Policy Committee Meeting
2nd Revised

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of the Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will take public comment at this meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Virtual via Teams Webinar: Registration link can be found below.
Commissioners and staff will attend virtually.
Physical location: 111 Israel Rd SE, TC2 Room 166, Tumwater, WA 98501

Thursday, February 27, 2025

Open Session

4:00 pm	Agenda	
To attend virtually, please **register** here: WMC Policy Committee		
The goal of this meeting is to create an open and welcoming forum for public input, allowing anyone to review, comment on, and suggest changes to the WMC's policies, guidance documents, procedures, and interpretive statements. We strongly encourage members of the public, healthcare professionals, and other interested parties to share their perspectives, as their feedback plays a vital role in shaping clear and effective policies.		
Organizers: Kyle Karinen, Executive Director & Micah Matthews, Deputy Executive Director		
1	**Policy: Complaints Against Students, Residents, and Fellows** *Discussion of policy which has completed DOH Secretary review*	Pages 3-5
2	**Guidance Document: Sexual Misconduct and Abuse (GUI2017-03)** *Review and discuss proposed revisions to the document as part of its scheduled four-year review process.*	Pages 6-11
3	**Policy: Elective Educational Rotations (POL2020-01)** *Review and discuss proposed revisions to the document as part of its scheduled four-year review process.*	Pages 12-13
4	**Interpretive Statement: Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants** *Review and discussion of current document.*	Pages 14-19
5	**Interpretive Statement: Opioid Prescribing & Monitoring for Patients** *Review and discussion of current document.*	Pages 20-24
6	**Written Comments** These comments are provided for consideration by the panel of Commissioners. They should review the comments, decide if action is needed, and explain their decision.	
	6.1 Comment from Dr. Partlow	Page 25
	6.2 Comment from Dr. Funk	Pages 26-30
	6.3 Comment from Cyndi Hoenhous, Co-Chair, Washington Patients in Intractable Pain	Pages 31-35

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Public Comment
The public will have an opportunity to provide comments about the items on this agenda. If you would like to comment, please use the Raise Hand function. Please identify yourself and who you represent, if applicable. If you would prefer to submit written comments, please email medical.policy@wmc.wa.gov by 5 pm on ***February 24, 2025****.*

Future Topics for Discussion

The following items are next up for review. Feel free to provide comments regarding these items at medical.policy@wmc.wa.gov.

	2025
1	Guidance Document: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety (GUI2014-02)
2	Policy: Elective Educational Rotations (POL2020-01)
3	Procedure: Interactive and Transparent Development of Evidence-based Policies and Guidelines (PRO2018-02)
	2026
1	Guidance Document: Medical Professionalism (GUI2018-01)
2	Guidance Document: Practitioner competence (GUI2018-02)
3	Guidance Document: Overlapping and simultaneous surgeries (GUI2018-03)
4	Guidance Document: Reentry to Practice guideline (GUI2019-01)
5	Guidance Document: Reentry to Practice for suspended licenses guideline (GUI2019-02)
6	Guidance Document: Informed Consent and Shared Decision-Making (GUI2022-01)
7	Guidance Document: Ownership of Clinics by Physician Assistants MD2015-06
8	Guidance Document: Medical marijuana authorization guidelines
9	Policy: Discrimination in Healthcare (POL2022-01)
10	Policy: Self-Treatment or Treatment of Immediate Family Members (POL2022-02)
11	Policy: Terminating the Practitioner-Patient Relationship (POL2022-03)

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Washington Medical Commission

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Policy Statement

Title:	Complaints Against Students, Residents, and Fellows
Policy Statement Number:	POL2025-02
Document Number:	
References:	NA
Contact:	Policy Manager
Phone:	(360) 236-2750
Email:	medical.policy@wmc.wa.gov
Effective Date:	TBD
Supersedes:	NA
Approved By:	TBD

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

Referring Student Complaints

PA, AA, and MD students are generally in the early stages of learning and practicing medicine, have little control over their practice conditions, and are being monitored in a highly structured, supervised environment. While the Commission may receive complaints against PA, AA, or MD students, the Commission recognizes that training Program directors and Deans are generally better

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

equipped to address standard of care concerns in an educational setting than the Commission. Complaints received by the Commission regarding actions outside of the training program related to the practice of medicine or not, may be investigated under the authority of RCW 18.71.230 and the investigatory and discipline process authorized under RCW 18.130. Examples of actions outside of a program of interest to the Commission include but are not limited to boundary violations, sexual misconduct, diversion, or criminal convictions.

Complaints against Residents

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

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

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

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

Complaints against Fellows

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

Guidance Document

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Sexual Misconduct and Abuse

"I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons."[1]

Guidance to Practitioners

To help prevent sexual misconduct and abuse, and to help practitioners maintain good professional boundaries with patients and key third parties, the Commission strongly recommends that a practitioner:

1. Consider having a chaperone present during examination of any sensitive parts of the body.
2. Be aware of any feelings of sexual attraction to a patient or key third party. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party. The practitioner should discuss such feelings with a supervisor or trusted colleague.
3. Be alert to signs that a patient or key third party may be interested in a romantic or sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the patient.
4. Transfer care of a patient to whom the practitioner is sexually attracted to another health care provider. Recognizing that such feelings in themselves are not compatible with competent professional practice, a practitioner should seek help in understanding and resolving them without exposing them to or impacting the patient or key third party in any way.
5. Respect patient and/or key third party's dignity and privacy at all times.
6. Provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a patient might have regarding the practitioner's intentions and the care being given.
7. Communicate with a patient in a clear, appropriate and professional manner. A practitioner should never engage in communication with a patient or key third party that

[1] Excerpt from Hippocratic Oath, Fourth Century B.C.

could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.

8. Refrain from discussing the practitioner's personal problems, or any aspect of the practitioner's intimate life with a patient or key third party.

Background

Sexual misconduct between practitioners and patients or key third parties detracts from the goals of the practitioner-patient relationship, exploits the vulnerability of the patient, and obscures the practitioner's objective judgment concerning the patient's health care.~~, and~~ It is a fundamental betrayal of trust and detrimental to the patient's well-being. Abusive behavior by a practitioner ~~can~~ harms ~~a~~ patients. The Washington Medical Commission (Commission) does not tolerate sexual misconduct or abuse in any form.

