Allopathic physicians (MD) chapter rule review

Rules Workshop

October 13, 2025

Rules Workshop Agenda

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

The Washington Medical Commission (WMC) is providing a virtual option for 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

Monday, October 13, 2025 – 1 pm to 3 pm

Allopathic physicians (MD) chapter rule review

Register for this virtual meeting at: Rules Workshop

Agenda	Page(s)
1. Housekeeping	
2. Roll Call	
3. Open workshop	
4. Overview of rules process and proposed timelines	3-8
5. Discuss proposed draft language	9-94
6. Next steps	98
7. Close workshop	
CR-101, Preproposal Statement of Inquiry, WSR #25-12-014	97
Written comments	111-247

What is a rule?

A rule, or regulation, is a written requirement that applies broadly across a group of individuals or entities that enables, guides, or directs them to do something, or prohibits them from doing something. Specifically, a rule:

- establishes or subjects individuals or entities to penalties if it is violated; or
- is a qualification or requirement that gives a benefit or privilege; or
- sets qualifications or standards that an individual or entity must meet to get a license or permit; or
- sets standards that must be met before a product or material can be sold.

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Rulemaking Process

- CR-101 – Preproposal Statement of Inquiry
- CR-102 – Proposed Rulemaking Notice
- CR-103 – Rulemaking Order
  - Concise Explanatory Statement

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Why amend the rules?

- RCW 43.70.041 requires the commission to review its administrative rules every five years to ensure that regulations are current and relevant.
- Modernize language, add clarity, and bring the rules more in line with current practice.
- Rulemaking is the best approach because requirements must be in rule to be enforced.

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WACs That May Be Amended

WAC 246-919-010 through 246-919-520

WAC 246-919-602 through 246-919-700

WAC 246-919-601 is open under a different rulemaking - Establishing the use of nitrous oxide in office-based surgical settings | Washington Medical Commission

WAC 246-919-850 through 246-919-985 are open under a different rulemaking - Opioid Prescribing General Provisions for MDs and PAs | Washington Medical Commission

WAC = Washington Administrative Code

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Background

- Revised Code of Washington (RCW)
  - Find your representatives: https://app.leg.wa.gov/districtfinder
- WMC Authority
  - RCW 18.71 – allopathic physicians or MDs

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Proposed Rule Development Timeline

May 2025: Inquiry CR-101 – Announces possible rulemaking

October 2025: Interested parties work begins – workshops, drafts, formal input

August 2026: request to initiate CR-102 – formal proposal

January 2027: Public hearing and written comments

April 2027: CR-103 – Final rule adoption and Concise Explanatory Statement

Mid-2027: Rules effective

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WAC 246-919-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant" is an individual who has completed the application form and has paid the application fee.

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

(3) "Delegation" means assigning certain tasks or duties to a qualified and trained individual while retaining ultimate responsibility for patient care outcomes.

(4) "Direct supervision" means the supervising physician is physically present and immediately available in the facility where services are provided, or, in the case of telemedicine or remote services, available via real-time communication and able to respond promptly.

(5~~3~~) "Emergent" means a circumstance calling for immediate action.

(6) "Good standing" means that a license is active and not currently encumbered by disciplinary action, restriction, or condition that limits the ability to practice.

Commented [DB1]: define "appropriate medical practice" for IMGs Bill SSB 5118

Commented [DB2R1]: This is already included in rule: 246-919-345(2)

Commented [DB3]: Should we add a definition for telemedicine?

Commented [DB4R3]: It is already defined in RCW 70.41.020(13) and RCW 48.43.735(9)(j)

(74) "Hospital" means any health care institution licensed under chapter 70.41 RCW.

(85) "Intermittent" means providing services on a part-time or full-time nonpermanent basis.

(96) "Physician" means a person licensed under chapter 18.71 RCW and chapter 18.71B RCW.

(10) "Postgraduate training" mans a period of clinical education and training following graduation from medical school, including internships, residencies, or fellowships, that is recognized by the commission or accredited by an organization recognized by the commission.

Commented [MM5]: We have historically allowed Panel L to recognize non-accredited fellowships after individual examination.

(117) "Unprofessional conduct" means the conduct described in RCW 18.130.180.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-010, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-010, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-010, filed 1/17/96, effective 2/17/96.]

WAC 246-919-020 Commission addresses. The commission's official mailing address is:

Washington Medical Commission

Department of Health

P.O. Box 47866

Olympia, WA 98504-7866

Licensing fees, in the form of a check or money order, should be sent to:

Department of Health

P.O. Box 1099

Olympia, WA 98507-1099

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-020, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-020, filed 1/17/96, effective 2/17/96.]

WAC 246-919-110 Commission meetings. Regular commission meetings shall be held at least four times yearly. Additional regular or special meetings may be called at the discretion of the chair or by a quorum of the commission.

[Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-110, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-110, filed 1/17/96, effective 2/17/96.]

APPLICATIONS AND EXAMINATIONS

WAC 246-919-300 Application withdrawals. An application for a license may not be withdrawn after the commission determines that grounds exist for denial of the license or for the issuance of a conditional license. Applications that are subject to investigation for unprofessional conduct or impaired practice may not be withdrawn.

The commission shall deny any application, regardless of mitigating circumstances, that contains the following information or conditions that constitute violations of 9A.32 through 9A.68A RCW:

(1) Murder in the 1st degree;

(2) Murder in the 2nd degree;

(3) Rape in the 1st degree;

(4) Rape in the 2nd degree;

(5) Rape in the 3rd degree;

Commented [MM6]: Language on mandatory denials and referrals related to criminal justice, board actions, and personal health issues added.

This is in response to national best practices and previous legislative attempts to require "pre-application determination reviews". This is a needed transparency and consistency measure.

(6) Rape of a child in the 1st degree;

(7) Rape of a child in the 2nd degree;

(8) Rape of a child in the 3rd degree;

(9) Molestation of a child in the 1st degree;

(10) Molestation of a child in the 2nd degree;

(11) Molestation of a child in the 3rd degree;

(12) Human trafficking;

(13) Kidnapping in the 1st degree of a non-family member;

(14) Abuse of human remains;

(15) Stalking;

(16) Criminal impersonation, specifically, impersonating a physician or other credentialed health care worker;

(17) Sexual exploitation of a minor;

(18) Commercial sex abuse of a minor;

(19) Promoting commercial sex abuse of a minor;

(20) Promoting travel or commercial sex abuse of a minor;

(21) Permitting commercial sex abuse of a minor.

The commission shall deny any application, regardless of mitigating circumstances, that contains the following

information or conditions relating to state regulatory action(s):

(1) Revocation of license;

(2) Current suspension of license;

(3) Three or more significant disciplinary actions, which do not include:

a. Actions mirrored under 18.130.370 RCW;

b. Public letters of concern, reprimand, or warning;

c. Private letters of concern, reprimand, or warning;

d. Actions taken by other states that do not constitute a violation of the Washington Medical Practice act.

The commission shall take the following actions on any application that contains the following information or conditions:

(1) Three or greater DUI/DWI arrests, deferred prosecutions, prosecutions, Alfred pleas, or convictions in the five (5) years preceding the date of the application shall result in a denial;

(2) Any DUI/DWI arrests, deferred prosecutions, prosecutions, Alfred pleas, or convictions in the five (5) years preceding the date of the application shall result in a referral to the recognized physician health program for evaluation;

~~(1)~~(3) Any mental, physical or other health condition that is not disclosed to the commission and falls outside of the safe harbor provision of being "known" to the state physician health program shall result in a referral to the recognized physician health program for evaluation.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-300, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-300, filed 1/17/96, effective 2/17/96.]

WAC 246-919-320 Approved United States and Canadian medical schools. For the purposes of RCW 18.71.055, the commission approves medical schools accredited by the Liaison Committee on Medical Education. The commission recognizes as equivalent the Committee on Accreditation of Canadian Medical Schools (CACMS) for the purposes of accepting Canadian medical

school graduates to apply for physician licensure. The commission reserves the authority to approve medical schools without accreditation or those medical schools, domestic or international, that have lost accreditation due to non-quality related reasons.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-320, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-320, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-320, filed 1/17/96, effective 2/17/96.]

WAC 246-919-330 Postgraduate medical training. (1) Postgraduate medical training means clinical training approved by the commission in general medicine or surgery, or a specialty or subspecialty in the field of medicine or surgery as recognized by the American Board of Medical Specialties listed in the 2017-2018 ABMS Board Certification Report and new specialties or subspecialties approved by the commission.

