WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting
May 26-27, 2022
1st Revised

2022 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 13-14	Virtual Meeting	Regular Meeting
March 3-4	Virtual Meeting	Regular Meeting
April 14-15	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
May 26-27	Virtual Meeting	Regular Meeting
July 14-15	Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
August 25-26	Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting
October 6	Virtual Meeting	Case Reviews
November 17-18	Hybrid – Virtual Options Available Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512	Regular Meeting

Association Meetings		
Association	**Dates**	**Location**
Federation of State Medical Boards (FSMB) Annual Conference	April 28-30, 2022	New Orleans, LA
WAPA Spring Conference	April 22-25, 2022	Seattle, WA
WSMA Annual Meeting	October 1-2, 2022	Spokane, WA
WAPA Fall Conference	October 27-29, 2022	Cle Elum, WA

Other Meetings		
Program	**Dates**	**Location**
Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium	January 5, 2022	Virtual Event
CLEAR Annual Conference	September 14-17, 2022	Louisville, KY
FSMB Board Attorneys Workshop	November 3-4, 2022	TBD

Approved 11/15/19

Updated: May 10, 2022

2023 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 12-13	TBD	Regular Meeting
March 2-3	TBD	Regular Meeting
April 13-14	TBD	Regular Meeting
May 25-26	TBD	Regular Meeting
July 13-14	TBD	Regular Meeting
August 24-25	TBD	Regular Meeting
October 5-7	TBD	Educational Conference
November 16-17	TBD	Regular Meeting

Association Meetings		
Association	**Dates**	**Location**
Federation of State Medical Boards (FSMB) Annual Conference	TBA	TBA
WAPA Spring Conference	TBA	TBA
WSMA Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA	TBA

Other Meetings		
Program	**Dates**	**Location**
Council on Licensure, Enforcement & Regulation (CLEAR) Winter Symposium	TBA	TBA
CLEAR Annual Conference	TBA	TBA
FSMB Board Attorneys Workshop	TBA	TBA

2024 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Dates	Location	Meeting Type
January 11-12	TBD	Regular Meeting
March 7-8	TBD	Regular Meeting
April 18-19	TBD	Regular Meeting
May 23-24	TBD	Regular Meeting
July 11-12	TBD	Regular Meeting
August 22-23	TBD	Regular Meeting
October 3-5	TBD	Educational Conference
November 21-22	TBD	Regular Meeting

FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Hearing	Respondent	Specialty	Case No.	Counsel	AAG	Staff Atty	PANEL	Presiding Officer	Location	Panel Composition (as of 5/17/22)
17-May										
2022 June		*NO COMMISSION MEETING THIS MONTH*								
NO HEARINGS SCHEDULED THIS MONTH										
2022 July		*Commission meeting 7/14/2022*								
7-8 Jul	KIMURA, Irene K., MD	BC - Family Medicine	M2020-930	Garth Dano	Brewer	Elder	A	Kavanaugh	TBD	
22-Jul	OSTEN, Thomas J., MD	BC - Family Medicine	M2021-652	Pro Se	Bahm	Balatbat	B	Herington	TBD	
2022 August		*Commission meeting 8/25/2022*								
3-5 Aug	WRIGHT, Jonathan V., MD	Non-BC - Family Medicine	M2019-236	James B. Meade, II	Brewer	Wright	A	Kavanaugh	TBD	
8-11 Aug	MILLER, Scott C., PA-C	Phys. Asst.	M2021-272	Klaus O. Snyder	Brewer	Karinen	A	Kuntz	TBD	
2022 September		*NO COMMISSION MEETING THIS MONTH*								
8-9 Sept	EDGERLY, Richard D., MD	Non-BC - Family Medicine	M2022-46	John C. Versnell, III	Bahm	Farrell	A	Herington	TBD	
15-16 Sept	SHARMA, Bhanoo, MD	Non-BC - Cosmetic Surgery	M2021-756	Pro Se	Little	Elder	B	Herington	TBD	
19-22 Sept	TRAN, Hoan-Vu Phan, MD	BC - Neurological Surgery	M2020-65	David J. Corey	Brewer/Little	Balatbat	A	Kavanaugh	TBD	
2022 October		*Commission meeting 10/6/2022*								
11-12 Oct	GREENMAN, Christopher G., MD	BC - Internal Medicine & Cardiovascular Disease	M2021-909	Daniel R. Kyler	Defreyn	Elder	B	Kuntz	TBD	
2022 November		*Commission meeting 11/17/2022*								
NO HEARINGS SCHEDULED THIS MONTH										
2022 December		*NO COMMISSION MEETING THIS MONTH*								
NO HEARINGS SCHEDULED THIS MONTH										
2023 January		*Commission meeting 1/12/2023*								
NO HEARINGS SCHEDULED THIS MONTH										
2023 February		*NO COMMISSION MEETING THIS MONTH*								
6-Feb	THOMAS, Paul, MD	Non-BC Pediatrics	M2021-378	Troy Bundy	Bahm	Balatbat	A	Kavanaugh	TBD	

Commission Meeting Agenda
May 26-27, 2022

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for these meetings. Virtual public meetings, without a physical meeting space, will be held instead. The access links can be found below.

Thursday – May 26, 2022

Closed Sessions

8:00 am Case Reviews – Panel A
8:00 am Case Reviews – Panel B

Lunch & Learn: RCM Training

Please **register** for this session at:
https://attendee.gotowebinar.com/register/6205297704151489294
After registering, you will receive an email containing a link that is unique to you to join the webinar.

12:30 pm to 1:30 pm
DynaMed
Patricia Devine, MLS
Director, Community Outreach & HEALWA, University of Washington

1:30 pm Case Reviews – Panel A
1:30 pm Case Reviews – Panel B

Open Session

4:00 pm **Policy Committee Meeting**

Please **register** for this session at:
https://attendee.gotowebinar.com/register/3697552474240802829
After registering, you will receive an email containing a link that is unique to you to join the webinar.

Agenda Items	Presented By:	Page(s)
Proposed Policy: Informed Consent *Presentation, discussion, and possible revisions to proposed policy.*	Mike Farrell	39-45
Guidance Document: Medical Professionalism *Review, discussion, and possible revisions to guidance document.*	Mike Farrell	46-50
Guidance Document: Practitioner Health *Review, discussion, and possible revisions to guidance document.*	Mike Farrell	51-53
Guidance Document: Ownership of Clinics by Physician Assistants *Routine review, discussion, and possible revisions to guidance document.*	Mike Farrell	54-55

Friday – May 27, 2022

Open Session

8:00 am –9:30 am **Business Meeting**

Please **register** for this session at:
https://attendee.gotowebinar.com/rt/2466603027457431312
After registering, you will receive an email containing a link that is unique to you to join the webinar.

1.0 Chair Calls the Meeting to Order

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2.0 Housekeeping

3.0 Chair Report

4.0 Consent Agenda

Items listed under the Consent Agenda are considered routine agency matters and will be 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 Minutes – Approval of the April 15, 2022 Business Meeting minutes. — Pages 9-13

4.2 Agenda – Approval of the May 27, 2022 Business Meeting agenda. — Pages 6-8

5.0 Old Business

5.1 **Committee/Workgroup Reports** — Update

The Chair will call for reports from the Commission's committees and workgroups. Written reports begin on page 14.

See page 15 for a list of committees and workgroups.

5.2 **Rulemaking Activities** — Update

Rules Progress Report provided on page 17.

5.3 **Bylaws** — Review & Discussion

Review of proposed changes to WMC Bylaws. Discussion of additions and revisions. Final revised document to be presented at the July 15, 2022 Business meeting for possible adoption. — Pages 18-38

6.0 Public Comment

The public will have an opportunity to provide comments. ***If you would like to comment during this time, please limit your comments to two minutes. Please identify yourself and who you represent, if applicable, when the Chair opens the floor for public comment.***

7.0 Policy Committee Report

Dr. Karen Domino, Chair, will report on items discussed at the Policy Committee meeting held on May 26, 2022. See the Policy Committee agenda on page 1 of this agenda for the list of items to be presented. — Report/Action Begins on page 39

8.0 Member Reports

The Chair will call for reports from Commission members.

9.0 Staff Member Reports — Pages 56-63

The Chair will call for further reports from staff.

10.0 AAG Report

Heather Carter, AAG, may provide a report.

11.0 Leadership Elections

11.1 Restatement of Nominating Committee Report — Report

11.2 Nominations from the floor

11.3 Election of Leadership — Action

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12.0 Installation of Medical Commission Chair

12.1 Remarks by outgoing chair

12.2 Installation of Medical Commission Chair by outgoing chair

12.3 Remarks by incoming Chair

13.0 Adjournment of Business Meeting

Open Sessions

9:45 am	Personal Appearances – Panel A Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/792815789	Page 64
9:45 am	Personal Appearances – Panel B Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/345525861	Page 65

Closed Session

Noon to 1:00 pm Lunch Break

Open Sessions

1:15 pm	Personal Appearances – Panel A Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/792815789	Page 64
1:15 pm	Personal Appearances – Panel B Please join this meeting from your computer, tablet or smartphone: https://global.gotomeeting.com/join/345525861	Page 65

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 (Commission) meetings. This agenda is subject to change. The Policy Committee Meeting will begin at 4:00 pm on May 26, 2022 until all agenda items are complete. The Commission will take public comment at the Policy Committee Meeting. The Business Meeting will begin at 8:00 am on May 27, 2022 until all agenda items are complete. The Commission 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 civil.rights@doh.wa.gov.

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Business Meeting Minutes
April 15, 2022

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Capital Event Center (ESD 113), 6005 Tyee Drive SW, Tumwater, WA 98512
Virtual Meeting via GoToWebinar – Link to recording: https://youtu.be/fupziR8DfaE

Commission Members

James E. Anderson, PA-C – Virtual
Michael Bailey, Public Member – Virtual
Christine Blake, Public Member – Virtual
Toni Borlas, Public Member
Charlie Browne, MD – Virtual
Jimmy Chung, MD, 2nd Vice Chair
Diana Currie, MD
Arlene Dorrough, PA-C
Anjali D'Souza, MD – Absent
Karen Domino, MD
Harlan Gallinger, MD – Absent
April Jaeger, MD – Virtual
Sarah Lyle, MD
John Maldon, Public Member, Chair
Terry Murphy, MD
Alden Roberts, MD
Scott Rodgers, JD, Public Member – Absent
Robert Small, MD – Virtual
Claire Trescott, MD, 1st Vice Chair
Richard Wohns, MD
Yanling Yu, PhD, Public Member – Virtual

WMC Staff

Christine Babb, Investigator
Jennifer Batey, Legal Support Staff Manager
Anjali Bhatt, Bus. Practices & Efficiency Manager
Amelia Boyd, Program Manager
Sarah Chenvert, Performance Manager
Melanie de Leon, Executive Director
Joel DeFazio, Staff Attorney
Anthony Elders, Compliance Officer
Michael Farrell, Policy Development Manager
Gina Fino, MD, Investigator
Rick Glein, Director of Legal Services
George Heye, MD, Medical Consultant
Mike Hively, Director of Operations & Informatics
Jenelle Houser, Legal Assistant
Ken Imes, Information Liaison
Kyle Karinen, Staff Attorney
Chris Knight, Forms & Records Analyst
Pam Kohlmeier, MD, JD, Attorney
Micah Matthews, Deputy Executive Director
Joe Mihelich, Health Services Consultant
Lynne Miller, Paralegal
Freda Pace, Director of Investigations
Chris Waterman, Case Manager
Trisha Wolf, Staff Attorney
Gordon Wright, Staff Attorney
Mahlet Zeru, Equity & Social Justice Manager

Others in Attendance

Heather Cantrell, Policy Analyst, Department of Health (DOH)
Heather Carter, Assistant Attorney General
Mary Curtis, MD, Pro Tem Commissioner
Renee Fullerton, Executive Director, Board of Osteopathic Medicine and Surgery
Susan Gragg, Program Manager, DOH
Davis Hylkema, Assistant Program Manager, DOH
Katerina LaMarche, Washington State Medical Association
Gregory Terman, MD, Pro Tem Commissioner

1.0 Call to Order

John Maldon, Public Member, Chair, called the meeting of the Washington Medical Commission (Commission) to order at 8:00 a.m. on April 15, 2022.

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2.0 Housekeeping

Amelia Boyd, Program Manager, gave an overview of how the meeting would proceed.

3.0 Chair Report

Mr. Maldon gave an overview of conflict of interest and how it can affect Commissioners. He asked Heather Carter, Assistant Attorney General to provide more information on this subject.

4.0 Consent Agenda

The Consent Agenda contained the following items for approval:

4.1 Minutes from the March 4, 2022 Business Meeting.

4.2 Revised agenda for April 15, 2022 – addition of Discrimination in Healthcare Policy to the Policy Committee agenda.

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

5.0 New Business

5.1 Outstanding Performance Awards

Melanie de Leon, Executive Director announced the outstanding performance awards for 2020 as follows:

- Administrative Staff – Mike Hively, Director of Operations & Informatics
- Investigative Staff – Christine Babb, Investigator
- Legal Staff – Jenelle Houser, Legal Assistant

Ms. de Leon then presented the staff outstanding performance awards for 2021 as follows:

- Administrative Staff – Anjali Bhatt, Business Performance & Efficiency Manager
- Investigative Staff – Chris Waterman, Case Manager
- Legal Staff – Trisha Wolf, Staff Attorney

5.2 Meeting Dates for 2023

Ms. Boyd presented proposed meeting dates for July 2023.

> ***Motion:*** The Chair entertained a motion to approve the proposed July 2023 meeting dates. The motion was approved unanimously.