The Commission ~~first adopted a policy on sexual misconduct in 1992. The Commission revised the policy in 1996 and again in 2002. In 2006, the Commission established separate rules prohibiting sexual misconduct and prohibiting abuse.~~ maintains rules prohibiting sexual misconduct and abuse. The Commission issues these guidelines to increase practitioner awareness of the rules and to help practitioners maintain appropriate practitioner-patient boundaries.

Definitions

A "patient" is a person who is receiving health care or ~~treatment, or~~treatment or has received health care or treatment ~~without a termination of the physician-patient relationship~~. The determination of when a person is a patient is made on a case-by-case basis with consideration given to ~~a number of~~several factors, including the nature, extent and context of the professional relationship between the ~~physician~~ practitioner and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.[2]

A "practitioner" is a physician licensed under Chapter 18.71 or 18.71B RCW, ~~or~~ a physician assistant as licensed under Chapter 18.71A or 18.71C RCW, or a certified anesthesiologist assistant licensed under Chapter 18.71D RCW.

A "key third party" is a person in a close personal relationship with the patient and includes, but is not limited to spouses, partners, parents, siblings, children, guardians and proxies.[3]

Former Patients or Key Third Parties

As provided in the rules, a practitioner cannot engage in any of the above behaviors with a former patient or former key third party if the practitioner

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or
(b) Uses or exploits privileged information or access to privileged information to meet the practitioner's personal or sexual needs.

[2] WAC 246-919-630(1)(a) and WAC 246-918-410(1)(a).
[3] WAC 246-919-630(1)(c) and WAC 246-918-410(1)(c).

Guideline

The Commission ~~will~~ does not tolerate ~~a~~ practitioners engaging in sexual misconduct with a patient or key third party. As stated in the rules, a practitioner engages in sexual misconduct when ~~he or she~~they engage~~s~~ in the following behaviors with a patient or key third party, ~~whether or not it~~regardless of setting, professional or otherwise: ~~occurred outside the professional setting.~~

(a) Sexual intercourse or genital to genital contact;
(b) Oral to genital contact;
(c) Genital to anal contact or oral to anal contact;
(d) Kissing in a romantic or sexual manner;
(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;
(f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;
(g) Not allowing a patient the privacy to dress or undress;
(h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient or key third party is present;
(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;
(j) Soliciting a date;
(k) Communicating regarding the sexual history, preferences or fantasies of the physician.[4]

Commented [MM1]: Update with new rules update from OS to WMC rules.

Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.[5]

Consent

A patient's or key third party's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the prohibited nature of the conduct. ~~The~~ As the party in the professional relationship with the power imbalance, practitioner has full and sole responsibility to maintain proper professional boundaries at all times and in all settings. It is not a defense or a mitigating factor that the patient or key third party consented to, proposed, or initiated ~~the sexual~~sexual contact or the sexual or romantic relationship.

~~It is improper for a practitioner who engages in sexual misconduct with a patient or key third party to make efforts to avoid full and sole responsibility by pointing to the patient's or key third party's consent or initiation, or by making any other attempt to shift responsibility to the patient, for example, by asserting that the patient or key third party was seductive or manipulative.~~

Commented [MM2]: Previous paragraph fully prohibits and places responsibility. This is a qualifier that confuses the issue. Suggest deleting.

Termination of Practitioner-Patient Relationship

Best practice for practitioners licensed with the Commission is to never enter a relationship of a non-professional, romantic, or sexual nature with a patient or key third party. Once the

[4] WAC 246-919-630 (physicians), WAC 246-918-410 (physician assistants).
[5] Id.

practitioner-patient relationship has been established, the practitioner has the burden of showing that the relationship no longer exists. The mere passage of time is not determinative of the issue. Because of the varying nature of types of practitioner-patient relationships, variety of settings, differing practice types, and imbalance in power between practitioner and patient, individual analysis by the Commission is essential. As stated in the rules, the Commission will analyze each case individually and will consider ~~a number of~~several factors including, but are not limited to, the following:

(a) Documentation of formal termination;
(b) Transfer of the patient's care to another health care provider;
(c) The length of time that has passed;
(d) The length of time of the professional relationship;
(e) The extent to which the patient has confided personal or private information to the physician;
(f) The nature of the patient's health problem;
(g) The degree of emotional dependence and vulnerability of the patient or key third party.

Some practitioner-patient relationships may never effectively terminate because of the nature and extent of the relationship. As such, there is never an acceptable time when relationships of a sexual or romantic nature may occur in such instances. An example of one such specialty is psychiatry, where the national association has determined there is never an ability for the practitioner to engage in a non-therapeutic relationship of any kind with the patient or key third party. These relationships ~~may~~ will always raise concerns of sexual misconduct whenever there is sexual contact.[6]

~~**Former Patients or Key Third Parties**~~
~~As provided in the rules, a practitioner cannot engage in any of the above behaviors with a former patient or former key third party if the practitioner~~

~~(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or~~
~~(b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.~~

[6] Two opinions from the Washington Supreme Court provide guidance on the issue of whether a person is a current patient. In *Haley v. Medical Disciplinary Board,* 117 Wn.2d 1062 (1991), the court held that a patient whose contact with the surgeon was limited to the removal of her spleen and two follow up appointments was not a patient six months after the last follow up when a sexual relationship began. The court said that if the surgeon had been in another specialty that typically has an ongoing relationship with the patient, such as a family practitioner or an ob-gyn, the court would have found differently. In *Heinmiller v. Dept. of Health,* 127 Wn.2d 595 (1995), the same court found that a social worker who began a sexual relationship with a patient one day after terminating the professional relationship had sex with a client in violation of RCW 18.130.180(24).

