	Average defense costs
Settled by parties	1,111	960	$592,125	885	$114,647
Abandoned by claimant	897	55	$42,996	859	$27,123
Court disposed claim	590	12	$1,054,578	590	$96,589
Alternative dispute resolution	445	410	$1,057,992	438	$152,681
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**

Alternative dispute resolutions ("ADR") include arbitration, mediation and private trials. Of the claims settled by ADR, 92.1% resulted in an indemnity payment, and those payments averaged $1.1 million. By comparison, negotiations between parties resulted in an indemnity payment 86.4% of time, and those payments averaged $592,125.

The following chart shows how the usage of ADR has changed over the last 10 years.



Size of indemnity payments

This table shows that insurers and self-insurers settled 52.8% of claims without making an indemnity payment. 52.7% of the remaining claims had indemnity payments of $200,000 or less.

Closed claim data based on the size of the indemnity payment

Range of paid indemnity	Claims reported	% of claims reported	Paid Indemnity	% of paid indemnity	Average paid indemnity
$0	1,606	52.8%	$0	0.0%	$0
$1 - $200,000	757	24.9%	$46,769,342	4.6%	$61,782
$200,001 - $400,000	215	7.1%	$64,599,914	6.4%	$300,465
$400,001 - $600,000	92	3.0%	$46,290,955	4.6%	$503,163
$601,000 - $800,000	64	2.1%	$46,262,191	4.5%	$722,847
$800,001 - $999,999	32	1.1%	$28,488,097	2.8%	$890,253
$1 million or more	277	9.1%	$784,826,223	77.2%	$2,833,308
Total	**3,043**	**100.0%**	**$1,017,236,722**	**100.0%**	**$707,889**

This next table shows how defense costs are related to the size of the indemnity payment.

Defense cost data based on the size of the indemnity payment

Range of paid indemnity	Claims with defense costs	% of claims with defense costs	Defense costs	% of total defense costs	Average defense cost
$0	1,606	57.9%	$96,715,909	38.9%	$60,222
$1 - $200,000	508	18.3%	$27,414,316	11.0%	$53,965
$200,001 - $400,000	208	7.5%	$21,167,384	8.5%	$101,766
$400,001 - $600,000	86	3.1%	$12,556,025	5.1%	$146,000
$600,001 - $800,000	64	2.3%	$6,761,569	2.7%	$105,650
$800,001 - $999,999	31	1.1%	$2,784,820	1.1%	$89,833
$1 million or more	269	9.7%	$81,223,310	32.7%	$301,945
Total	**2,772**	**100.0%**	**$248,623,333**	**100.0%**	**$89,691**

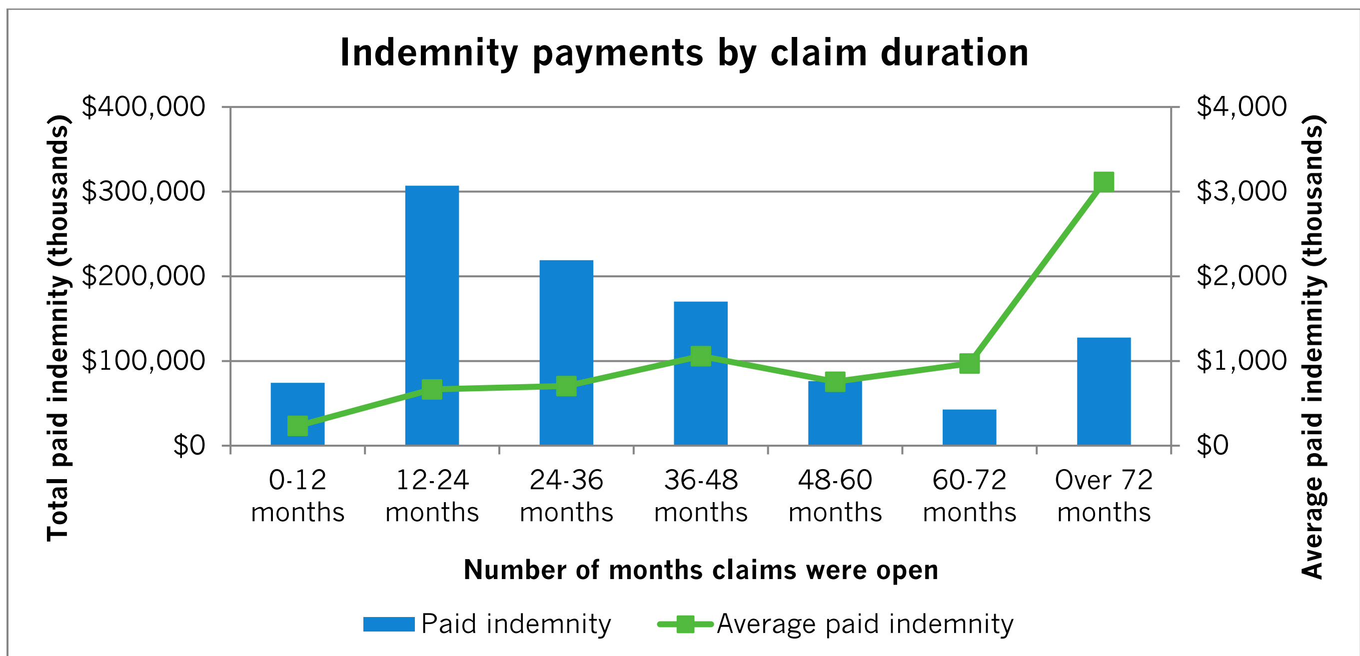
Claim duration

This table shows claims by age on the date they were closed. Average indemnity payments and average defense costs tend to increase with the age of the claim.

Closed claim data by claim duration

Notice date to closed date	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense costs
0-12 months	768	317	$234,126	578	$11,663
12-24 months	1,002	462	$664,759	945	$48,353
24-36 months	561	311	$704,266	545	$127,276
36-48 months	327	161	$1,056,978	324	$155,036
48-60 months	193	101	$755,633	190	$141,005
60-72 months	101	44	$970,478	101	$206,004
Over 72 months	91	41	$3,114,146	89	$325,773
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**

For the 3,043 claims, the average length of time between the notice date and the closed date was 25.6 months, and the median length of time was 20.8 months. Insurers and self-insurers closed 76.6% of all claims within 36 months. Overall, claims closed within 36 months accounted for 59% of total paid indemnity and 49% of total defense costs.

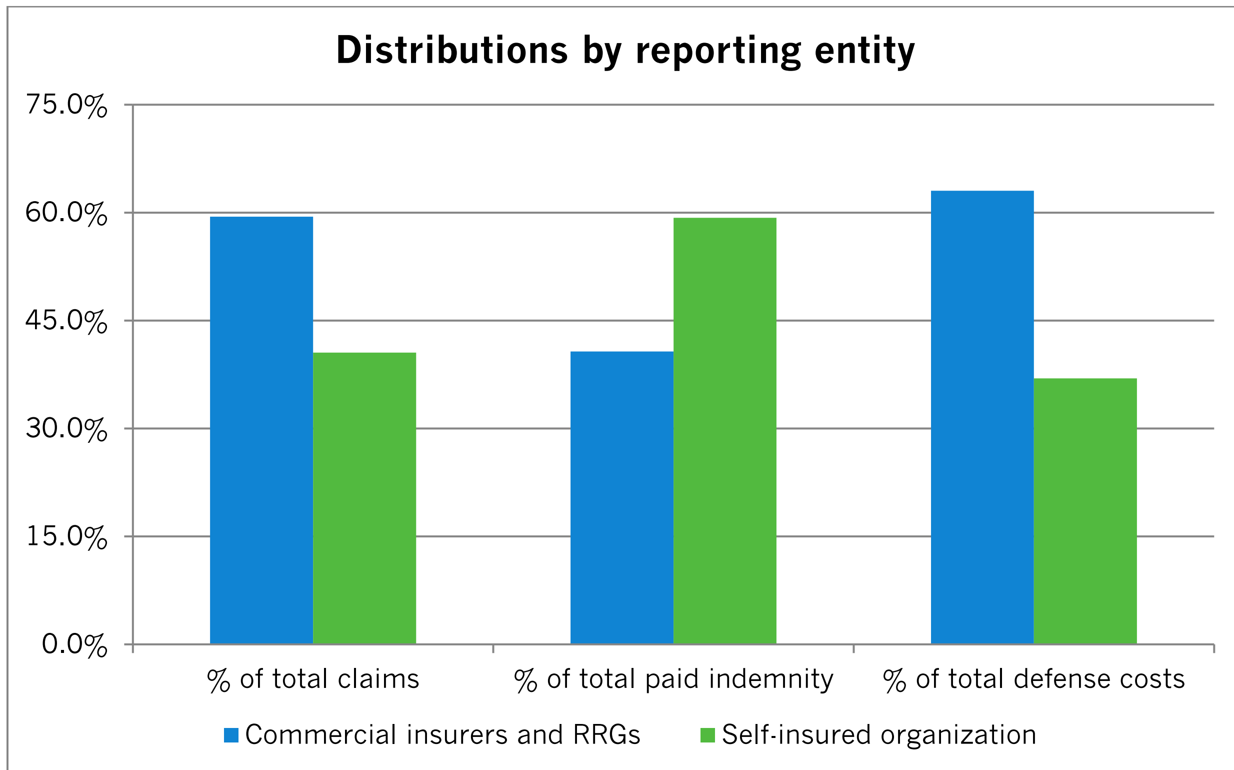


Type of reporting entity

Commercial insurers[39] and risk retention groups ("RRGs") reported the highest number of claims, but only 38% of those claims resulted in indemnity payments. By comparison, self-insured organizations reported indemnity payments for 60.7% of claims. Self-insured organizations also reported significantly higher indemnity payments.

Closed claim data by reporting entity type

Reporting entity	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense costs
Commercial insurers and RRGs	1,809	688	$601,929	1,755	$89,296
Self-insured organization	1,234	749	$805,220	1,017	$90,372
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**



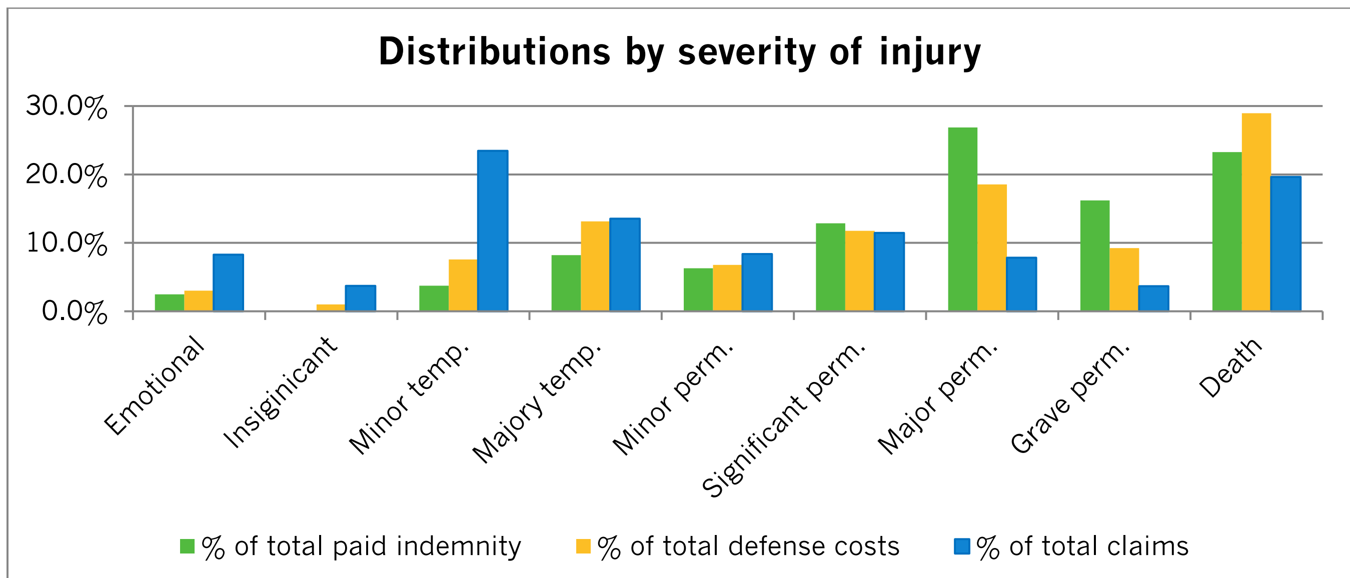
[39] Commercial insurers include admitted (licensed) insurers, surplus line insurers and joint underwriting associations.