6.0 Old Business

6.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet.

Mr. Maldon proposed disbanding the following:

1. Osteopathic Manipulative Therapy Workgroup – Micah Matthews, Deputy Executive Director, gave background information on this workgroup.

   > ***Motion:*** The Chair entertained a motion to disband the workgroup. The motion was approved unanimously.

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2. Reduction in Medical Errors Workgroup – Mr. Maldon provided some background on this workgroup. There was a robust discussion where the decision was to defer the disbanding of this workgroup until a later date.

3. Collaborative Drug Treatment Agreement Workgroup – Ms. de Leon explained this workgroup can be disbanded because the WMC has moved to rulemaking on this subject. Ms. Boyd explained there is an open CR-101 (first step in the rulemaking process) on this subject that has been on hold.

   Motion: The Chair entertained a motion to disband the workgroup. The motion was approved unanimously.

4. Commissioner Education Workgroup – Ms. de Leon provided background on this workgroup. She explained the workgroup fulfilled their mission by creating a list of educational subjects for Lunch & Learn sessions to be held for the next couple of years. Because of this, the workgroup does not have a need to meet and can be disbanded and possibly reformed in the future.

   Motion: The Chair entertained a motion disband the workgroup. The motion was approved unanimously.

6.2 Nominating Committee

Alden Roberts, MD, announced the nominees for leadership:

Chair – Jimmy Chung, MD
1st Vice Chair – Karen Domino, MD
2nd Vice Chair – Terry Murphy, MD

The vote for leadership will be held at the May 27, 2022, meeting.

6.3 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet.

In addition to the written report, Ms. Boyd explained that the rules hearing scheduled for April 13, 2022 regarding the Opioid Prescribing Patient Exemptions had to be rescheduled as she was unable to establish a quorum. The hearing will now be held on Friday, May 27, 2022, at 4 pm. Ms. Boyd asked that Commissioners who are able to participate in the hearing to please email her.

6.4 Lists & Labels Request

The following lists and labels requests were discussed for possible approval or denial. Approval or denial of these requests is based on whether the entity meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

- Agility COHE SPC – Reconsideration

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

- Frank Madura

  Motion: The Chair entertained a motion to deny the request. The motion was

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seconded and approved unanimously.

7.0 Public Comment

No member of the public was signed up to speak therefore no public comment was given.

8.0 Policy Committee Report

Dr. Karen Domino, Policy Committee Chair, reported on the items discussed at the Policy Committee meeting held on April 14, 2022:

Add-on – Proposed Policy: Discrimination in Health Care

Dr. Domino stated that this document had been approved at the March 4, 2022, meeting to be sent to the DOH Secretary for review. Dr. Domino stated that after that review, there were some revisions and she explained them. Dr. Domino reported the Committee recommended approval of the revised document.

> ***Motion:*** The Chair entertained a motion to approve the proposed policy as revised. The motion was approved unanimously.

Proposed Policy: Informed Consent

Dr. Domino stated that this document is the result of the Informed Consent Workgroup's research. She asked that this document be reviewed by all Commissioners and to provide feedback to Mike Farrell, Policy Development Manager.

Guidance Document: Medical Professionalism

Dr. Domino stated that this document is being presented as part of the WMC's established four-year review schedule. She asked that this document be reviewed by all Commissioners and to provide feedback to Mike Farrell, Policy Development Manager.

Guidance Document: Practitioner Competence

Dr. Domino stated that this document is being presented as part of the WMC's established four-year review schedule. She asked that this document be reviewed by all Commissioners and to provide feedback to Mike Farrell, Policy Development Manager. She stated that the Committee did suggest the name be changed to Practitioner Health.

9.0 Member Reports

There were no Member reports provided.

10.0 Staff Reports

Mr. Matthews pointed out Ms. Boyd's staff report stating we need more applications for our upcoming Member vacancies. He asked that everyone encourage those they may know who would be a good fit as a Public Member to apply.

Mr. Hively introduced Ken Imes as the new Information Liaison.

11.0 AAG Report

Heather Carter, AAG, had nothing to report.

12.0 Adjournment

The Chair called the meeting adjourned at 9:11 am.

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Submitted by

Amelia Boyd, Program Manager

John Maldon, Public Member, Chair
Washington Medical Commission

Approved May 27, 2022

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WASHINGTON Medical Commission
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Committee/Workgroup Reports: May 2022

Reduction of Medical Errors Workgroup – Chair: Dr. Chung
Staff: Mike Farrell

I will arrange a meeting to discuss how to re-engage this workgroup.

Annual Educational Conference Workgroup – Chair: Toni Borlas
Staff: Jimi Bush

It has been decided to hold a virtual learning series in lieu of an in-person conference this year.

I am looking for **speaker suggestions** for the following topics:

1. Infectious disease in the aftermath of COVID
2. How racism creates a systems issue in healthcare.
3. Doctor patient communication.

Summer CME – Addiction Medicine

- June: DEA Update
- July 21: Washington Society for Addiction Medicine - Addressing the ubiquity of the fentanyl-driven "3rd wave" of the opioid crisis.
- August 22:
- Treating co-occurring chronic pain and SUD.
- Treatment of separate SUDs such as alcohol, stimulants, and benzodiazepines.

Fall CME: Lessons for Primary Care

- September 28: Enabling positive practice improvement through data-driven feedback: A model for understanding how data and self-perception lead to practice change

In Planning

- What do patients lie to their doctor about?
- Restorative Justice.

If you have additional speaker suggestions, please let Jimi know.

Healthcare Disparities Workgroup – Chair: Dr. Currie
Staff: Melanie de Leon

Awaiting the final approval of the Discrimination Policy by Office of the Secretary.

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Executive Committee
John Maldon, Public Member, Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Dr. Domino, Policy Committee Chair
Dr. Roberts, Immediate Past Chair
Melanie de Leon
Micah Matthews
Heather Carter, AAG

Policy Committee
Dr. Domino, Chair (B)
Dr. Roberts (B)
Christine Blake, Public Member (B)
Jim Anderson, PA-C (A)
John Maldon, Public Member (B)
Scott Rodgers, Public Member (A)
Dr. Trescott (B)
Heather Carter, AAG
Melanie de Leon
Mike Farrell
Amelia Boyd

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

Legislative Subcommittee
Dr. Roberts, Chair
John Maldon, Public Member
Dr. Terman, Pro Tem Commissioner
Christine Blake, Public Member
Dr. Wohns
Melanie de Leon
Micah Matthews

Panel L
John Maldon, Public Member, Chair
Dr. Browne
Dr. Roberts
Christine Blake, Public Member
Dr. Chung
Arlene Dorrough, PA-C
Dr. Trescott
Dr. Barrett, Medical Consultant
Marisa Courtney, Licensing Supervisor
Rick Glein, Director of Legal Services
Pam Kohlmeier, MD, JD, Staff Attorney
Micah Matthews

Finance Workgroup
Dr. Roberts, Immediate Past Chair, Workgroup Chair
John Maldon, Current Chair
Dr. Trescott, 1st Vice Chair
Dr. Chung, 2nd Vice Chair
Melanie de Leon
Micah Matthews
Jimi Bush

Annual Educational Conference Workgroup
Toni Borlas, Chair
Theresa Schimmels, PA-C
Dr. Domino
Jimi Bush, Organizer

Reduction of Medical Errors Workgroup
Dr. Chung, Chair
John Maldon, Public Member
Dr. Roberts
Dr. Domino
Dr. Jaeger
Christine Blake, Public Member
Scott Rodgers, Public Member
Melanie de Leon
Mike Farrell

Updated: May 12, 2022

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Healthcare Disparities Workgroup
Dr. Currie, Chair
Dr. Browne
Dr. Jaeger
Christine Blake, Public Member
Melanie de Leon

Informed Consent Policy Workgroup
Dr. Roberts
John Maldon, Public Member
Yanling Yu, Public Member
Mike Farrell

Collaborative Drug Therapy Agreements Rulemaking Committee
Dr. Roberts, Chair
Dr. Chung
Dr. Small
John Maldon, Public Member
Tim Lynch, PQAC Commissioner
Teri Ferreira, PQAC Commissioner
Melanie de Leon
Micah Matthews
Kyle Karinen, Staff Attorney
Amelia Boyd
Heather Carter, AAG
Christie Strouse, Deputy Director, PQAC
Lindsay Trant, DOH Rules Coordinator

Opioid Prescribing – Patient Exemptions Rulemaking Committee
Dr. Roberts, Chair
Dr. Small
Dr. Terman, Pro Tem Commissioner
James Anderson, PA-C
Melanie de Leon
Mike Farrell
Amelia Boyd
Heather Carter, AAG

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

Updated: May 12, 2022

WMC Rules Progress Report								Projected filing dates		
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**Submitted in RMS**	**SBEIS Check**	**CR-101**	**CR-102**	**CR-103**
Opioid Prescribing - LTAC, SNF patient exemption	CR-102 Filed	2/16/2022	Hearing	5/27/2022				Complete	Complete	May 2022
Collaborative Drug Therapy Agreements (CDTA)	CR-101 filed	7/22/2020	Workshops	TBD				Complete	TBD	TBD
Emergency Licensing Rules	Secretary Review	3/26/2020	File CR-105	TBD	Holding until proclamation is lifted.					
SB 6551 - IMG licensing	CR-102 Approved	3/4/2022	File CR-102	July 2022				Complete	July 2022	September 2022
Medical Records	CR-101 Approved	3/4/2022	File CR-102	November 2022				Sept. 2022	TBD	TBD

Updated: 5/19/2022

Washington Medical Commission

Bylaws

Article I: Purpose

The purpose of the Washington Medical Commission (Commission or WMC) is to protect the public by assuring the competency and quality of professional health care providers under its jurisdiction, by establishing and enforcing qualifications for licensure and standards of practice, by educating practitioners and the public, and, where appropriate, by disciplining and monitoring practitioners. The WMC exists to maintain and improve the quality of care provided to the citizens of Washington. Rules, policies, and procedures developed by the Commission must promote the delivery of quality health care to the residents of the state of Washington.

Article II: Membership

1. Commission Composition:

The 13 physicians, two physician assistants, and six public members of the Commission are appointed by the Governor to serve a four year term. The WMC ~~may~~ makes recommendations to the Governor concerning such appointments for clinical and public member positions. There must be at least one member from each of the congressional districts as specified in RCW 18.71.015. Commissioners may be appointed by the Governor to a second term. When vacancies occur, the Chair of the WMC shall make recommendations to the Governor to assure appropriate specialties are represented. When the workload requires, the WMC may appoint *pro tempore* members from among those qualified to be members of the Commission. Governor appointed members and *pro tempore* members are considered state officers and eligible for full rights and remunerations due under state law. *Pro tempore* members may vote ~~on case~~on discipline and licensing deliberations but are not eligible to vote on any other Commission business.

2. Qualification for voting

a. Only the 21 Governor-appointed members of the Commission are eligible to vote at business meetings of the WMC.

~~c.~~b. All members of committees, subcommittees, *ad hoc* committees, and workgroups are eligible to vote on questions arising during deliberations within those groups

3. Compensation and Reimbursement for Expenses:

a. The WMC will compensate its members for performing the duties of the Commission in accordance with RCW 43.03.265.

b. The WMC will reimburse its members for travel and other bona fide expenses in accordance with RCW 43.03.050 and 43.03.060

c. The WMC shall adopt a protocol specifying the procedures for carrying out compensation and reimbursement~~,~~ and update it as necessary.

4. Removal:

A Commissioner may be removed from the WMC by the Governor as outlined in RCW 18.71.015.

5. Staff and Operations

a. In accordance with RCW 18.71.430 the WMC selects and manages its own Executive Director, whom is exempt from provisions of civil service law.

b. The Executive Director is responsible for the overall management of WMC staff and operations including but not limited to performing all administrative duties ~~of the commission, including preparing an annual budget,~~ and any other duties as delegated by the WMC.

Article III: Officers

1. Officers:

The officers of the WMC shall consist of the Chair, ~~1st Vice Chair~~~~Chair-elect~~Vice Chair, ~~2nd Vice Chair~~Officer-at Large, and the Immediate Past-Chair.

2. Elections/Terms of Office:

a. The WMC shall elect its officers at its regular meeting ~~in or~~ immediately preceding the month of July.

b. ~~Officers shall serve for a one-year term~~The term of office for all WMC officer positions is one year. A second consecutive term is permitted. ~~The expectation of s~~Service in an officer position is to assure succession planning and leadership continuity.

~~b.~~c. The new officers begin their terms at the meeting following election ~~or sooner.~~ ~~,~~ U~~u~~pon agreement of the Chair and Chair-elect, terms may begin any time after the election of officers.

~~c.a. Officers shall serve for a one-year term. A second consecutive term is permitted.~~

3. Duties of Officers:

a. The Chair presides at all meetings of the WMC and has all powers and duties conferred by law, the Bylaws and commonly accepted practice consistent with state statutes. The Chair or a designee shall represent the WMC at official functions. The Chair shall approve and sign correspondence that reflects the position of the WMC on matters that are not purely

administrative in nature, including correspondence with the Legislature and other government agencies on matters of policy. The Chair is an ex-officio member of all committees, without vote unless specifically designated a member of the committee.

b. The ~~1st Vice Chair~~Chair-elect (and in order, the ~~2nd~~ Vice Chair, then Immediate Past-Chair) shall act in the capacity of the Chair when the Chair is absent, unavailable, has a conflict of interest, or is otherwise unable to serve.