Diagnosis and Treatment

Sexual misconduct does not include conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

Abuse

The Commission ~~will~~ does not tolerate a practitioner abusing a patient. As stated in the rules, a practitioner abuses a patient when ~~he or she~~they:

(a) Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;
(b) Removes a patient's clothing or gown without consent;
(c) Fails to treat an unconscious or deceased patient's body or property respectfully; or
(d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.[7]

~~**Discipline**~~

~~Upon a finding that a practitioner has engaged in sexual misconduct or abuse, the Commission will impose one or more sanctions set forth in RCW 18.130.160. In some cases, revocation may be the appropriate sanction. In others, the Commission may restrict and monitor the practice of a practitioner who is actively engaging in a treatment program. When imposing sanctions, the Commission must first consider what sanctions are necessary to protect the public. Only after this is done may the Commission consider and include sanctions designed to rehabilitate the practitioner.~~

Commented [MM3]: This is pretty common knowledge and is likely assumed. Suggest deleting.

~~**Recommendations to Practitioners**~~

~~To help prevent sexual misconduct and abuse, and to help practitioners maintain good practitioner-patient boundaries, the Commission strongly recommends that a practitioner:~~

~~1. Consider having a chaperone present during examination of any sensitive parts of the body.~~
~~2. Be aware of any feelings of sexual attraction to a patient or key third party. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party. The practitioner should discuss such feelings with a supervisor or trusted colleague. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party.~~
~~3. Transfer care of a patient to whom the practitioner is sexually attracted to another health care provider. Recognizing that such feelings in themselves are neither wrong nor abnormal, a practitioner should seek help in understanding and resolving them.~~
~~4. Be alert to signs that a patient or key third party may be interested in a sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the patient.~~
~~5. Respect a patient's dignity and privacy at all times.~~

[7] WAC 246-919-640 (physicians), WAC 246-918-420 (physician assistants).

6. ~~Provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a patient might have regarding the practitioner's intentions and the care being given.~~
7. ~~Communicate with a patient in a clear, appropriate and professional manner. A practitioner should never engage in communication with a patient or key third party that could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.~~
8. ~~Refrain from discussing the practitioner's personal problems, or any aspect of the practitioner's intimate life with a patient.~~

Guideline Number:	~~GUI2017-03~~GUI2025-04
Date of Adoption:	~~June 30, 2017~~TBD
~~Reaffirmed/~~Updated:	~~May 14, 2021~~TBD
Supersedes:	~~MD2002-05~~GUI2017-03

Policy

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Title:	Elective Educational Rotations
Policy Statement Number:	TBD
Document Number:	
References:	RCW 18.71.030(6) and (8), RCW 18.71.230, Chapter 18.130 RCW
Contact:	Washington Medical Commission
Phone:	(360) 236-2750
Email:	medical.policy@wmc.wa.gov
Effective Date:	TBD
Supersedes:	POL2020-01
Approved By:	,Chair

Policy

Medical students, ~~and~~ residents, and fellows in post-graduate medical training who are completing an elective educational rotation in the state of Washington are exempt from licensure for the specific purpose of completing the rotation.

RCW 18.71.030 lists exemptions to the requirement to have a license to practice medicine, and states, in part:

> Nothing in the chapter shall be construed to . . . prohibit:
> ...
> (6) The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state;
> ...
> (8) The practice of medicine by a person serving a period of postgraduate medical training in a program of clinical medical training sponsored by a college or university in this state or by a hospital accredited in this state, however, the performance of such services shall be only pursuant to his or her duties as a trainee.

The lack of a license requirement does not exempt those trainees covered by this policy from accountability by the Commission. Per RCW 18.71.230, any person practicing in the state of Washington under exemptions in RCW 18.71.030(5) through (12) is subject to

disciplinary action by the Washington Medical Commission. Any complaints received by the Commission on trainees, licensed or not, are processed according to the relevant procedure: Complaints against students, residents, fellows WMC

Therefore, medical students, ~~and~~ residents, and fellows who are in post-graduate medical training who are completing an elective educational rotation in Washington State are exempt from licensure for the specific purpose of completing the rotation.

Interpretive Statement

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Title:	Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants
Interpretive Statement Number:	INS2025-XX
Document Number:	
References:	RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-935
Contact:	Washington Medical Commission
Phone:	(360) 236-2750
Email:	medical.policy@wmc.wa.gov
Effective Date:	TBD
Supersedes:	INS2019-01, INS2023-03
Approved By:	,Chair

Description of the Issue

The Washington Medical Commission (Commission) is aware of concerns by practitioners that the Commission's opioid prescribing rules are inflexible and do not allow for variation based on patient presentation. The Commission is also aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids.

Interpretive Statement

The Intent and Scope section of both the physician opioid prescribing rule, WAC 246-919-850, and the physician assistant opioid prescribing rule, WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. The Commission encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments.

It is important to note that the rules are not inflexible and recognize the importance of sound clinical judgment. Those concerned about the use of the word "shall" within the rules are encouraged to review the Intent and Scope Section. This opening provision describes the purpose of the rules and sets the tone for interpretation and application of the entire opioid prescribing rule set by the Commission.

Background

In 2011, the Commission established rules for managing chronic, noncancer pain to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. Since 2011, the Legislature and Commission have made changes on the management of chronic pain to improve patient care and safety.

In 2018, at the direction of the Legislature,[1] the Commission created new rules regarding opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids. The Commission made minor modifications to the existing rules for managing chronic pain as well.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a physician to inform a patient that the patient has the right to refuse an opioid prescription for any reason and to require documentation and clarification regarding honoring that refusal.[2]

Additionally, in 2022, the Commission amended the rules to state the rules do not apply to the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities, and residential habilitation centers.[3]

Analysis

The opioid prescribing rules for physicians (WAC 246-919-850) and physician assistants (WAC 246-918-800) describe the Commission's intent and scope of the rules as follows:

> The [commission] recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.
>
> The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages [practitioners] to view pain management as a part of quality medical practice for all patients with pain, including acute, perioperative, subacute, and chronic pain. All [practitioners] should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids, including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.
>
> Inappropriate pain treatment may result from a [practitioner's] lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies

[1] Engrossed Substitute House Bill 1427.
[2] RCW 18.71.810; WAC 246-919-865(1)(e); WAC 246-918-815(1)(d).
[3] WAC 246-919-851(5); WAC 246-918-801(5).

may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that [practitioners] incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

[Practitioners] should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a [practitioner]-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the [practitioner's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist [practitioners] in providing appropriate medical care for patients. The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The

variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist [practitioners] in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

For more specific best practices, the [practitioner] may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

Commonly Asked Questions

1. What is episodic care and how does it apply to my practice?

For the purpose of these rules, episodic care usually includes patients seen in an emergency department or urgent care facility for chronic pain when complete medical records are not available. Additionally, patients seen in an ambulatory care setting with complaints associated with chronic pain whose complete medical records are not available would also be covered by this rule. However, some healthcare systems and clinics may have an associated urgent care facility with complete availability of medical records. These facilities would be excluded from the definition of episodic care for the purposes of these rules.