Injury outcome

This exhibit shows compensation and defense costs by severity of injury.[40] Injuries were most often classified as minor and temporary, but these claims comprised only 3.7% of total paid indemnity and 7.6% of total defense costs. Grave permanent injuries[41] had the highest average paid indemnity and average defense costs, followed by major permanent injuries in both respects.

Closed claim data by injury outcome

Injury outcome	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense costs
Emotional injury only	252	92	$274,342	222	$33,836
Insignificant injury	113	29	$27,679	101	$24,589
Minor temporary injury	714	335	$113,583	578	$32,599
Major temporary injury	412	211	$395,919	369	$88,520
Minor permanent injury	255	118	$542,898	239	$70,639
Significant permanent injury	349	150	$871,473	335	$87,340
Major permanent injury	238	144	$1,897,946	231	$199,554
Grave permanent injury	112	57	$2,893,310	110	$208,523
Death	598	301	$786,045	587	$122,566
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**



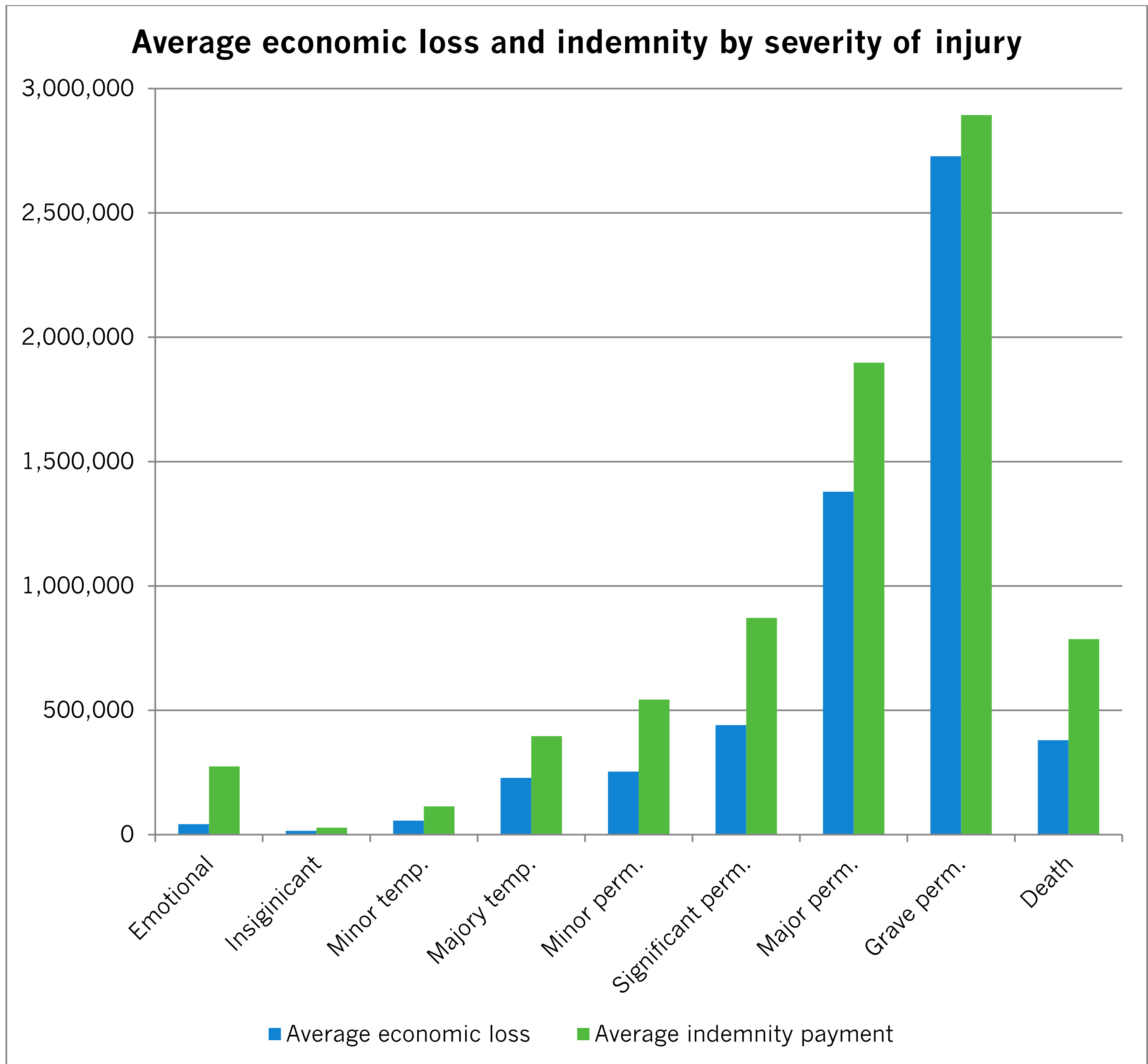
[40] For a description of each type of injury outcome, see WAC 284-24D-220.

[41] Grave permanent injuries include quadriplegia and severe brain damage, requiring lifelong dependent care.

If they made an indemnity payment, insurers and self-insurers reported the economic loss related to the injury.[42] The insurer or self-insurer either estimated the economic loss or reported the amount of economic loss awarded by a court.

Patient death claims had a lower average economic loss than claims for significant permanent injury, major permanent injury, or grave permanent injury. If a patient dies, compensation for economic loss is largely calculated based on lost income and services the patient would have provided.

This chart shows the relationship between injury outcome, average paid indemnity and average economic loss.



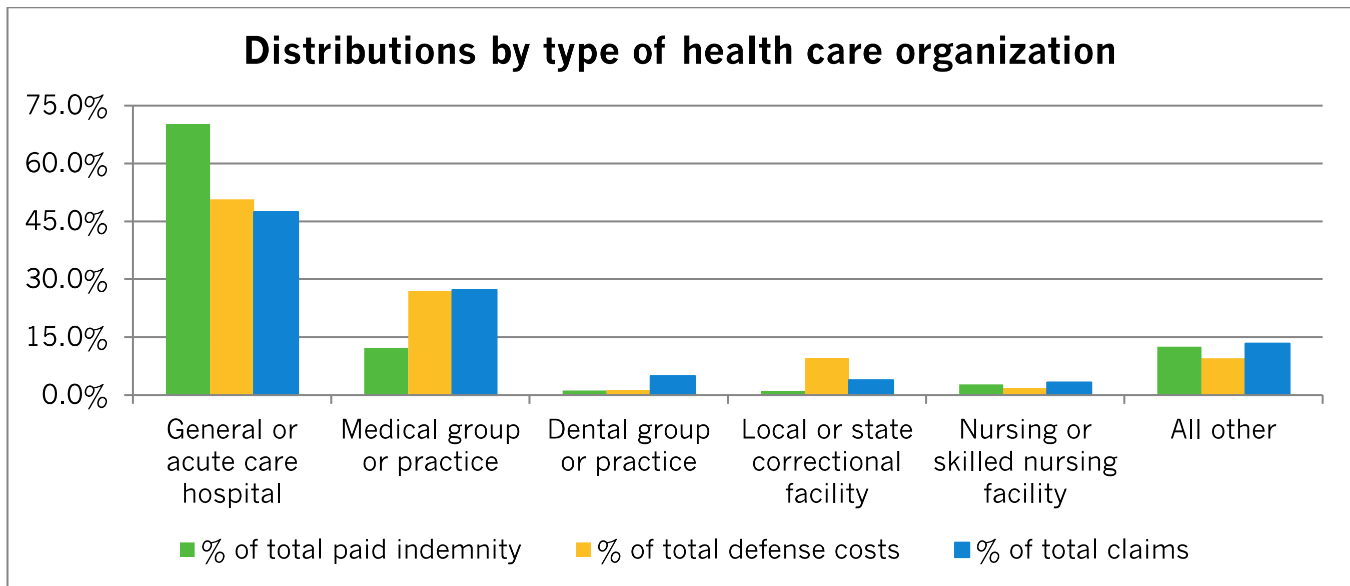
[42] The components of economic losses are described in WAC 284-24D-360.

Type of health care organization

This exhibit shows data segmented by the type of health care organization or provider group.[43]

Closed claim data by health care organization or provider group type

Health care organization	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense costs
General or acute care hospital	1,442	738	$967,492	1,293	$97,519
Medical group or practice	830	305	$409,219	791	$84,857
Dental group or practice	151	66	$178,155	138	$23,993
Local or state correctional facility	116	37	$303,712	100	$239,482
Nursing or skilled nursing facility	99	62	$448,445	96	$47,280
Chiropractic group or practice	37	23	$320,826	36	$81,977
Ambulatory surgical center	31	10	$424,000	30	$71,647
Podiatric group or practice	30	14	$300,000	30	$43,484
Ambulatory clinic or center	23	12	$850,388	22	$113,360
All other organizations	284	170	$597,605	236	$62,337
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**



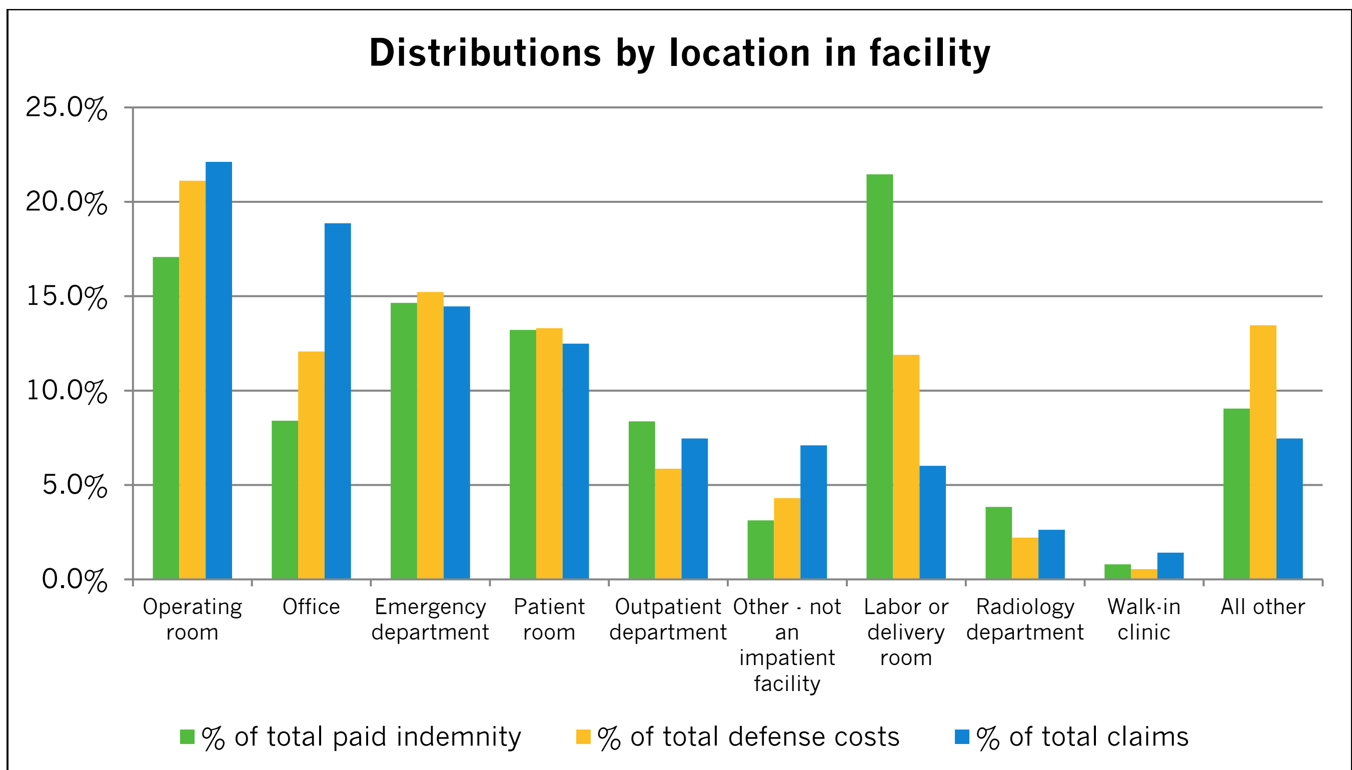
[43] Under RCW 48.140.060 and RCW 42.56.400(10), the insurance commissioner must protect the identify of each insuring entity, self-insurer, claimant, health care provider, or health care facility involved in a particular claim or collection of claims. For this reason, types of organizations with few claims are grouped together.