Vacancies:

If any officer position becomes vacant, the ~~executive~~ Executive ~~committee~~ Committee shall fill the vacancy by appointment of a qualified Commissioner, ~~which~~ whose appointment, when ratified by the WMC, will be effective until the next election cycle. A qualified Commissioner is a Governor appointee.

Article IV: Meetings

1. Regular Board Meetings:

a. The WMC shall meet not ~~fewer~~less than four times a year, at such times and places as the Commission deems necessary and/or appropriate.

b. Prior to the beginning of each calendar year ~~The~~ the ~~chair~~ Chair will ~~develop and~~ recommend to the WMC a schedule of dates and locations for regular Commission meetings during the forthcoming year. The WMC may modify the schedule as necessary.

c. All meetings of the WMC shall be held in ~~conformance with~~ the letter and spirit of the Open Public Meetings Act, RCW 42.30. It is the intent of the WMC that all meetings of the WMC, other than executive sessions, licensing panels, case review panels, ~~,~~ and other adjudicative deliberations, shall be open and public~~,~~ ~~and any and a~~All~~l~~ persons shall be permitted to attend any other ~~meetings~~public meetings of the WMC.

2. Special Board Meetings:

a. The Chair may call a special meeting of the WMC at any time.

b. The Commission, by simple majority vote, may call a special meeting at any time.

c. Special meetings must be properly noticed as required by the Open Public Meetings Act, RCW 42.30, and shall be held in accordance with Article IV, 1.d. above.

d. The notice of a special meeting must specify the nature of the business to be conducted at the meeting. At a special meeting the WMC may not take final action on any item that is not listed in the public notice.

~~3. Quorum:~~

~~A majority of the Commission members appointed and serving constitutes a quorum for business meetings, and a majority vote of those present decides any issue.~~

~~4.~~3. Adjournment:

a. The WMC may postpone a portion of any meeting already in progress and reconvene at another time and/or place by adopting a motion to adjourn. The motion must specify where and when the meeting will resume.

b. A simple majority of the Commission members at a meeting may approve a motion to adjourn, even if there is not a quorum present. If all members are absent from a meeting, the Chair or Commission staff may adjourn the meeting to a stated time and place.

c. Whenever the WMC adjourns a meeting temporarily or prior to completing the agenda scheduled for that meeting, a notice of adjournment shall be posted immediately on or near the door of the room where the meeting was being held announcing the postponing of the meeting and stating when and where the meeting will resume.

d. The WMC must provide notice of when an adjourned meeting is resuming~~, just as if the new meeting time and place were~~ using the same procedure as a special meeting.

~~When a motion to adjourn a meeting fails to state the hour at which the adjourned meeting is to be held, the meeting must be held at a time when the Commission would typically hold a regular meeting.~~

~~In the event that a person or group of people disrupt the ability of the WMC to carry on business, the Chair may call for a recess or adjourn as necessary.~~

~~5.~~4. Rules Hearing Continuances:

a. Any rules hearing being held at any WMC meeting may be continued to any subsequent meeting if the WMC adopts a motion to continue.

~~b. Per RCW 34.05.340, the Commission may contemplate making a substantial variance from a proposed rule that has been described in a published notice by the Code Reviser, and may file a supplemental notice with the Code Reviser that meets all requirements of RCW 34.05.320 to reopen the proceedings for public comment on the proposed variance in rule language. The date, time, and location of the public hearing to consider public testimony on the proposed, substantial variance in rule language will be published in the state register at least twenty days before the supplemental rule-making hearing. Upon publication of the public hearing on the proposed, substantial variance in rule language in the state register, a notice will be disseminated by the Commission to the public that will include the date, time, and location of the public hearing...~~

~~c.~~b. The WMC must inform the public whether it is continuing to take public testimony or if ~~only~~ limited to Commission member discussion and possible action is scheduled. ~~It~~ The WMC may choose to take additional testimony only at the discretion of the rules hearing Chair or an appropriate designee. Notice shall be given when the WMC adopts the motion to continue, or in a supplemental CR-102.

~~d.~~c. Any continuance of a WMC rule hearing must be properly noticed in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

~~6.~~5. Meetings Interrupted by ~~Group~~ Individuals or Groups of Persons:

a. If the disorderly conduct of a person or a group of people makes it impractical to continue a WMC meeting, the Commission should first order that the individuals interrupting the meeting leave the room. If that fails to restore order, the WMC ~~can~~ may clear the room. It can also adjourn the meeting and reconvene at another place selected by a majority of the Commission members.

b. If the WMC clears the room or adjourns to another location, it may only take action on matters that have appeared on the meeting agenda.

c. Representatives of the press or other news media, except those participating in the disturbance, must be allowed to attend if they sufficiently identify themselves as such, even if the room has been cleared or the Commission has reconvened elsewhere.

d. The WMC ~~can~~ shall determine how ~~it might~~ to re-admit ~~any~~ individuals who were not disrupting the meeting.

~~7.~~6. Meetings, Minutes, and Agendas:

a. The minutes of all WMC business meetings shall be taken by a member of the Commission staff.

b. The minutes shall accurately capture and record member attendance and the action of the WMC on each question or motion.

c. All minutes will be produced for WMC review and approval at regular meetings.

~~**8. Meeting Attendance:**~~

~~a. All Commission and committee meetings should be attended by at least one member of the Commission staff.~~

~~b. Commission staff taking the minutes of a Commission meeting shall record the attendance of the members in the minutes for the permanent record.~~

~~9.~~7. Meeting procedures

a. **Rules of Procedure**:

1) The procedures used to conduct WMC business will be determined by these Bylaws, the Administrative Procedures Act, the Open Public Meetings Act, and the Commission's authorizing statute, Chapter 18.71 RCW and Article XX of the Washington State Constitution.

2) If a procedural issue arises that is not covered by these Bylaws and applicable state statutes, and the Commission cannot reach consensus on how to proceed, the WMC will follow the procedures contained in the most current version of *Robert's Rules of Order*.

~~a.~~b. **Quorum**:

1) A simple majority of the WMC shall constitute a quorum for the transaction of business at meetings. ~~In the event that~~If there are vacancies on the WMC, a majority of existing Governor appointed members shall constitute a quorum.

2) The WMC may discuss issues and deal with administrative matters in the absence of a quorum, but it may not adopt any resolution, rule, regulation, order, or directive during a meeting unless a quorum first has been established. ~~It may entertain a motion to adjourn without a quorum.~~

3) Any~~one~~ Governor appointed Commissioner participating in the meeting ~~, including a member of the public in the audience,~~ may call for a roll call at any time after a quorum has been established. If WMC staff wish to call for a roll call, such a request must be presented by the Executive Director or appropriate designee in the chain of command.

~~3)~~4) If a quorum is not present at the time of the roll call, no further actions can be taken, unless additional members enter the room and re-establish a quorum.

~~b.~~c. **Order of Business**:

The order of business shall be determined by the posted agenda unless the agenda is altered by the Chair in an open meeting with the concurrence of the WMC.

~~c.~~d. **Public Comment**:

The Chair may solicit public comment on any or all agenda items during regular meetings and all agendas shall include a public comment item. All public comments regarding cases before the WMC or active litigation will be interrupted and overruled by the Chair or presiding officer for reasons of due process and legal risk management.

~~d.~~e. **Motions, Resolutions, and Regulations**:

1) All proposals for actions or decisions of the WMC ~~should~~ shall be by motion and/or resolution.

2) A motion or resolution will be deemed "passed" only if it receives the affirmative votes of a simple majority of the members present eligible to vote.

3) No Commission member or employee may use the name, branding, or indicia of the WMC ~~to support or oppose any issue or cause~~for any reason other than official, Commission sanctioned operations.

4) The Commission and its members/employees may not lobby in support or opposition to legislative proposals~~, but the Commission may provide information to appropriate parties about proposed legislation and its potential effect on the Commission and/or medical profession.~~ However, in accordance to RCW 18.71.460 and in addition to the authority provided in RCW 42.52.804, Commissioners or staff as directed by the commission, may communicate, present information requested, volunteer information, testify before legislative committees, and educate the legislature, as the commission may from time to time see fit. A Commission member/employee may lobby support or opposition to legislative proposals only as a private citizen and only without reference to the WMC or their position with the WMC.

~~e.~~f. **Manner of Voting**:

~~1)~~ The voting on elections, motions, and resolutions shall be conducted by voice vote unless a roll call is requested in accordance with section 8 a. 3) of these

Bylaws. ~~lieu of voice vote, a Commission member may request a vote by roll call or show of hands, and the Chair will honor any such request.~~

Proxy voting is not permitted.

~~f. **Rules of Procedure**:~~

~~1) The procedures used to conduct Commission business will be determined by these Bylaws, the Administrative Procedures Act, the Open Public Meetings Act, and the Commission's authorizing statute, Chapter 18.71 RCW and Article XX of the Washington State Constitution.~~

~~2) If a procedural issue arises that is not covered by these Bylaws and applicable state statutes, and the Commission cannot reach consensus on how to proceed, the organization will follow the procedures contained in the most current version of *Robert's Rules of Order*.~~

Article V: Committees, Subcommittees, Panels, ~~Subcommittees,~~ and Workgroups

1. General provisions

a. The WMC may establish standing committees, subcommittees, *ad hoc* committees, panels, ~~*ad hoc* committees~~, ~~subcommittees~~ and workgroups to assist in executing its work plan.

1) Standing committees are of an enduring nature to deal with matters of long-term ongoing interest and concern to the Commission.

2) Subcommittees are established under the jurisdiction of standing committees for specific purposes, and render their reports to the full Commission through the parent committee. Subcommittees disband at the direction of the parent committee.

3) *Ad hoc* committees are established to study and deal with highly specific issues, and disband upon completion of the assignment.

~~2)~~4) Panels are established to conduct case and licensing application reviews ~~, issue licensing decisions~~~~decisions regarding licensing,~~ or other Commission business that may be delegated to the panel. Panels function for ~~and continue to function~~ as long as the assigned task remains. The quorum of a panel is a simple majority of panel members. For standard of care and complex licensing decisions, at least half of the members must be clinicians. Decisions are made by majority vote. Panels should be rotated on a regular basis.

~~3) *Ad hoc* committees are established to study and deal with highly specific issues, and disband upon completion of the assignment~~

~~4)~~1) ~~Subcommittees are established under the jurisdiction of standing committees for specific purposes, and render their reports to the full Commission through the parent committee. Subcommittees disband at the direction of the parent committee.~~

5) Workgroups are composed of Commissioners and non-commissioners possessing particular expertise and/or interest in a particular subject of interest to the Commission, to render recommendations to the WMC regarding possible action about that subject. Workgroups disband upon reporting completion of their assignment.

b. The officers, at ~~their~~ the first Executive Committee meeting after election, ~~shall~~ should choose which standing committees to activate and designate the duties thereof for the ensuing year.

The Chair ~~shall~~ should appoint committee chairs at the first Commission meeting after the election. Commission members shall be given ample opportunity to volunteer to serve on the various committees.

c. Standing committees, subcommittees~~panels~~, *ad hoc* committees, panels ~~subcommittees~~ and workgroups ~~will be~~are composed of commissioners appointed by the Commission ~~chair~~Chair, and~~, with the exception of the Executive Committee, and the Nominating Committee,~~ may include others (such as pro-tem members or ~~even~~ non-Commission members) as designated by the ~~chair~~Chair. The Executive Committee and the Nominating Committee are exceptions to this process.

d. Chairs of standing committees, subcommittees~~panels~~, *ad hoc* committees, panels ~~subcommittees~~ and workgroups will be designated by the Commission chair.

e. Appropriate staff shall be identified by the Executive Director to support and advise all standing committees, subcommitteespanels, *ad hoc* committees, panels subcommittees and workgroups

f. Each standing committee, subcommitteepanel, *ad hoc* committee, panel subcommittee and workgroup will function under a written charter, signed by the Commission Chair or Policy Chair, designating the group's composition, purpose, inception and termination date and expectations regarding provision and routing of reports and recommendations. Staff shall create written charters under the approval of the Executive Director or their designee with standard termination date of one year.

g. The termination date of a standing committee, subcommitteepanel, *ad hoc* committee, panel subcommittee or workgroup can be extended at the discretion of the Commission Chair or by vote of the full Commission.

h. Standing committees, subcommitteespanels, *ad hoc* committees, panels subcommittees and workgroups are subject to review by the full Commission and may be modified or disbanded by majority vote.

i. Any Commission member may attend any standing committee, subcommitteepanels, *ad hoc* committee, panels subcommittee or workgroup meeting, but only designated committee members may vote on committee deliberations.

2. Executive Committee

a. The Executive Committee shall be a standing committee of the Commission. Its purpose is to provide clear and direct communication to executive staff, assist in carrying out the administrative direction of the WMC, and act as a resource to executive staff and the Chair of the WMC.

b. The Executive Committee members are the Commission Chair, 1st and 2nd Vice ChairsChair-electVice Chair, Vice-ChairOfficer-at Large, and the immediate past Commission Chair (if that person remains an eligible member of the Commission)., and the Chair of the Policy Committee. At least oOne member of the Executive Committee must be a public member of the Commission; in the event thatif one of the named positions is not filled by a public member, an additional public member shall be appointedelected as an additional member of the Executive Committee.

c. Ex-officio non-voting members are the Policy Chair, and the Chairs of Panel A and B.

c.d. Staff ofattached to the Executive Committee as ex-officio, non-voting members, includesare the Executive Director, the Deputy Executive Director, and the advising Assistant Attorney General assigned to the WMC.

d.e. The Executive Committee functions to provide administrative oversight for the WMC in the intervals between Commission regular meetings and to advise the Executive Director regarding administrative matters and ongoing or urgent/emergent Commission business as necessary.

e.f. The Executive Committee reports to the full Commission. and is responsible to it forAny action recommended by the Executive Committee must be approved by the full commission action taken. It cannot take action on its own that would require full Commission concurrence.

