UPDATE!

WASHINGTON MEDICAL COMMISSION

LICENSING. ACCOUNTABILITY. LEADERSHIP

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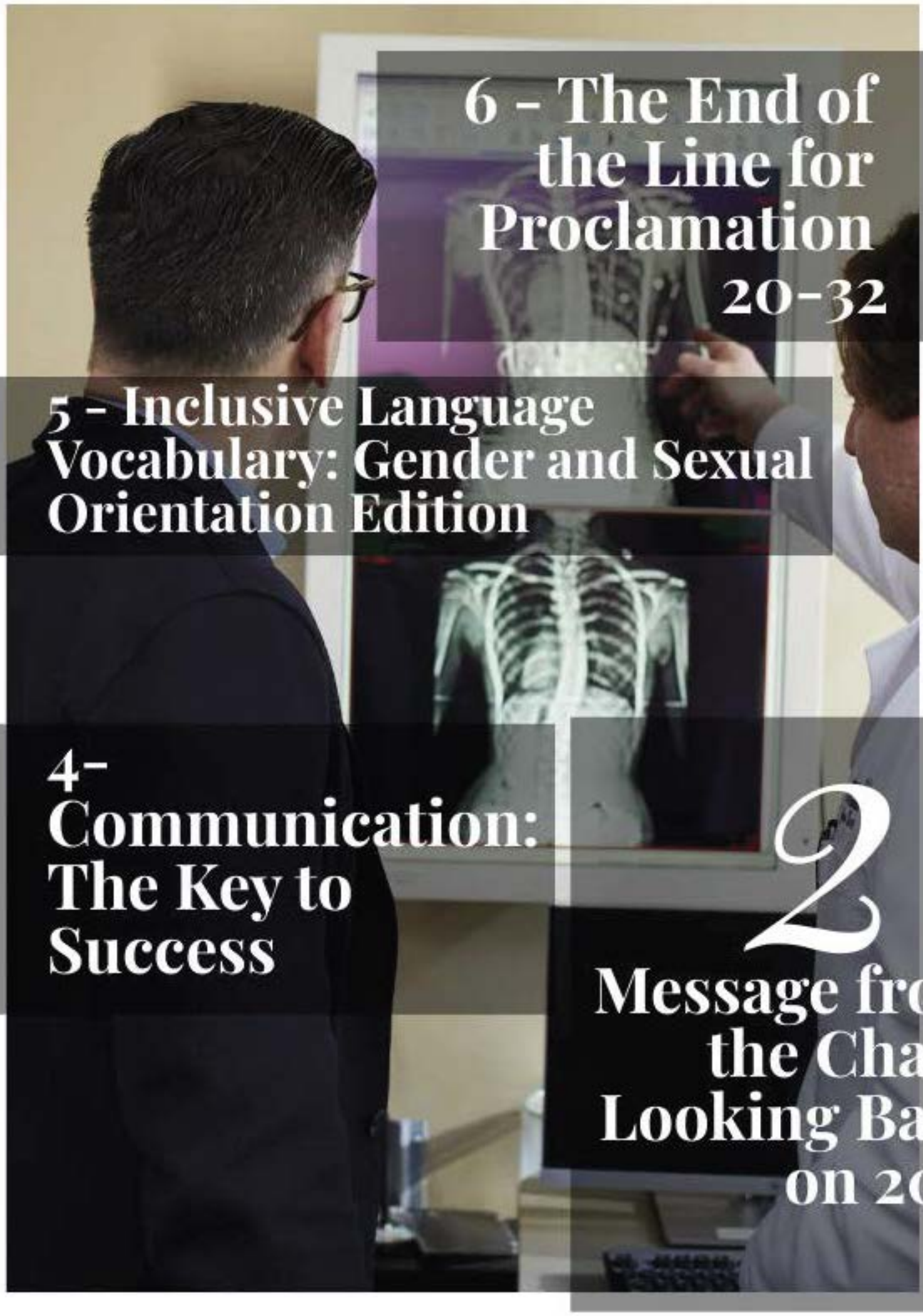

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Message from the Chair

WASHINGTON Medical Commission
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Looking Back on 2022

Jimmy Chung, MD

Nearly three years ago, a novel coronavirus began spreading rapidly across the globe and caught the human race off guard. The virus that we still call Covid-19 has changed healthcare—and perhaps human civilization itself—in ways that we had never seen previously on a global scale. Responsible for over a million deaths in the US, Covid-19 has become the nation's 3rd leading cause of death over the past three years, and even in its currently semi-blunted state, it will remain among the top ten causes, according to the CDC.