2. Does the rule define the entire standard of care for the management of pain?

No. The contents of the rules do address some important elements of the standard of care for pain management, but they do not define the entire standard of care. The rules are not exhaustive. The standard of care (current practice guidelines articulated by expert review) will continue to control circumstances and issues not addressed by the rule.

3. Is the 120 mg. MED "consultation threshold" a maximum dose under the rules?

No. The 120 mg morphine equivalent dose (MED) threshold is a triggering dose, intended to alert the practitioner to the fact that prescribing at this dose or higher significantly increases the potential for morbidity and mortality, and requires a consultation with a pain specialist unless the practitioner or circumstances are exempted under the rules. The articulation of this dose in the rules is consistent with the Legislature's requirement in RCW 18.71.450[4] to adopt rules that contain a dosage amount that must not be exceeded without pain specialist consultation.

Some have referred to the 120 mg MED threshold (or "triggering") dose as a "maximum dose". The rules do not provide a maximum dose. They simply require, absent an exemption, that the practitioner obtain a pain specialist consultation before continuing to

[4] ESHB 2876, effective June 10, 2010.

prescribe opioids at a level that is associated with significant increases in opioid-related overdoses and deaths.

4. Is the 120 mg. MED "consultation threshold" the minimum dosage at which a consultation should be obtained under the rules?

No. A practitioner should obtain a consultation when warranted. In WAC 246-919-930(2) and WAC 246-918-880(2), the threshold for mandatory consultation is set at 120 mg MED for adult patients. However, WAC 246-919-930(1) and WAC 246-918-880(1) reference, more generally, additional evaluation that *may* be needed to meet treatment objectives. This section makes specific reference to evaluation of patients under age 18 who are at risk, or who are potential high-risk patients. However, other circumstances may call for a consultation with a pain management specialist for patients who have not yet met the "consultation threshold" dose.

Specific Guidance from the Rules

WAC 246-919-955 and 246-918-905 provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- New patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:
    - The patient was previously being treated for the same conditions;
    - The patient's dose is stable and nonescalating;
    - The patient has a history of compliance with written agreements and treatment plans; and
    - The patient has documented function improvements or stability at the presenting dose.

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- There is evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- There is unauthorized escalation of doses;
- The patient is receiving an authorized escalation of dose with no improvement in pain or function.

A practitioner treating a patient on a stable, nonescalating dose with positive impact on function would not be required to seek additional consultation with a pain specialist. Additionally, there is no upper MED limit in Washington State or federal law. The Commission's opioid prescribing rules represent the only legal requirement and cite a 120

mg MED “consultation threshold” for allopathic physicians and physician assistants who are not considered pain management specialists under the rule. The rules do not prohibit practitioners from referring a patient to a pain specialist before patients reach the “consultation threshold,” nor do they prevent a practitioner from self-imposing a smaller MED limit for their patients.

For practitioners not considered pain management specialists treating patients over the 120 mg MED “consultation threshold,” there are several options to satisfy the exemption to the consultation requirement, including but not limited to:

- Receiving a peer-to-peer consult with a pain management specialist;
- Participating in an electronic (audio/video) case consult with the University of Washington (UW) Telepain, the Washington Health Care Authority (HCA) Opioid Hotline, or other pain consulting service;
- Documenting in a chart note the attempt to get a consult but the lack of success in attaining one; and
- Successfully completing a minimum of twelve category I continuing education hours in chronic pain management within the previous four years with at least two of those hours dedicated to substance use disorders.

The practitioner should document the outcomes, reasoning, and discussions with the patient as outlined in the rules and described in this interpretive statement in the patient’s medical record as part of the normal course of medical practice.

Interpretive Statement

WASHINGTON Medical Commission
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Title:	Opioid Prescribing & Monitoring for Patients
Interpretive Statement Number:	INS2025-XX
Document Number:	
References:	RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-935
Contact:	Washington Medical Commission
Phone:	(360) 236-2750
Email:	medical.policy@wmc.wa.gov
Effective Date:	TBD
Supersedes:	INS2019-02, INS2023-04
Approved By:	,Chair

Description of the Issue

The Washington Medical Commission (Commission) is aware that some practitioners are refusing to see or continue to treat patients who have taken or are currently using opioids. To help underscore and clarify the need for patient access and the rights of patients for treatment, the Commission issues this interpretive statement for patient and practitioner use.

Interpretive Statement

The Intent and Scope section of both the physician opioid prescribing rule, WAC 246-919-850, and the physician assistant opioid prescribing rule, WAC 246-918-800, states that appropriate pain management is the responsibility of the treating practitioner and that the inappropriate treatment of pain, including lack of treatment, is a departure from the standard of care. The Commission encourages practitioners, especially those in primary care, to view pain management as a part of standard medical practice for all patients and to become knowledgeable about assessing pain and effective treatments.

The Commission interprets physician rules WAC 246-919-850 to 246-919-985 and corresponding physician assistant rules WAC 246-918-800 to WAC 246-918-935 as encouraging practitioners to not exclude, undertreat, or dismiss a patient from a practice solely because the patient has used or is currently using opioids in the course of normal medical care. While in most circumstances a practitioner is not legally required to treat a particular patient, the refusal to see or continue to treat a patient merely because the patient has taken or is currently using opioids is contrary to the clear intent of the

Commission's rules governing opioid prescribing. Ending opioid therapy or initiating a forced tapering of opioids to a particular morphine equivalent dose (MED) level for reasons outside of abuse or clinical efficacy or improvement in quality of life and/or function would violate the intent of the rules.