Location within the facility

This exhibit shows data by location within the facility where the incident leading to the claim occurred.

Closed claim data by location within the facility

Location within facility	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense costs
Operating room	673	310	$560,442	618	$84,956
Office	574	218	$392,312	552	$54,360
Emergency department	440	188	$792,657	405	$93,469
Patient room	380	212	$634,199	337	$98,190
Outpatient department	227	134	$635,406	181	$80,558
Other - not an impatient facility	216	90	$353,895	198	$54,043
Labor or delivery room	183	104	$2,098,217	177	$167,045
Radiology department	80	31	$1,260,677	73	$75,342
Walk-in clinic	43	22	$370,476	36	$37,580
All other locations	227	128	$719,257	195	$171,630
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**

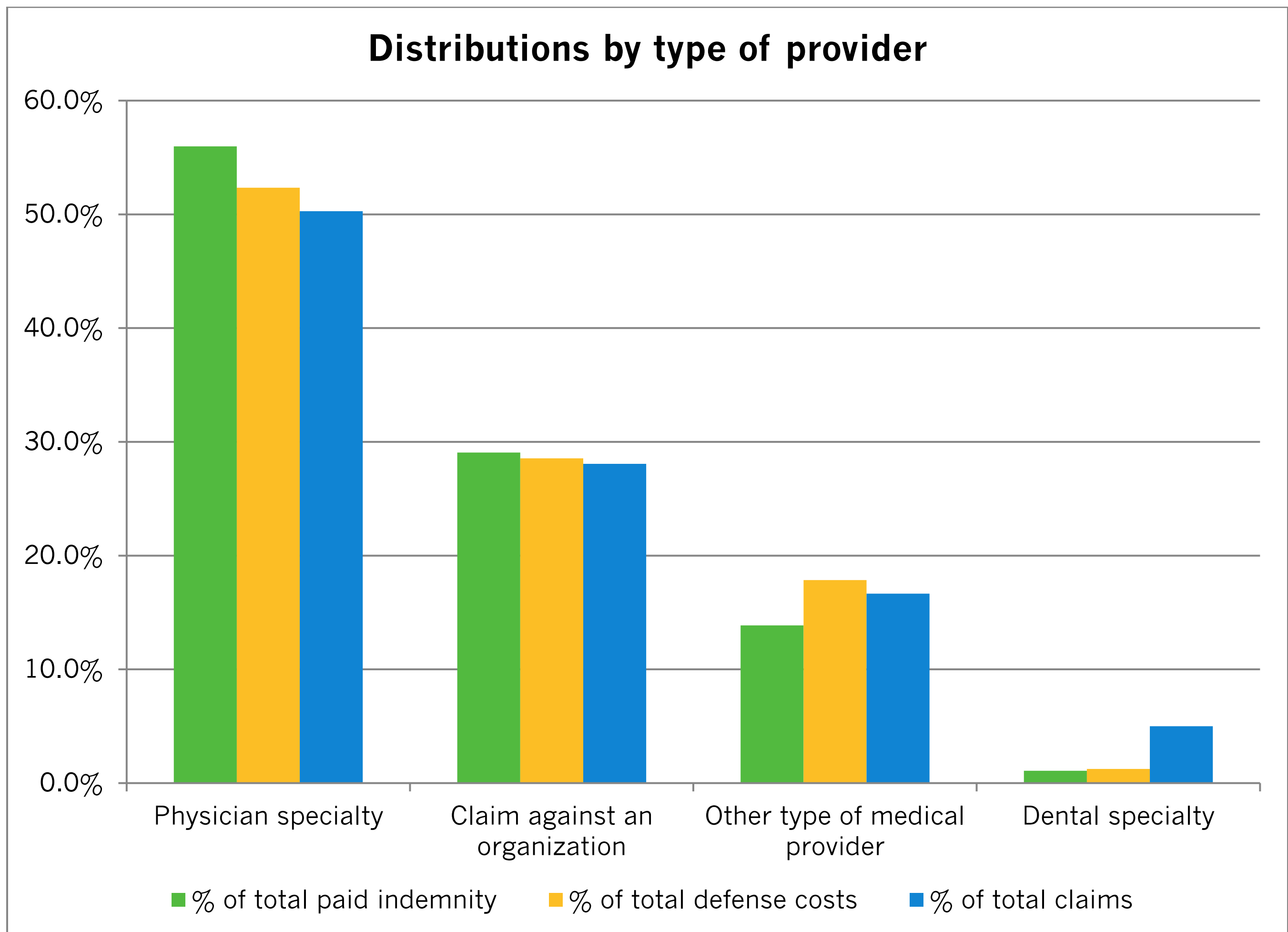


Type of medical provider

This exhibit shows data by type of medical provider. The "physician specialty" category includes surgeons, general practice physicians, radiologists, neurologists, psychiatrists and many more. The "other type of medical provider" category includes nursing, physician assistants, technicians, pharmacy, podiatry and psychology, among others.

Closed claim data by provider type

Provider type	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Physician specialty	1,530	675	$843,593	1,435	$90,695
Claim against an organization	854	403	$733,641	771	$92,082
Other type of medical provider	507	293	$481,546	428	$103,667
Dental specialty	152	66	$167,594	138	$22,548
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**



This table shows claim data for physician specialties that had the largest number of claims.[44]

Closed claim data by physician type

Provider specialty	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Obstetrics and gynecology	189	101	$1,184,577	181	$126,144
Emergency medicine	173	64	$886,440	160	$96,778
Family practice	159	66	$789,141	144	$88,657
Orthopedic surgery	148	72	$350,282	136	$55,428
Radiology	136	52	$979,499	133	$84,616
General surgery	132	64	$396,985	123	$79,917
Internal medicine	80	30	$865,967	75	$67,646
Anesthesiology	73	41	$585,006	61	$102,490
Neurological surgery	70	26	$2,455,854	70	$107,541
Cardiovascular diseases	43	23	$1,345,538	40	$86,165
Gastroenterology	42	21	$695,151	37	$123,450
Pediatrics	39	13	$2,018,522	37	$212,244
Urological surgery	31	14	$473,410	31	$40,828
All other physician types	215	88	$536,086	207	$69,834
Total	**1,530**	**675**	**$843,593**	**1,435**	**$90,695**

The largest number of claims against physician specialties were for obstetrics and gynecology. The most common allegations against this specialty were “improper performance” with 31 claims, “improper management” with 30 claims, and “failure to diagnose” with 14 claims.

Neurological surgery ranked highest among physician specialties in average paid indemnity. The most common allegation against this specialty was “improper performance” with 21 claims.

Pediatrics ranked highest among physician specialties in average defense costs. The most common allegations against this specialty were “failure to diagnose” and “improper performance” with five claims each.

[44] Under RCW 48.140.060 and RCW 42.56.400(10), some specialties are grouped together to maintain confidentiality.

This table shows claim data for other types of medical providers.[45] Nursing staff accounted for the majority of these claims. The most common allegation against nursing staff was "failure to ensure patient safety" with 35 claims, followed by "failure to monitor" with 23 claims and "failure to diagnose" with 21 claims. Physician assistants had the second-highest number of claims, and the most common allegation against this type was "failure to diagnose" with 24 claims.

Closed claim data for other types of medical providers

Provider type	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Nursing	260	155	$495,220	205	$59,279
Physician assistant	83	44	$505,810	73	$166,207
Podiatry	37	18	$355,694	37	$312,017
Chiropractic	34	21	$347,333	33	$87,845
Emergency medicine	20	10	$870,834	16	$107,490
All other types	73	45	$437,188	64	$61,266
Total	**507**	**293**	**$481,546**	**428**	**$103,667**

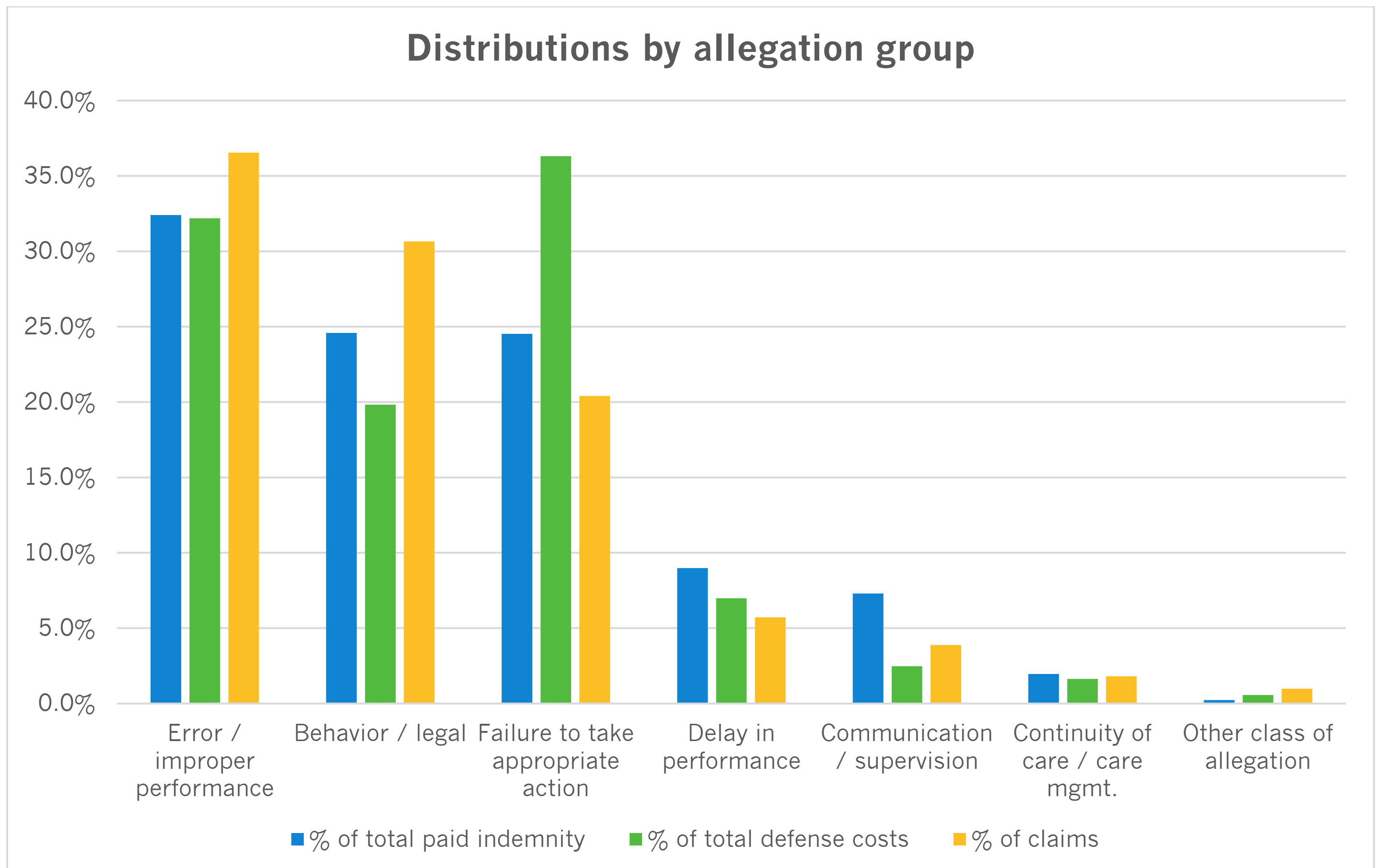
[45] Under RCW 48.140.060 and RCW 42.56.400(10), some types of providers are grouped together to maintain confidentiality.