2022 was a transitional year of sorts. Most travel restrictions were lifted, shopping and dining out returned to normal with proof of vaccination becoming a fading memory, and people returned to their workplace without masks or social distancing. However, this was not due to the eradication of the virus from our lives, as we had hoped herd immunity would bring. Far from it, getting Covid-19 not just once but multiple times seems to be a regular occurrence now, and most people seem to have accepted a life of co-existence, only taking extra caution for the elderly and those with chronic illnesses. With the acceptance of a milder virus among us, it would seem that arguments over previously controversial topics such as vaccine mandates and non-approved treatments have become moot and faded out of mainstream media.

However, we cannot forget that the pandemic and the politicization of public health by a polarized government created the perfect storm for a health system disaster. A healthcare delivery system designed to reward providers for acute care rather than prevention was the perfect breeding ground for a deadly airborne virus. The pandemic would quickly be mismanaged by poorly prepared and misaligned leaders in a nation that was already struggling with inequities in social determinants of health and access to care and result in hundreds of thousands of preventable deaths. As the virus ebbed and returned in its numerous variants and death rates of hospitalized patients decreased from over 15% to a somewhat more manageable rate of 4.9%, Covid-19 is still very much a part of our lives. The social and economic impacts of the pandemic still reverberate such as supply chain disruptions, the workforce crisis, and skepticism of government health agencies. Furthermore, the long-term effects of Covid-19 infection and their impact on the already over-burdened health system has yet to declare themselves.

At the end of 2021, many of us in healthcare were hopeful that 2022 would signify a new beginning. We would take our lessons learned to action and address the social and political policies to prevent the mistakes and miscues of the previous year. We would not return to the pre-Covid days but leverage new technologies and accelerated processes to fast-track much needed healthcare and public health policies that had remained stagnant for so long, such as health equity and disparities in social determinants of health. As we close out 2022, we can remain hopeful that the gains realized during 2022 will be sustained in 2023 as we continue our journey to a healthier nation and world.

Message From the Chair

There can be no argument that Covid-19 forced innovation, perhaps mainly from desperation, but some of these are turning out to be long-term solutions to long standing problems rather than just temporary measures. Vaccine research and development, telehealth, remote home monitoring, and digital tools for mental health are just a few examples of advances that have benefited patients and populations by improving access and shifting scarce resources.

The Washington Medical Commission (WMC) has also learned from the crisis and made changes that we hope will bring improvements to the pursuit of our mission to protect the public and uphold the integrity of the medical profession. For example, transitioning from in-person meetings to virtual and back uncovered opportunities to improve our processes, public access to the meetings, and communication with licensees under disciplinary action. Through some innovative work by our staff, the Licensing Unit is now able to process most applications under four weeks, instead of 20 weeks before Covid. In addition, we will be examining our processes for intake of complaints and case disposition to streamline our work even further.

The WMC also fully recognizes the urgency of the workforce crisis. Recent surveys suggest half of healthcare workers are considering quitting. While these are not all physicians, this frightening statistic represents the stress and burnout present in healthcare as a whole, and we are committed to pursuing our work without further contributing to the attrition of our medical professionals. We continue to focus on helping physicians and physician assistants remain in the workforce to provide the best care possible through education and appropriate actions. In addition, we continue to advocate for our patients and professionals at the state legislature and maintain close relationships with the Washington Physicians Health Program (WPHP), Washington State Medical Association (WSMA) and the Washington Academy of Physician Assistants.