Background

In 2011, the Commission established rules for managing chronic, noncancer pain to alleviate practitioner uncertainty, encourage better pain management, and assist practitioners in providing appropriate medical care for patients. Since 2011, the Legislature and Commission have made changes on the management of chronic pain to improve patient care and safety.

In 2018, at the direction of the Legislature, the Commission created new rules regarding opioid prescribing for acute nonoperative, acute perioperative, and subacute pain, including the use of multimodal pharmacologic and nonpharmacological therapies as possible alternatives to opioids.[1] The Commission made minor modifications to the existing rules for managing chronic pain as well.

In 2020, at the direction of the Legislature, the Commission revised its rules to require a practitioner to inform a patient that the patient has the right to refuse an opioid prescription for any reason.[2]

Additionally, in 2022, the Commission amended the rules to state the rules do not apply to the treatment of patients in nursing homes, long-term acute care facilities, residential treatment facilities, and residential habilitation centers.[3]

Analysis

The opioid prescribing rules for physicians (WAC 246-919-850) and physician assistants (WAC 246-918-800) describe the Commission's intent and scope of the rules as follows:

> The [commission] recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity, mortality, and costs associated with untreated or inappropriately treated pain. For the purposes of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.
>
> The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages [practitioners] to view pain management as a part of quality medical practice for all patients with pain, including acute, perioperative, subacute, and chronic pain. All [practitioners] should become knowledgeable about assessing

[1] Engrossed Substitute House Bill 1427.
[2] RCW 18.71.810; WAC 246-919-865(1)(e); WAC 246-918-815(1)(d).
[3] WAC 246-919-851(5); WAC 246-918-801(5)

patients' pain and effective methods of pain treatment, as well as become knowledgeable about the statutory requirements for prescribing opioids, including co-occurring prescriptions. Accordingly, these rules clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate [practitioner] uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from a [practitioner's] lack of knowledge about pain management. Fears of investigation or sanction by federal, state, or local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating [practitioner's] responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis. The commission recognizes that controlled substances including opioids may be essential in the treatment of acute, subacute, perioperative, or chronic pain due to disease, illness, trauma or surgery. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain.

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the [practitioner]. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. [Practitioners} should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids and are not the same as opioid use disorder.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that [practitioners] incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

[Practitioners] should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioids, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a [practitioner]-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the [practitioner treatment of the patient based on available documentation, rather than solely on the quantity and duration of

medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist [practitioners] in providing appropriate medical care for patients. The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not guarantee an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist [practitioners] in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

For more specific best practices, the [practitioner] may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

Examples

Existing Patient

A patient with a longstanding history in a medical practice develops an injury or condition that becomes a pain condition requiring chronic opioid therapy. Generally, a practitioner who refuses to treat the condition properly, including the appropriate utilization of opioids when opioids are clearly indicated, would be practicing below the standard of care. Similarly, a practitioner who refers the patient to a pain management specialist as defined by Commission rule but refuses to continue or support the pain management treatment plan designed by the specialist while responding to all other aspects of patient care, would generally be practicing below the standard of care. Finally, electing to terminate the patient from the practice because their regular care involves pain management or opioid therapy would be generally be practicing below the standard of care.

New Patient

The Commission's opioid prescribing rules provide incentives for practitioners to take new patients into their practice who are on existing opioid therapy regimens.

WAC 246-919-955 and 246-918-905, and the corresponding physician assistant rules, provide specific guidance to the practitioner to do the following with new patients on high dose opioids:

- Maintain the patient's current opioid doses until an appropriate assessment suggests that a change is indicated (see second bullet point).
- Evaluate over time if any tapering can or should be done.
- Be aware that new patients on high dose opioids are exempt from mandatory pain specialist consultation requirements for the first three months of newly established care if:

- The patient was previously being treated for the same condition(s);
- The presenting dose is stable and nonescalating;
- There is a history of compliance with written agreements and treatment plans; and
- There is documented function improvements or stability at the presenting dose.

Tapering

A patient on opioid therapy, chronic or otherwise, is on a stable nonescalating dose. A practitioner has observed the patient's function and quality of life to be positive. However, citing reasons related to state or federal law or desire to have the patient below a certain MED per day, the practitioner initiates a tapering schedule without receiving the patient's consent or considering the patient's function or quality of life. This would be a clear violation of the Commission opioid prescribing rules.

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when one or more of the following occurs:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- There is evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- There is an unauthorized escalation of doses; or
- The patient is receiving an authorized escalation of dose with no improvement in pain or function.

A practitioner treating a patient on a stable nonescalating dose with positive impact on function would not be required to seek additional consultation with a pain specialist. Additionally, there is no upper MED limit in Washington State or federal law. The Commission's opioid prescribing rules represent the only legal requirement for licensed allopathic physicians and physician assistants in Washington state and set a 120 mg MED consultation threshold for practitioners who are not considered pain management specialists under the rule. The rules do not prohibit practitioners from referring a patient to a pain specialist before patients reach the "consultation threshold," nor do they prevent a practitioner from self-imposing a smaller MED limit for their patients.

The practitioner should document the outcomes, reasoning, and discussions with the patient as outlined in the rules and described in this interpretive statement in the patient's medical record as part of the normal course of medical practice.

From: Kenneth Partlow
To: WMC Medical Policy
Subject: The disruptive MD
Date: Wednesday, January 22, 2025 3:03:39 PM

External Email

Sirs and Madams,

I have already sent a letter to your attorney about my time as a disruptive MD. He told me he would get the letter to you so I won't send it again.

My concern is the disempowerment of physicians.

I speak as a surgeon and disagree with your opening statement that disruptive behavior is a risk to patient safety.

The psychologists, who I assume are consulting for the WMC, have no deep knowledge of the operating room and its interactions and their conclusions, like that of many of the consultants I hired to analyze our business, are likely to be both superficial and expensive.

In your model, disruptive behavior is never seen as a positive. Rather it's always selfish, and the result of mental illness or (pejorative) manipulative behavior that leads to a bad outcome for the patient.