Claim allegations

Insurers and self-insurers identified the primary complaint that led to the medical malpractice claim. This table shows the most common classes of allegations.

Closed claim data by claim allegation group

Allegation group	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Error / improper performance	1,112	543	$607,104	1,007	$79,480
Behavior / legal	933	406	$616,077	841	$58,617
Failure to take appropriate action	621	281	$887,929	584	$154,602
Delay in performance	174	92	$994,148	164	$105,854
Communication / supervision	118	77	$964,475	100	$61,522
Continuity of care / care mgmt.	55	28	$710,912	48	$84,912
Other class of allegation	30	10	$231,220	28	$50,533
Total	**3,043**	**1,437**	**$707,889**	**2,772**	**$89,691**



The next two pages show the most common specific allegations for each major class of allegation.

Closed claim data for specific allegations

Error / improper performance	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Improper performance	464	203	$527,841	441	$70,732
Improper technique	164	94	$380,930	131	$53,640
Improper management	163	70	$1,138,928	155	$124,043
Patient history, exam, or workup problem	49	17	$1,014,543	45	$61,610
Wrong diagnosis or misdiagnosis	34	16	$791,500	33	$87,325
Surgical or other foreign body retained	30	19	$308,043	28	$62,055
Equipment utilization problem	20	16	$376,962	17	$43,385
Wrong body part	17	14	$135,926	12	$33,109
Behavior / legal	**Claims reported**	**Claims paid**	**Average paid indemnity**	**Claims with defense costs**	**Average defense cost**
Vicarious liability	721	285	$725,404	655	$61,515
Failure to ensure patient safety	92	69	$270,476	74	$57,745
Sexual misconduct	30	21	$691,619	27	$49,580
Failure to take appropriate action	**Claims reported**	**Claims paid**	**Average paid indemnity**	**Claims with defense costs**	**Average defense cost**
Failure to diagnose	343	159	$899,146	330	$90,096
Failure to treat	72	22	$427,604	69	$208,591
Failure to monitor	63	31	$488,038	52	$452,577
Failure to recognize a complication	35	18	$1,264,672	31	$68,086
Failure to order appropriate test	35	16	$706,837	33	$399,020
Failure to identify fetal distress	19	12	$3,219,109	19	$178,242

Delay in performance	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Delay in diagnosis	102	49	$942,342	96	$102,653
Delay in treatment	45	25	$578,783	43	$75,137
Delay in performance	19	11	$712,937	17	$106,960
Communication / supervision	**Claims reported**	**Claims paid**	**Average paid indemnity**	**Claims with defense costs**	**Average defense cost**
Failure to instruct or communicate w/patient	46	32	$1,178,622	32	$49,215
Improper supervision	21	14	$483,759	20	$70,797
Failure to supervise	19	11	$310,872	19	$54,957
Communication problem btwn. practitioners	17	11	$872,406	15	$50,996
Continuity of care / care management	**Claims reported**	**Claims paid**	**Average paid indemnity**	**Claims with defense costs**	**Average defense cost**
Failure or delay in referral or consultation	21	11	$505,146	16	$79,008

This table shows the most common allegations against physician specialties.

Closed claim data based on allegations against physicians

Allegation made against physician specialty	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Failure to diagnose	290	132	$943,792	279	$95,140
Improper performance	278	120	$738,851	270	$88,025
Improper technique	127	61	$555,599	107	$60,210
Improper management	112	44	$1,274,617	107	$127,918
Delay in diagnosis	83	39	$871,339	79	$108,796
Patient history, exam, or workup problem	43	14	$974,088	40	$65,710
Failure to treat	42	12	$607,083	42	$139,223
Failure to instruct or communicate w/patient	28	20	$720,644	22	$43,594
Wrong diagnosis or misdiagnosis	27	15	$811,600	26	$101,264
Failure to order appropriate test	27	13	$791,876	26	$96,281
Delay in treatment	26	12	$535,012	24	$98,892
Surgical or other foreign body retained	26	18	$320,990	24	$68,410
Failure to recognize a complication	24	10	$1,972,905	23	$62,777

This table shows the most common allegation against dental specialties. "Improper performance" was alleged in almost two-thirds of these claims.

Closed claim data based on allegations against dental providers

Allegation made against dental provider	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Improper performance	99	38	$166,645	92	$24,833

This table shows the most common allegations made against other types of medical providers.

Closed claim data based on allegations against other types of medical providers

Allegation made against other type of provider	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Improper performance	85	45	$270,158	77	$66,696
Failure to diagnose	49	25	$654,400	47	$65,436
Failure to ensure patient safety	40	33	$152,264	25	$48,723
Improper management	32	17	$487,284	32	$104,167
Improper technique	29	25	$48,936	18	$29,415
Failure to monitor	26	16	$131,004	17	$85,117

This table shows the most common allegations made against an organization. The most common allegation, “vicarious liability,” is secondary liability in which the organization becomes responsible for the acts of an employee or another third party when it had the right, ability or duty to control those actions.

Closed claim data based on allegations against organizations

Allegation made against an organization	Claims reported	Claims paid	Average paid indemnity	Claims with defense costs	Average defense cost
Vicarious liability	654	274	$728,037	590	$63,573
Failure to ensure patient safety	43	33	$402,431	40	$52,399
Failure to supervise	17	10	$341,559	17	$57,604
Improper supervision	15	12	$560,958	15	$72,958

Counties

Insurers and self-insurers reported the county where the medical incident occurred.[46] To provide information about differences by location, we divided the state into 10 regions.[47] A few claims were reported as occurring outside of Washington state (not shown).

Closed claim data by region

County/region	Claims reported	Claims paid	Average paid indemnity	Average economic loss	Claims with defense costs	Average defense costs
King	844	430	$971,361	$684,747	755	$126,345
Pierce	364	181	$803,664	$452,751	344	$102,311
Spokane	351	145	$511,711	$316,957	319	$90,396
Yakima - Tri Cities	244	114	$406,385	$222,353	226	$52,598
Snohomish	244	96	$732,712	$459,063	225	$56,293
Puget Sound Metro	233	99	$693,819	$407,294	228	$79,926
East balance	217	99	$487,006	$282,580	194	$48,797
Clark	189	101	$422,474	$220,575	159	$75,322
West balance	174	86	$709,330	$347,458	156	$92,703
North Sound	169	79	$509,481	$289,126	154	$63,929

King County had the most claims, the highest average paid indemnity, the highest average economic loss, and the highest average defense costs.

The proportion of indemnity payments attributed to economic damages varied significantly by region. The highest such proportion was in King County, where insurers and self-insurers attributed 70.5% of indemnity payments to economic loss. The lowest was in the “west balance” region, where insurers and self-insurers attributed 49% of indemnity payments to economic loss.

[46] Under RCW 48.140.060 and RCW 42.56.400(10), some counties are grouped together to maintain confidentiality.
[47] **Yakima-Tri Cities** includes Benton, Franklin and Yakima counties. **East balance** includes Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Walla Walla and Whitman counties. **Puget Sound Metro** includes Kitsap and Thurston counties. **West balance** includes Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania and Wahkiakum counties. **North Sound** includes Island, San Juan, Skagit and Whatcom counties.

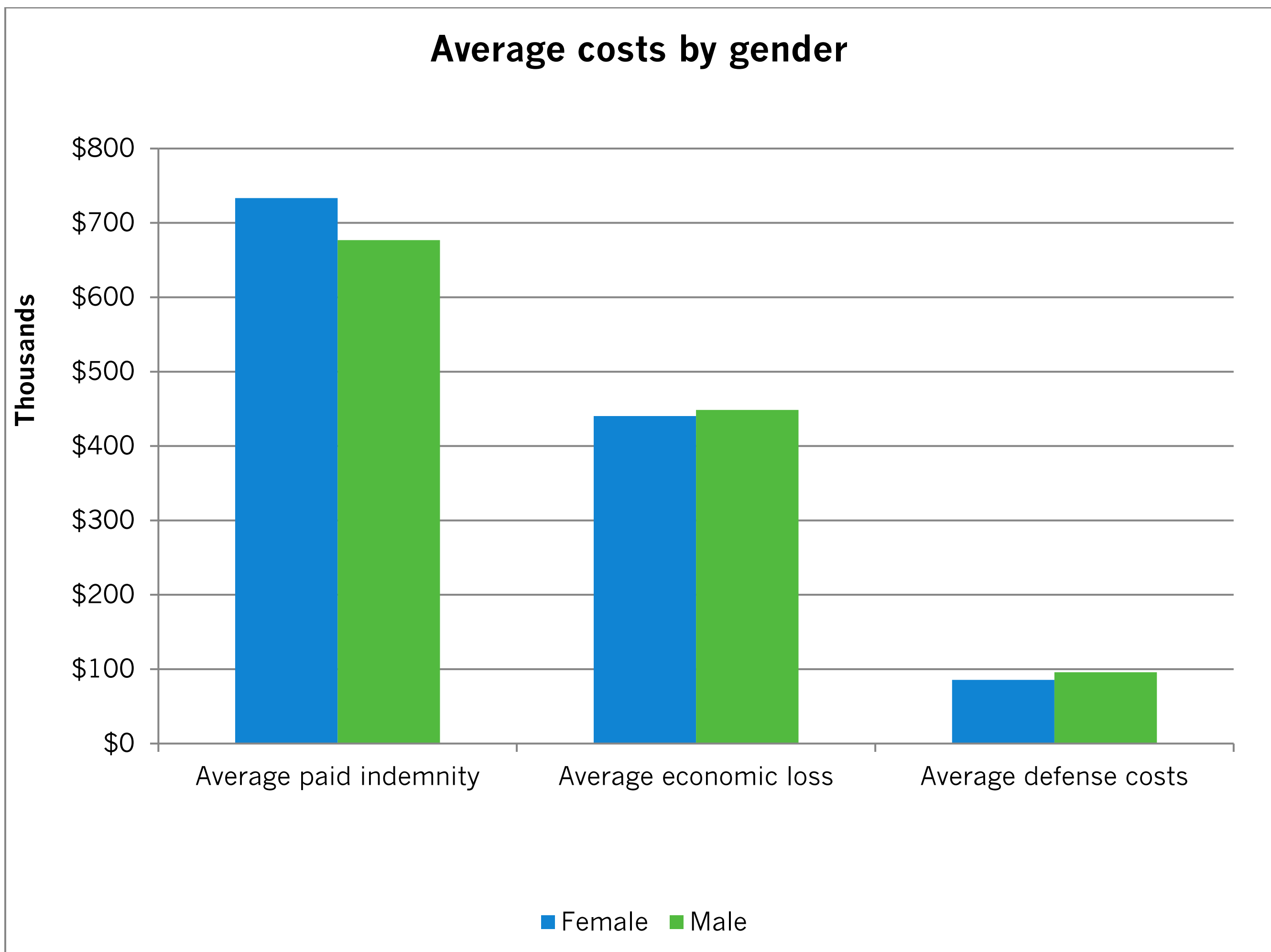
Gender of claimant

This exhibit shows data by gender. For a few claims, the gender was reported as unknown (not shown).

Closed claim data by gender of claimant

Gender	Claims reported	Claims paid	Average paid indemnity	Average economic loss	Claims with defense costs	Average defense costs
Female	1,760	839	$733,429	$440,310	1,604	$85,703
Male	1,274	593	$676,851	$448,464	1,159	$95,833

Average indemnity payments were higher when the injured person was female, while average economic losses and average defense costs were higher when the injured person was male. The chart below illustrates this comparison.