Commented [DB7]: MM addition

Commented [DB8]: MM addition

Commented [MM9]: The WMC can delegate these decisions to Panel L. Need this flexibility due to accreditation changes like the one with Canadian schools in 2025.

Commented [DB10]: Update to the most current version.

Commented [DB11R10]: MM: Alternatively, there are other WA health regulators who simply say "most current version of X" and they don't seem to have issues. Can we reconsider our approach on this?

Commented [DB12R10]: Washington law requires that if an agency incorporates material by reference in rule we must clearly identify the specific version or edition being adopted. RCW 34.05.365: Incorporation by reference.

(2) The commission approves only the following postgraduate clinical training courses:

(a) Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) at the time of residency.

(b) Programs accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC), or programs accredited by the RCPSC or CFPC at the time of residency.

(c) Programs accredited by the Commission On Dental Accreditation (CODA), either for the full duration of the training, or a portion, or accredited by multiple accrediting bodies as approved by the commission.

Commented [KK13]: We should make an attempt to fix this for six-year OMFS residencies where it is accredited by CODA for the entirety, but only for one year by ACGME.

Commented [MM14R13]: Suggested language in part c.

Commented [MC15R13]: Thank you! That is perfect

(3) Postgraduate medical training includes, but is not limited to, internships, residencies and medical or surgical fellowships.

(4) A physician must complete two years of postgraduate medical training. The physician must acquire this training after completion of a formal course of undergraduate medical

instruction outlined in RCW 18.71.055. The commission will accept only satisfactory clinical performance evaluations. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 24-13-019, § 246-919-330, filed 6/6/24, effective 7/7/24; WSR 20-22-003, § 246-919-330, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71.050. WSR 05-07-024, § 246-919-330, filed 3/7/05, effective 4/7/05. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-087, § 246-919-330, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-330, filed 1/17/96, effective 2/17/96.]

WAC 246-919-340 Additional requirements for international medical school graduates. All graduates of medical schools outside the United States, Canada, or Puerto Rico must satisfy one of the following requirements:

(1) Held a full and unrestricted license to practice medicine in another state prior to 1958. This provision expires January 1, 2030, and no further applicants will be considered after that date. Licensees who previously applied and were licensed through this pathway will be deemed valid until the expiration of their license.;

Commented [DB16]: MM: Someone meeting this would be 88 years old roughly. Maybe expire this provision on a specific timeline?

Commented [MC17R16]: I wouldn't be opposed removing this section

Commented [MM18R16]: Logic on the expiration date is 2025-1958+26 years for MD education. Assuming no PGT. Makes them 93 currently. Expiration in 2030 makes them 98 years old.

(1) Held a full and unrestricted license to practice medicine in another state prior to 1958;

(2) Obtained a certificate with an indefinite status granted by the Educational Commission for Foreign Medical Graduates (ECFMG); or

(3) Successfully completed one year of supervised academic clinical training in the United States, commonly referred to as a Fifth Pathway program.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-340, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-086, § 246-919-340, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-340, filed 1/17/96, effective 2/17/96.]

WAC 246-919-345 Limited physician and surgeon clinical experience license. (1) The commission may issue a limited physician and surgeon clinical experience license to an applicant who does not qualify for licensure under RCW 18.71.050 or chapter 18.71B RCW and who does meet the requirements established in RCW 18.71.095(6) for the purpose of gaining

clinical experience at an approved facility or program. For purposes of medical practice, employment role definition, malpractice coverage, credentialing, and insurance billing for plans described in, but not limited to, Title 48 RCW, the licensee shall be considered a full scope physician, unless disciplinary action limits the scope of the license held by the licensee or the supervising physician.

Commented [MM19]: From 2025 law update. Need this here for clarity and reference.

(2) An appropriate medical practice, as referenced in RCW 18.71.095 (6)(a), is a practice that meets the following criteria:

(a) The practice is physically located in the state of Washington and is providing clinical care to Washington patients.

(b) The practice falls within one of the following categories:

(i) Is a practice setting within a federal system such as military, Indian health services, tribal health setting, or community health center; or

(ii) Is a practice setting that:

(A) Has three or more physicians for the purposes of delivering direct patient care; and

(B) Has a quality review, improvement, and assurance program for practitioners.

(3) Prior to commencing practice, a limited physician and surgeon clinical experience license holder must file a practice agreement with the commission.

(4) To apply for a limited physician and surgeon clinical experience license, an applicant shall submit to the commission:

(a) An application provided by the commission; and

(b) Applicable fees as established in WAC 246-919-990.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 22-22-038, § 246-919-345, filed 10/25/22, effective 11/25/22.]

WAC 246-919-355 Examination accepted by the commission.

(1) The commission accepts the United States Medical Licensing Examination (USMLE) as the examination for licensure.

(2) The minimal passing scores for each component of any approved examination combination shall be defined by the examining authority.

(3) Applicants must have passed all components of the USMLE within seven years after passing the first examination. The commission recognizes that an applicant with a combined degree may require an exception to the seven-year requirement. The commission will review exception requests on a case-by-case basis.

(4) Beginning July 1, 2025, the commission will accept as equivalent passage of the Canadian Medical Licensing Exam in place of a valid USMLE score.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-355, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-355, filed 1/17/96, effective 2/17/96.]

WAC 246-919-360 Examinations accepted for licensure. (1) The commission may accept certain examinations as a basis for licensure. These examinations include USMLE, Federation Licensure Examination (FLEX), National Boards Examination (NBE), or those given by the other states, or territories of the United States. Those who have taken the Licentiate of the Medical

Commented [DB20]: MM: Out of date. Scores are three digit now and the 7 in 7 standard has been reduced. See Marisa for update.

Commented [MC21R20]: Can we say: (2) The minimum passing score for each component of any examination combination as defined by the examining authority.

Section 3 is still accurate. The number of attempts has changed, but we do not mention that in the WAC, so we do not need to update it.

Commented [DB22]: MM: Placeholder until I can find out if our recognition of CAN medical school accreditation translates into USMLE access for them.

Commented [MM23R22]: Update: Confirmed with FSMB that they will not allow Canadian graduates access to USMLE without ECFMG certification.

Council of Canada (LMCC) and hold a valid LMCC certification obtained after 1969, may be granted a license without examination.

Commented [DB24]: MM: Same issue as above. With dual accreditation going away, we need to make sure this will still be recognized as valid.

(2) ~~Examination combination acceptable.~~ Any applicant who has successfully completed Part I (NBE) or Step 1 (USMLE) plus Part II or Step 2 plus Part III or Step 3; or FLEX Component 1 plus Step 3; or Part I or Step 1, plus Part II or Step 2, plus FLEX Component 2 shall be deemed to have successfully completed a medical licensure examination as required by RCW 18.71.070. (For clarification, see Table 1.)

Table 1

Accepted Examinations taken in Sequence	**Other Acceptable Combinations**
NBME Part I *plus* NBME Part II *plus* NBME Part III	NBME Part I or USMLE Step 1 *plus* NBME Part II or USMLE Step 2 *plus* NBME Part III or USMLE Step 3
FLEX Component 1 *plus* FLEX Component 2	FLEX Component 1 *plus* USMLE Step 3 or NBME Part I or USMLE Step 1 *plus* NBME Part II or USMLE Step 2 *plus* FLEX Component 2

Accepted Examinations taken in Sequence	Other Acceptable Combinations
USMLE Step 1 *plus* USMLE Step 2 *plus* USMLE Step 3	

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-360, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.050, 18.71.090, and [18.71.]095. WSR 06-18-042, § 246-919-360, filed 8/30/06, effective 9/30/06. Statutory Authority: RCW 18.71.017. WSR 04-04-067, § 246-919-360, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-360, filed 1/17/96, effective 2/17/96.]

WAC 246-919-365 FLEX examination standards.

(1) The Federation Licensing Examination (FLEX) is no longer administered. However, the commission may consider FLEX scores for applicants who took the exam prior to its discontinuation.

(2) The commission accepts a FLEX weighted average score of 75 or higher, as officially reported by the Federation of State Medical Boards (FSMB).

(3) All FLEX scores must be submitted directly to the Commission by FSMB. FLEX scores submitted by other states or third parties will not be accepted.

~~The commission will accept the Federation Licensing Examination (FLEX) weighted average of 75 reported from the Federation of State Medical Boards. All FLEX scores must be submitted directly from the Federation of State Medical Boards. FLEX scores reported by other states will not be accepted.~~

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-365, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-365, filed 1/17/96, effective 2/17/96.]