By adopting this policy without the appropriate meta-analysis support, the committee is behaving like a psychologist not like a doctor and is furthering the ability of those with no extended responsibility for the care of the individual patient to be able to manipulate doctors for potential emotional or personal reasons. Thus adding more burdens to the beleaguered MDs of Washington State.

The cancel culture is gradually fading away. Don't admit it into the hospital.

Ken Partlow, MD

Kay Funk, MD

February 24, 2025

Washington Medical Commission Policy
Committee PO Box 47866
Olympia, Washington 98504-7866
Medical.Commission@wmc.wa.gov

Honored Commissioners:

I am writing to support your decision to discontinue referrals of medical students to the Washington Physician Health Program (WPHP). Some participants benefit from WPHP, but the collateral damage is excessive. By my reading, none of the statutes which give the WMC authority, create mandated reporting by or about healthcare professionals, or define the tasks of a physician health program mention medical students. The contract between the Washington Department of Health (DOH) and WPHP does not include authority over medical students.

I am a retired family medicine physician who practiced in Yakima for 32 years and was elected to Yakima City Council. I began speaking out against the systematic intimidation of excellent physicians in 2008, when Yakima Valley Memorial Hospital became the only hospital in WA to ever lose an appellate court decision for dishonest peer review[1].

Innocent physicians and medical students began to come to me with stories of abuse by WPHP. Also, there are many published reports, including suicides. PHP spokespersons consistently dismiss these reports as “anecdotes”. PHPs also claim that participation is “voluntary”, but it is coercion when medical students are given a choice of participation or expulsion from school.

I am aware of two medical students, to whom I will refer as A (from UW) and B (from WSU). They have both been falsely diagnosed with Substance Use Disorder (SUD), although they are completely innocent and have exonerating evaluations from equally credentialed clinicians. They have both been recommended for inappropriate SUD inpatient treatment (estimated cost $60-180K out of pocket) or face expulsion from medical school. Both medical schools have said that they “trust” WPHP to make these punitive decisions, but have not provided any evidence of due diligence in evaluating lawfulness or program efficacy.

WPHP and the Alcoholic Anonymous treatment model

Within the current SUD treatment industry, there is a sharp polarization between an Alcoholic Anonymous (AA) treatment model vs. a “harm reduction” model[2]. Although outcome studies do not favor the AA model, and the Federation of State Physician Health Programs (FSPHP) has minimal evidence base of its own, they remain closely adherent to AA.

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[1] ***Smigaj vs. Yakima Valley Memorial Hospital***
Settlement is Landmark for Medical Peer Review, Yakima Herald-Republic, July 18, 2014
http://www.yakimaherald.com/news/yhr/friday/2345048-8/settlement-is-landmark-for-medical-peer-review#print

[2] ***Like Kennedy, I Recovered From Heroin Addiction. I Don’t Agree With His Approach.*** Maia Szalavitz. *New York Times*. Dec. 22, 2024.
https://www.nytimes.com/2024/12/22/opinion/kennedy-addiction.html

One of the quasi-religious tenets of AA is that history of addiction is a critical qualification for treatment of other addicts. Evidence does not support this belief, but it is consistent with the Physician Health Programs' apparent preferential use of addicts to conduct assessment of physicians and medical students. Preferential hiring improves the employment opportunities of these providers.

Not coincidentally, Dr. Chris Bundy, Executive Medical Director of WPHP and Chief Medical Officer of the Federation of State Physician Health Programs, and Dr. Laura Moss, Associate Medical Director of WPHP have both publicly confessed history of addiction, as have a number of their staff.

The Washington medical students were given a choice of four WPHP "preferred" facilities for evaluation:

- Student A traveled to Positive Sobriety Institute in Chicago and was evaluated by Dr. Frances Langdon[3]. The evaluation interview sounds inappropriate and sub-standard. This doctor had her Illinois medical license suspended because of "fraudulently dispensing and obtaining multiple Controlled Substances"[4].
- Student B was evaluated by Scott Teitelbaum, MD, Medical Director of Florida Recovery Center[5]. The evaluation interview sounds sub-standard. This doctor had his Connecticut license suspended for 5 years for abuse of multiple controlled substances, including crack cocaine[6].
- At Caron, another WPHP "preferred" facility in Pennsylvania, two of the treating physicians have been criminally prosecuted[7].
- Another recommended, and WPHP "preferred", facility is Pine Grove in Mississippi, where there have been multiple reports of patient abuse[8], and where Dr. Jay Neufeld died by suicide[9,10,11].

Some WPHP participants with SUD have had positive outcomes, which may be enhanced by the strict and prolonged substance abuse monitoring. But there have also been innumerable published reports of bad outcomes among PHP participants, including a recent review specific to medical students[12]. Amongst my personal contacts, there are multiple individuals who were referred to WPHP for a variety of reasons, including whistleblowing, and were falsely diagnosed with SUD. This is evidence of WPHP's clinicians' bias and projection.

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[3] https://www.positivesobrietyinstitute.com/new-model-comprehensive-addiction-treatment/
[4] https://idfprapps.illinois.gov/Forms/DISCPLN/2014_03enf.pdf Page 13
[5] https://floridarecoverycenter.ufhealth.org/category/scott-teitelbaum-md/
[6] https://disruptedphysician.blog/wp-content/uploads/2015/05/teitelbaum1.pdf
[7] Four links:
https://www.caron.org/our-team/dr-eric-heffelfinger
https://www.justice.gov/usao-edpa/pr/physician-pay-50000-and-permanently-cease-prescribing-opioids-resolve-allegations
https://www.caron.org/our-team/adam-scioli
https://www.poconorecord.com/story/lifestyle/2004/11/05/philly-doc-nabbed-in-drug/51058266007
[8] https://mississippitoday.org/2024/02/13/traumatized-by-past-abuse-women-say-therapist-added-to-their-pain
[9] ***Broken*: The *Jay Neufeld Story*,** from **If I *Betray These Words.*** Wendy Dean, MD & Simon Talbot, MD. 2023 Steerforth Press LLC.
[10] ***Jacob Neufeld's Legacy.*** Obituary. Journal of Pediatric Rehabilitation Medicine. https://jpedrehabmed.com/jacob-neufelds-legacy
[11] https://www.yelp.com/biz/pine-grove-behavioral-health-and-addiction-services-hattiesburg-3#reviews
[12] ***Medical schools need to offer students alternatives to state physician health programs.*** J. Wesley Boyd. Dec. 11, 2024. STAT https://www.statnews.com/2024/12/11/medical-school-state-mental-health-physician-health-programs/

In addition, PHPs and their "preferred Evaluation and Treatment Centers (ETACs)" routinely demand cessation of appropriate medications prescribed by equally credentialed physicians. The US Department of Justice (DOJ) has recently brought action against a state regulatory board for discrimination against an applicant taking appropriately prescribed medication in an equivalent situation[13]. There is no evidence that WPHPs are qualified to evaluate or treat any mental health problems other than addiction.