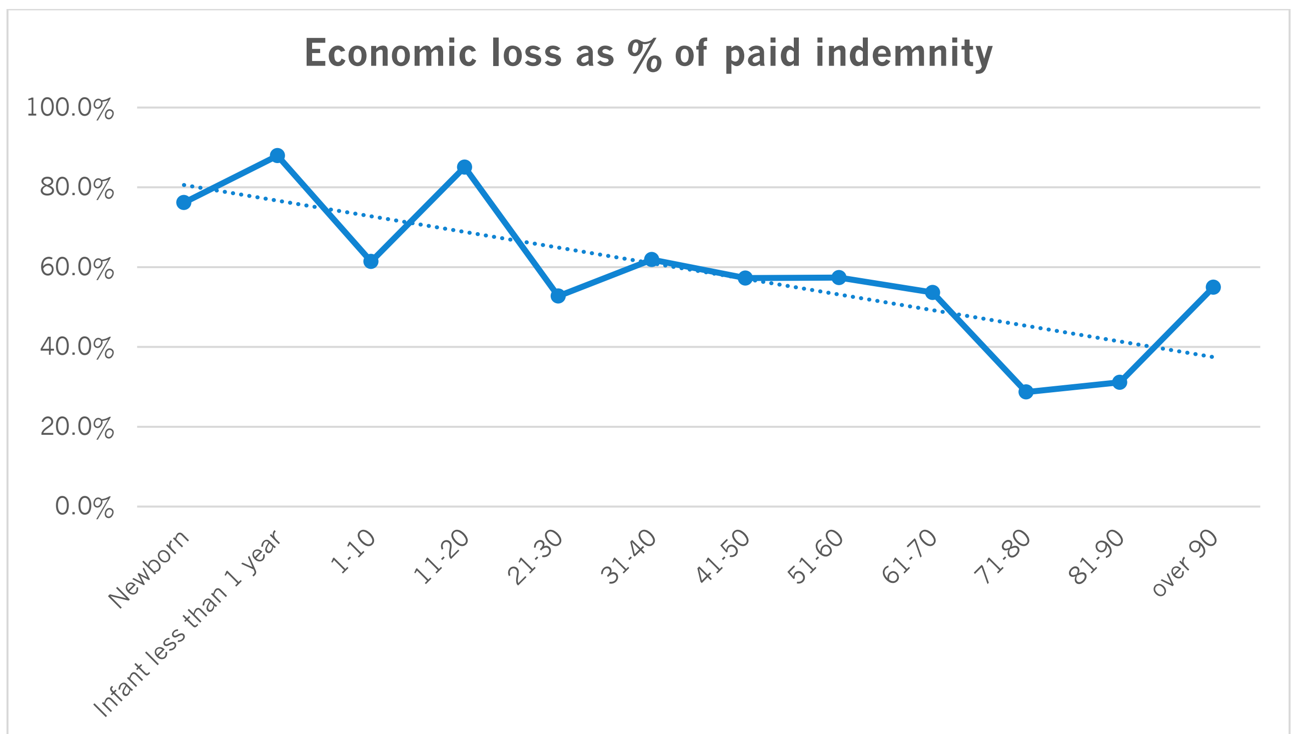


Age of claimant

Insurers and self-insurers reported the age group of the claimant.

Closed claim data by claimant age group

Age group	Claims reported	Claims paid	Average paid indemnity	Average economic loss	Claims with defense costs	Average defense cost
Newborn	140	82	$2,246,392	$1,711,180	136	$214,043
Infant less than 1 year	41	19	$3,524,887	$3,099,197	39	$123,750
1-10	91	45	$996,935	$612,257	81	$89,352
11-20	89	50	$1,525,863	$1,297,867	75	$108,118
21-30	245	107	$678,081	$357,588	222	$165,151
31-40	385	170	$554,208	$343,046	345	$72,744
41-50	471	185	$756,206	$432,946	433	$66,196
51-60	704	303	$486,454	$279,096	646	$81,111
61-70	469	239	$444,096	$238,258	429	$82,764
71-80	257	140	$398,905	$114,472	234	$53,826
81-90	119	78	$314,118	$97,778	104	$63,331
over 90	32	19	$229,149	$125,935	28	$65,461
Total	**3,043**	**1,437**	**$707,889**	**$442,503**	**2,772**	**$89,691**



Trends

This chart shows estimates of trends in frequency and severity.[48]

Ten-year fitted trends

Year closed	Average paid indemnity	Average limited indemnity	Average defense costs	Average of limited indemnity + defense costs	Number of claims closed
2014	$269,353	$236,575	$57,946	$156,488	1,043
2015	$379,443	$222,156	$65,547	$147,899	1,018
2016	$281,475	$219,375	$66,183	$155,416	894
2017	$330,787	$195,279	$62,103	$138,894	813
2018	$454,123	$276,282	$73,733	$203,129	819
2019	$619,126	$290,427	$75,141	$200,059	667
2020	$593,185	$316,672	$98,605	$229,344	604
2021	$546,385	$331,798	$68,756	$225,488	563
2022	$864,749	$411,475	$113,558	$303,769	638
2023	$900,549	$419,683	$90,028	$289,520	571
Annual trend	**14.3%**	**8.2%**	**5.9%**	**8.8%**	**-7.1%**

Average limited indemnity amounts were calculated by restricting individual claims to a maximum of $1 million, which is a way to reduce volatility in the trend estimate. The estimated trend in the number of claims closed is low due to late-reported claims. There will likely be more claims than the 571 already reported for 2023.

These trends in medical malpractice insurance costs are not reliable estimates of changes over time for several reasons. Medical malpractice claims can take several years to close, and the averages shown for each closed-year include data from incidents that occurred over many years. Thus, trends estimated using closed-year data can be distorted by changes in claim settlement rates. Because of these distortions, the trend in the number of claims closed is a poor estimate of frequency trend. A frequency is calculated as the number of claims per exposure (e.g., per policy or per physician). Since insurers do not report policy counts, physician counts or other exposure data, we cannot calculate a true frequency trend. These trend estimates could also be distorted by changes in data reporting compliance over time.

[48] An analysis of trends in frequency and severity is required by RCW 48.140.050(1)(a)(i). Trends shown are based on exponential least squares regression.

Summary data for lawsuits reported by attorneys

This section of the report presents data submitted by plaintiffs' attorneys following the resolution of lawsuits against health care providers and facilities.

Overall summary of lawsuit settlement data by year settled

Item	2019	2020	2021	2022	2023
Settlements reported by attorneys	18	11	15	12	19
Settlements with paid indemnity	16	11	14	11	18
Total paid indemnity	$15,340,000	$12,520,000	$30,144,287	$16,325,000	$56,385,000
Average payment to claimant	$958,750	$1,138,182	$2,153,163	$1,484,091	$3,132,500
Median payment to claimant	$700,000	$650,000	$750,000	$450,000	$750,000
Total legal expenses	$6,313,494	$4,818,014	$11,883,351	$5,307,299	$11,245,121
Average legal expense	$350,750	$438,001	$792,223	$442,275	$591,848
Total attorney fees	$5,351,851	$4,321,180	$10,931,815	$4,901,279	$10,121,500
Average fee paid to attorney	$334,491	$392,835	$780,844	$445,571	$562,306

From 2019 to 2023, claimants received $131 million in compensation on 70 settlements, averaging $1.9 million per settlement.

Claimants paid $40 million for legal expenses, averaging $527,564 per lawsuit. Claimants also paid $36 million in attorney fees, averaging $508,966 per settlement with paid indemnity.[49] On average, the attorney fee was 27.3% of the total compensation paid to the claimant.

The average indemnity payment per settlement reported by attorneys was much higher than the average indemnity payment reported by insurers on a per-defendant basis. Per-lawsuit averages are expected to be higher than per-defendant averages, since settlements reported by attorneys can involve multiple defendants. Averages reported by attorneys may be biased high; attorneys might be less likely to report data to the OIC for lawsuits resulting in small indemnity payments.

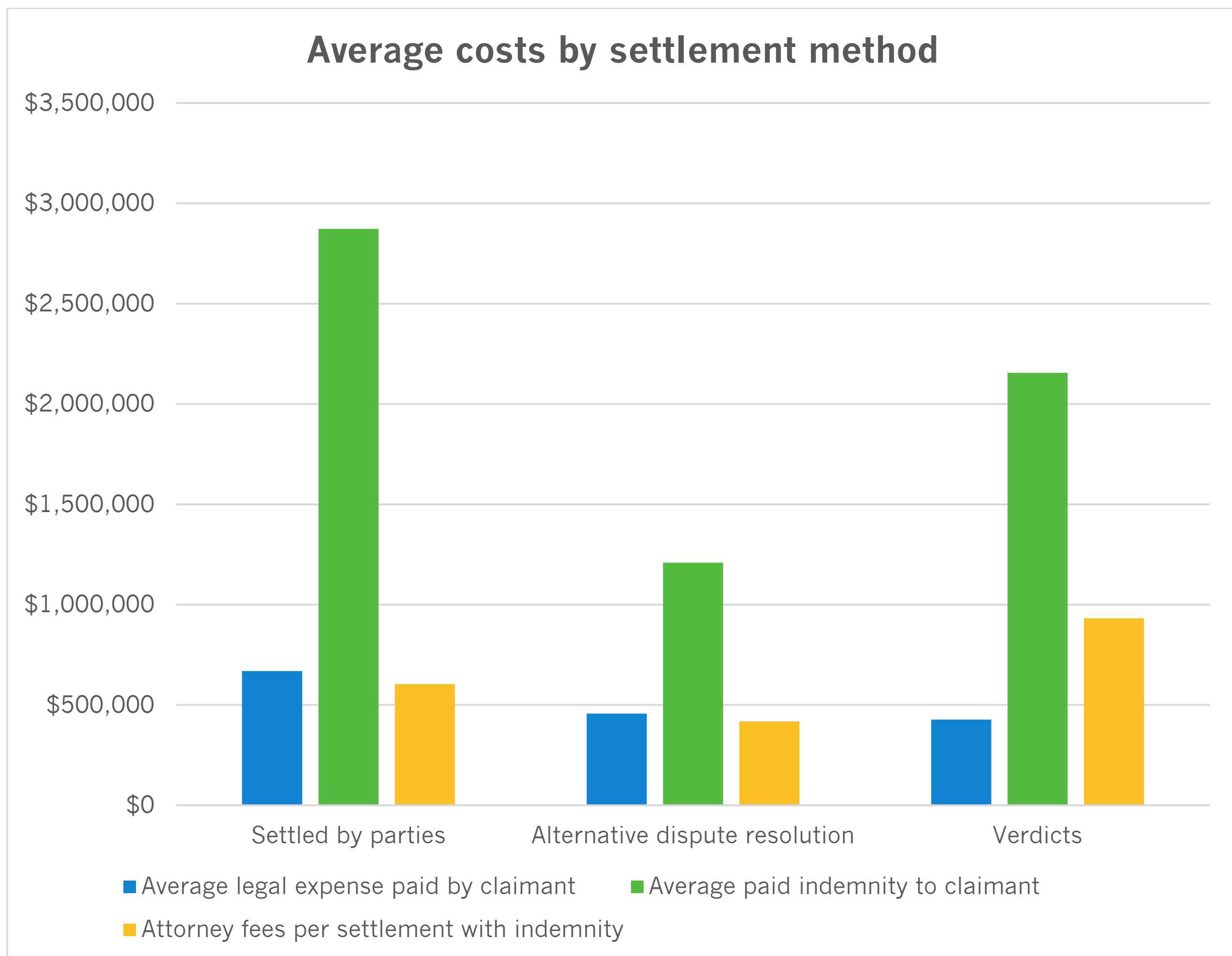
[49] Attorneys in this area of litigation typically work on a contingency basis and receive fees if one or more defendants compensate the claimant.

Method of settlement

This exhibit shows data segmented by lawsuit settlement method.