3. Policy Committee

a. The Policy Committee ~~shall be~~is a standing committee of the Commission.

b. Policy Committee consists of a maximum of 10 commissioners, designated by the Commission Chair.

c. The Policy Committee is the principal clearinghouse for all matters being considered by the WMC regarding policy, development of procedures, establishment of guidelines, rulemaking, ~~and~~ legislative recommendations and support.

d. The Policy Committee reports to the full Commission on a regular basis.

4. Nominating Committee.

a. The Nominating Committee functions to assure effective leadership, diverse representation, and robust succession planning for the WMC.

~~a.~~ The Chair shall appoint the Nominating Committee a minimum of two ~~Commission~~ regular meetings prior to the scheduled election meeting date.

b. The Nominating Committee shall have a minimum of three members.~~, and at least one member should have served on the previous year's Nominating Committee.~~ If still a full member of the WMC, the Immediate Past Chair shall serve on the Nominating Committee.

c. The Nominating Committee reports its recommended slate of candidates for consideration by ~~to~~ the full Commission ~~at the meeting immediatelyone~~two regular meeting prior to the ~~meeting for which elections are scheduled~~election. At the election meeting, nominations may be made from the floor providing that the nominee has given prior consent to the nominator~~nominator has the prior consent of the nominee.~~

d. In the event of a contested election, each candidate for office shall be present to state their case for office to the full Commission during open session on the day of the election. Candidates unable or unwilling to state their case for office shall not be considered for election.

~~c.~~e. Candidates for office shall depart the room during deliberations and voting associated with their election.

Article VII: Amendments to the Bylaws

Amendments to the Bylaws may be proposed from the floor at a Commission meeting or by the Executive Committee itself.~~,~~ Proposed amendments shall be circulated to the entire Commission between meetings and voted upon by attendees at the next meeting. A ~~two-thirds~~simple majority of those present constituting a quorum is required for approval. Unless otherwise specified, amendments take effect upon adoption.

~~Warren Howe~~~~Alden Roberts~~John Maldon, Chair
Washington Medical ~~Quality Assurance~~ Commission
Adopted Date:

Bylaws

Article I: Purpose

The purpose of the Washington Medical Commission (Commission or WMC) is to protect the public by assuring the competency and quality of professional health care providers under its jurisdiction, by establishing and enforcing qualifications for licensure and standards of practice, by educating practitioners and the public, and, where appropriate, by disciplining and monitoring practitioners. The WMC exists to maintain and improve the quality of care provided to the citizens of Washington. Rules, policies, and procedures developed by the Commission must promote the delivery of quality health care to the residents of the state of Washington.

Article II: Membership

1. Commission Composition:

The 13 physicians, two physician assistants, and six public members of the Commission are appointed by the Governor to serve a four-year term. The WMC makes recommendations to the Governor concerning such appointments for clinical and public member positions. There must be at least one member from each of the congressional districts as specified in RCW 18.71.015. Commissioners may be appointed by the Governor to a second term. When vacancies occur, the Chair of the WMC shall make recommendations to the Governor to assure appropriate specialties are represented. When the workload requires, the WMC may appoint *pro tempore* members from among those qualified to be members of the Commission. Governor appointed members and *pro tempore* members are considered state officers and eligible for full rights and remunerations due under state law. *Pro tempore* members may vote on discipline and licensing deliberations but are not eligible to vote on any other Commission business.

2. Qualification for voting

a. Only the 21 Governor-appointed members of the Commission are eligible to vote at business meetings of the WMC.

b. All members of committees, subcommittees, *ad hoc* committees, and workgroups are eligible to vote on questions arising during deliberations within those groups.

3. Compensation and Reimbursement for Expenses:

a. The WMC will compensate its members for performing the duties of the Commission in accordance with RCW 43.03.265.

b. The WMC will reimburse its members for travel and other bona fide expenses in accordance with RCW 43.03.050 and 43.03.060

c. The WMC shall adopt a protocol specifying the procedures for carrying out compensation and reimbursement and update it as necessary.

4. Removal:

A Commissioner may be removed from the WMC by the Governor as outlined in RCW 18.71.015.

5. Staff and Operations

a. In accordance with RCW 18.71.430 the WMC selects and manages its own Executive Director, whom is exempt from provisions of civil service law.

b. The Executive Director is responsible for the overall management of WMC staff and operations including but not limited to performing all administrative duties and any other duties as delegated by the WMC.

Article III: Officers

1. Officers:

The officers of the WMC shall consist of the Chair, Vice Chair, Officer-at Large, and the Immediate Past-Chair.

2. Elections/Terms of Office:

a. The WMC shall elect its officers at its regular meeting immediately preceding the month of July.

b. The term of office for all WMC officer positions is one year. A second consecutive term is permitted. Service in an officer position is to assure succession planning and leadership continuity.

c. The new officers begin their terms at the meeting following election. Upon agreement of the Chair and Chair-elect, terms may begin any time after the election of officers.

3. Duties of Officers:

a. The Chair presides at all meetings of the WMC and has all powers and duties conferred by law, the Bylaws and commonly accepted practice consistent with state statutes. The Chair or a designee shall represent the WMC at official functions. The Chair shall approve and sign correspondence that reflects the position of the WMC on matters that are not purely

administrative in nature, including correspondence with the Legislature and other government agencies on matters of policy. The Chair is an ex-officio member of all committees, without vote unless specifically designated a member of the committee.

b. The Chair-elect (and in order, the Vice Chair, then Immediate Past-Chair) shall act in the capacity of the Chair when the Chair is absent, unavailable, has a conflict of interest, or is otherwise unable to serve.

Vacancies:

If any officer position becomes vacant, the Executive Committee shall fill the vacancy by appointment of a qualified Commissioner, whose appointment, when ratified by the WMC, will be effective until the next election cycle. A qualified Commissioner is a Governor appointee.

Article IV: Meetings

1. Regular Board Meetings:

a. The WMC shall meet not less than four times a year, at such times and places as the Commission deems necessary and/or appropriate.

b. Prior to the beginning of each calendar year the Chair will recommend to the WMC a schedule of dates and locations for regular Commission meetings during the forthcoming year. The WMC may modify the schedule as necessary.

c. All meetings of the WMC shall be held in the letter and spirit of the Open Public Meetings Act, RCW 42.30. It is the intent of the WMC that all meetings of the WMC, other than executive sessions, licensing panels, case review panels, and other adjudicative deliberations, shall be open and public. All persons shall be permitted to attend any other public meetings of the WMC.

2. Special Board Meetings:

a. The Chair may call a special meeting of the WMC at any time.

b. The Commission, by simple majority vote, may call a special meeting at any time.

c. Special meetings must be properly noticed as required by the Open Public Meetings Act, RCW 42.30, and shall be held in accordance with Article IV, 1.d. above.

d. The notice of a special meeting must specify the nature of the business to be conducted at the meeting. At a special meeting the WMC may not take final action on any item that is not listed in the public notice.

3. Adjournment:

a. The WMC may postpone a portion of any meeting already in progress and reconvene at another time and/or place by adopting a motion to adjourn. The motion must specify where and when the meeting will resume.

b. A simple majority of the Commission members at a meeting may approve a motion to adjourn,

even if there is not a quorum present. If all members are absent from a meeting, the Chair or Commission staff may adjourn the meeting to a stated time and place.

c. Whenever the WMC adjourns a meeting temporarily or prior to completing the agenda scheduled for that meeting, a notice of adjournment shall be posted immediately on or near the door of the room where the meeting was being held announcing the postponing of the meeting and stating when and where the meeting will resume.

d. The WMC must provide notice of when an adjourned meeting is resuming using the same procedure as a special meeting.

4. Rules Hearing Continuances:

a. Any rules hearing being held at any WMC meeting may be continued to any subsequent meeting if the WMC adopts a motion to continue.

b. The WMC must inform the public whether it is continuing to take public testimony or if limited to Commission member discussion and possible action is scheduled. The WMC may choose to take additional testimony only at the discretion of the rules hearing Chair or an appropriate designee. Notice shall be given when the WMC adopts the motion to continue, or in a supplemental CR-102.

c. Any continuance of a WMC rule hearing must be properly noticed in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

5. Meetings Interrupted by Individuals or Groups of Persons:

a. If the disorderly conduct of a person or a group of people makes it impractical to continue a WMC meeting, the Commission should first order that the individuals interrupting the meeting leave the room. If that fails to restore order, the WMC may clear the room. It can also adjourn the meeting and reconvene at another place selected by a majority of the Commission members.

b. If the WMC clears the room or adjourns to another location, it may only take action on matters that have appeared on the meeting agenda.

c. Representatives of the press or other news media, except those participating in the disturbance, must be allowed to attend if they sufficiently identify themselves as such, even if the room has been cleared or the Commission has reconvened elsewhere.

d. The WMC shall determine how to re-admit individuals who were not disrupting the meeting.

6. Meetings, Minutes, and Agendas:

a. The minutes of all WMC business meetings shall be taken by a member of the Commission staff.

b. The minutes shall accurately capture and record member attendance and the action of the WMC on each question or motion.

c. All minutes will be produced for WMC review and approval at regular meetings.

7. Meeting procedures

a. **Rules of Procedure**:

1) The procedures used to conduct WMC business will be determined by these Bylaws, the Administrative Procedures Act, the Open Public Meetings Act, and the Commission's authorizing statute, Chapter 18.71 RCW and Article XX of the Washington State Constitution.

2) If a procedural issue arises that is not covered by these Bylaws and applicable state statutes, and the Commission cannot reach consensus on how to proceed, the WMC will follow the procedures contained in the most current version of *Robert's Rules of Order*.

b. **Quorum**:

1) A simple majority of the WMC shall constitute a quorum for the transaction of business at meetings. If there are vacancies on the WMC, a majority of existing Governor appointed members shall constitute a quorum.

2) The WMC may discuss issues and deal with administrative matters in the absence of a quorum, but it may not adopt any resolution, rule, regulation, order, or directive during a meeting unless a quorum first has been established.

3) Any Governor appointed Commissioner participating in the meeting may call for a roll call at any time after a quorum has been established. If WMC staff wish to call for a roll call, such a request must be presented by the Executive Director or appropriate designee in the chain of command.

4) If a quorum is not present at the time of the roll call, no further actions can be taken, unless additional members enter the room and re-establish a quorum.

c. **Order of Business**:

The order of business shall be determined by the posted agenda unless the agenda is altered by the Chair in an open meeting with the concurrence of the WMC.

d. **Public Comment**:

The Chair may solicit public comment on any or all agenda items during regular meetings and all agendas shall include a public comment item. All public comments regarding cases before the WMC or active litigation will be interrupted and overruled by the Chair or presiding officer for reasons of due process and legal risk management.

e. **Motions, Resolutions, and Regulations**:

1) All proposals for actions or decisions of the WMC shall be by motion and/or resolution.

2) A motion or resolution will be deemed "passed" only if it receives the affirmative votes of a simple majority of the members present eligible to vote.

3) No Commission member or employee may use the name, branding, or indicia of the WMC for any reason other than official, Commission sanctioned operations.

4) The Commission and its members/employees may not lobby in support or opposition to legislative proposals However, in accordance to RCW 18.71.460 and in addition to the authority provided in RCW 42.52.804, Commissioners or staff as directed by the commission, may communicate, present information requested, volunteer information, testify before legislative committees, and educate the legislature, as the commission may from time to time see fit. A Commission member/employee may lobby support or opposition to legislative proposals only as a private citizen and only without reference to the WMC or their position with the WMC.

f. **Manner of Voting**:

The voting on elections, motions, and resolutions shall be conducted by voice vote unless a roll call is requested in accordance with section 8 a. 3) of these Bylaws. Proxy voting is not permitted.

Article V: Committees, Subcommittees, Panels, and Workgroups

1. General provisions

a. The WMC may establish standing committees, subcommittees, *ad hoc* committees, panels, and workgroups to assist in executing its work plan.

1) Standing committees are of an enduring nature to deal with matters of long-term ongoing interest and concern to the Commission.

2) Subcommittees are established under the jurisdiction of standing committees for specific purposes, and render their reports to the full Commission through the parent committee. Subcommittees disband at the direction of the parent committee.

3) *Ad hoc* committees are established to study and deal with highly specific issues, and disband upon completion of the assignment.

4) Panels are established to conduct case and licensing application reviews or other Commission business that may be delegated to the panel. Panels function for as long as the assigned task remains. The quorum of a panel is a simple majority of panel members. For standard of care and complex licensing decisions, at least half of the members must be clinicians. Decisions are made by majority vote. Panels should be rotated on a regular basis.