WAC 246-919-370 Special purpose examination. (1) The commission may require an applicant to pass the Special Purpose Examination (SPEX) or any other examination deemed appropriate. An applicant may be required to take an examination when the commission has concerns with the applicant's ability to practice competently for reasons which may include, but are not limited to, the following:

(a) Resolved or pending malpractice suits;

Commented [DB25]: MM: Not offered anymore, but licensing still sees these applicants.

Commented [MC26R25]: Correct

Commented [DB27R25]: Possible rewrite: (1) The Federation Licensing Examination (FLEX) is no longer administered. However, the commission may consider FLEX scores for applicants who took the exam prior to its discontinuation.
(2) The commission accepts a FLEX weighted average score of 75 or higher, as officially reported by the Federation of State Medical Boards (FSMB).
(3) All FLEX scores must be submitted directly to the Commission by FSMB. FLEX scores submitted by other states or third parties will not be accepted.

Commented [MM28R25]: I like that new language, Amelia.

(b) Pending action by another state licensing authority;

(c) Actions pertaining to privileges at any institution; or

(d) Not having practiced for the immediate two years prior to the application.

(e) As an alternate examination for International medical Graduates unable to access the USMLE due to hardship as determined by the commission. SPEX exams offered under this process will be approved by commission delegates on a case-by-case basis.

Commented [DB29]: MM: SPEX oversight committee granted us this use case authority in 2024.

(2) The minimum passing score on the SPEX examination shall be seventy-five. The passing score for any other examination under this rule shall be determined by the commission. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-370, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-370, filed 1/17/96, effective 2/17/96.]

WAC 246-919-395 Substantially equivalent licensing standards—Temporary practice permit. (1) An applicant who holds an unrestricted, active license in another state with licensing standards substantially equivalent to those in Washington may

apply for a temporary practice permit authorizing the applicant to practice as a physician in Washington.

(2) The commission will issue the physician a temporary practice permit if the following requirements are met:

(a) The applicant submits a completed application for a physician and surgeon license on a form provided by the commission on which the applicant indicates that ~~he or she~~they wish~~es~~ to receive a temporary practice permit;

(b) The applicant submits payment of the application fee and temporary practice permit fee under WAC 246-919-990;

(c) The commission receives the American Medical Association's physicians' data profile verifying states in which the applicant is or was licensed;

(d) The commission receives the practitioner profile from the Federation of State Medical Boards;

(e) The applicant requests and the commission receives written verification attesting that the applicant has a license in good standing and is not subject to charges or disciplinary action for unprofessional conduct or impairment from all states which the applicant is or was licensed;

(f) The applicant is not subject to denial of a license or issuance of a conditional license under chapter 18.130 RCW; and

~~(g) The applicant is licensed in a state that has licensing standards substantially equivalent to Washington.~~

(3) The temporary practice permit allows the applicant to work in the state of Washington as a physician without restriction until the permit expires. The temporary practice permit is a full scope license to practice medicine and shall be recognized as such for the purposes of credentialing and insurance panel processes.

(4) The temporary practice permit shall expire upon the issuance of a license by the commission; initiation of an investigation by the commission of the applicant; or ninety days after the temporary practice permit is issued, whichever occurs first. The temporary permit will not be renewed, reissued, or extended.

(5) An applicant who receives a temporary practice permit and who does not complete the application process may not receive additional temporary practice permits even upon submission of a new application in the future.

Commented [DB30]: MM: This is stated in (1) of this section. Delete?

Commented [DB31R30]: I believe we can delete this one.

Commented [DB32R30]: Marisa: I am ok with us deleting

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-395, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.130.075. WSR 17-18-098, § 246-919-395, filed 9/6/17, effective 10/7/17. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-395, filed 1/17/96, effective 2/17/96.]

WAC 246-919-396 Background check—Temporary practice permit. The commission conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

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

permit allowing time to complete the national criminal background check requirements.

The commission will issue a temporary practice permit that is valid for six months. A one-time extension of six months will be granted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician during the time period specified on the permit. The temporary practice permit is a full scope license to practice medicine and shall be recognized as such for the purposes of credentialing and insurance panel processes.

Commented [MC33]: Thank you for adding this because it has been an issue in the past with facilities.

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

(4) The temporary practice permit is no longer valid after the license is issued or action is taken on the application because of the background check.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-396, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.130.064 and 18.130.075. WSR 10-05-029, § 246-919-396, filed 2/9/10, effective 2/11/10.]

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

(1) An expedited temporary license may be issued to an applicant who is a military spouse and:

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

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

(c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body in any other state

or United States territory in which the applicant holds a license.

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

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

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

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

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

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

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

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

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

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

(ii) A marriage license; or

(iii) Documentation of a state registered domestic partnership.

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

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

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States. [Statutory Authority: RCW 18.71.017, 18.130.050, and 2023 c 165. WSR 24-24-098, s 246-919-397, filed 12/3/24, effective 1/3/25.

Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-397, filed 10/21/20, effective 11/21/20.]

RENEWAL AND CME REQUIREMENTS

WAC 246-919-421 Two year renewal cycle. A licensed physician shall renew ~~his or her~~their license every two years in compliance with WAC 246-12-030. Prior to the commission authorizing a renewal, ~~A~~a licensed physician must also submit information about ~~his or her~~their current professional practice as required by RCW 18.71.080 (1)(b).

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-421, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-421, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-421, filed 11/16/99, effective 1/1/00.]

WAC 246-919-422 Transition from post-graduate limited license to full license. In order to obtain full license status, a physician with a post-graduate limited Washington license will pay the fee difference between the limited license

application and the full license application. This license will expire on their second birth date after issuance and every two years thereafter.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-422, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-422, filed 7/22/16, effective 8/22/16.]

WAC 246-919-430 Requirements for maintenance of licensure. A licensed physician must complete one of the following to satisfy maintenance of licensure requirements during renewal:

(1) Complete two hundred hours of continuing education every four years as required in chapter 246-12 WAC and as described in WAC 246-919-460. Participation in a residency program accredited by the Accreditation Council for Graduate Medical Education or in a fellowship program, accredited or not, may be credited fifty hours of Category I continuing medical education per year of training towards the ~~two hundred hour~~two-hundred-hour requirement;

(2) Obtain a current Physician's Recognition Award from the American Medical Association in at least two of the four years preceding the renewal due date;

(3) Obtain certification from a member board of the American Board of Medical Specialties (ABMS), or, if an international medical graduate ineligible for ABMS certification, from the American Board of General Practice, within the four years preceding the renewal due date.~~Become certified by a member board of the American Board of Medical Specialties in the four years preceding the renewal due date~~;

(4) Meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-430, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-430, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-430, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-430, filed 1/17/96, effective 2/17/96.]

WAC 246-919-435 ~~Training in suicide assessment, treatment, and management~~Suicide prevention training.

In accordance with RCW 43.70.442, all allopathic physicians licensed under chapter 18.71 RCW, excluding those holding a limited license as defined in RCW 18.71.095(3), must complete a one-time training in suicide assessment, treatment, and management.

(1) The training must be at least six hours in duration and may be completed in one or multiple sessions. It must be included on the model list of approved training programs developed by the Department of Health pursuant to RCW 43.70.442.

(2) The training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever occurs later.

(3) Allopathic physicians who have brief or limited patient contact, or no patient contact, are exempt from this requirement.

~~(1) A licensed physician, other than a resident holding a limited license issued under RCW 18.71.095(3), must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.~~

~~(2) The training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education period after initial licensure, whichever occurs later, or during the first full continuing education reporting period after the exemption in subsection (6) of this section no longer applies. The commission accepts training completed between June 12, 2014, and January 1, 2016, that meets the requirements of RCW 43.70.442 as meeting the one-time training requirement.~~

~~(3) The training must be on the model list developed by the department of health under RCW 43.70.442. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.~~

~~(4) The hours spent completing training in suicide assessment, treatment, and management count toward meeting~~

Commented [DB34]: MM: Do we need this anymore due to the statute?

Commented [DB35R34]: We have to retain at least part of this section because we specify the amount of hours and the exemption, which is not in the statute. This edit is my attempt at rewriting it.

Commented [DB36R34]: Note: If we make this change, we will need to update both the PA and AA chapters.

~~applicable continuing education requirements in the same category specified in WAC 246-919-460.~~

~~(5) The commission exempts any licensed physician from the training requirements of this section if the physician has only brief or limited patient contact, or no patient contact.~~

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-435, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 43.70.442. WSR 17-07-043, § 246-919-435, filed 3/8/17, effective 4/8/17.]