I am truly excited about 2023 and what we can achieve together to serve the people of this great state. I am confident that the momentum of 2022 will take us to new and exciting opportunities and reenergize our passion to improve our health system.

Executive Director Report

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Communication – The Key to Success

Melanie de Leon, JD, MPA

Communication issues between the patient and the physicians or physician assistant (PA) is one of the most common complaints we receive. Out of over 5,000 complaints filed with WMC between January 2020 and November 28, 2022, almost 10 percent regarded poor communication between the provider and the patient.

Why is it difficult for providers to effectively communicate? Providers say that the increased demand for clinical productivity shortens their time with the patient and makes having a conversation difficult. Providers say that dealing with an increase of misinformation patients get after "googling" their symptoms takes time away from talking about actual issues. Providers say that having to enter information into the electronic medical record takes their focus away from the patient, uses up valuable face-to-face time with the patient, thus adversely impacting communication efforts.

While all of these are true, having a conversation with the patient about the healthcare issues that they alone are facing is the most important aspect of that patient's visit. Patients want - no they need - to truly understand what is happening to them, why it is happening (if known) and how to fix it. And the words need to be at a level and in a language they can understand.

Due to issues that we have seen through our complaint process, the WMC has published two guidance documents regarding provider/patient communication:

- Communicating Diagnostic Test Results to Patients provides a list of elements that all practitioners should incorporate to have an effective system to provide timely and reliable communication of test results to patients and appropriate follow-up. You can read the guidance here: Communicating test results to patients (wa.gov)
- Informed Consent and Shared Decision-Making provides the essential elements of the consent process. You can read the guidance here: Informed Consent Guidance

Inclusive Language Vocabulary: Gender and Sexual Orientation Edition

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Mahi Zeru
Equity and Social Justice Manager

Words have power. Choosing the right words in language is important as it can promote equity and create sense of belonging or be exclusionary and perpetuate stigma.

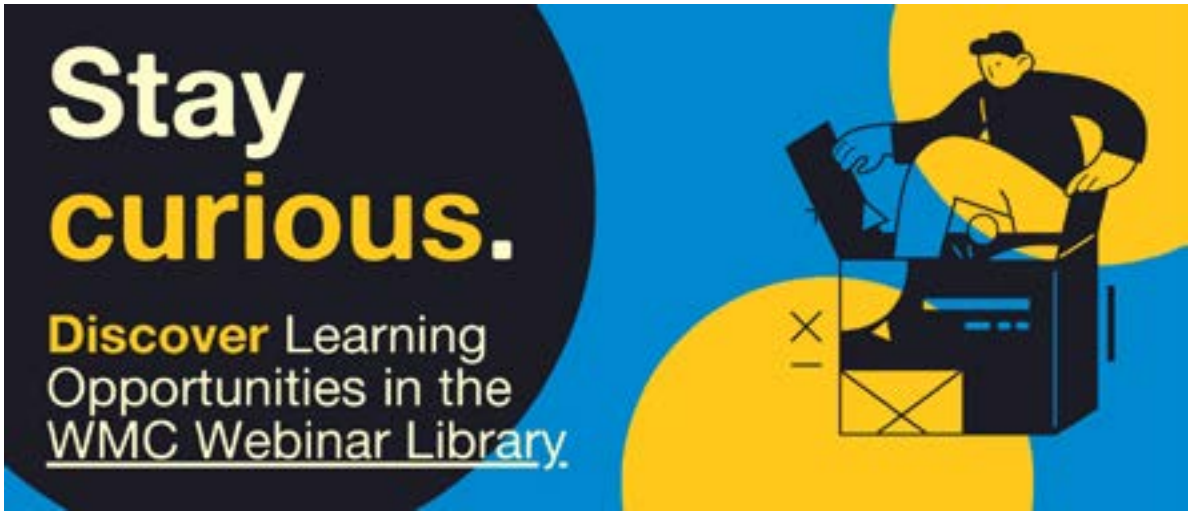
Effective communication is a fundamental skill for providers to be able to address the needs of diverse patient populations. Applying inclusive language is the hallmark of effective communication as it serves to foster positive patient-provider relationships. The term "inclusive language" is used to describe words or phrases that are neutral and free of discrimination based on a person's race or ethnicity, sexuality, gender, age, ability, or socioeconomic status.