Lawsuit settlement data by settlement method

Lawsuit settlement method	Average legal expense paid by claimant	Average paid indemnity to claimant	Attorney fees per settlement with indemnity	Attorney fee as % of indemnity
Settled by parties	$669,542	$2,872,115	$603,636	21.0%
Alternative dispute resolution	$457,107	$1,209,146	$417,971	34.6%
Verdicts	$427,223	$2,154,762	$932,089	43.3%

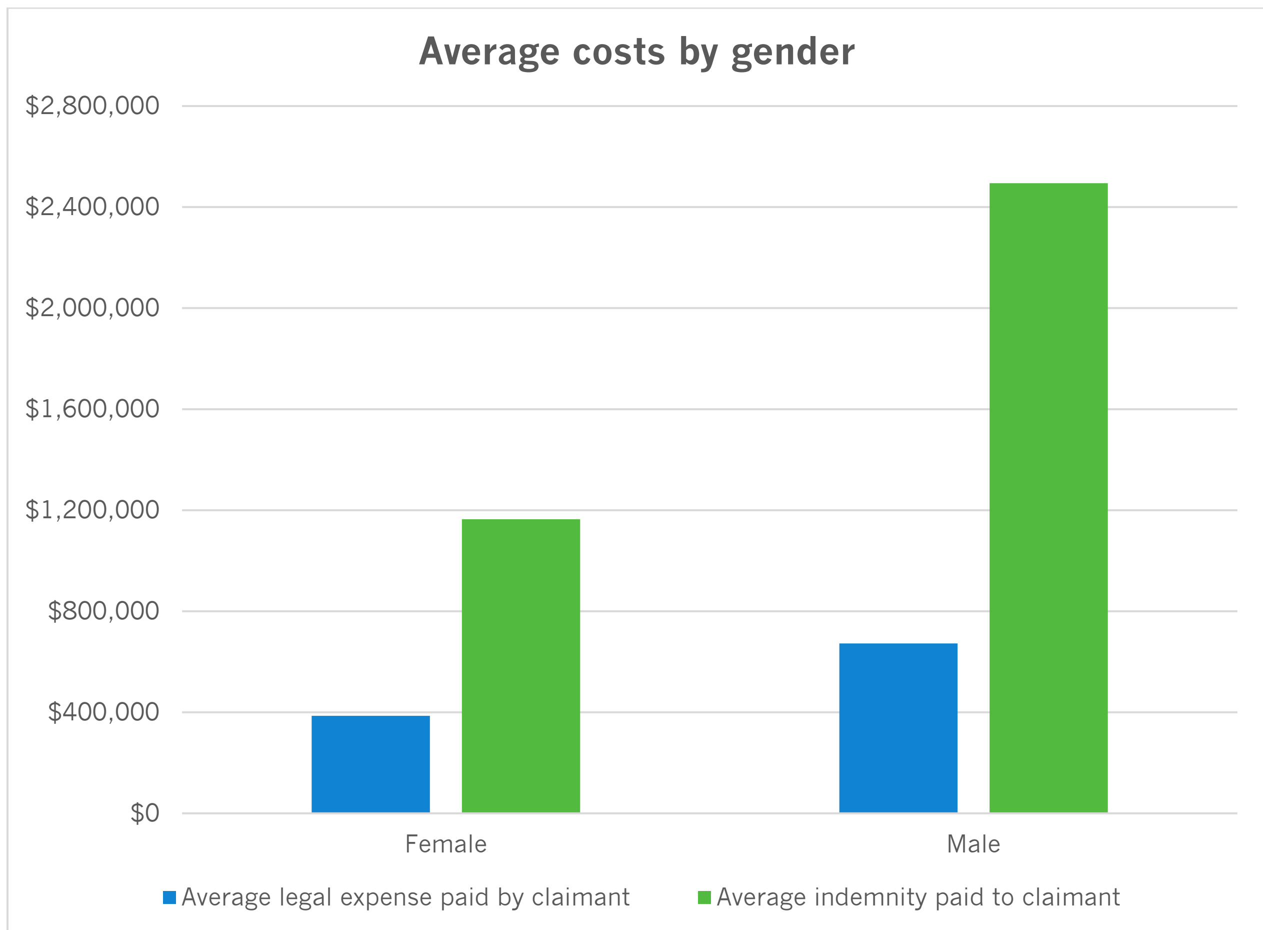


Gender of claimant

Slightly more settlements involved female claimants: 50.7% compared to 49.3% with male claimants. However, male claimants accounted for 70.6% of the total paid indemnity and 62.9% of the total legal expense.

Lawsuit settlement data by gender

Gender	Settlements with legal expenses	Total legal expenses	Average legal expense paid by claimant	Settlements with paid indemnity	Total paid indemnity	Average indemnity paid to claimant
Female	38	$14,678,067	$386,265	33	$38,425,000	$1,164,394
Male	37	$24,889,212	$672,681	37	$92,289,287	$2,494,305
Total	**75**	**$39,567,279**	**$527,564**	**70**	**$130,714,287**	**$1,867,347**

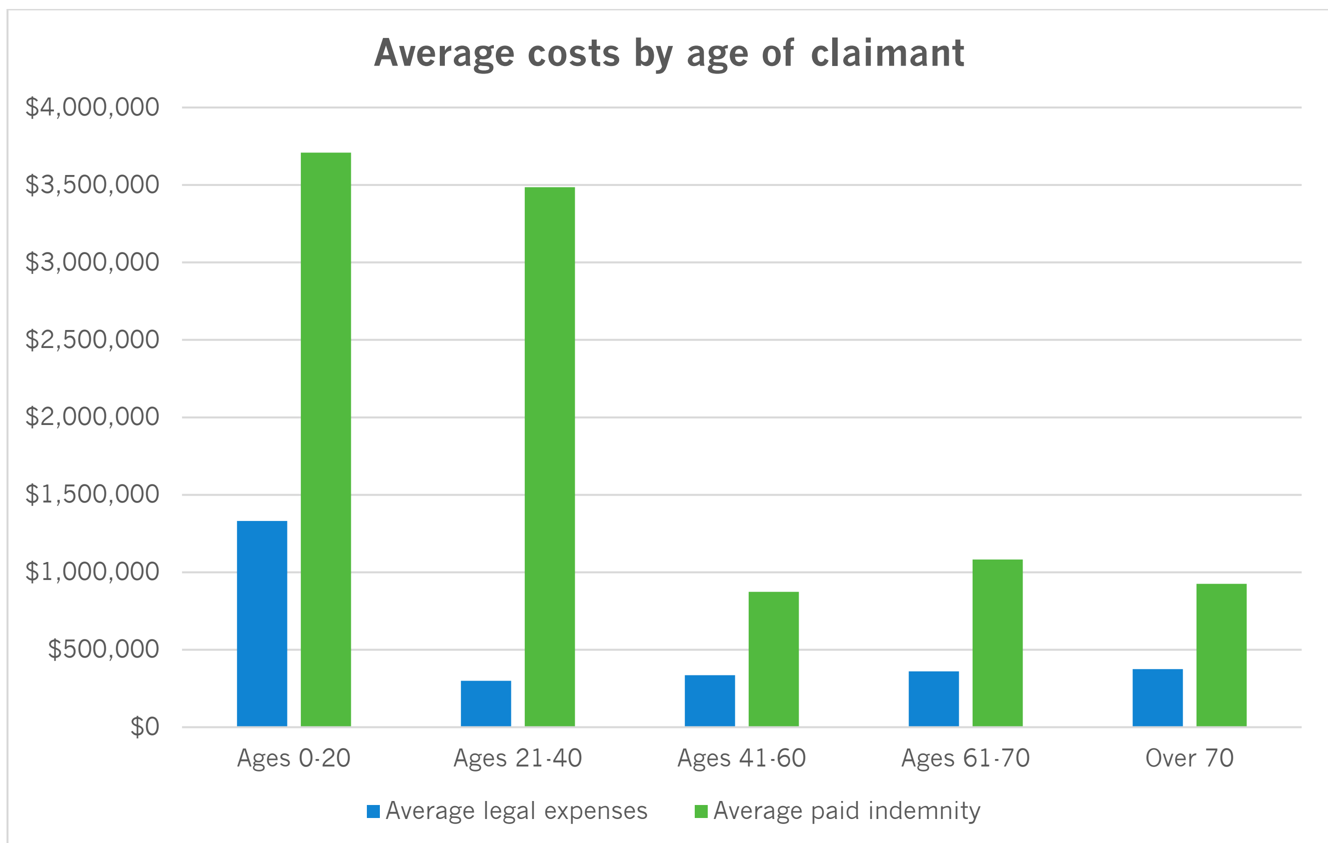


Age of claimant

This table shows data segmented by the age of the claimant. Lawsuits involving claimants in the youngest age group were the most expensive to settle and had the highest average indemnity payment.

Lawsuit settlement data by claimant age group

Age group	Settlements with legal expenses	Total legal expenses	Average legal expenses	Settlements with paid indemnity	Total paid indemnity	Average paid indemnity
Ages 0-20	14	$18,636,342	$1,331,167	13	$48,214,287	$3,708,791
Ages 21-40	12	$3,593,476	$299,456	11	$38,345,000	$3,485,909
Ages 41-60	20	$6,713,418	$335,671	18	$15,720,000	$873,333
Ages 61-70	17	$6,124,203	$360,247	16	$17,325,000	$1,082,813
Over 70	12	$4,499,840	$374,987	12	$11,110,000	$925,833
Total	**75**	**$39,567,279**	**$527,564**	**70**	**$130,714,287**	**$1,867,347**

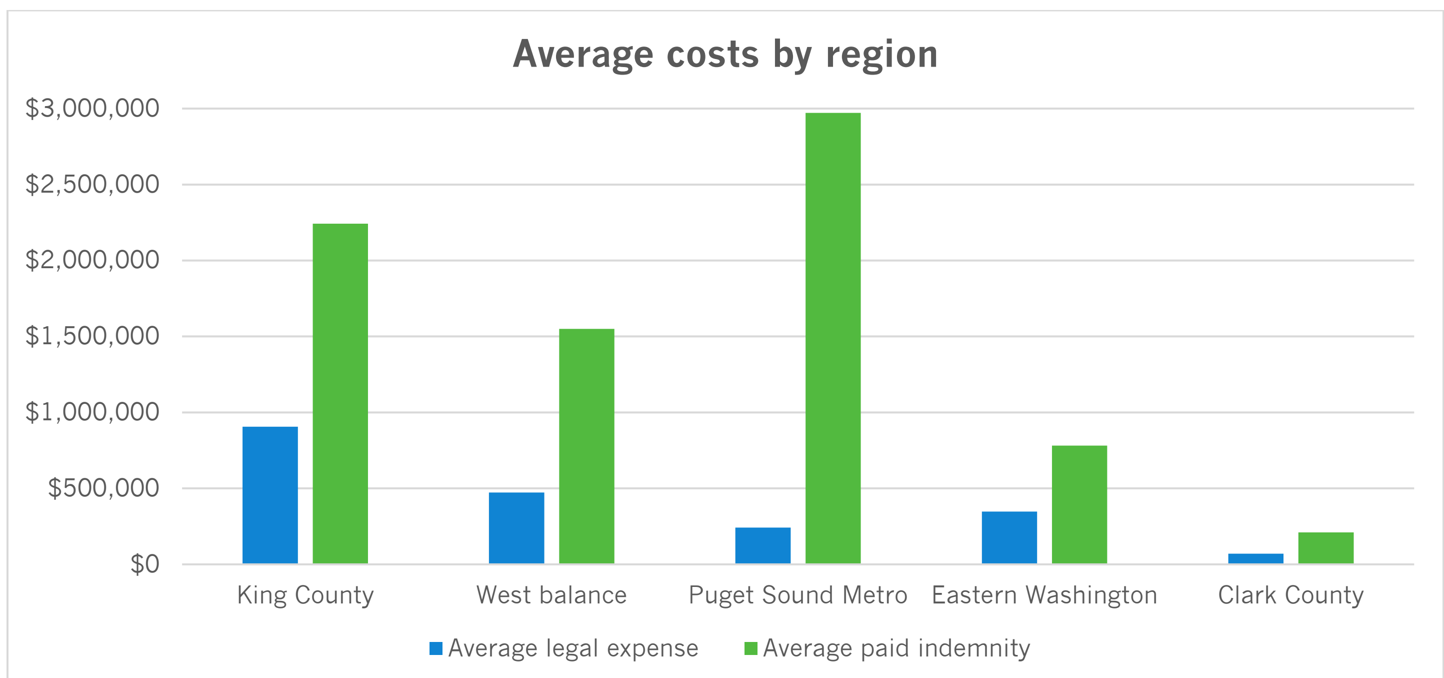


Counties

Attorneys reported settlement data by county where the medical incident occurred. To provide meaningful information regarding differences by location, we divided the state into five regions.[50] [51]

Lawsuit settlement data by region

County/region	Settlements with legal expenses	Total legal expenses	Average legal expense	Settlements with paid indemnity	Total paid indemnity	Average paid indemnity
King County	27	$24,460,728	$905,953	27	$60,544,287	$2,242,381
West balance	17	$8,040,362	$472,962	15	$23,250,000	$1,550,000
Puget Sound Metro	14	$3,381,752	$241,554	13	$38,625,000	$2,971,154
Eastern Washington	9	$3,126,053	$347,339	9	$7,030,000	$781,111
Clark County	8	$558,384	$69,798	6	$1,265,000	$210,833
Total	**75**	**$39,567,279**	**$527,564**	**70**	**$130,714,287**	**$1,867,347**



[50] Under RCW 48.140.060 and RCW 42.56.400(10), some counties are grouped together to maintain confidentiality.
[51] **Puget Sound Metro** includes Kitsap, Pierce and Thurston counties. **West balance** includes Clallam, Cowlitz, Grays Harbor, Island, Jefferson, Klickitat, Lewis, Mason, Pacific, San Juan, Skagit, Skamania, Snohomish, Wahkiakum and Whatcom counties. **Eastern Washington** includes Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman and Yakima counties.