WAC 246-919-445 ~~Health equity~~Cultural safety continuing medical education training requirements. (1) A physician must complete two hours of health equity continuing education training, which focuses on cultural safety, every four years as described in WAC 246-12-800 through 246-12-830. Cultural safety is defined in 43.70 (5)(c) as an examination by health care professionals of themselves and the potential impact of their own culture on clinical interactions and health care service delivery.

This requires individual health care professionals and health care organizations to acknowledge and address their own

Commented [MM37]: Change is based on best practices coming out of Australia's health regulatory organization. Their findings are that "health equity" CME is not effective and focus on cultural safety education and even accreditation is effective.

Commented [DB38R37]: The statute that supports this rule does not have a requirement that the training focus on "cultural safety." It states that course topics may include "cultural safety" but are not limited to that subject. Therefore, the WMC can't limit the training be focused on "cultural safety." The minimum number of hours has been established in WAC 246-12-820 - which is 2 hours. So, I believe we can change this section to say that a physician must complete two hours of health equity training and that one hour must focus on cultural safety.

Commented [DB39]: This reference should be 43.70.613(3)(c)(vii)

biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care organizations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires health care professionals and their associated health care organizations to influence health care to reduce bias and achieve equity within the workforce and working environment.

Commented [DB40]: This section as written isn't a requirement. We may need to put this in a guidance document?

(2) The two hours of health equity continuing education a physician completes count toward meeting applicable continuing education requirements in the same category specified in WAC 246-919-460.

[Statutory Authority: RCW 18.71.017, 18.130.050, and 43.70.613. WSR 23-24-033, § 246-919-445, filed 11/29/23, effective 1/1/24.]

WAC 246-919-460 Categories of creditable continuing medical education activities. (1) **Category I: Continuing medical education activities with accredited sponsorship.** The licensed physician may earn all two hundred credit hours in Category I. The commission will accept attendance at a continuing education program that is recognized as Category I credit and is offered by an organization or institution that meets the standards adopted by the Accreditation Council for Continuing Medical Education the American Medical Association, the American Osteopathic Association, the American Academy of Family Physicians or recognized providing organizations~~its designated interstate accrediting agency, the Washington State Medical Association~~.

(2) **Category II: Continuing medical education activities with nonaccredited sponsorship.** A licensed physician may earn a maximum of eighty credit hours by attendance at continuing medical education programs that are not approved but which are in accordance with the provisions of Category I. Acting as a physician reviewer on regulatory cases, serving as an clinical expert witness, or participating in peer reviews at recognized

Commented [MM41]: Updating to reflect that there are numerous CME providers that are not accredited through ACCME. Responsive WAFP comment as well.

healthcare institutions may be claimed on an hour for hour basis as category II if not accredited as category I.

Commented [MM42]: Longstanding request from commissioners and other boards allow this for expert witnesses. Peer review just makes sense as it is in the same vein as residency or being an instructor.

(3) **Category III: Teaching of physicians or other allied health professionals.** A licensed physician may earn a maximum of eighty credit hours for serving as an instructor of medical students, house staff, other physicians or allied health professionals from a hospital or institution with a formal training program if the hospital or institution has approved the instruction.

(4) **Category IV: Books, papers, publications, exhibits.** A licensed physician may earn:

(a) A maximum of eighty ~~cCredit~~credit hours under Category IV, with specific subcategories listed below. Credit may be earned only during the forty-eight-month period following presentations or publications.

(b) Ten ~~cCredit~~credit hours for a paper, exhibit, publication, or for each chapter of a book that is authored by the licensed physician and published. A paper must be published in a recognized medical journal. A licensed physician who

presents a paper at a meeting or an exhibit must present to physicians or allied health professionals. Credit may be claimed only once for the scientific materials presented. Credit should be claimed as of the date materials were presented or published.

Medical editing will not be accepted in this or any other category for credit.

(5) **Category V: Self-directed activities.** A licensed physician may earn:

(a) A maximum of eighty ~~cCredit~~credit hours under Category V.

(b) Self-assessment: Credit hours for completion of a multimedia medical education program.

(c) Self-instruction: Credit hours for the independent reading of scientific journals and books.

(d) Specialty board examination preparation: Credit hours for preparation for specialty board certification or recertification examinations.

(e) Prior authorization ~~Quality care~~ or utilization review: Credit hours for participation on a staff committee for ~~quality~~

Commented [MM43]: Moved quality up to Cat 2. We should incentivize that more.

~~of care~~prior authorization or utilization review in a hospital or institution or government agency.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-460, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-919-460, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-460, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-460, filed 1/17/96, effective 2/17/96.]

WAC 246-919-470 Approval not required. (1) Except as required by law, the commission will not give prior approval for any continuing medical education. The commission will accept any continuing medical education that reasonably falls within these rules and relies upon each individual physician's integrity to comply with this requirement.

(2) The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of creditable hours may be determined by counting the contact hours of instruction and rounding to the

nearest quarter hour. The commission relies upon the integrity of program sponsors to present continuing medical education that constitutes a meritorious learning experience.

[Statutory Authority: RCW 18.71.002, 18.71.017, and 18.71.080. WSR 16-16-028, § 246-919-470, filed 7/22/16, effective 8/22/16. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-470, filed 1/17/96, effective 2/17/96.]

WAC 246-919-475 Expired license. (1) If the license has been expired for three years or less, the physician must meet the requirements of chapter 246-12 WAC, Part 2.

(2) A license that has lapsed or remained expired for more than three years is deemed surrendered to the commission. ~~If the license has been expired for over three years, the physician must:~~ Reissuance of the license is not automatic and may be subject to denial. A physician seeking licensure after such a lapse must:

(a) Reapply for licensing under current requirements as stipulated in RCW 18.71.050 (1)(b) and WAC 246-919-330; ~~and~~

(b) Meet the requirements of chapter 246-12 WAC, Part 2; and

Commented [DB44]: Freda Pace: Does this mean we still have jurisdiction even after the license is surrendered back to the commission? Seeking clarity when processing new complaints and the respondent's license has lapsed or expired for over 3 years.

Commented [DB45R44]: MM: My read is there is no license or property right. We would likely need to have a canceled status added to our SOPs. It is in ILRS, not sure if it came over to HELMS.

(c) Satisfy any additional requirements by the commission to demonstrate competence to practice.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-475, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017. WSR 01-03-115, § 246-919-475, filed 1/22/01, effective 2/22/01.]

WAC 246-919-480 Retired/Emeritus ~~active~~ license. (1) To obtain a ~~retired active~~retired/emeritus license a physician must comply with chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

(2) A physician with a ~~retired active~~retired/emeritus license may not receive compensation for health care services;

(3) A physician with a ~~retired active~~retired/emeritus license may practice only in emergent or intermittent circumstances; and

(4) A physician with a ~~retired active~~retired/emeritus license must renew every two years and must report one hundred hours of continuing medical education at every renewal. The commission will accept a maximum of forty hours of continuing medical education in Categories II through V, as defined in WAC

Commented [DB46]: MM: Is this a place where we stipulate that reactivation is not automatic and could be subject to denial? We really need clarity on that.

Commented [DB47R46]: Does this edit work to cover that stipulation?

Commented [DB48R46]: MM: I hope so. I fully support this clarification. Nice work.

Commented [DB49]: We can't use / in rule. We can say "or" instead.

Commented [DB50R49]: We would need to define "emeritus" in the definitions section.

Commented [DB51]: We will need to request a change to the fees section as that is where the different license types are called out.

246-919-460, during each renewal period. There is no limit to the number of hours that may be accepted in Category I. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-480, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.250, 18.71.440. WSR 11-05-025, § 246-919-480, filed 2/7/11, effective 3/10/11. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-919-480, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-480, filed 1/17/96, effective 2/17/96.]

WAC 246-919-490 Non-Clinical Status License.

The commission recognizes there are instances where a practitioner requires a medical license but does not intend to practice. Working in medical informatics, utilization review, and prior authorization services are examples requiring use of medical training but not involving direct patient care. For these purposes, the commission may issue a physician license with a non-clinical status designation under 18.71 RCW for new licenses or those who request such a conversion. The non-clinical status is a non-reportable and non-disciplinary designation that does not permit any form or amount of direct patient care. Licenses issued under 18.71B RCW through the

compact are not eligible for non-clinical status unless those licenses are converted to a license governed by 18.71 RCW.

(1) To obtain a non-clinical license status a physician must submit a request in writing on the form provided by the commission.