Inclusive language creates a space where the patient/family feel valued and respected. When providers use inclusive language, it creates a space of trust and understanding, paving a way to positive therapeutic relationship. While unintentional, lack of sensitivity and care to use inclusionary language leads us to exclusion. Beyond limiting conversations, using inappropriate language may lead to health disparities. People who have negative experiences may avoid getting the necessary care leading to a delay in diagnoses and premature death. Languages also contributes to distrust in the medical system and avoidance of preventative measures critical to health.

Accepted inclusive terminology is ever evolving and utilizing the following three basic principles can be applied to remain respectful.

1. People first language: Place the person before their condition Ex. People with Disabilities.
2. Specific: Be as specific as possible (Instead of foreign born- state the specific country of birth).
3. Ask for relevant information: Avoid assumptions- ask your patient how they would like to be identified. More information can be found in this article "What are personal pronouns and why do they matter?"

The LGBTQ Stylebook, GLAAD Media Reference Guide - 11th Edition and Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People are excellent sources for accepted terminologies to help raise awareness and increase understanding around gender and sexual orientation identities and should be used as a reference to use consistent and respectful language.



The End of the Line for Proclamation 20-32

Arlene Dorrough, PA-C, MCHS/MPH

Hello, PAs, out there. If you are anything like me, you feel the pressure of end-of-the-year events, getting your CME credits documented and licensing fees taken care of, in the midst of heavy workloads and increasing social events as the holidays come around.

The increasingly lower incidents of Covid have reduced isolation protocols all around us, and along with reduced protocols, we find ourselves returning to business as usual. The most talked about news item among PAs right now involves the end of the CME grace period.

In July we found out Governor Inslee would be rescinding Proclamation 20-32, which suspended certain sections of the Washington Administrative Code pertaining to CME requirements for PAs and Physicians. Chapter 246-918 WAC, temporarily suspended CME requirements for PAs in the state of Washington from March 26th, 2020, to October 27th 2022. Which means for PAs with birthdays that fall after October 27th of this year, your CME attestation is now due by your birthdate in 2026. For those PAs whose birthdays fall before October 27th of 2023, your CME attestation is now due by your birthday in 2027. We held a virtual Q&A session to answer your questions and the webinar recording can be accessed here.

That being said, I have gotten plenty of notices all year from the American Academy of Physician Assistants that my CME credits were all due at the usual time in December of this year (my birthday falls before October 27th), so for the past 2 years, I have been keeping my CME credits current through Zoom conferences, online medical classes and presentations pertaining to my medical specialty.

I will say I am proud of how quickly medical organizations around the country have quickly accommodated the Covid-related isolation protocols and in-person restrictions and were still able to provide excellent medical educational content that met CME educational requirements and provided rewarding experiences, (technical glitches aside), that allowed me to stay current with my CMEs and gain relevant, practice changing clinical information.

There are many options to fulfill CME credits in the extra time we have been allotted to get them. The Washington Medical Commission hosts a webinar library on our website, with new classes coming in the new year. To be notified when they are announced, I encourage you to join our mailing list. I highly recommend that all PAs practicing in the state of Washington join the Washington Academy of Physician Assistants for a rich source of CME opportunities, educational classes and workshops

The increasingly lower incidents of Covid have reduced isolation protocols all around us, and along with reduced protocols, we find ourselves returning to business as usual. The most talked about news item among PAs right now involves the end of the CME grace period

pertaining to most medical specialties. The American Academy of Physician Assistants also provides CME opportunities for most medical specialties and has activities to participate in, which can also provide CME educational opportunities. I cannot emphasize how helpful it can be to have a connection to professionals in your field that practice both in your state and nationwide.