Report limitations

Analysis based on historical closed claim data has multiple limitations:

1. There is a natural mismatch in timing between premiums and losses used to calculate loss ratios and profitability ratios for commercial insurers. Premiums used for loss ratios are earned during the calendar year, but the amounts booked as incurred losses during the same calendar year are from claims from various accident years. As a result, most losses do not correspond to the same policies that the premium comes from.
2. Claims are reported based on the year in which they reach final resolution. Some arose from recent medical incidents, but many arose from incidents that occurred several years prior.
3. This report contains claims that closed during a limited period.
4. The OIC cannot use data in this report to evaluate past or current medical professional liability insurance rates. Insurers develop medical malpractice rates using an analysis of open and closed claims, and develop rates based on an estimate of expected future claim costs and expenses.
5. In producing this report, the OIC relied upon data submitted by insurers, self-insurers and attorneys. Data may contain anomalies. The OIC audits data and adopted administrative rules that contain data definitions and reporting instructions, but the accuracy of the report still depends largely on the accuracy of the data reported by others. People who report data may interpret data fields differently or make errors.
6. The OIC did not adjust the data for economic differences occurring during the report period, such as inflation and the cost of medical care.
7. Insurers and self-insurers do not report policy limits, so the report does not analyze the data by type of policy, whether coverage is primary or excess, limits of coverage, or size of deductibles or retentions to determine if coverage limits affect the frequency or severity of claims.
8. Insurers and self-insurers reported data separately for each defendant. This reporting method may overstate the frequency of "incidents" and understate the severity of an "incident," but it reduces inconsistencies and inaccuracies by limiting the amount of incomplete reporting.
9. This report analyzes only closed claims. Any claims that are still open, such as claims that are in settlement negotiations or on trial, are not included in this study. The analysis of closed claim information is valuable. However, open claims information may be more indicative of the current claims environment. For example, the impact of recent legislation or judicial decisions will not be reflected in a closed claim database.
10. Although insurers and self-insurers report data only after the claim has been closed, they occasionally re-open claims that were previously closed. Amounts reported may not be the true, ultimate amounts.

Appendices

Appendix A: Profitability

Profitability data for Physicians Insurance A Mutual Company

Year	Net premium written	Net premium earned	U/W expense ratio	Loss & LAE ratio	Divid. ratio	Comb. ratio	Net invest. income	Op. ratio
2014	76,701,101	75,121,138	16.6%	82.1%	6.7%	105.5%	19.8%	85.7%
2015	76,301,471	71,271,073	18.9%	84.4%	7.0%	110.3%	20.8%	89.5%
2016	78,240,313	78,437,989	20.9%	82.2%	6.4%	109.5%	18.8%	90.6%
2017	81,130,272	79,275,075	19.9%	81.0%	6.3%	107.3%	18.5%	88.7%
2018	94,256,910	93,442,936	20.5%	81.0%	5.4%	106.9%	16.1%	90.8%
2019	110,476,767	104,381,324	20.4%	88.5%	4.8%	113.7%	17.6%	96.0%
2020	115,217,227	109,632,385	26.4%	85.9%	4.6%	116.8%	11.3%	105.5%
2021	109,485,335	117,147,815	22.5%	92.1%	0.0%	114.7%	9.6%	105.1%
2022	118,999,420	115,148,844	19.5%	85.6%	0.0%	105.1%	9.9%	95.2%
2023	134,623,064	123,797,768	18.4%	95.6%	0.0%	113.9%	11.4%	102.5%
Total	**995,431,880**	**967,656,347**	**20.5%**	**86.6%**	**3.6%**	**110.7%**	**14.6%**	**96.1%**
Five-year period-to-period results								
2014-18	406,630,067	397,548,211	19.4%	82.1%	6.3%	107.8%	18.7%	89.2%
2019-23	588,801,813	570,108,136	21.3%	89.7%	1.8%	112.8%	11.8%	100.9%

Profitability data for The Doctors Company, an Interinsurance Exchange

Year	Net premium written	Net premium earned	U/W expense ratio	Loss & LAE ratio	Divid. ratio	Comb. ratio	Net invest. income	Op. ratio
2014	644,037,543	659,903,069	23.1%	78.3%	2.8%	104.2%	1.4%	102.7%
2015	622,861,093	628,266,492	24.2%	74.5%	3.8%	102.5%	4.4%	98.1%
2016	602,359,134	610,408,597	25.0%	77.7%	4.6%	107.3%	5.7%	101.6%
2017	595,891,924	600,702,260	24.9%	77.0%	3.8%	105.7%	12.0%	93.6%
2018	620,395,036	620,335,603	25.3%	85.7%	2.2%	113.2%	17.5%	95.7%
2019	627,555,678	623,780,051	28.2%	81.0%	1.4%	110.7%	11.3%	99.3%
2020	654,774,790	652,428,039	28.2%	73.6%	0.1%	101.9%	7.8%	94.1%
2021	782,820,035	749,761,353	28.5%	68.2%	1.1%	97.8%	7.9%	89.9%
2022	815,105,449	813,002,941	26.6%	71.0%	0.9%	98.5%	7.6%	91.0%
2023	864,181,824	855,295,789	26.3%	68.7%	1.0%	96.0%	11.2%	84.8%
Total	**6,829,982,506**	**6,813,884,194**	**26.1%**	**75.1%**	**2.0%**	**103.2%**	**8.7%**	**94.6%**
Five-year period-to-period results								
2014-18	3,085,544,730	3,119,616,021	24.5%	78.6%	3.4%	106.5%	8.1%	98.4%
2019-23	3,744,437,776	3,083,493,003	27.5%	72.1%	0.9%	100.4%	9.1%	91.3%

Profitability data for The Medical Protective Company[52]

Year	Net premium written	Net premium earned	U/W expense ratio	Loss & LAE ratio	Divid. ratio	Comb. ratio	Net invest. income	Op. ratio
2014	-680,001,929	-575,282,426	-3.1%	114.5%	0.0%	111.5%	-17.0%	128.5%
2015	226,451,495	214,665,128	23.7%	59.5%	0.0%	83.2%	46.1%	37.2%
2016	255,837,377	228,980,322	23.7%	65.0%	0.0%	88.8%	39.5%	49.3%
2017	239,978,122	251,862,659	26.0%	58.0%	0.0%	84.0%	37.2%	46.7%
2018	260,421,768	260,308,096	24.0%	64.2%	0.0%	88.1%	40.2%	47.9%
2019	288,139,624	274,597,913	22.1%	72.5%	0.0%	94.6%	45.7%	48.8%
2020	347,993,367	349,375,371	19.9%	76.9%	0.0%	96.8%	35.9%	60.9%
2021	355,953,566	339,815,409	19.4%	71.1%	0.0%	90.5%	33.2%	57.3%
2022	392,160,910	359,055,198	19.4%	68.0%	0.0%	87.4%	31.2%	56.1%
2023	368,851,131	368,571,581	21.8%	65.2%	0.0%	87.0%	33.9%	53.1%
Total	**2,055,785,431**	**2,071,949,251**	**30.1%**	**54.3%**	**0.0%**	**84.3%**	**52.4%**	**31.9%**
Five-year period-to-period results								
2014-18	302,686,833	380,533,779	85.8%	-18.2%	0.0%	67.7%	127.6%	-59.9%
2019-23	1,753,098,598	1,230,414,118	20.4%	70.6%	0.0%	91.0%	35.5%	55.5%

[52] Net data for 2014 and 2015 for Medical Protective were distorted by loss portfolio transfer agreements between Medical Protective and its affiliates.

Appendix B: Reserve development

Incurred net losses and cost containment expenses for Physicians Insurance A Mutual Company ($000 omitted)

Year in which losses occurred	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Prior	114,549	92,735	80,833	69,582	68,447	65,852	65,815	66,262	66,201	66,092
2014	65,379	63,625	59,703	55,647	49,941	49,884	48,820	47,795	47,931	47,569
2015		67,830	64,651	65,694	62,944	64,173	62,406	61,017	60,983	60,421
2016			66,696	62,982	53,921	52,100	53,946	54,874	53,523	53,312
2017				66,331	68,246	69,232	69,300	70,884	71,487	72,459
2018					72,676	71,001	78,728	81,882	88,760	91,712
2019						77,955	70,307	65,942	62,742	61,945
2020							73,508	83,473	86,028	87,603
2021								77,667	73,949	80,465
2022									73,615	73,391
2023										83,933

Cumulative development for Physicians Insurance A Mutual Company ($000 omitted)

Year in which losses occurred	One-Year Dev.	Two-Year Dev.	Total Dev.
Prior	-109	-170	-48,457
2014	-362	-226	-17,810
2015	-562	-596	-7,409
2016	-211	-1,562	-13,384
2017	972	1,575	6,128
2018	2,952	9,830	19,036
2019	-797	-3,997	-16,010
2020	1,575	4,130	14,095
2021	6,516	2,798	2,798
2022	-224		-224
Total	**9,750**	**11,782**	**-61,237**

Losses and defense and cost containment expenses for The Doctors Company, an Interinsurance Exchange ($000 omitted)

Year in which losses occurred	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Prior	797,047	722,487	671,307	613,758	608,703	569,525	531,459	541,182	530,644	511,172
2014	523,776	523,475	523,475	520,327	519,162	425,875	394,734	395,845	394,132	390,890
2015		499,160	499,644	498,925	495,904	483,729	461,959	418,049	414,999	407,642
2016			467,527	465,811	467,528	499,157	504,310	496,827	482,741	469,076
2017				466,642	466,886	490,691	490,901	465,749	456,211	449,780
2018					474,260	496,802	503,509	498,148	482,361	448,170
2019						463,018	470,539	471,095	466,350	460,446
2020							456,428	456,422	446,379	431,722
2021								472,809	460,399	460,055
2022									491,782	492,682
2023										548,880

Cumulative development for The Doctors Company, an Interinsurance Exchange ($000 omitted)

Year in which losses occurred	One-Year Dev.	Two-Year Dev.	Total Dev.
Prior	-19,472	-30,010	-285,875
2014	-3,242	-4,955	-132,886
2015	-7,357	-10,407	-91,518
2016	-13,665	-27,751	1,549
2017	-6,431	-15,969	-16,862
2018	-34,191	-49,978	-26,090
2019	-5,904	-10,649	-2,572
2020	-14,657	-24,700	-24,706
2021	-344	-12,754	-12,754
2022	900		900
Total	**-104,363**	**-187,173**	**-590,814**

Losses and defense and cost containment expenses for The Medical Protective Company ($000 omitted)