(2) A physician with a non-clinical status ~~may~~shall not participate in any aspect of direct patient care while holding a license with this status;

(3) A physician with a non-clinical license status may provide direct patient care only in emergent or intermittent circumstances not related to their employment; and

(4) A physician with a non-clinical status license must renew every two years and comply with the continuing medical education requirements of 249-919-421 through 470.

(5) Those licensees wishing to convert from non-clinical status to a full scope active clinical status must:

(a) Submit the request to the commission in writing on a form prepared by the commission;

Commented [DB52]: Since this is in the body of rule and not in an intent or scope section, I suggest changing this language as follows:
(1) A practitioner may hold a medical license without engaging in direct patient care for a variety of professional reasons. These may include, but are not limited to:
(a) Employment in medical informatics;
(b) Participation in utilization review activities;
(c) Work in prior authorization or similar administrative services; or
(d) Other roles that require medical training but do not involve the delivery of clinical care.
(2) A physician license with a non-clinical status designation may be issued under chapter 18.71 RCW for new applicants or for current licensees who request conversion to non-clinical status.
(3) A non-clinical status designation is non-disciplinary and non-reportable. A license in non-clinical status does not authorize the licensee to provide any form or amount of direct patient care.
(4) Licenses issued under chapter 18.71B RCW through the interstate medical licensure compact are not eligible for non-clinical status unless converted to a license governed by chapter 18.71 RCW.

(b) Submit the documentation required and requested demonstrating how the applicant maintained their knowledge and skills while in non-clinical status;

(C) Undertake any assessments or examinations required by the commission and provide the commission direct access to the full results;

(d) If requested, provide a re-entry to practice plan to include preceptors, institutional sponsorship, retraining, or other relevant information for the commission to consider in its decision to authorize the conversion.

(6) The commission approval of a request from non-clinical to full status and active status is discretionary and subject to the denial procedures contained in 18.130 RCW.

Commented [DB53]: These are fine as written and just need to be renumbered once the previous paragraph is changed.

ADJUDICATIVE PROCEDURES

WAC 246-919-520 Revocation of a physician's license. A physician may request a review by the commission of its decision to revoke the physician's license under RCW 18.71.019:

Commented [DB54]: MM: Between the DOH review officer and judicial review, why do we have this as an option? Does it ever get used? Does it need to be? Delete?

Commented [DB55R54]: Response from Mike F.: The reason we have this option is it is required by statute: RCW 18.71.019.

Also, the DOH review officer does not review WMC actions. They only review Secretary actions.

Yes, one respondent requested this a long time ago.

We have to keep it.

(1) If the commission issues a final order revoking a physician's license following an adjudicative proceeding, the physician may request a review of the decision by a review panel of the commission.

(2) The physician shall file a written request with the commission within twenty days of the effective date of the final order. The physician may not request an extension of the twenty-day period to file a request for review.

(3) The physician's request for review of the final order does not change the effective date of the final order.

(4) A review panel shall review the final order. The review panel is composed of the members of the commission who did not:

(a) Review the initial investigation and make the decision to issue a statement of charges against the physician in this matter; or

(b) Hear the evidence at the adjudicative proceeding and issue the final order revoking the physician's license.

(c) The review panel may find that a license holder can never be rehabilitated due to one or more of the following factors that include but are not limited to:

Commented [DB56]: Kyle: We should consider some non-exhaustive factors per Farrell's email to the revocations standards workgroup on June 2:

The disciplining authority may order permanent revocation of a license if it finds that the license holder can never be rehabilitated or can never regain the ability to practice with reasonable skill and safety. A disciplinary authority may find that a license holder can never be rehabilitated due to one or more of the following factors: an extensive disciplinary history; the heinousness of the conduct and vulnerability of the victim(s), serious criminal conviction(s); failure to comply with Commission orders; a refusal to acknowledge the need for rehabilitation; a lack of remorse, self-reflection and accountability; exploitation and disregard for others; and gross violations of professional and ethical standards that erode public trust in the profession demonstrating an unfitness to bear the responsibilities of, and enjoy the privileges of, the profession.

i. An extensive disciplinary history or pattern of condcut;

ii. the heinousness of the conduct and vulnerability of the victim(s) or~~,~~ serious criminal conviction(s);

iii. Conduct that represents an irreparable breach of trust in the eyes of the public or the social contract of the profession;

iv. failure to comply with Commission orders;

v. A refusal to acknowledge the need for rehabilitation;

vi. A lack of remorse, self-reflection and accountability; exploitation and disregard for others; ~~and~~,

vii. gross violations of professional and ethical standards that erode public trust in the profession demonstrating an unfitness to bear the responsibilities of, and enjoy the privileges of, the profession.

Commented [DB57]: MM addition in response to Kyle's comment above.

(5) Within seven days of receipt of the request for review of the final order, a scheduling order is issued setting a date for the review hearing, and a date for the filing of written argument by the parties. The review hearing must take place within sixty days of the physician's request for review of the final order.

(6) The review panel shall convene in person for the review hearing on the date set in the scheduling order. If a commission member is unavailable to meet on the scheduled date, a pro tempore member shall take that person's place on the review panel. At the review hearing, the review panel:

(a) Shall review the final order;

(b) Shall review written argument presented by the parties; and

(c) May hear oral argument by the parties.

(7) If the review panel determines that revocation of the physician's license is not the appropriate sanction, it shall issue an amended order setting the appropriate sanction(s) necessary to protect the public.

(8) If the review panel determines that revocation of the physician's license is appropriate, it shall issue an order confirming that decision.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-520, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.019. WSR 97-21-053, § 246-919-520, filed 10/13/97, effective 11/13/97.]

WAC 246-919-602 Administration of deep sedation and general anesthesia by physicians in dental offices. (1) Purpose. The purpose of this section is to govern the administration of deep sedation and general anesthesia by physicians in dental offices. The commission establishes these standards to promote effective perioperative communication and appropriately timed interventions, and mitigate adverse events and outcomes.

(2) Definitions. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Administering physician" means an individual licensed under chapter 18.71 RCW who administers deep sedation or general anesthesia to a patient in a dental office.

(b) "Deep sedation" has the same meaning as in WAC 246-919-601.

(c) "Dental office" means any facility where dentistry is practiced, as defined in chapter 18.32 RCW, except a hospital licensed under chapter 70.41 RCW or ambulatory surgical facility licensed under chapter 70.230 RCW.

(d) "General anesthesia" has the same meaning as in WAC 246-919-601.

(e) "Perioperative" includes the three phases of surgery: Preoperative, intraoperative, and postoperative.

(3) An administering physician is responsible for the perioperative anesthetic management and monitoring of a patient and must ensure patient care, recordkeeping, equipment, personnel, facilities, and other related matters are in accordance with acceptable and prevailing standards of care including, but not limited to, the following:

(a) Preoperative requirements. An administering physician shall ensure the patient has undergone a preoperative health evaluation and document review of the evaluation. The physician shall also conduct and document a risk assessment to determine whether a patient is an appropriate candidate for deep sedation or general anesthesia and discussion of the risks of deep sedation or general anesthesia with the patient. For a pediatric patient, this assessment must include:

(i) Whether the patient has specific risk factors that may warrant additional consultation before administration of deep

sedation or general anesthesia, and how each patient meets criteria for deep sedation or general anesthesia in an outpatient environment. This must include a specific inquiry into whether the patient has signs and symptoms of sleep-disordered breathing or obstructive sleep apnea;

(ii) A discussion with a parent or guardian of a pediatric patient of the particular risks of deep sedation or general anesthesia for a patient who: (A) Is younger than six years old; (B) has special needs; (C) has airway abnormalities; or (D) has a chronic condition. This discussion must include reasoning why the pediatric patient can safely receive deep sedation or general anesthesia in an outpatient environment and any alternatives.

(b) Medical record. The anesthesia record must be complete, comprehensive, and accurate for each patient, including documentation at regular intervals of information from intraoperative and postoperative monitoring. The recordkeeping requirements under WAC 246-919-601 and 246-817-770 apply to an administering physician, including the elements of a separate anesthesia record. The anesthesia record must also include

temperature measurement and a heart rate and rhythm measured by electrocardiogram. For a pediatric patient, the administering physician shall ensure vital signs are postoperatively recorded at least at five-minute intervals until the patient begins to awaken, then recording intervals may be increased to ten to fifteen minutes.