5) Workgroups are composed of Commissioners and non-commissioners possessing particular expertise and/or interest in a particular subject of interest to the Commission, to render recommendations to the WMC regarding possible action about that subject. Workgroups disband upon reporting completion of their assignment.

b. The officers, at the first Executive Committee meeting after election, should choose which standing committees to activate and designate the duties thereof for the ensuing year. The Chair should appoint committee chairs at the first Commission meeting after the election. Commission members shall be given ample opportunity to volunteer to serve on the various committees.

c. Standing committees, subcommittees, *ad hoc* committees, panels and workgroups are

composed of commissioners appointed by the Commission Chair, and may include others (such as pro-tem members or non-Commission members) as designated by the Chair. The Executive Committee and the Nominating Committee are exceptions to this process.

d. Chairs of standing committees, subcommittees, *ad hoc* committees, panels and workgroups will be designated by the Commission chair.

e. Appropriate staff shall be identified by the Executive Director to support and advise all standing committees, subcommittees, *ad hoc* committees, panels and workgroups

f. Each standing committee, subcommittee, *ad hoc* committee, panel and workgroup will function under a written charter, signed by the Commission Chair or Policy Chair, designating the group's composition, purpose, inception and termination date and expectations regarding provision and routing of reports and recommendations. Staff shall create written charters under the approval of the Executive Director or their designee with standard termination date of one year.

g. The termination date of a standing committee, subcommittee, *ad hoc* committee, panel or workgroup can be extended at the discretion of the Commission Chair or by vote of the full Commission.

h. Standing committees, subcommittees, *ad hoc* committees, panels and workgroups are subject to review by the full Commission and may be modified or disbanded by majority vote.

i. Any Commission member may attend any standing committee, subcommittee, *ad hoc* committee, panels or workgroup meeting, but only designated committee members may vote on committee deliberations.

2. Executive Committee

a. The Executive Committee shall be a standing committee of the Commission. Its purpose is to provide clear and direct communication to executive staff, assist in carrying out the administrative direction of the WMC, and act as a resource to executive staff and the Chair of the WMC.

b. The Executive Committee members are the Commission Chair, Vice Chair, Officer-at Large, and the immediate past Chair (if that person remains an eligible member of the Commission) and the Chair of the Policy Committee. At least one member of the Executive Committee must be a public member of the Commission; if one of the named positions is not filled by a public member, a public member shall be elected as an additional member of the Executive Committee.

c. Ex-officio members are the Chairs of Panel A and B.

d. Staff of the Executive Committee as ex-officio are the Executive Director, the Deputy Executive Director, and the advising Assistant Attorney General assigned to the WMC.

e. The Executive Committee functions to provide administrative oversight for the WMC in the intervals between regular meetings and to advise the Executive Director regarding administrative matters and ongoing or urgent/emergent Commission business as necessary.

f. The Executive Committee reports to the full Commission. Any action recommended by

the Executive Committee must be approved by the full commission. It cannot take action on its own that would require full Commission concurrence.

3. Policy Committee

a. The Policy Committee is a standing committee of the Commission.

b. Policy Committee consists of a maximum of 10 commissioners, designated by the Commission Chair.

c. The Policy Committee is the principal clearinghouse for all matters being considered by the WMC regarding policy, development of procedures, establishment of guidelines, rulemaking, legislative recommendations and support.

d. The Policy Committee reports to the full Commission on a regular basis.

4. Nominating Committee.

a. The Nominating Committee functions to assure effective leadership, diverse representation, and robust succession planning for the WMC.

b. The Chair shall appoint the Nominating Committee a minimum of two regular meetings prior to the scheduled election meeting date.

c. The Nominating Committee shall have a minimum of three members. If still a full member of the WMC, the Immediate Past Chair shall serve on the Nominating Committee.

d. The Nominating Committee reports its recommended slate of candidates for consideration by the full Commission two regular meeting prior to the election. At the election meeting, nominations may be made from the floor providing that the nominee has given prior consent to the nominator

e. In the event of a contested election, each candidate for office shall be present to state their case for office to the full Commission during open session on the day of the election. Candidates unable or unwilling to state their case for office shall not be considered for election.

f. Candidates for office shall depart the room during deliberations and voting associated with their election.

Article VI: Amendments to the Bylaws

Amendments to the Bylaws may be proposed from the floor at a Commission meeting or by the Executive Committee itself. Proposed amendments shall be circulated to the entire Commission between meetings and voted upon by attendees at the next meeting. A simple majority of those present constituting a quorum is required for approval. Unless otherwise specified, amendments take effect upon adoption.

John Maldon, Chair

Washington Medical Commission
Adopted Date:

Policy Statement

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Title:	Informed Consent and Shared Decision-Making	POL2022-0x
References:		
Contact:	Washington Medical Commission	
Phone:	(360) 236-2750	E-mail: medical.commission@wmc.wa.gov
Effective Date:		
Approved By:	John Malden, Chair (signature on file)	

Introduction

Informed consent to medical treatment is a fundamental part of the practitioner-patient relationship. It is a process of communication, and not merely signing a form. Informed consent involves a dialogue between the practitioner and the patient[1] by which information is exchanged concerning the risks, benefits, and alternatives of the tests or treatments being recommended. The obligation of a practitioner to obtain informed consent from a patient is rooted in the recognition of patients' autonomy. Patents who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their providers' recommendations. The practitioner "must supply the patient with material facts the patient will need to intelligently chart that destiny with dignity."[2]

The Washington Medical Commission (WMC) issues this policy to provide guidance to allopathic physicians and physician assistants to ensure that patients are being adequately informed of the risks, benefits, and alternatives of proposed tests and treatments, such that patients can make informed care decisions that best reflect their goals and preferences in entering the care agreement. This policy serves to ensure that practitioners and patients understand their role in the processes of informed consent and shared decision-making.

Policy

Elements of the Informed Consent Process

A valid process of informed consent has four elements:

[1] The term "patient" in this policy includes a person with a power of attorney for health care when the patient is incapacitated.

[2] *Miller v. Kennedy,* 11 Wn. App. 272, 281-82, 522 P.2d 852 (1974), *aff'd per curium*, 85. Wn.2d 151 (1975). For a comprehensive review of the legal aspects of informed consent, see Washington Health Law Manual, 4th ed., Chapter 2A.3 (2016).

1. **Voluntariness**. A patient's decision must be free from coercion or undue influences. For example, if a decision is instead made under duress from a clinician, family member, or other third party, a patient's decision is not voluntary and, as such, informed consent cannot be obtained.

2. **Disclosure.** The practitioner must share all information that "a reasonably prudent person in the position of the patient" would find significant for the patient to make an informed decision,[3] including the nature, character, and anticipated results of the proposed test/treatment; material risks inherent to the proposed test or treatment; and alternative courses of action, including no action, and the benefits and risks of those alternatives.

3. **Understanding.** The practitioner must ensure that the patient has not only been informed but also understands and appreciates the nature of the proposed test/treatment, in addition to associated risks, benefits, and alternatives. The practitioner has a duty to ensure that informed consent is obtained using a form of communication (e.g., language) that the patient understands. Understanding can be difficult to ascertain with certainty. One way to gauge understanding is for the practitioner to ask the patient to state in their own words what they just discussed and what they understood. The practitioner should be aware that cultural differences can significantly impact understanding

4. **Capacity.** The practitioner must ensure that the patient has the ability to engage in reasoned deliberation (e.g., comparing the risks and benefits of the procedure with personal life goals). A patient who lacks the ability to engage in reasoned decision-making lacks the capacity to give informed consent.

Lack of capacity can take many forms. One ~~example~~ form involves statutory criteria, which are required to determine lack of capacity (e.g., as declared by a court or by certain types ~~and numbers~~ of health care providers) regarding advance directives.[4] Outside of specific legal criteria, there are ~~numerous~~ scenarios when patients may lack capacity to make reasoned medical decisions, such as the following two examples.

~~Another example involves h~~Health literacy is one example. Many patients may not understand complex medical information. Practitioners should explain medical information using plain language that a patient can understand. A patient who is confused by the medical terminology may be able to provide informed consent when these complex terms are explained using more basic terminology.

Another example involves a patient overwhelmed by complexity or volume of information at hand. An overwhelmed patient may lack the capacity to provide informed consent. This may create a challenge for practitioners, as it can be difficult to adequately explain all pertinent risks, benefits, and alternatives without overwhelming the patient. Practitioners should focus on explaining all concepts that a reasonably prudent patient would likely need

[3] RCW 7.70.050(2)
[4] RCW 71.32.110

to know to make an informed decision in a manner that promotes dialogue and understanding.

If a practitioner believes that a patient does not have the mental capacity necessary to make an informed decision, the practitioner may consider recommending the patient have a court-ordered guardian ad litem appointed before proceeding with any elective treatment.

Capacity is not an all-or-nothing phenomenon; a patient may have the capacity to make some decisions but not others.[5] The American Medical Association Code of Medical Ethics Opinion 2.1.2 provides excellent guidance to a practitioner who encounters an adult patient who seemingly lacks decision-making capacity.[6]

Shared Decision-Making

Washington became the first state to codify shared decision-making as an alternative to traditional informed consent. The statute, RCW 7.70.060 was first amended in 2012 and then again in 2022. The statute states that shared decision-making is a process in which a practitioner discusses with the patient, or his or her representative, information to make a decision that aligns with the patient's values and goals.

Both the Robert Bree Collaborative in Washington State and the National Institute for Health and Care Excellence have issued excellent guides to implementing shared decision-making into a practitioner's medical practice. As noted in the 2019 Bree Collaborative, "Shared decision making is a key component of patient-centered care, 'a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.'"[7]

Shared decision-making takes the traditional notion of informed consent a step further by encouraging practitioners and patients to undertake, not just an informed, but an active role in complex medical decisions that affect the patient's health. Shared decision-making requires a high-quality communication between a practitioner and a patient, and in some cases family members or others, about risks, benefits, values, and goals.

The goal of shared decision-making is to help patients arrive at informed decisions that respect what matters most to them.[8]Shared decision-making is especially useful in complex cases where a patient is faced with multiple options and high stakes decisions need to be made in a narrow window of time, such as the decision-making regarding which treatments to undergo

[5] "The Limits of Informed Consent for an Overwhelmed Patient: Clinician's Role in Protecting Patient and Preventing Overwhelm," AMA Journal of Ethics, Vol. 18, no. 9:869-886 (September 2016).
[6] AMA Code of Medical Ethics Opinion 2.1.2.
[7] Dr. Robert Bree Collaborative, Shared Decision Making, 2019, at 3. (hereinafter Bree Collaborative paper) https://www.qualityhealth.org/bree/topic-areas/shared-decision-making/
[8] "The Limits of Informed Consent for an Overwhelmed Patient: Clinician's Role in Protecting Patient and Preventing Overwhelm," AMA Journal of Ethics, Vol. 18, no. 9:869-886 (September 2016).

when cancer is diagnosed.[9] Shared decision-making is appropriate for treatments that are (patient) preference-sensitive and either have (1) high-quality scientific evidence supporting more than one option, which may include no treatment, or (2) a lack of evidence and/or no clinical consensus on what is the best option.[10] The practitioner may encourage the patient to have a patient advocate involved in this process.

Shared decision-making is, however, not appropriate when there is clear evidence of a net benefit, or harm. For example, generally, a clear net benefit of immunization against measles, mumps, and rubella (MMR) excludes MMR vaccination as a shared decision-making opportunity, as does the clear net harm of using antibiotics to treat a common cold.[11]

Shared decision-making can sometimes be assisted with patient decision aids. Certified by one or more national certifying organization[12], the tool provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes.[12] A decision aid can be in any format, including written, electronic, audio-visual, or web based. A decision aid is not essential for shared decision-making to occur, but studies have shown that patients who engaged in shared decision-making with a decision aid had a greater knowledge of the evidence, understood better about what mattered to them, had more accurate expectations of the risks and benefits, and participated more in the decision-making process.[13] The commission recommends that any use of patient decision aid be documented in medical record.

Generally, shared decision-making is associated with improved patient satisfaction, improved health outcomes, and better appropriateness of care.[14] When patients participate in decision-making and understand what they need to do, there are benefits to patients: they are more likely to follow through on their treatment plans,[15] there is a reduction in the chance of "preference misdiagnosis,"[16] and there is a reduction in health care disparities.[17] Shared decision-making may also benefit practitioners by improving doctor-patient relationships, improving communication, and providing certain legal protections to practitioners.

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[9] "Development of a Program Theory for Shared Decision-Making: a realist synthesis," Waldron, et al., BMC Health Services Research 20:59 (2020).

[10] Dr. Robert Bree Collaborative, Shared Decision Making, 2019, at 3. https://www.qualityhealth.org/bree/topic-areas/shared-decision-making/

[11] Bree Collaborative paper, at 4.

[12] RCW 7.70.060(4)(a).

[13] Spatz E, Krumholz H, Moulton B, The New Era of Informed Consent: Getting to aa Reasonable-Patient Standard Through Shared Decision Making, Viewpoint, JAMA Vol 315, No 19, May 17, 2016.

[14] Bree Collaborative paper at 4, citing Arterburn D, Wellman R, Westbrook E, Rutter C, Ross T, McCulloch D, et al. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. Health Aff (Millwood). 2012 Sep;31(9):2094-104; and Stacey D, Légaré F, Col NF, Bennett CL, Barry MJ, Eden KB, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2014 Jan 28;(1):CD001431.

[15] Shared Decision-Making Fact Sheet, HealthIT.gov, National Learning Consortium (December 2013).

[16] C Brach, "Making Informed Consent an Informed Choice," Health Affairs bog April 4, 2019.

[17] Bree Collaborative paper, at 4-5, citing as an example the increasing rates of total knee replacement for black patients with osteoarthritis to rates closer to those of white patients.