PAs can also maintain certification through their clinical specialty. CME opportunities in your department or clinical specialty can be found through your current employer, or you can find a state or national organizations through your medical specialty online. I was able to get 10 AAPA accredited CME credits for free over one weekend through the Practicing Clinicians Exchange Oncology Conference. PCE also provides complimentary CME content in a variety of other clinical specialties. ReachMD is another resource for free CME content.

Another cost-effective way to meet CME requirements is to take advantage of accredited medical podcasts that regularly provide clinical practice content. It is important to make sure the podcast is accredited and sponsored by a governing medical program. A popular one I can highly recommend is The Curbsiders Internal Medicine Podcast, which can be found on most podcast platforms. Curbsiders provides practical clinical pearls and educational content that rivals any other medical podcast I have come across to date. Further, Curbsiders has a PA involved in production of their content. VCU Health sponsors and provides CME credit for some if not most of the content on this podcast. I have personally gotten great information and practice changing pearls from this worthwhile podcast that has become a part of my weekly activities.

There it is people. Good luck getting back into the swing of things as we all navigate the almost post-Covid medical landscape. I hope this information has been helpful. I will close with another recommendation for you to join the AAPA and WAPA professional organizations, which will keep you connected to other PA professionals and up to date information about our profession and news events related to PA practice.

Keep up the good work everyone!

Legal Actions

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August 1, 2022 -October 31, 2022

Below are summaries of interim suspensions and final actions taken by the Medical Commission. Statements of Charges, Notices of Decision on Application, Modifications to Orders and Termination Orders are not listed. We encourage you to read the legal document for a description of the issues and findings. All legal actions can be found with definitions on the Medical Commission website.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Summary Actions				
Brecht, Kristine S., MD MD00044369 King County	Order of Summary Suspension	9/16/22	Alleged failure to comply with Commission Order.	Indefinite suspension of license.
Lucke, John C., MD MD60790314 Out of state	Order of Summary Suspension	9/2/22	Surrender of Massachusetts license.	Indefinite Suspension of license.
Formal Actions				
Greenman, Christopher G., MD MD60285495 Pierce County	Agreed Order	10/6/22	Negligent performance of percutaneous coronary intervention procedures.	PACE clinical competency assessment and compliance with all recommendations; personal appearances; fine; may petition to modify or terminate upon completion of PACE recommendations.
Grierson, James B., MD MD00043397 Island County	Agreed Order	9/15/22	Sexual contact with a patient; interference with an investigation.	Indefinite suspension of license; may petition for reinstatement in 3 years after undergoing mental health examination.
Heitsch, Richard C., MD MD00016822 Out of state	Final Order	9/9/22	Restriction of Oregon license.	Restricted from treating any patient with hyperbaric oxygen therapy; performing hyperbaric oxygen therapy.
Klos, Martin M., MD MD60271665 Out of state	Default Order	8/1/22	Surrender of Oregon license.	Indefinite suspension of Washington license.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Miller, Scott C., PA PA60427988 Clark County	Final Order	10/4/22	Prescribed ivermectin without proper documentation; failed to provide accurate information regarding the treatment of COVID-19 infection; misrepresented the purpose of a prescription for ivermectin; abused and harassed hospital staff disrupting the therapeutic alliance between providers and their patients; failed to cooperate with the investigation; and engaged in misrepresentation in an application for a license.	Indefinite suspension of license; multidisciplinary evaluation to determine fitness to practice; ethics course; may petition for reinstatement after completing the evaluation and ethics course, then must make personal appearances, write a paper; and submit to practice reviews.
Norton, Robert S., MD MD00024728 Thurston County	Default Order	9/12/22	Failure to comply with a Commission Order.	Indefinite suspension of license.
Osten, Thomas J., MD MD00011131 Spokane County	Default Order	8/30/22	Failure to obtain permission from patient before lifting her shirt, and for making inappropriate comments.	Indefinite suspension of license.
Sharma, Bhanoo MD MD.MD.60101028 Out of state	Agreed Order	8/25/22	Surrender of Oregon license.	Surrender of license.
Informal Actions				
Baxter, Robin L., MD MD00016767 King County	STID	10/6/22	Alleged failure to comply with opioid rules, poor documentation; and permitted patient to provide care giving services to her.	CME course on record-keeping and development of written protocol for psychiatric evaluations; CME and written paper on diagnosing ADHD; CME and written paper on diagnosing anxiety; written paper on acute and subacute pain prescribing regulations; development of written protocol for opioid prescribing; written paper on co-prescribing opioids and benzodiazepines; educational course and written paper on boundaries in psychiatric practice; practice reviews; personal appearances; costs; may petition to terminate after 3 years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Frandsen, Brad R., MD MD00029864 Kitsap County	STID	10/7/22	Alleged failure to document physical exam and to order stool sample in patient complaining of abdominal pain, black stool, and shortness of breath. Patient later diagnosed with GI bleed.	CME on documentation and appropriate examination of patient with abdominal pain and shortness of breath; paper; personal appearances; costs; may petition to terminate after 3 years.
Gowen, Paul C., MD MD00040249 Out of state	STID	8/25/22	Resignation of license in Oregon.	Surrender of license.
Lawson, Ian, MD MD00035040 Pierce County	STID	8/25/22	Alleged negligent performance of wrist surgery.	CME on treating wrist fractures; paper; personal appearances; costs; may petition to terminate after 2.5 years.
Madi, Hala MD MD60958718 Benton County	STID	8/25/22	Alleged prescribing medication to patient without documenting prescription and without informing patient's primary physician. The medication prescribed was contraindicated when prescribed with medications primary physician prescribed.	Ethics and boundaries course; CME in prescribing and record-keeping; paper; personal appearances; costs; may petition to terminate in one year.
Moghis, Sobia MD MD.MD.60206226 King County	STID	10/6/22	Alleged ordering of excessive blood draws for 2 patients that were not indicated based on the patients' medical history or concerns.	CME in communication; develop an informed consent template; personal appearances; costs; may petition to terminate after completion of requirements.