(c) Equipment. An administering physician shall ensure the requirements for equipment and emergency medications under WAC 246-817-724 and 246-817-770 are met, regardless of any delineated responsibility for furnishing of the equipment or medications in a contract between the physician and dental office. Additionally, for a pediatric patient, an administering physician shall ensure there is a complete selection of equipment for clinical application to the pediatric patient. The physician shall also ensure equipment is available in the recovery area to meet the requirements in this section for monitoring during the recovery period. The physician shall ensure all equipment and medications are checked and maintained on a scheduled basis.

(d) Recovery and discharge requirements. An administering physician shall ensure that:

(i) A physician licensed under chapter 18.71 RCW capable of managing complications, providing cardiopulmonary resuscitation, and currently certified in advanced cardiac life support measures appropriate for the patient age group is immediately available for a patient recovering from anesthesia. For a pediatric patient, the physician shall also be trained and experienced in pediatric perioperative care;

(ii) At least one licensed health care practitioner experienced in postanesthetic recovery care and currently certified in advanced cardiac life support measures appropriate for the patient age group visually monitors the patient, at all times, until the patient has met the criteria for discharge from the facility. Consideration for prolonged observation must be given to a pediatric patient with an anatomic airway abnormality, such as significant obstructive sleep apnea. A practitioner may not monitor more than two patients simultaneously, and any such simultaneous monitoring must take place in a single recovery room. If a practitioner is qualified

to administer deep sedation or general anesthesia, the practitioner may not simultaneously administer deep sedation or general anesthesia and perform recovery period monitoring functions. The practitioner shall provide: (A) Continuous respiratory monitoring via pulse oximetry and cardiovascular monitoring via electrocardiography during the recovery period; and (B) monitoring, at regular intervals, during the recovery period of the patient for color of mucosa, skin, or blood, oxygen saturation, blood pressure, and level of consciousness; and (C) measurement of temperature at least once during the recovery period. If a patient's condition or other factor for the patient's health or safety preclude the frequency of monitoring during the recovery period required by this section, the practitioner must document the reason why such a departure from these requirements is medically necessary;

(iii) Emergency equipment, supplies, medications, and services comply with the provisions of WAC 246-817-770 and are immediately available in all areas where anesthesia is used and for a patient recovering from anesthesia. Resuscitative equipment and medications must be age and size-appropriate,

including for care of a pediatric patient, pediatric defibrillator paddles, and vasoactive resuscitative medications and a muscle relaxant such as dantrolene sodium, which must be immediately available in appropriate pediatric concentrations, as well as a written pediatric dose schedule for these medications. The administering physician shall ensure that support personnel have knowledge of the emergency care inventory. All equipment and medications must be checked and maintained on a scheduled basis; and

(iv) Before discharge, the patient is awake, alert, and behaving appropriately for age and developmental status, normal patient vital signs, and if applicable, a capable parent or guardian present to assume care of the patient.

(e) Emergency care and transfer protocol. An administering physician shall monitor for, and be prepared to treat, complications involving compromise of the airway and depressed respiration, particularly with a pediatric patient. The physician shall ensure that in the event of a complication or emergency, ~~his or her~~their assistive personnel and all dental office clinical staff are well-versed in emergency recognition,

rescue, and emergency protocols, and familiar with a written and documented plan to timely and safely transfer a patient to an appropriate hospital.

(4)(a) An administering physician shall submit to the commission a report of any patient death or serious perioperative complication, which is or may be the result of anesthesia administered by the physician.

(b) The physician shall notify the commission or the department of health, by telephone, email, or fax within seventy-two hours of discovery and shall submit a complete written report to the commission within thirty days of the incident. The written report must include the following:

(i) Name, age, and address of the patient;

(ii) Name of the dentist and other personnel present during the incident;

(iii) Address of the facility or office where the incident took place;

(iv) Description of the type of anesthetic being utilized at the time of the incident;

(v) Dosages, if any, of any other drugs administered to the patient;

(vi) A narrative description of the incident including approximate times and evolution of symptoms;

(vii) Additional information which the commission may require or request.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-602, filed 10/21/20, effective 11/21/20.]

STANDARDS FOR PROFESSIONAL CONDUCT

NEW SECTION

WAC 246-919-604 Qualified Physician Under Optometry Law. This section establishes the qualifications and scope of a "qualified physician" for the purposes of chapter 18.53 RCW.

(1) A "qualified physician" means a person who:

(a) Holds an active, unrestricted license to practice medicine and surgery in the state of Washington under chapter 18.71 or 18.71B RCW;

(b) Is not currently under an order or a stipulation to informal disposition with the commission;

(c) Holds a current and unrestricted certification from the American Board of Ophthalmology or is eligible to do so; and

(d) Has a surgical suite on site or holds privileges at a ~~local~~ hospital local to the ophthalmologist. Local to the ophthalmologist is considered within twenty (20) minutes or less of surface travel.

(2) A qualified physician may provide consultation, supervision, or collaborative care to licensed optometrists consistent with applicable laws and rules governing both professions.

Commented [MM1]: Current IS language.

(3) A qualified physician under this section may enter into an allowable agreement under 18.53.010 (5) (iii) RCW with an optometrist granted an expanded procedures endorsement by the board of optometry, so long as the qualified physician abides by the following requirements:

a. No more than three agreements with three individual optometrists may be active at given time;

b. No agreement may extend beyond 12-months before requiring updating and renewal;

c. No valid agreement shall stipulate referral to a primary care practitioner, urgent care, emergency department, or any combination thereof as an appropriate response to complications from expanded scope procedures performed under the agreement;

d. The qualified physician named in the agreement may not be located more than fifty (50) miles or one hour of surface travel, whichever is shorter, from the site of patient care delivery by the optometrist;

e. Agreements must stipulate the specific procedures the qualified physician will intervene on should complications arise;

f. Agreements must be filed with the commission by the qualified physician within fourteen (14) days of execution. Agreements shall be sent to medical.commission@wmc.wa.gov or submitted on a form provided by the commission;

g. The qualified physician shall file a report with the commission if any emergent response is required under the agreement. The report:

i. Serves as notification only and is non-disciplinary;

ii. Shall detail the dates, times, procedure, intervention, and outcome for the patient;

iii. Shall not detail names or contact information of patients;

iv. Shall be sent to the commission at medical.commission@wmc.wa.gov or submitted on a form provided by the commission.

WAC 246-919-605 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this rule, laser, light, radiofrequency, and plasma devices (hereafter LLRP devices) are medical devices that:

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

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

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

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

~~PHYSICIAN RESPONSIBILITIES~~

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

(5) A physician must use an LLRP device in accordance with standard medical practice.

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

(7) Regardless of who performs LLRP device treatment, the physician is ultimately responsible for the safety of the patient.

(8) Regardless of who performs LLRP device treatment, the physician is responsible for assuring that each treatment is documented in the patient's medical record.

(9) The physician must ensure that there is a quality assurance program for the facility at which LLRP device procedures are performed regarding the selection and treatment of patients. An appropriate quality assurance program shall include all of the following:

(a) A mechanism to identify complications and untoward effects of treatment and to determine their cause;

(b) A mechanism to review the adherence of supervised professionals to written protocols;

(c) A mechanism to monitor the quality of treatments;

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection (10)(d) of this section and physician supervising practices; and

(e) Ongoing training to maintain and improve the quality of treatment and performance of treating professionals.

~~PHYSICIAN DELEGATION OF LLRP TREATMENT~~

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

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

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

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

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

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

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

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

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

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

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

(vii) A statement of the activities, decision criteria, and plan the supervised professional shall follow when performing

delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made;

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

(f) The delegating physician ensures that the supervised professional uses the LLRP device only in accordance with the written office protocol, and does not exercise independent medical judgment when using the device;

(g) The delegating physician shall be on the immediate premises during the patient's initial treatment and be able to treat complications, provide consultation, or resolve problems, if indicated. The supervised professional may complete the initial treatment if the physician is called away to attend to an emergency; and

(h) Existing patients with an established treatment plan may continue to receive care during temporary absences of the delegating physician provided that there is a local back-up physician who satisfies the requirements of subsection (4) of this section. The local back-up physician must agree in writing to treat complications, provide consultation or resolve problems if medically indicated. The local back-up physician shall be reachable by phone and able to see the patient within sixty minutes. The delegating physician's absence from the site where the treatment occurs must be for brief and intermittent periods of time. The delegating physician's absence from the site where the treatment occurs cannot be an ongoing arrangement.

(11) The use of, or the delegation of the use of, an LLRP device by a physician assistant is covered by WAC 246-918-125. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-605, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(12). WSR 07-03-177, § 246-919-605, filed 1/24/07, effective 3/1/07.]