Practitioners should document shared decision-making in the patient's medical record as follows:

- A description of the services that the patient and provider jointly have agreed will be furnished;
- A description of the patient decision aid or aids that have been used by the patient and provider to address the needs for (a) high quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (b) clarification to help patients sort out their values and preferences; and (c) guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process;
- A statement that the patient or his or her representative understand: the risk or seriousness of the disease or condition to be prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and
- A statement certifying that the patient or his or her representative has had the opportunity to ask the provider questions, and to have any questions answered to the patient's satisfaction, and indicating the patient's intent to receive the identified services.[18]

The Informed Consent Process Cannot be Delegated

Obtaining informed consent is an interactive process that is integral to the practitioner-patient relationship and cannot be delegated to others. For elective procedures, the treating practitioner is the one primarily responsible for the process of obtaining a patient's informed consent. At the end of that process, the treating practitioner may rely on ancillary personnel to obtain a patient's signature on a consent form. However, the practitioner is responsible for any act or statement made by the ancillary personnel when obtaining the patient's signature.[19] The practitioner retains responsibility for obtaining consent and for communications regarding consent.

Exceptions

There are certain situations in which informed consent is not required. For example, in an emergency when immediate treatment is necessary to preserve life or to prevent serious deterioration of a patient's condition, and the patient is unable to make an informed decision and a surrogate is not available, consent is not required.[20] Informed consent is also not required to detain a child without the consent of the parents when there is an imminent danger to the child,[21] when a patient is involuntarily committed to a psychiatric unit or facility under the

[18] RCW 7.70.060.
[19] Washington Health Law Manual, 4th ed., Chapter 2A.3 (2016). *See also, Shinal v. Toms*, 640 Pa. 295, 162 A.3d 429 (2017) (Pennsylvania court rules that the physician must obtain informed consent himself).
[20] RCW 7.70.050(4).
[21] RCW 26.44.056(1).

Involuntary Treatment Act,[22] or when disclosure of information would be detrimental to the patient's best interests.[23]

Additionally, a patient may choose not to be informed about the details of a proposed treatment, including risks, benefits, and alternatives. A patient may also refuse treatment, or withdraw consent to treatment, no matter how unreasonable. In these scenarios, the practitioner should accept a patient's wishes and document their decision in the medical record.[24] The practitioner should consider having the patient confirm these types of decisions by documenting them in writing.

Special Considerations for Surgery or Invasive Procedures

When a practitioner proposes a surgery or an invasive procedure, the need for informed consent, or shared decision-making, is amplified. Barring an urgent or emergent situation, dialogue between the practitioner and the patient to discuss the proposed procedure, including the risks, benefits, and alternatives, should generally take place well in advance. Patients are naturally apprehensive and vulnerable on the day of a procedure, and may be reluctant or unable to ask questions, and engage fully in the decision-making process. Thus, for non-urgent procedures, having an informed consent discussion in advance optimizes a patient's ability to consider the information, ask questions, and seek advice from another practitioner, friend, or family member, prior to consenting.

Another special consideration in obtaining consent includes the names and roles of practitioners to whom the patient consent to a procedure. The practitioner should advise the patient of the names of any other practitioners who will perform surgical interventions or other important parts of the procedure, including anesthesia.[25] The primary surgeon may not know who will be involved in the procedure at the time informed consent is obtained, in which case, the primary surgeon should advise the patient that other practitioners may be involved and explain their planned scope of involvement in the procedure. The primary surgeon or practitioner should also discuss any applicable overlapping procedures.

The WMC issued a guideline on Overlapping and Simultaneous Elective Surgeries[26] in 2018, in which the WMC recommended that the primary attending surgeon inform the patient of the circumstances of the overlapping or simultaneous surgery, including:

1. Who will participate in the surgery, including residents, fellows, physician assistants and nurse practitioners who are directly supervised by the surgeon;

[22] RCW 71.05 (adults) and RCW 71.34 (minors age 13017). See also Washington State Health Care Authority, "The Involuntary Treatment Act," December 2021.
[23] *Holt v. Nelson*, 11 Wn. App. 230, 523 P.2d 211 (1974), *rev denied*, 84 Wn.2d 1008 (1974).
[24] RCW 7.70.060(1)(b).
[25] The Center for Medicare and Medicaid Services has a detailed example of a well-designed informed consent process for surgical procedures. A-0392 Surgical Services, Interpretive Guidelines §482.51(b)(2). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf
[26] Overlapping and Simultaneous Elective Surgeries, GUI2018-03, adopted July 13, 2018.

2. When the primary attending surgeon will be absent for part of the surgery; and
3. Who will continue the surgery when the primary attending surgeon leaves the operating room.[27]

A surgeon should not allow a substitute surgeon to perform the procedure without the patient's consent.[28] According to the AMA Principles of Medical Ethics, patients are entitled to accept or refuse the care of a substitute practitioner,[29] and a patient is only able to do this with prior knowledge of its occurrence.

Regulations and Requirements of Other Regulators and Organizations

In addition to Washington statutes regarding informed consent and shared decision-making, it is important to remember that there may be additional requirements of other regulators or organizations. Healthcare organizations or regulatory bodies may have their own regulations or requirements that also must be followed. For example, a physician needs to honor Department of Health facility regulations, Department of Social and Health Services regulations, Joint Commission requirements, and Center for Medicare and Medicaid requirements regarding consent and shared decision-making. The practitioner is responsible for compliance with all applicable statutes, regulations, and requirements to help ensure that quality patient care is provided in the state.

Conclusion

Informed consent and shared decision-making are integral to a healthy practitioner-patient relationship. Evidence suggests that, following these recommendations, as well as reviewing the resources cited, will enhance communication, improve practitioner-patient relationships, decrease legal risk, and result in better overall patient care.

[27] Washington Medical Commission Guideline GUI2018-03, "Overlapping and Simultaneous Surgeries," adopted July 13, 2018.
[28] AMA Code of Ethics Opinion 2.1.6, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf
[29] AMA Code of Ethics Opinion 2.1.6, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf

Medical Professionalism

Introduction

In 2002, the American Board of Internal Medicine Foundation, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine developed a Charter on Medical Professionalism, and published it simultaneously in the Annals of Internal Medicine and The Lancet.[1] The Charter on Medical Professionalism is designed to reaffirm the medical profession's commitment to patients and to the health care system by setting forth fundamental and universal principles of medical professionalism.

The Washington Medical Commission (WMC) largely adopts the Charter on Medical Professionalism (Charter), as guidance for Washington physicians and physician assistants in fulfilling their professional responsibilities to their patients and to the public. [2]

Charter on Medical Professionalism

Preamble

Professionalism is the basis of medicine's contract with society. Professionalism demands placing the best interests of patients above those of the practitioner[3], setting and maintaining standards of competence and integrity, and providing scientifically accurate advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and the public. Public trust in practitioners depends on the integrity of both individual practitioners and the profession as a whole.

At present, the medical profession is confronted by an explosion of technology, evolving practice conditions, and heightened regulatory obligations. As a result, practitioners find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all practitioners, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical

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[1] "Medical Professionalism in the New Millennium: A Practitioner Charter." Annals of Internal Medicine, 2002;136(3):243-246, *available at* http://annals.org/aim/article/474090/medical-professionalism-new-millennium-practitioner-charter

[2] This Guidance Document is not identical to the previous Charter on Medical Professionalism. The WMC has edited that previous document in order to conform to state laws and rules. For example, in many places in this document, the WMC has replaced the word "shall" with the word "should," so as not to create mandates outside of the rule-making process.

[3] In this guidance document, the WMC uses the term "practitioner" to refer to both allopathic physicians and physician assistants.

delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this Charter in the form of three fundamental principles, and as a set of definitive professional responsibilities.

Fundamental Principles

1. *Principle of primacy of patient welfare*. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the practitioner–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

2. *Principle of patient autonomy.* Practitioners should respect patient autonomy. Practitioners should be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical principles and do not lead to demands for inappropriate care.

3. *Principle of social justice*. The medical profession should promote justice in the health care system, including the fair distribution of health care resources. Practitioners should work actively to eliminate discrimination in health care, whether based on race, gender, gender identity, sexual orientation, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Practitioners should be committed to lifelong learning and to maintaining the medical knowledge and clinical and team skills necessary to deliver quality care. More broadly, the profession as a whole must strive to see that all of its members are competent[4] and must ensure that appropriate mechanisms are available for the profession to accomplish this goal.

Commitment to honesty with patients. Practitioners should ensure that patients are adequately and honestly informed before the patient has consented to treatment, and also after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on their course of therapy. Practitioners should acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide opportunities to develop and apply appropriate risk management strategies that should improve patient care, not only for patients who have been injured but also to prevent future harm moving forward.

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[4] Professional competence refers to "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287(2):226-235), *available at* https://jamanetwork.com/journals/jama/article-abstract/194554?casa_token=nY5Pp29vutgAAAAA:fUtkGd2lVdq0e1p1T61lgKV1MYyhQNxUHoO4aEOxeZL21IchaFYoxgdHGC-nwjX0YNQJkhYTK9k6

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to prevent disclosure of patient information unless disclosure is legally necessary. This commitment extends to discussions with persons acting on a patient's behalf when obtaining a patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever given the increasing availability of genetic information and the widespread use of electronic information systems for compiling patient data. However, practitioners recognize that their commitment to patient confidentiality must occasionally yield to overriding legal requirements that protect public health and safety (for example, when patients endanger themselves or others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between practitioners and patients must be avoided. Practitioners should avoid exploiting patients for personal financial gain, or other private purpose. For example, state law prohibits practitioners from engaging in sexual or romantic relationships with current patients. This ~~misconduct, which is defined in rule and~~ includes behaviors such as soliciting a date or kissing a patient in a romantic or sexual manner.[5] State law also prohibits romantic or sexual relationships with former patients if the practitioner uses or exploits the trust, knowledge, influence or emotions derived from the professional relationship, or uses or exploits privileged information to meet the practitioner's personal or sexual needs.[6] Practitioners should also abide by any ethical restrictions regarding romantic or sexual relationships with former patients that are applicable to their specialties.[7]

Commitment to improving quality of care. Practitioners should be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Practitioners should actively participate in the development and application of better quality of care measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Practitioners, both individually and through their professional associations, should take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems is the availability of a reasonable and adequate standard of care that is accessible to all patients. Practitioners should individually and collectively strive to reduce barriers to equitable health care. Within each system, the practitioner should help eliminate barriers to access which are often based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine without concern for the self-interest of the practitioner or the profession.

Commitment to a just distribution of finite resources. While treating individual patients, practitioners should provide health care that is based on the standard of care which considers cost-effective management and

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[5] WAC 246-919-630, 246-918-410. See also RCW 18.130.180(24).
[6] WAC 246-919-630(3). For additional guidance, see the WMC Guidance Document on "Sexual Misconduct and Abuse," GUI2017-03.
[7] For example, the American Psychiatric Association takes the position that sexual activity with a current or former patient is unethical. American Psychiatric Association: The principles of medical ethics (with annotations especially applicable to psychiatry), section 2. Arlington, VA: American Psychiatric Association, 2013. https://www.psychiatry.org/psychiatrists/practice/ethics. Accessed May 7, 2019.

limited resources. When medically necessary resources are scarce, such as during a pandemic, practitioners are encouraged to follow guidance from the Washington State Department of Health and local health departments to prioritize the needs of the public when there are not enough resources for all patients. Otherwise, practitioners should be committed to working with other practitioners, hospitals, and payers to develop and implement guidelines focused on the delivery of cost-effective care. While a practitioner, at times, may be tempted to "overtest" and "overtreat" to decrease their risk of medical malpractice claims, the practitioner's professional responsibility involving appropriate resource allocation requires scrupulous avoidance of superfluous tests and procedures. Providing unnecessary services not only exposes patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on integrity and the appropriate use of scientific knowledge, technology, and evidence-based medicine. Practitioners should uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence, practitioner experience, and effective communication.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including pharmaceuticals, laboratory services, medical equipment, and insurance companies. Practitioners should recognize, disclose to the public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determines the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, practitioners are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should define and organize the educational and standard-setting process for current and future members. Practitioners have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment, offering constructive feedback to peers, and accepting external scrutiny of all aspects of their professional performance.

Summary

The practice of medicine in the modern era faces unprecedented challenges in virtually all cultures within our society. These challenges center on disparities in our health care system, an inability to meet the legitimate needs of patients due to insufficient resources, the increasing dependence on market forces to transform health care systems, and the temptation for practitioners to forsake their traditional commitment to the primacy of patient interests for their own personal gain. To maintain the fidelity of medicine's social contract, the WMC believes that practitioners must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve our health care system for the welfare of society. The WMC adopts this Charter on Medical

Professionalism to encourage such dedication among practitioners and the profession in general, and to assure the public that the WMC upholds ideals of professionalism in the State of Washington.

Number:	GUI2018-01
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Reaffirmed:	N/A
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Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Practitioner Health

Assessment Framework

~~Practitioners~~[1]Physicians and physician assistants(PAs) have a duty to undergo an ongoing assessment of their health and competence to practice medicine, which involves a life-long process over the course of their careers. The Washington Medical Commission (WMC) recommends ~~practitioners~~ physicians and PAs participate in regular health evaluations as part of their ongoing professional responsibility. These health evaluations should include ~~physical dexterity as appropriate to the practitioner's practice~~, physical, psychological, cognitive, screening, ~~mental,~~ and substance use components and assessments should be individualized to the job-specific demands of the physician or PA's practice such as eyesight and manual dexterity evaluations for those performing surgical procedures. .

The WMC recommends that physicians and PAs~~practitioners~~ begin regular health evaluations upon completion of their first certification cycle (ABMS for physicians or NCCPA for physician assistants). If a physician or PAs~~practitioner~~ does not have a ~~pursue~~ certification cycle,[2] they ~~practitioner~~ should initiate a health evaluation upon completing their postgraduate training. These initial evaluations may serve as a baseline metric for future comparison during the physicians or PA's~~practitioner's~~ career.