Year in which losses occurred	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Prior	575,640	512,143	462,963	404,019	363,342	344,486	343,635	335,079	334,059	329,911
2014	174,469	177,627	172,179	162,275	153,700	140,992	134,612	128,159	126,884	122,023
2015		186,030	183,767	175,535	168,667	160,859	152,707	142,509	132,941	127,703
2016			185,285	184,199	180,654	175,884	175,177	166,166	156,409	150,896
2017				187,661	185,686	182,851	186,928	180,223	171,476	163,714
2018					193,274	193,409	197,958	193,708	184,621	183,508
2019						199,180	200,850	199,421	191,406	178,307
2020							211,449	213,567	208,908	199,077
2021								223,240	222,550	213,784
2022									222,115	220,412
2023										224,547

Cumulative development for The Medical Protective Company ($000 omitted)

Year in which losses occurred	One-Year Dev.	Two-Year Dev.	Total Dev.
Prior	-4,148	-5,168	-245,729
2014	-4,861	-6,136	-52,446
2015	-5,238	-14,806	-58,327
2016	-5,513	-15,270	-34,389
2017	-7,762	-16,509	-23,947
2018	-1,113	-10,200	-9,766
2019	-13,099	-21,114	-20,873
2020	-9,831	-14,490	-12,372
2021	-8,766	-9,456	-9,456
2022	-1,703		-1,703
Total	**-62,034**	**-113,149**	**-469,008**

Appendix C: Rate filing information

Rate changes approved in Washington since January 1, 2023

Company	Description	Approved Change	Filed Loss & LAE Trend	Effective Date
ProAssurance Ins. Co. of America	Podiatrists	2.8%	3.0%	9/1/2024
Fortress Insurance Co.	Dentists	3.6%	5.0%	9/1/2024
Insurance Services Office Inc.	Hospitals, Physicians, Surgeons	3.7%	4.5%	9/1/2024
American Cas. Co. of Reading, PA	Dentists	8.8%	5.0%	8/1/2024
ProSelect Ins. Co.	Physicians, Surgeons	5.7%	2.1%	6/1/2024
Insurance Services Office Inc.	Physicians, Surgeons, Dentists	-16.0%	-3.0%	5/1/2024
Medical Protective Co.	Dentists	-1.6%		4/1/2024
Pharmacists Mutual Ins. Co.	Pharmacists	6.2%	9.0%	3/1/2024
ProSelect Ins. Co.	Dentists	25.8%	5.0%	3/1/2024
ProSelect Ins. Co.	Phys. Assist., Nurse Practitioners	29.0%	5.0%	3/1/2024
American Cas. Co. of Reading, PA	Nurse Practitioners	5.8%	6.0%	12/1/2023
Medical Protective Co.	Chiropractors, Optometry, Podiatry	15.0%	3.6%	11/1/2023
Medical Protective Co.	Nurse Practitioners	8.7%	3.4%	10/1/2023
Medical Protective Co.	Physician Assistants	2.4%	3.2%	10/1/2023
Fortress Ins. Co.	Dentists	7.7%	5.0%	8/1/2023
Liberty Ins. Underwriters, Inc.	Optometrists	15.0%	4.0%	8/1/2023
Allied World Ins. Co.	Nurse Practitioners	New Prog.	6.1%	7/14/2023
American Cas. Co. of Reading, PA	Dentists	15.3%	4.5%	7/1/2023
ProSelect Ins. Co.	Physicians, Surgeons	9.0%	2.2%	3/1/2023
Doctors Co. An Interins. Exchange	Physicians, Surgeons, Ancillary	3.0%	2.0%	1/16/2023
Midwifery/Birthing Ctr. Mal. Ins. JUA	Midwives and Birthing Centers	10.0%	2.0%	1/1/2023

Appendix D: 2022 NAIC profitability of medical professional liability insurance

Profitability data by state (ratios: percent of direct premiums earned)

State	Direct premiums earned (000s)	Incurred losses and LAE	U/W expense	Divid.	U/W profit	Invest gain on ins. trans.	Tax on ins. trans.	Profit on ins. trans.
Alabama	$165,993	110%	19%	1%	-29%	12%	-4%	-13%
Alaska	$24,610	11%	21%	5%	64%	1%	14%	51%
Arizona	$234,074	75%	21%	7%	-4%	12%	1%	7%
Arkansas	$79,595	79%	23%	1%	-4%	11%	1%	7%
California	$950,150	49%	23%	1%	28%	12%	8%	32%
Colorado	$188,688	58%	21%	7%	14%	10%	5%	19%
Connecticut	$251,023	115%	19%	0%	-34%	15%	-5%	-14%
Delaware	$38,604	153%	24%	0%	-77%	13%	-14%	-50%
Dist. of Columbia	$33,157	36%	27%	0%	37%	12%	10%	39%
Florida	$879,598	61%	23%	1%	15%	11%	5%	21%
Georgia	$386,945	89%	23%	2%	-13%	15%	0%	2%
Hawaii	$38,804	107%	21%	5%	-33%	12%	-5%	-16%
Idaho	$40,659	65%	24%	2%	8%	13%	4%	17%
Illinois	$534,607	66%	23%	0%	11%	17%	5%	23%
Indiana	$157,338	80%	19%	0%	1%	15%	3%	13%
Iowa	$77,292	108%	22%	0%	-31%	15%	-4%	-12%
Kansas	$95,894	74%	23%	1%	3%	13%	3%	13%
Kentucky	$133,320	79%	24%	1%	-3%	16%	2%	10%
Louisiana	$115,472	48%	23%	0%	29%	12%	8%	33%
Maine	$52,469	58%	18%	11%	13%	13%	5%	21%
Maryland	$363,984	62%	20%	7%	11%	10%	4%	17%
Massachusetts	$356,429	75%	19%	2%	4%	18%	4%	19%
Michigan	$250,007	81%	22%	0%	-3%	12%	2%	8%
Minnesota	$101,059	70%	23%	0%	7%	10%	3%	14%
Mississippi	$58,893	62%	22%	1%	15%	12%	5%	21%
Missouri	$195,975	91%	20%	8%	-19%	12%	-2%	-6%
Montana	$40,962	59%	25%	0%	15%	10%	5%	21%
Nebraska	$47,197	81%	24%	0%	-5%	15%	2%	9%

Profitability data by state (ratios: percent of direct premiums earned)

State	Direct premiums earned (000s)	Incurred losses and LAE	U/W expense	Divid.	U/W profit	Invest gain on ins. trans.	Tax on ins. trans.	Profit on ins. trans.
Nevada	$98,351	52%	25%	0%	23%	11%	7%	27%
New Hampshire	$56,749	106%	24%	2%	-31%	17%	-4%	-11%
New Jersey	$516,627	79%	23%	0%	-1%	18%	3%	14%
New Mexico	$70,498	196%	24%	0%	-121%	18%	-23%	-81%
New York	$1,761,481	96%	19%	0%	-15%	24%	1%	9%
North Carolina	$194,275	54%	22%	1%	23%	12%	7%	28%
North Dakota	$14,106	70%	25%	2%	4%	10%	2%	11%
Ohio	$263,155	76%	23%	1%	0%	14%	2%	12%
Oklahoma	$116,045	77%	23%	0%	1%	13%	2%	12%
Oregon	$113,641	118%	21%	0%	-40%	12%	-6%	-21%
Pennsylvania	$876,575	95%	17%	0%	-12%	15%	0%	3%
Rhode Island	$37,314	57%	23%	0%	20%	23%	8%	35%
South Carolina	$90,536	88%	25%	1%	-14%	17%	0%	3%
South Dakota	$17,644	94%	25%	0%	-18%	13%	-2%	-4%
Tennessee	$258,809	99%	19%	2%	-21%	18%	-2%	-2%
Texas	$476,269	57%	24%	0%	19%	10%	6%	24%
Utah	$74,764	81%	23%	2%	-6%	13%	1%	6%
Vermont	$20,657	139%	37%	6%	-82%	16%	-15%	-52%
Virginia	$230,864	78%	24%	2%	-3%	11%	1%	7%
Washington	**$224,149**	**87%**	**23%**	**0%**	**-10%**	**11%**	**0%**	**1%**
West Virginia	$68,455	77%	24%	0%	-1%	12%	2%	9%
Wisconsin	$85,263	86%	20%	0%	-7%	13%	1%	6%
Wyoming	$19,283	36%	23%	0%	41%	13%	11%	43%
Guam	$1,054	-115%	26%	0%	189%	9%	41%	157%
Puerto Rico	$72,925	61%	24%	0%	15%	11%	5%	21%
US Virgin Islands	$668	150%	32%	0%	-82%	8%	-16%	-58%
N. Mariana Islands	$26	-27%	25%	0%	102%	10%	23%	88%
Countrywide	**$11,652,985**	**79%**	**21%**	**1%**	**-1%**	**15%**	**2%**	**12%**

Profitability data by state (ratios: percent of net worth)

State	Direct premiums earned (000s)	Earned prem. to net worth	Inv. gain on net worth	Tax on inv.gain on net worth	Return on net worth
Alabama	$165,993	44%	3%	1%	-3%
Alaska	$24,610	45%	NR	NR	23%
Arizona	$234,074	41%	3%	1%	6%
Arkansas	$79,595	46%	3%	1%	6%
California	$950,150	44%	3%	1%	17%
Colorado	$188,688	50%	3%	1%	13%
Connecticut	$251,023	37%	3%	1%	-3%
Delaware	$38,604	39%	3%	1%	-17%
Dist. of Columbia	$33,157	43%	3%	1%	20%
Florida	$879,598	48%	3%	1%	13%
Georgia	$386,945	36%	3%	1%	4%
Hawaii	$38,804	43%	3%	1%	-4%
Idaho	$40,659	42%	3%	1%	10%
Illinois	$534,607	32%	3%	1%	10%
Indiana	$157,338	36%	3%	1%	8%
Iowa	$77,292	37%	3%	1%	-2%
Kansas	$95,894	42%	3%	1%	8%
Kentucky	$133,320	35%	3%	1%	7%
Louisiana	$115,472	44%	3%	1%	17%
Maine	$52,469	41%	3%	1%	11%
Maryland	$363,984	52%	3%	1%	12%
Massachusetts	$356,429	32%	3%	1%	9%
Michigan	$250,007	42%	3%	1%	6%
Minnesota	$101,059	50%	3%	1%	10%
Mississippi	$58,893	45%	3%	1%	13%
Missouri	$195,975	44%	3%	1%	0%
Montana	$40,962	50%	3%	1%	13%
Nebraska	$47,197	36%	3%	1%	6%

Profitability data by state (ratios: percent of net worth)

State	Direct premiums earned (000s)	Earned prem. to net worth	Inv. gain on net worth	Tax on inv.gain on net worth	Return on net worth
Nevada	$98,351	46%	3%	1%	15%
New Hampshire	$56,749	33%	3%	1%	-1%
New Jersey	$516,627	31%	3%	1%	7%
New Mexico	$70,498	32%	3%	1%	-23%
New York	$1,761,481	25%	3%	1%	5%
North Carolina	$194,275	44%	3%	1%	15%
North Dakota	$14,106	50%	3%	1%	8%
Ohio	$263,155	38%	3%	1%	7%
Oklahoma	$116,045	40%	3%	1%	7%
Oregon	$113,641	44%	3%	1%	-7%
Pennsylvania	$876,575	38%	3%	1%	4%
Rhode Island	$37,314	26%	3%	1%	12%
South Carolina	$90,536	33%	3%	1%	4%
South Dakota	$17,644	42%	3%	1%	1%
Tennessee	$258,809	32%	3%	1%	2%
Texas	$476,269	48%	3%	1%	14%
Utah	$74,764	42%	3%	1%	5%
Vermont	$20,657	35%	3%	1%	-15%
Virginia	$230,864	46%	3%	1%	6%
Washington	**$224,149**	**48%**	**3%**	**1%**	**3%**
West Virginia	$68,455	43%	3%	1%	7%
Wisconsin	$85,263	41%	3%	1%	5%
Wyoming	$19,283	42%	3%	1%	21%
Guam	$1,054	52%	3%	1%	85%
Puerto Rico	$72,925	46%	3%	1%	13%
US Virgin Islands	$668	56%	3%	1%	-30%
N. Mariana Islands	$26	48%	3%	1%	45%
Countrywide	**$11,652,985**	**37%**	**3%**	**1%**	**7%**