WAC 246-919-606 Nonsurgical medical cosmetic procedures.

(1) The purpose of this rule is to establish the duties and responsibilities of a physician who delegates the injection of medication or substances for cosmetic purposes or the use of prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfiguration, hypopigmentation and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011(3).

(2) This rule does not apply to:

(a) Surgery;

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

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

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

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

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

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

PHYSICIAN RESPONSIBILITIES

(4) A physician must be fully and appropriately trained in a nonsurgical medical cosmetic procedure prior to performing the procedure or delegating the procedure. The physician must keep a

record of ~~his or her~~their training in the office and available for review upon request by a patient or a representative of the commission.

(5) Prior to authorizing a nonsurgical medical cosmetic procedure, a physician must:

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent;

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

(g) Prepare an appropriate medical record.

(6) Regardless of who performs the nonsurgical medical cosmetic procedure, the physician is ultimately responsible for the safety of the patient.

(7) Regardless of who performs the nonsurgical medical cosmetic procedure, the physician is responsible for ensuring that each treatment is documented in the patient's medical record.

(8) The physician must ensure that there is a quality assurance program for the facility at which nonsurgical medical cosmetic procedures are performed regarding the selection and treatment of patients. An appropriate quality assurance program must include the following:

(a) A mechanism to identify complications and untoward effects of treatment and to determine their cause;

(b) A mechanism to review the adherence of supervised health care professionals to written protocols;

(c) A mechanism to monitor the quality of treatments;

(d) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future protocols required by subsection (11)(d) of this section and physician supervising practices; and

(e) Ongoing training to maintain and improve the quality of treatment and performance of supervised health care professionals.

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

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

PHYSICIAN DELEGATION

(11) A physician who meets the above requirements may delegate a nonsurgical medical cosmetic procedure to a properly trained physician assistant, registered nurse or licensed practical nurse, provided all the following conditions are met:

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

(b) The physician delegates procedures that are within the delegate's lawful scope of practice;

(c) The delegate has appropriate training in, at a minimum:

(i) Techniques for each procedure;

(ii) Cutaneous medicine;

(iii) Indications and contraindications for each procedure;

(iv) Preprocedural and postprocedural care;

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

(vi) Infectious disease control involved with each treatment.

(d) The physician has a written office protocol for the delegate to follow in performing the nonsurgical medical cosmetic procedure. A written office protocol must include, at a minimum, the following:

(i) The identity of the physician responsible for the delegation of the procedure;

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

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

(iv) A statement of the activities, decision criteria, and plan the delegate shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

(e) The physician ensures that the delegate performs each procedure in accordance with the written office protocol;

(f) Each patient signs a consent form prior to treatment that lists foreseeable side effects and complications, and the identity and license of the delegate or delegates who will perform the procedure; and

(g) Each delegate performing a procedure covered by this section must be readily identified by a name tag or similar means so that the patient understands the identity and license of the treating delegate.

(12) If a physician delegates the performance of a procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is used, the physician must be on-site during the entire duration of the procedure.

(13) If a physician delegates the performance of a procedure that uses a medication or substance that is approved by the federal Food and Drug Administration for the particular purpose for which it is used, the physician need not be on-site

during the procedure, but must be reachable by phone and able to respond within thirty minutes to treat complications.

(14) If the physician is unavailable to supervise a delegate as required by this section, the physician must make arrangements for an alternate physician to provide the necessary supervision. The alternate supervisor must be familiar with the protocols in use at the site, will be accountable for adequately supervising the treatment under the protocols, and must have comparable training as the primary supervising physician.

(15) A physician performing or delegating nonsurgical cosmetic procedures may not sponsor more than three physician assistants at any one time.

(16) A physician may not permit a delegate to further delegate the performance of a nonsurgical medical cosmetic procedure to another individual.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-606, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(4). WSR 10-11-001, § 246-919-606, filed 5/5/10, effective 6/5/10.]

WAC 246-919-610 Use of drugs or autotransfusion to enhance athletic ability. (1) A physician shall not prescribe, administer or dispense anabolic steroids, growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), other hormones, or any form of autotransfusion for the purpose of enhancing athletic ability.

(2) A physician shall complete and maintain patient medical records which accurately reflect the prescribing, administering or dispensing of any substance or drug described in this rule or any form of autotransfusion. Patient medical records must indicate the diagnosis and purpose for which the substance, drug, or autotransfusion is prescribed, administered or dispensed and any additional information upon which the diagnosis is based.

(3) A violation of any provision of this rule constitutes grounds for disciplinary action under RCW 18.130.180(7). A violation of subsection (1) of this section constitutes grounds for disciplinary action under RCW 18.130.180(6).
[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-610, filed 10/21/20, effective 11/21/20.

Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-610, filed 1/17/96, effective 2/17/96.]

WAC 246-919-620 Cooperation with investigation. (1) ~~A physician must comply with a request, under RCW 70.02.050, for health care records or documents from an investigator who is acting on behalf of the disciplining authority under RCW 18.130.050(2)~~ Pursuant to RCW 70.02.050 and RCW 18.130.050, physicians licensed under this chapter must cooperate fully and promptly with any investigation or inquiry initiated by the commission concerning the physician's professional conduct or fitness to practice.

(2) Upon request by an investigator acting on behalf of the commission, the physician shall provide all relevant health care records, documents, or information within 21 calendar days of receipt of the request.

(3) A physician may request a reasonable extension of time to comply for good cause, but such extension shall not exceed 30 calendar days unless otherwise authorized by the commission.

Commented [DB2]: MM: This is presumable direct quoting the UDA. Do we need to have that here? Delete?

Commented [DB3R2]: Freda Pace: Not sure. Defer to the experts.

Commented [DB4R2]: -620 doesn't directly quote the UDA. It incorporates requirements from both RCW 70.02.050 and 18.130.050. The timelines in this rule have been established by the WMC. The edits here are my attempt at a rewrite.

(4) Failure to comply with the requirements of this rule or to cooperate as required under RCW 70.02.050 and RCW 18.130.050 may be grounds for disciplinary action, including the issuance of a statement of charges pursuant to RCW 18.130.180(8), suspension, or other sanctions authorized by law.

(5) The commission may consider the physician's level of cooperation in investigations when negotiating settlements or determining appropriate disciplinary measures.

(~~a) The physician shall submit the requested items within twenty-one calendar days of receipt of the request by the physician or the physician's attorney, whichever is first. If the physician fails to comply with the request within twenty-one calendar days, the investigator shall contact the physician or the physician's attorney by letter as a reminder.~~

~~(b) Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.~~

~~(c) If the physician fails to comply with the request within three business days after the receipt of the written reminder, a statement of charges may be issued under RCW 18.130.180(8) and, if there is sufficient evidence to support additional charges, those charges may be included in the statement of charges.~~

~~(d) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.~~

~~(2) A physician shall comply with a request from an investigator who is acting on behalf of the disciplining authority under RCW 18.130.050(2) for information, which may include, but is not limited to:~~

~~(a) Nonhealth care records or documents including, but not limited to:~~

~~(i) An explanation of the matter under investigation;~~

~~(ii) Curriculum vitae;~~

~~(iii) Continuing medical education credits;~~

~~(iv) Malpractice action summaries; or~~

~~(v) Hospital affiliations.~~

~~(b) The physician shall submit the requested items within twenty-one calendar days of receipt of the request by the physician or the physician's attorney, whichever is first. If the physician fails to comply with the request within twenty-one calendar days, the investigator shall contact the physician or the licensee's attorney by letter as a reminder.~~

~~(c) Investigators may extend the time for response if the physician requests an extension for good cause for a period not to exceed thirty calendar days. Other requests for extension may be granted by the commission chair or the commission's executive director.~~

~~(d) If the physician fails to comply with the request within three business days after the receipt of the written reminder, then a subpoena shall be served upon the physician to obtain the requested items.~~

~~(e) If the physician fails to comply with the subpoena, a statement of charges may be issued under RCW 18.130.180(8) and, if there is sufficient evidence to support additional charges, then those charges may be included in the statement of charges.~~

~~(f) In negotiating a settlement on a statement of charges based on RCW 18.130.180(8), the commission may take into consideration whether the physician has complied with the request after the statement of charges has been issued.~~

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-620, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-620, filed 1/17/96, effective 2/17/96.]