Order of Summary Suspension: An order suspending a license prior to a hearing based on a determination that the licensee's continued practice represents a danger to the public.
Order of Summary Restriction: : An order restricting an aspect of a licensee's practice prior to a hearing based on a determination that the licensee's continued practice with an unrestricted license represents a danger to the public.
Agreed Order: a settlement resolving a statement of charges. This order is an agreement by a licensee to comply with certain terms and conditions to protect the public.
Final Order: an order issued after a formal hearing before the Commission.
Final Order of Default: an order issued after the licensee fails to respond to a statement of charges.
Final Order (Waiver of Hearing): an order issued after the licensee waives the right to a hearing on a statement of charges by the licensee to comply with certain terms and conditions to protect the public.
Stipulation to Informal Disposition (STID): a document detailing allegations, but with no findings or admissions, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Rulemaking Efforts

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Amelia Boyd
Program Manager

Exclusions – Opioid Prescribing
The WMC has amended WAC 246-918-801 Exclusions (physician assistants) and WAC 246-919-851 Exclusions (physicians) to expand the types of patients who are exempt from certain provisions of rule when being prescribed opioid drugs.

As part of the WMC's rulemaking for Engrossed Substitute House Bill (ESHB) 1427 (chapter 297, Laws of 2017), the WMC received comments that adhering to the opioid prescribing rules for patients admitted to long term acute care (LTAC) and nursing homes, is onerous. Specifically, the rules require a history and physical as well as a check of the Prescription Monitoring Program be completed prior to prescribing opioids. It has been stated that patients transferred to LTACs and nursing homes had a history and physical while in the previous facility and that practitioners in LTACs and nursing homes can rely on that assessment.

Inpatient hospital patients are currently exempt from the opioid prescribing rules. The WMC recognizes that patients in LTACs and nursing homes are similarly situated to hospital patients receiving inpatient treatment.