Delegation of Responsibility for Diagnosis and Sanction

The University of Washington School of Medicine is a leader in evidence based methodology (meta-analysis) for evaluation of clinical trials. However, school administrators have said that they "trust" WPHP with authority for punitive decision making without any published and peer reviewed evidence. The object appears to be to immunize the schools from liability.

However, multiple online references describe "delegation" of Americans with Disabilities Act (ADA) responsibility as actionable[14], including *"If recipients of federal funds could evade liability by simply placing the burden on third-parties with which the recipient enters into a contract, then the statutes would lose much of their force."* - Honorable Edmond E. Chang United States District Judge[15].

Washington Department of Health contract with WPHP

Review of the Washington Department of Health contract with WPHP, reveals some worrisome discrepancies from WPHP practice. The program is required to annually report:

> *e) Participant suicide data*
> *f) Americans with Disabilities Act (ADA) grievances filed with WPHP and, for each, a general description of how the grievance was resolved, including whether there was an accommodation made.*[16]

However, the 2023 Annual Report found on the WPHP website does not contain this data.[17] This information should be public record, as are Washington Medical Commission (WMC) sanctions against physicians. For minimal due diligence, the medical schools should review this collected data before placing "trust" in WPHP.

The contract allows broad power for WPHP to choose "*acceptable evaluators*" to judge physicians. However, both medical schools and WPHP refuse to consider input from any clinician outside their established stable of evaluators. That is not part of the contract or statutes:

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[13] ***DOJ Finds That Tennessee Attorney Regulatory Boards Discriminated Against Lawyers for Using Opioid Disorder Medications.*** *The Tennessee Star***.** Rachel Alexander. December 26, 2024
https://tennesseestar.com/news/doj-finds-that-tennessee-attorney-regulatory-boards-discriminated-against-lawyers-for-using-opioid-disorder-medications/rachel-alexander/2024/12/26/

[14] ***DOJ Goes All in on ADA is a Nondelegable Duty***. By William Goren. June 11, 2022.
https://www.understandingtheada.com/blog/2022/06/11/doj-statement-of-interest-ada-nondelegable-duty/

[15] **Access Living of Metro. Chi. v. City of Chicago.** United States District Court, Northern District of Illinois. Sep 30, 2024. 1:18-CV-03399 (N.D. Ill. Sep. 30, 2024)

[16] DOH Contract CBO26124 Page 8 of 37 Revision May 2021
STATEMENT OF WORK DOH CONTRACT CBO26124
WASHINGTON PHYSICIANS HEALTH PROGRAM
JULY 1, 2021-JUNE 30, 2026 pdf attached

[17] https://wphp.org/about/annual-reports/

> *WPHP shall refer professionals to **acceptable evaluators** that are licensed to operate as evaluators and/or treatment providers by the state in which they are located. To avoid conflict of interest, WPHP and its staff shall have no interest, financial or otherwise, with any program offering assessment and treatment."*

The criteria by which some programs are chosen or preferred are not transparent[18], and become circular when programs are "deemed acceptable [when they] comply with Federation of State Physician Health Program (FSPHP) ETAC guidelines." Those guidelines appear to be sold on their website, to members who are interested in providing such services, for $99[19] which is inconsistent with the transparency usually expected for patient care procedures.

In order to be a "chosen" program:

> *"b) The assessment program staff must have demonstrated expertise in recognition of the unique characteristics of health professionals and their response to these illnesses. A multi-disciplinary team experienced in setting firm limits and boundaries with health professionals shall provide the assessment."*

WPHP offers no objective evidence that there are "*unique characteristics of health professionals".* It is undisputed that addicts have neurophysiologic characteristics which are not shared by non-addicts. Because FSPHP treatment principles are driven by physician addicts, there is a predilection to see the "unique characteristics" of addicts as common to all health professionals. FSPHPs have no demonstrated competence to treat other mental health challenges, so addiction is overdiagnosed.

"S*etting firm limits"* sounds like a euphemism for the aggressive shaming to which participants report being subjected, and is absolutely antithetical to "trauma-informed" treatment. There are many published reports regarding trauma and suicide among medical professionals subjected to PHPs and their "preferred" ETACs.

> *"f) The professional must undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations must include appropriate toxicology testing and should be supervised by a physician with demonstrable knowledge of mental health and/or substance use disorders."*

The measurement of alcohol in blood and breath is not controversial. But WPHP utilizes alcohol metabolite testing which is not settled science,[20] [21] [22] and which is forbidden in forensic evaluation. In 2023, the US Department of Justice successfully prosecuted one WPHP-contracted laboratory[23] for kickbacks and fraudulent billing for tests which are not FDA approved[24], but WPHP continued to use this laboratory until April of 2024 when the laboratory declared bankruptcy. That WPHP contract violated the explicit WA DOH requirement that "Toxicology testing will be conducted by approved testing sites and laboratories in accordance with industry standards."

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[18] DOH Contract CBO26124 Page 9 of 37 Revision May 2021

[19] https://www.fsphp.org/guidelines

[20] ***Specificity of Blood Phosphatidylethanol (PEth) as a Marker for Alcoholic Beverage Consumption.*** January 4, 2021. Mike Cox
https://www.centerforprofessionalrecovery.com/specificity-of-blood-phosphatidylethanol-peth-as-a-marker-for-alcoholic-beverage-consumption/

[21] ***False Positive Results of Phosphatidylethanol (PEth) Quantitation in Dried Blood Spots (DBS): The Influence of Alcohol Vapors.*** *Separations* 2022, 9(9), 250. Anton Bashilov, et.al.
https://www.mdpi.com/2297-8739/9/9/250

[22] ***PEth Testing False Positives*** Published: 16 April 2024 Contributor: Karlene Petitt. Mendeley Data
https://data.mendeley.com/datasets/fg3r3qf7rj/1#:~:text=PEth%20is%20a%20biomarker%20determining,a%20false%20positive%20was%20possible.