WAC 246-919-630 Sexual misconduct. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment~~,~~ or has received health care or treatment without a termination of the physician-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 factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Key third party" means immediate family members and others who would be reasonably expected to play a significant role in the health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client.~~means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, and guardians or proxies~~.

(2) A physician shall not engage, or attempt to engage, in sexual misconduct with a current patient or a key third party, inside or outside the healthcare setting. Sexual misconduct shall constitute grounds for disciplinary action. A physician engages in sexual misconduct when ~~he or she~~they engage~~s~~ in ~~any of~~ the following ~~behaviors~~ with a patient or key third party:

(a) Sexual intercourse~~ or genital to genital contact~~;

(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis, and treatment within the physician's scope of practice;

(c) Rubbing against a patient or key third party for sexual gratification;

~~(b) Oral to genital contact;~~

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

(d) Kissing~~ in a romantic or sexual manner~~;

(e) Hugging, touching, fondling, or caressing of a romantic or sexual nature;

~~(c) 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 except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient or key third party;

(j) Removing patient's clothing or gown or draping without consent, emergent medical necessity, or being in a custodial setting;

(k) Encouraging ~~the patient to~~ masturbation~~e~~ or other sex act in the presence of the physician

(l) ~~or m~~Masturbation or other sex act by the physician ~~while the patient is present~~in the presence of the patient or key third party;

(m) Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;

(n) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;

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

(o~~j~~) Soliciting a date with the patient or key third party; ~~or~~

(~~k~~p) ~~Communicating regarding~~Discussing the sexual history, preferences, or fantasies of the physician;

(q) Any behavior, gestures, or expressions that may reasonably interpreted as seductive or sexual;

(r) Making statements regarding the patient or key third party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;

(s) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient or key third party;

(t) Photographing or creating a ~~video~~ recording of any kind of the body or any body part or pose of patient or key third party other than for the legitimate health care purposes; or

(u) Showing a patient or key third party sexually explicit photographs or video recordings, other than for legitimate health care purposes.

(3) 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.

(~~3~~4) A physician shall not:

Commented [DB5]: Sarah K: We should discuss (r) and (s) as they overlap with .640 Abuse WAC. Do we want conduct now charged as abuse to be considered sexual misconduct and subject to the sexual misconduct notification requirements? Would -640 need to be amended?

Commented [DB6R5]: Mike F. suggests deleting both (r) and (s). I think we should keep (s) because it is a little different than what is in -640.

Question: could (r) be abuse without being sexual misconduct? If yes, then we should keep (r) here.

Commented [DB7R5]: Mike F.: I suppose it could. I see no harm in keeping it. Yes, there is overlap between 630 and 640. The WMC can choose which one is appropriate in a given case. I see no need to amend 640.

Commented [DB8]: Mike F. suggests this phrase instead of "filming"

Commented [DB9]: Be sure this is linked to: RCW 9.94A.030: Definitions. (Effective until January 1, 2026.)

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient or key third party for the purpose of engaging in sexual misconduct; or

(c) Use health care information or access to health care information to meet or attempt to meet the physician's sexual needs.

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

(a) There is a significant likelihood that the patient or key third party will seek or require additional services from the physician; or

(b) There is an imbalance of power, influence, opportunity or special knowledge of the professional relationship.

~~(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.~~

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

(6~~5~~) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed since the last health care services to the patient;

(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; ~~and~~

(g) The degree of emotional dependence and vulnerability of the patient; and,

(h) If the code of ethics for the physician specialty in question ever allows for a relationship with a former patient.

~~(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.~~

(7) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for legitimate health care purposes and that meets the standard of care.

(8) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(9~~8~~) A violation of any provision of this rule constitutes grounds for disciplinary action.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-630, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017, 18.130.062, and Executive Order 06-03. WSR 16-06-010, § 246-919-630, filed 2/18/16, effective 3/20/16. Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-630, filed 1/9/06, effective 2/9/06.]

WAC 246-919-640 Abuse. (1) A physician commits unprofessional conduct if the physician abuses a patient. A physician abuses a patient when ~~he or she~~they:

(a) Makes statements regarding the patient~~'s~~ or key third party'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.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-919-640, filed 1/9/06, effective 2/9/06.]

MANDATORY REPORTING

WAC 246-919-700 Mandatory reporting. The commission adopts the rules for mandatory reporting in chapter 246-16 WAC. [Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-700, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-919-700, filed 1/17/96, effective 2/17/96.]

WASHINGTON ACADEMY OF
FAMILY PHYSICIANS
CARING FOR WASHINGTON

June 17, 2025

Washington Medical Commission
Department of Health
P.O. Box 47866
Olympia, WA 98504-7866

Re: American Academy of Family Physicians (AAFP) credit towards CME licensure requirements, WSR 25-12-014

The American Academy of Family Physicians (AAFP) and the Washington Academy of Family Physicians request a modification to the Washington Administrative Code to explicitly recognize AAFP as an accreditor for continuing medical education (CME) activities.

In the United States, physicians may earn CME credit through three organizations:

1. AAFP (American Academy of Family Physicians)
2. AMA (American Medical Association)/ACCME Accreditation Council for Continuing Medical Education
3. AOA (American Osteopathic Association)

AAFP's national Credit/Accreditation System was the first national CME accreditor for physicians in the U.S., predating the Accreditation Council for Continuing Medical Education (ACCME). The AAFP works with more than 1,000 CME provider organizations annually including hospitals, health systems, medical schools, residencies, association chapters, and medical education companies to grant accreditation when their CME activities meet the AAFP's strict accreditation requirements.

In Washington, the Washington Administrative Code (246-919-460), does not explicitly identify the AAFP as an accreditor. This omission has the potential to create unnecessary barriers and confusion, particularly as some states move toward automated continuing education processes. Since the commission announced a review of the associated WAC in WSR 25-12-014, we ask the following:

Request
Appropriately designate AAFP as a CME accreditor for physicians. Our recommendation is listed below. Note that the recommended language is similar to the CME section for osteopathic physicians covered in WAC 246-853-070, harmonizing the sections.

WAC 246-919-460
Categories of creditable continuing medical education activities.

(1) **Category I: Continuing medical education activities with accredited sponsorship.** The licensed physician may earn all two hundred credit hours in Category I. The commission will accept attendance at a continuing education program that is recognized as Category I credit and is offered by

an organization or institution that meets the standards adopted by the Accreditation Council for Continuing Medical Education or its designated interstate accrediting agency, the Washington State Medical Association; or nationally recognized organizations and their affiliates including, but not limited to, the American Academy of Family Physicians or the American Medical Association.

We are available to provide additional information as needed. Please contact Kim McCaulou, kim@wafp.net with questions.

Regards,

Kim McCaulou
Executive Vice President

WSR 25-12-014
PREPROPOSAL STATEMENT OF INQUIRY
DEPARTMENT OF HEALTH
(Washington Medical Commission)
[Filed May 22, 2025, 11:51 a.m.]

Subject of Possible Rule Making: Allopathic physicians (MD) chapter rule review. The Washington medical commission (commission) is considering amending the following rules to modernize language, add clarity, and bring the rules more in line with current practice: WAC 246-919-010 through 246-919-520; and WAC 246-919-602 through 246-919-700.

Statutes Authorizing the Agency to Adopt Rules on this Subject: RCW 18.71.015 and 18.130.050.

Reasons Why Rules on this Subject may be Needed and What They Might Accomplish: The commission is considering updating rules to more closely align with current industry standards and provide clearer rule language for licensed MDs. In addition, RCW 43.70.041 requires the commission to review its administrative rules every five years to ensure that regulations are current and relevant. As part of this effort, the commission is also considering incorporating its interpretive statements into rule to provide greater clarity and consistency. Rule amendments being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

Process for Developing New Rule: Collaborative rule making.

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting Amelia Boyd, Program Manager, P.O. Box 47866, Olympia, WA 98504-7866, phone 360-918-6336, TTY 711, email amelia.boyd@wmc.wa.gov, website https://wmc.wa.gov.

Additional comments: To join the interested parties email list, please visit https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153.

May 19, 2025
Kyle S. Karinen
Executive Director

Next Steps

- Additional workshops
  - 2nd workshop – Tentative: December 8 @ 1pm
  - 3rd workshop – Tentative: January 26, 2026 @ 1 pm
  - 4th workshop – Tentative: March 9, 2026 @ 1 pm
  - 5th workshop – Tentative: April 13, 2026 @ 1 pm
  - 6th workshop – Tentative: June 15, 2026 @ 1 pm

Please feel free to provide written comments to:

medical.rules@wmc.wa.gov

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Thank you!