Physicians and PAs~~Practitioners~~ who participate in recertification may find it convenient to do these assessments in conjunction with their recertification process, which generally occurs every seven to ten years. The WMC generally recommends physicians and PAs ~~practitioners~~ increase the frequency of these evaluations --to coincide with the increase in risk of developing limitations-- as they age. ~~Practitioners~~ Those with chronic conditions or with ~~known~~ disabilities that might impair safe practice should consider increasing the frequency of their assessments, regardless of age, to better enable monitoring of status changes.

Age	Minimum Recommended Frequency of Health Evaluations
25-54	Health evaluations every 5-7 years
55-64	Health evaluations every 2-5 years
65-74	Health evaluations every 2 years

[1] ~~Practitioner as used in this Guidance Document includes allopathic physicians and physician assistants.~~

[2] A practitioner may not have a certification cycle if the practitioner has a lifetime certification or if the practitioner pursued certification, but did not attain certification.

≥75	Health evaluations every year

Practice Modification

~~A practitioner will commonly encounter~~ With enough time in practice, a physician or PA will eventually encounter a point ~~in their practice~~ when their skills begin to decline. Such decline might be due to a physical limitation such as hearing loss or a tremor, or a cognitive limitation associated with normal aging or early dementia. ~~impairment such as early dementia~~. ~~While such decline is often associated with a normal aging process, the~~Age or health-related decline in practice performance may ~~inadvertently~~ impact a practitioner's ability to practice safely. Other causes of impairment, such as untreated mental illness and/or substance use disorder, also may create a risk of harm to patients. Regardless of etiology, it is important for ~~both the practitioner, and those in the practitioner's practice setting,~~the physician or PA, and those in their practice setting, to recognize signs of impairment and ~~address them for the safety of the practitioner and the patient~~intervene in support of the health of the physician or PA and the safety of the patients under their care.

~~Practitioners~~ Physicians and PAs should also be aware of the detrimental effects of burnout, a psychological response to chronic work-related stress, which may similarly impact their ability to practice safely. Burnout may be experienced as irritability, low frustration tolerance, exasperation, fatigue, dreading work, callousness toward patients, interpersonal conflicts, diminished social functioning, and existential doubts about career or life choices. If signs of burnout are present, the WMC recommends that practitioners take active measures to address issues related to burnout (both cause and effect) as quickly as possible. This may involve identifying contributing sources of burnout in the practice environment and working collaboratively with leadership to mitigate these issues. In certain cases, burnout may involve mentally or physically burdensome responsibilities that need modifications to not only alleviate burnout, but also to minimize the health risks they may impose on ~~practitioners~~ physicians or PAs and their patients.

The Washington Physicians Health Program (WPHP) can provide further evaluation and assistance to ~~practitioners~~ physicians and PAs when there is concern that a health condition may threaten the safe practice of medicine. Regardless of the cause (skills decline, mental illness, substance use disorder, or burnout), the WMC recommends ~~practitioners~~ physicians and PAs consider altering their practices when practitioner responsibilities become mentally or physically burdensome or present a risk to patients. ~~Practitioners~~ Physicians and PAs may consider practice modifications, such as reducing or eliminating overnight call schedules, mandating call recovery periods, shifting into ~~part time~~part-time practice, reducing office hours, and/or eliminating certain procedures. The WPHP encourages ~~practitioners~~ physicians and PAs to reach out should they seek further evaluation or assistance in identifying reasonable practice modifications.

Conclusion

The WMC encourages all ~~practitioners~~ physicians and PAs to undergo regular health evaluations to gauge their ability to practice safely over the course of their careers. Additionally, throughout their careers, physicians and PAs~~practitioners~~ should self-monitor and seek evaluation if they develop signs of skills decline,

cognitive impairment, mental illness, or substance use disorder. Further, ~~practitioners~~ physicians and PAs should monitor for signs of burnout and mitigate issues related to burnout as they arise.

With appropriate consideration of current health, burnout, and ability status, ~~practitioners~~ physicians and PAs can usually modify their practices, as necessary, to extend fruitful and satisfying careers. The WMC strongly supports all ~~medical practitioners~~physicians and PAs in proactively evaluating their health and competence on a regular, career-long basis, and utilizing results to adapt their practice as needed to maintain patient safety. The WPHP can provide further evaluation and assistance to practitioners to help ensure safe practice.

Number:	GUI2018-02
Date of Adoption:	April 13, 2018
Reaffirmed / Updated:	N/A
Supersedes:	N/A

Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Ownership of Clinics by Physician Assistants

Purpose

The Washington Medical Commission (WMC) sets forth its position on physician assistants owning clinics and hiring their sponsoring physician.

Introduction

Physicians and physician assistants face numerous ethical challenges every day in their practice. The ability to avoid ethical pitfalls is built on a foundation of the training that physician assistants and physicians receive during their education, as well as the ongoing continuing education process physician assistants and physicians engage in throughout their career. With ethical conundrums never far away, such attention to professionalism and ethical conduct is essential to provide high-quality, sensitive, and respectful care to patients. In an average clinical day for a physician assistant or physician, the clinician faces an almost uncountable array of decision-points related to ethical and professional care. These include documentation, billing, interactions with colleagues and staff, the selection of words and phrases to be used when talking with patients, interactions with vendors and the public, dealing with inquiries about patient information from a variety of sources, use of social media, and navigating potentially complex and pressured decision making about screening, exam and plans of care. All of these are areas where lack of attention to detail and sub-par decision-making can lead to ethical breaches and patient harm, and safe physician-physician assistant practice requires constant vigilance.

As with the above areas of risk, the interactions between physicians and physician assistants are also a possible area in which ethical and professional lapses can compromise patient care. In rare cases, physicians and physician assistants work in settings where the physician assistant is the owner of the clinic or business, and employs the supervising physician.

Most clinics and medical facilities are not owned by either physicians or physician assistants, but instead by a variety of other organizations. Such organizations hire physicians to lead the medical practice, and it would clearly be an ethical breach for such a facility to dictate medical practice to a medical employee, just as it would be an ethical violation for a physician assistant owner to undermine the decision-making authority of an employed supervising physician. Solid grounding in ethical and professional principles is what prevents such situations from occurring.

Such is the case in the uncommon setting where a physician assistant owns a practice and hires a physician who is then the supervising physician. These situations require standard ethical and professional principles to assure quality care for patients. Physician assistant ownership does not

change the legal requirements for physician assistants and physicians. The ethical practice of physician assistants and physicians requires knowledge of, adherence to, and compliance with these rules and laws, regardless of the ownership of the business. Failure to adhere to these laws risks harm to the public and disciplinary action against physicians and physician assistants.

Guideline

Physician assistants and physicians who work in a setting in which the physician assistant owns a clinic and employs his or her supervising physician should:

1. Understand that the primary duty of an owner or employee of a clinic is to provide high quality care to patients.
2. Understand the ethical challenges that can arise in such a relationship, particularly the reluctance to address or report unprofessional conduct or impairment.
3. Fully abide by the law regulating physicians and physician assistants, Chapter 18.71 RCW, Chapter 18.71A RCW, Chapter 246-918 WAC, and Chapter 246-919 WAC.
4. Fully abide by the mandatory reporting laws, RCW 18.130.080, RCW 18.130.070, RCW 18.71.0195, WAC 246-16-220 *et seq.*, WAC 246-919-700 *et seq.*, particularly the laws requiring reporting of other license holders, to wit:
    a. A license holder must report knowledge of a conviction, determination or finding that another license holder has committed an act of unprofessional conduct. WAC 246-16-235(1).
    b. A license holder must report that another license holder may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition. WAC 246-16-235(2). When there is no patient harm, this report may be made to one of the approved impaired practitioner or voluntary substance abuse programs.
    c. A license holder, corporation, organization, health care facility, and state and local governmental agency that employs a license holder must report to the WMC when an employed license holder's services have been terminated or restricted based on a final determination that a license holder has either committed an act of unprofessional conduct or may not be able to practice with reasonable skill and safety as a result of a mental or physical condition. RCW 18.130.080(1)(b).
5. Understand that the failure to comply with the law may subject the physician assistant and the physician to discipline.

Number:	MD2015-06
Date of Adoption:	June 26, 2015
Reaffirmed / Updated:	November 15, 2018
Supersedes:	None

Staff Reports: May 2022

Melanie de Leon, Executive Director

I, along with the Executive Directors of the Nursing and Pharmacy Commissions and the Board of Osteopathic Medicine and Surgery, received a letter from Attorney General Ferguson on Monday, May 16th requesting that the addressees make a statement that sent "a clear message that Washington welcomes health care providers from other states who come here to provide medically appropriate care that may be criminalized where they currently practice." This request was in anticipation of the Supreme Court overturning their holding in *Roe v. Wade*. I am meeting with the other executive directors to discuss the request on June 2nd. I will work with Commission leadership on next steps.

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 Agency policy, requests submitted after the cutoff cannot be paid out.

FSMB

- I was the WMC voting delegate for the House of Delegates. The HOD took the following actions:
  - WMC resolution on amending telemedicine model policy-failed
  - WMC resolution on digital credentialing efforts-approved
  - Model policy on telemedicine-approved
  - Model policy on DEI-approved
  - Model policy on misinformation-approved with some changes
- I presented as a panelist on digital licensing in a concurrent session that seemed well received.

Budget

- After nearly one year, we have received our final budget numbers for this year from the central budget office. This will be a subject of discussion in our Joint Operating Agreement renegotiations.
- We are developing a budget request for the 2023 legislative session to request spending authority to cover staff added as a result of the pandemic and timeline shortfalls in Licensing. We will bring forward for approval at the July meeting. After that it goes through the Governor's review process as part of the DOH budget.

Micah Matthews, Deputy Executive Director continued

Audits

- **Prescription Monitoring Program Audit**
  - This audit added WMC at the last minute but was limited by statutory language that did not let the auditors inspect raw PMP data. Aside from basic process improvements and quality control recommendations to PMP and PQAC, the SAO is recommending to the legislature that they be granted unrestricted access to the raw PMP data for their review and inspection.
  - Report to Legislature is scheduled for October 2022.
- **WMC Licensing and Discipline Audit**
  - The contracts are signed, and the first data request fulfilled so this audit is underway.
  - Field work is anticipated to be complete by late fall with a report in November 2022.

Joint Operating Agreement Renegotiations

Our primary contact is Deputy Secretary Fahrenbach, and the first meeting is early June. Unsure of outlook or progress at this point, but we do have our list of discussion items.

Pandemic Related Items

We are in discussions with DOH, WSMA, and the Governor's office regarding winding down the health care practitioner related waivers. While there is not a specific timeline in place to rescind them, the fact that the meetings were requested by the Governor's office should be seen as a desire to do so when possible or needed. I have asked for as much advance notice as possible prior to rescinding which was echoed by WSMA. More updates as this develops.

Amelia Boyd, Program Manager

Recruitment

We are seeking a Psychiatrist to serve as a Pro Tem Member. 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.

On June 30, 2022, we will have the following vacancies:

- Congressional District 3 – Alden Roberts, MD – not eligible for reappointment
- Congressional District 5 – April Jaeger, MD – eligible for reappointment
- Congressional District 9 – Robert Small, MD – not eligible for reappointment
- Physician-at-Large – Charlie Browne, MD – not eligible for reappointment
- Physician Assistant – James Anderson, PA-C – not eligible for reappointment
- Public Member – Toni Borlas – not eligible for reappointment
- Public Member – John Maldon – not eligible for reappointment
- Public Member – Yanling Yu, PhD – not eligible for reappointment

The application deadline for the Public Member positions has been extended to May 31, 2022. Applications can be submitted on the Governor's site.

Mike Hively, Director of Operations and Informatics

Operations & Informatics:

Recalled 11-years of paper-based records scanning and processing them for digital archiving in support of an ongoing internal review, fulfilled a compulsory records request from the Office of Inspecting General, and a unique data request for psychiatry and OB/GYN data from the Health Care Authority, developed and implemented a process to reduce paper-based records at the State Records Center by 10% monthly, and are currently designing an internal litigation hold program complete with associated processes and procedures.

Unit Accomplishments Include:

Digital Archiving

- Scanned 237 sexual misconduct cases
    - Digitally archiving approximately 91
- 480 active MD Licenses.
- 198 BT closures.
- 1,027MD licenses have been consolidated on unit shared drives.
- Approximately 2,080 census forms.

Data Requests/Changes

- Approximately 800 open/closed inquiries.
- Approximately 475 address and/or name changes.

Demographics

- Entered approximately 2,080 census forms into the IRLS database.
- Conducted 814 secondary census contacts.
- Quality checks on census data continues weekly.

Our Demographics and Informatics Specialist created the quarterly aggregate census report and new licensees list April 1. He also reviewed, entered responses to ILRS, and cleaned out Opinio census survey data for complete but unsubmitted census forms, and researched the state and DOH retention schedules to verify 2-years retention for survey and forms and their corresponding quarterly reports.

Team members also continue to support WMC units by processing incoming physical mail and packages ensuring the correct recipients receive them and continue to improve our processes through the creation of user-friendly automated data entry forms for compulsory requests, and the litigation hold program.

Morgan Barrett, MD, Medical Consultant

The Practitioner Support Program has made several successful contacts with Practitioners who are surprised and happy to discover that the WMC has made the PSP voluntary. We have only contacted half of the eligible Practitioners but will accelerate the calls in the coming weeks.

George Heye, MD, Medical Consultant

Nothing to report.