Since the rules related to ESHB 1427 became effective January 1, 2019, the WMC has continued to receive comments related to LTAC and nursing home patients. To address this issue, the WMC filed an interpretive statement: "Exempting Patients in Nursing Homes and Long-Term Acute Care Hospital from the Opioid Prescribing Rules." While the interpretive statement has helped to curb the comments and concerns from prescribers, the WMC feels this important exemption should be in rule.

The WMC has also received a comment regarding patients in Residential Habilitation Centers (RHC) that they are also similarly situated to LTAC and nursing home patients. We received a similar comment about Residential Treatment Facilities (RTF), that stated RTFs are similar to RHCs except the stay at an RTF is usually short-term. As such, the WMC is also exempting patients in RHCs and RTFs.

Exempting patients in LTACs, nursing homes, RHCs, and RTFs from the opioid rules simply allows the practitioners in these facilities to continue the patient's pain medications without having to wait for a physician to perform a history and physical. It is standard for a nursing home or LTAC to have a physician conduct a history and physical within 30 days of admission. Exempting patients in nursing homes and LTACs from the opioid rules does not exempt a physician at these facilities from complying with the applicable standard of care. The physician would be expected to conduct a history and physical to assess the patient's functioning within a short time after admission. The LTAC is mainly for patients who were in intensive care in the hospital. These are sick patients in need of intensive care for an extended period of time.

These rules became effective November 25, 2022. The rulemaking order, filed as WSR #22-22-039, is now available.

Collaborative Drug Therapy Agreements
The CR-101 for creating rules related to Collaborative Drug Therapy Agreements was filed with the Office of the Code Reviser on July 22, 2020 as WSR #20-16-008.

One aspect of the practice of medicine is working with pharmacists to deliver drug therapy to patients. This coordination can take many forms, but the WMC's concern involves treating patients under a collaborative drug therapy agreement (CDTA). These arrangements occur pursuant to a written agreement entered into by an individual physician or physician assistant and an individual pharmacist.

The Pharmacy Quality Assurance Commission has adopted a rule that governs CDTAs from the

pharmacy perspective, however there are no statutes or rules that govern a physician's responsibilities under a CDTA. A rule is needed to define the roles and responsibilities of the physician or physician assistant who enters into a CDTA, any defined limit to the number of pharmacists who may have a CDTA with any one physician or physician assistant, and how the physician or physician assistant and pharmacist can best collaborate under these agreements.

Regulating the use of CDTAs would place the WMC in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. New sections 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.

Workshops for this rulemaking are ongoing. Please visit our Rules in Progress page for the current schedule and draft language.

Senate Bill (SB) 6551 – International Medical Graduates
The WMC has adopted a new section to chapter 246-919 WAC to implement Senate Bill 6551 (chapter 325, Laws of 2020) concerning licensure of International Medical Graduates (IMG).

In 2020, the Legislature passed Senate Bill (SB) 6551 (codified as RCW 18.71.095(5)) which requires the WMC to establish requirements for obtaining a Limited Physician and Surgeon Clinical Experience License by International Medical Graduates (IMG). Additionally, in 2021, the Legislature passed Substitute House Bill (SHB) 1129 (codified as RCW 18.71.095(6)) establishing requirements for issuing a limited license to an IMG.

This new section lays out the requirements for applying for the newly established license: Limited Physician and Surgeon Clinical Experience License. In the new section, the WMC also defined "appropriate medical practice," which incorporated a current WMC interpretive statement: Establishing Approval Criteria for Defining Appropriate Medical Practices for IMG Nomination, INS2022-02. Finally, the WMC has clarified that a Limited Physician and Surgeon Clinical Experience License applicant must file a practice agreement with the WMC prior to commencing practice.

These rules became effective November 25, 2022. The rulemaking order, filed as WSR #22-22-038, is now available.

More Information
Please visit our rulemaking site and for continued updates on rule development, interested parties are encouraged to join the WMC's rules GovDelivery.

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WMC Mission

Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education.

WMC Vision

Advancing the optimal level of medical care for the people of Washington State.