[23] *https://www.justice.gov/opa/media/1368296/dl*

[24] ***FDA finalizes new regulations for laboratory-developed tests.*** AMA News April 30, 2024
https://drive.google.com/file/d/1sh4VZyvdo4KQCSddOpjEFMWPbYzKRUC-/view

Involuntary Psychiatric Treatment

In addition to the long historical record of abusive psychiatric incarceration, current reporting reveals that the civil rights of this vulnerable population continue to be violated[25]. These incidents are traumatizing and increase risk of suicide[26]. Within standard medical treatment, there are strong statutory protections and judicial remedies for involuntary treatment. WPHP operates outside judicial restraints, though it is not clear that this was the intent of the enabling legislation. The ADA prohibition on "delegation" of responsibility to third parties specifically supports access to judicial remedies for disabilities.

Transfer of authority from the transparency of the judiciary to the regulatory state should always arouse skepticism. I hope that your members will be willing to discuss this problem and suggest regulation with less collateral damage.

With Sincere Regards,
Kay Funk, MD

WA DOH contract with WPHP.pdf

[25] ***How a Leading Chain of Psychiatric Hospital Traps Patients.*** Jessica Silver-Greenberg and Katie Thomas. *New York Times.* Sept. 1, 2024
https://www.nytimes.com/2024/09/01/business/acadia-psychiatric-patients-trapped.html?searchResultPos.ition=2

[26] ***Held Involuntarily in a Psychiatric Hospital.*** *Letters to the Editor. New York Times.* Sept. 15, 2024.
nytimes.com/2024/09/15/opinion/involuntary-acadia-psychiatric-hospital.html

WA Medical Commission,
February 25, 2025

WashPIP continues to be grateful to the WA Medical Commission for your continued support for patients with intractable pain and responsible approach to opioid prescribing.

Unfortunately, we continue to hear from patients whose lives are in shambles from the misapplication of the WA Opioid Prescribing Rules and the CDC Guidelines.

We are seeing an increase in barriers preventing patients from receiving appropriate pain care. It is more critical than ever to find solutions to insurance blockages, manufacturer and distributor shortages and thresholds imposed at pharmacies, co-prescribing limitations casting a net at even muscle relaxers, and an ever-changing MED limit imposed, not by just physicians, but the bureaucrats that own their practices. Everyone in those facilities must be tapered down to a predetermined MED, no matter what the diagnosis, no matter if the patient is stable, benefitting from decreased pain, or thriving with increased function. The outcome for the patient is irrelevant in a medical field where less is the only win for the prescriber.

Unfortunately, in retrospect, the Interpretive Statements have done little to nothing to keep the doors of access open for patients. We hope more can be done later this year via clear language changes within the Opioid Prescribing Rules themselves regarding expectations on nonmedical tapers, legacy patient exemptions, and requirements to follow patient outcomes.

WashPIP would appreciate your consideration for our amended language today, in both the Physician and the Patient Interpretive Statements. Our proposals act as a reminder that MED is not the goal, individualized patient care is the goal. This is a hail Mary toss to possibly help even one patient suffering under the mandatory tapers mentioned above. They are losing their ability to function, earn livelihoods, and to take care of their families, not to mention their severe physical and mental suffering.

Thank you for your consideration.

Cyndi Hoenhous
Washington Patients in Intractable Pain
WashPIP

WashPIP Amended Interpretive Statement -Opioid Prescribing and Monitoring for **Allopathic Physicians and Physician Assistants**

I. Proposed language Pg. 3 of 6, paragraph 3

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and non- pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. Physicians should not set rigid MED requirements that could result in the undertreatment of pain or the unnecessary taper of patients whose pain level and function are stable. The commission will judge the validity of the practitioner's treatment of the patient based on available documentation, rather than solely on the quantity and duration, or MED of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. Practitioners should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids

Drafted Edits

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and non- pharmacologic modalities according to the judgment of the (practitioner). Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. **Insert language** (Practitioners) should not set rigid MED requirements that could result in the undertreatment of pain or the unnecessary taper of patients whose pain level and function are stable. **(Move up paragraph 6)** The commission will judge the validity of the practitioner treatment of the patient based on available documentation, rather than solely on the quantity and duration, **(Add "or MED)** or MED of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. Practitioners should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids
-Continue as written until paragraph 6

Cyndi Hoenhous Co-chair WashPIP

~~The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.~~

Step by Step Edits

1. Insert to paragraph 3: Practitioners should not set rigid MED requirements that could result in the undertreatment of pain or the unnecessary taper of patients whose pain level and function are stable.

2. Move up language from paragraph 6 and add in "or MED" language after "quantity": The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity **or MED** and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

3. Strike original paragraph 6 so it is not repeated.

II. Proposed Addition of the "Examples" section from the Opioid Prescribing and Monitoring for Patients Interpretive Statement.

- Existing Patient
- New Patient
- Tapering (Practitioners are not hearing clearly enough regarding tapering. The example section in the Patient Interpretive Statement provides and elegant solution.)

WashPIP Amended Interpretive Statement

Opioid Prescribing and Monitoring for Patients

Proposed language Pg. 3 of 5, paragraph 4

The medical management of pain should consider current clinical knowledge, scientific research, and the use of pharmacologic and non- pharmacologic modalities according to the judgment of the (practitioner). Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration, impact of the pain, and treatment outcomes. (Practitioners) should not set rigid MED requirements that could result in the undertreatment of pain or the unnecessary taper of patients whose pain level and function are stable. The commission will judge the validity of the practitioner treatment of the patient based on available documentation, rather than solely on the quantity and duration, or MED of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. Practitioners should recognize that tolerance and physical dependence are normal consequences of sustained use of opioids

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