Rick Glein, Director of Legal Services

Summary Suspension:
In re Katherine G. Skelly, PA, Case No. M2020-834. On April 13, 2022, the Commission filed an Ex Parte Motion for Summary Action and Statement of Charges (SOC). On April 19, 2022, the Commission served an Ex Parte Order of Summary Suspension, summarily suspending Ms. Skelly's physician assistant license based on allegations of being unable to practice with reasonable safety due to a mental or physical condition. On May 9, 2022, Ms. Skelly filed an Answer to the SOC, along with her statement, and waived a hearing or settlement. A Final Order will be issued based on the facts available to the Commission.

Interim Stipulated Order:
In re Paul Thomas, MD, Case No. M2021-378. On February 10, 2022, the Commission filed a SOC alleging that on or about June 2021 an Interim Stipulated Order was filed with the Oregon Medical Board in which Dr. Thomas agreed to limit his practice to patients requiring acute care; not engage in consultations with parents or patients relating to vaccination protocols, questions, issues, or recommendations; and not perform any research involving patient care. On May 12, 2022, the Washington Medical Commission filed an Interim Stipulated Order mirroring the requirements of the Oregon Interim Stipulated Order. A hearing on the merits of the SOC is scheduled for February 6, 2023.

Orders Resulting from SOCs:
In re Andrew C. Tsen, MD, Case No. M2021-536. Final Order.* Dr. Tsen is board certified in general surgery and thoracic and cardiac surgery. Dr. Tsen's Washington medical license is currently expired. On September 14, 2021, the Commission filed a SOC alleging unprofessional conduct based on a Oregon Medical Board Stipulated Order which made findings and conclusions that Dr. Tsen violated the Oregon Medical Practice Act. On February 11, 2022, the Health Law Judge (HLJ) issued an Order on Partial Summary Judgment in which he granted the Commission's Motion and found there was no genuine issue of material fact. The sole remaining issue for hearing is the issue of sanctions. On March 15, 2022, the Commission filed a Case Specific Adjudication memo delegating decision-making authority of the Final Order to the HLJ. A virtual hearing was held March 25, 2022, regarding sanctions only. A Final Order was served on May 16, 2022, which ordered that Dr. Tsen must fully comply with the terms and conditions of the Oregon Board Order. Dr. Tsen must personally appear before the Commission within six months of applying to reactivate his Washington state medical license and pay a fine of $5,000.

In re Edmund Decato, PA, Case No. M2018-463. Final Order of Default (Failure to Respond).* In February 2022, the Commission filed a SOC alleging Mr. Decato failed to cooperate by not

furnishing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority. Mr. Decato did not file a response to the SOC within the time allowed. This matter came before a HLJ in March 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Mr. Decato's physician assistant license be indefinitely suspended**.

In re Jose de Jesus Martinez, MD, Case No. M2020-554. Final Order of Default (Failure to Respond).* On December 16, 2020, a HLJ, by delegation of the Commission, ordered that Dr. Martinez' medical license be suspended pending further disciplinary proceedings. The SOC alleges the Texas Medical Board issued a Final Order indefinitely suspending Dr. Martinez' medical license. Dr. Martinez did not file a response to the SOC within the time allowed. This matter came before a HLJ in March 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Dr. Martinez' medical license be indefinitely suspended**.

In re Michael Tepper, MD, Case No. M2020-938. Final Order of Default (Failure to Respond).* In February 2022, the Commission filed a SOC alleging Dr. Tepper failed to cooperate by not furnishing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority. Dr. Tepper did not file a response to the SOC within the time allowed. This matter came before a HLJ in March 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Dr. Tepper's medical license be indefinitely suspended**.

In re Richard Krebs, MD, Case No. M2020-933. Final Order of Default (Failure to Respond).* On February 19, 2021, a HLJ, by delegation of the Commission, ordered that Dr. Krebs' medical license be suspended pending further disciplinary proceedings. The SOC alleges that on or about April 2, 2020, the Oregon Medical Board accepted the surrender of Dr. Krebs' medical license while under investigation for dishonesty, diversion of controlled substances, use of a controlled substance without a valid prescription, and misrepresentation. Dr. Krebs did not file a response to the SOC within the time allowed. This matter came before a HLJ in March 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Dr. Krebs' medical license be indefinitely suspended**.

In re Muhammad Ahsan, MD, Case No. M2018-456. Final Order of Default (Failure to Respond).* In December 2018, the Commission served an Ex Parte Order of Summary Suspension, summarily suspending the medical license of Dr. Ahsan. The SOC alleges that the Michigan Board of Medicine issued a Final Order suspending Dr. Ahsan's medical license in that jurisdiction based on deficiencies regarding Dr. Ahsan's prescribing for and treatment of patients. Dr. Ahsan did not file a response to the SOC within the time allowed. This matter came before a HLJ in March 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Dr. Ahsan's medical license be indefinitely suspended**.

In re Jeffrey Lovin, MD, Case No. M2021-556. Final Order of Default (Failure to Respond).* On August 6, 2021, the Commission served an Ex Parte Order of Summary Suspension summarily suspending the medical license of Dr. Lovin. The SOC alleges that the Medical Board of California revoked Dr. Lovin's medical license in January 2021 for failure to comply with an order prohibiting him from practicing medicine after violating a previous agreement that restricted his practice. Dr. Lovin did not file a response to the SOC within the time allowed.

Rick Glein, Director of Legal Services continued

This matter came before a HLJ in March 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Dr. Lovin's medical license be indefinitely suspended**.

In re Adetokunbo Ladenika, MD, Case No. M2020-544. Final Order of Default (Failure to Respond).* On April 28, 2021, the Commission issued a SOC alleging Dr. Ladenika was sanctioned and reprimanded by the Virginia Board of Medicine based on his treatment of family members without establishing a bona fide practitioner-patient relationship. Dr. Ladenika did not file a response within the time allowed. This matter came before a HLJ in April 2022. The HLJ concluded sufficient grounds exist to take disciplinary action and ordered that Dr. Ladenika's medical license be indefinitely suspended**.

*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).

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

Items of Interest:

On April 29, 2022, Mike Farrell and Rick gave a presentation to the Washington Association of Medical Staff Services on the Commission's legal, investigative, and compliance functions. The presentation was well-received, with audience feedback of "this is one of the best sessions of the year" and requests to learn more about the Commission and closed cases.

On May 11, 2022, Kyle and Rick met virtually with Dr. Chris Bundy, Washington Physician Health Program (WPHP), for their quarterly meeting to discuss processes which lead to a productive relationship between WMC and WPHP and offer joint feedback in our ongoing mission of patient safety and enhancing the integrity of the profession through discipline and education.

Mike Farrell, Policy Development Manager

Other than the items on the policy committee agenda, nothing to report.

Freda Pace, Director of Investigations

CMT Sign-up for 2022

As of June 15th, we have several vacant slots for CMT through the end of the year. We need your help, support, and participation to complete this very important book of business.

If you sign up for a CMT slot and you have a last-minute schedule conflict, at your earliest opportunity, please notify Chris Waterman via email: chris.waterman@wmc.wa.gov. This courtesy cancellation notification will allow Chris the opportunity to fill any last-minute vacancy needs.

Freda Pace, Director of Investigations continued

CMT Statistics

	April 2022	April 2021
New cases reviewed	147	136
Cases Authorized	26 (17.6%)	40 (29.4%)
Cases closed	121 (82.3%)	96 (70.5%)
RFR reviewed	4	8
RFR authorized	1 (25%)	1 (12.5%)
RFR closed	3 (75%)	7 (87.5%)

New Voluminous Records process:

Often times Investigators receive records that are outside of the scope of the complaint. We will be rolling out a new process for Managing voluminous records in alignment with the State Government General Records Retention Schedule in the coming weeks. Part of making this process a success, investigators will continue to team up with the assigned Reviewing Commission Member to craft more detailed and specific records requests, designed to pare down documents that are germane to the investigation. This method will not only reduce the overall file size but reduce the risks to the agency by keeping documents that are superfluous and unnecessary.

Jimi Bush, Director of Quality and Engagement

Outreach / Engagement

Jimi Bush was presented with the Award of Merit at the Federation of State Medical Boards meeting in April. At that meeting we also presented a poster on our licensing program for international medical graduates. The poster was met with a lot of questions and praise and the Journal of Medical Regulation has asked us to submit a paper for peer reviewed publication. Jimi was also asked to give a presentation on engaging with stakeholders along with representatives from Ohio and California.

Performance

The end of the fiscal year is June 30th. Q&E will be compiling metrics and key performance indicators for our annual report. If there is a specific metric or area you would like to see detailed in that report, please let Jimi know by July 3rd.

Business Practices and Productivity

With the influx of new commissioners – we are taking a look at the orientation modules. If you think we need to include a topic or change the information in any of these topics, please let Jimi know ASAP.

We are also about to begin our annual website clean-up. If you have any feedback, please let Jimi know.

Marisa Courtney, Licensing Manager

Total licenses issued from 03/23/2022-05/17/2022= 902

Credential Type	Total Workflow Count
Physician And Surgeon Clinical Experience License	1
Physician And Surgeon Fellowship License	2
Physician And Surgeon Institution License	0
Credential Type	**Total Workflow Count**
Physician And Surgeon License	363
Credential Type	**Total Workflow Count**
Physician and Surgeon License Interstate Medical Licensure Compact	96
Physician And Surgeon Residency License	328
Physician And Surgeon Teaching Research License	2
Physician And Surgeon Temporary Permit	44
Physician Assistant Interim Permit	0
Physician Assistant License	59
Physician Assistant Temporary Permit	7
Totals:	**902**

Information on Renewals: March Renewals- 71.19% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	44	44
MD	986	368	1354
MDTR	2	4	6
PA	193	62	255
	71.19%	**28.81%**	**100.00%**

Information on Renewals: April Renewals- 72.01% online renewals

Credential Type	# of Online Renewals	# of Manual Renewals	Total # of Renewals
IMLC	0	33	33
MD	840	324	1164
MDRE	21	1	22
MDTR	5	0	5
PA	140	33	173
	72.01%	**27.99%**	**100.00%**

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Panel A
Personal Appearance Agenda

Friday, May 27th, 2022

Please join this meeting from your computer, tablet or smartphone:

https://global.gotomeeting.com/join/792815789

Panel Members:	Jimmy Chung, MD, Panel Chair	Charlie Browne, MD	Arlene Dorrough, PA-C	Anjali D'Souza, MD
	Harlan Gallinger, MD	Sarah Lyle, MD	Scott Rodgers, Public Member	Robert Small, MD
	Richard Wohns, MD	Yanling Yu, PhD, Public Member		
	Janet Barrall, MD, Pro-Tem	Alan Brown, MD, Pro-Tem	Mary Curtis, MD, Pro-Tem	Robert Golden, MD, Pro-Tem
	Charlotte Lewis, MD, Pro-Tem			

Compliance Officer: Anthony Elders

9:45 a.m.	**Stephen R. Kerr, MD** Attorney: Donna L. Lee	M2021-270 (13931 et al.) RCM: Robert Small, MD SA: Rick Glein
10:30 a.m.	**Carl Dezenberg, MD** Attorney: Stephen M. Lamberson	M2020-845 (2020-3750) RCM: Charlotte Lewis, MD SA: Trisha Wolf
11:15 a.m.	**Joshua A. Beers, MD** Attorney: Pro Se	M2020-692 (2019-17124) RCM: Charlotte Lewis, MD SA: Kelly Elder
Lunch Break		
1:15 p.m.	**Suraj Singh, MD** Attorney: Pro Se	M2021-181 (2020-12201) RCM: Scott Rodgers SA: Kyle Karinen
2:00 p.m.	**Sandra Bremner-Dexter, MD** Attorney: Steven J. Dixson	M2021-541 (2020-17633) RCM: Robert Small, MD SA: Joel DeFazio

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WASHINGTON Medical Commission
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Panel B

Personal Appearance Agenda

Friday, May 27th, 2022

Please join my meeting from your computer, tablet or smartphone:
https://global.gotomeeting.com/join/345525861

Panel Members:				
	April Jaeger, MD, Panel Chair	Terry Murphy, MD	Toni Borlas, Public Member	Alden Roberts, MD
	Diana Currie, MD	Karen Domino, MD	Claire Trescott, MD	Christine Blake, Public Member
	John Maldon, Public Member	James Anderson, PA-C	Michael Bailey, Public Member	
	Gregory Terman, MD, Pro Tem	William Brueggemann, MD, Pro Tem	Daniel Flugstad, MD, Pro Tem	
	Bruce Hopkins, MD, Pro Tem	Theresa Schimmels, PA-C, Pro Tem		

Compliance Officer: Mike Kramer

9:45 a.m.	**Victor O. Brooks, MD** Attorney: Pro Se	M2014-970 (2015-10678 et al.) RCM: Claire Trescott, MD SA: Kyle Karinen
10:30 a.m.	**David A. Baker, MD** Attorney: Colin F. Kearns	M2017-834 (2018-16198 et al.) RCM: Karen Domino, MD SA: Kyle Karinen
11:15 a.m.	**Christopher J. Godbout, MD** Attorney: Pro Se	M2017-823 (2016-11981) RCM: James Anderson, PA-C SA: Kyle Karinen
LUNCH BREAK		
1:15 p.m.	**Renee E. Grandi, MD** Attorney: Karen O'Casey	M2020-60 (2019-14342) RCM: Diana Currie, MD SA: Rick Glein
2:00 p.m.	**Hasan T. Ozgur, MD** Attorney: Amy J. Delisa	M2021-267 (2020-16630) RCM: Terry Murphy, MD SA: Kelly Elder
2:45 p.m.	**Cameron D. Chesnut, MD** Attorney: Hollie J. Westly	M2020-934 (2020-2178) RCM: Toni Borlas SA: Colleen Balatbat

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