UPDATE!

VOL. 14 Fall 2024

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

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

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Message from the Chair

WMC Advances Pathways for International Medical Graduates

Karen Domino, MD, MPH

In June, I attended the Federation of State Medical Board meeting in Washington DC devoted to alternative licensing models for International Medical Graduates (IMGs). Many states are considering licensure pathways to address physician shortages, which occur in a variety of specialties and in underserved, rural, and economically disadvantaged regions. I left the national meeting delighted that Washington State is a leader in the U.S. in creating these important pathways. For over 20 years, I've experienced the tremendous importance of the Washington Medical Commission's (WMC) adoption of the Teaching-Research Pathway to medical licensure. This pathway has attracted outstanding IMGs to provide exceptional medical care, education, and research at Harborview Medical Center and the University of Washington Medical Center. The WMC is now making strides in creating a new opportunity for IMGs to work outside of academic institutions. This new program allows IMGs to gain clinical experience and progress towards Washington full MD licensure.

Who is an IMG?

The Accredited Council for Graduate Medical Education (ACGME) defines an IMGs as individuals who received their basic MD from a medical school outside of the U.S. and Canada. Note that the country of the medical school is important, not citizenship. U.S. citizens who graduate from medical schools outside of the U.S. or Canada are considered IMGs. In July 2025, students graduating from Canadian medical schools will be considered IMGs for GME programs in the US due to changes in Canadian certifications.

Clinical Experience Licenses

In a significant step forward, the WMC began issuing Clinical Experience (CE) Licenses in 2021. This limited license allows qualified IMGs to practice medicine under supervision for up to four years without completing a residency program. This pathway provides invaluable clinical experience, enhancing competitiveness for residency and other postgraduate programs. In fiscal year 2023, the WMC approved 11 of 22 CE License applications, with 24 licenses currently in practice.

Supporting IMGs: The IMG Implementation Workgroup

To further assist IMGs, Washington has established the IMG Implementation Workgroup. This group is dedicated to developing grant programs for organizations providing career guidance and clinical training to IMGs. Additionally, the workgroup is exploring processes for hardship waivers.

National Trends

Washington is not alone in its efforts to support IMGs. Several states, including Idaho, Colorado, Arizona, Iowa, Massachusetts, Missouri, Nevada, Vermont, and Wisconsin, have implemented or are considering legislation to address IMG licensure challenges. These initiatives reflect a growing recognition of the value IMGs bring to the healthcare workforce.

Looking Ahead

The WMC's commitment to creating opportunities for IMGs is commendable. As the healthcare landscape evolves, it is essential to continue exploring innovative pathways to integrate IMGs into the medical profession.

Executive Director Report

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Kyle Karinen, J.D., LL.M

On a trip over the summer, I stayed at a hotel on the east coast. As many hotels do, this one had information laid out to greet a visitor highlighting various services. One of the cards caught my attention:

IV DRIP REPAIR – REHYDRATE – RENEW

Pricing from $350

- IMMUNITY
- ENERGY
- HANGOVER
- BEAUTY
- STRESS
- JET LAG
- WEIGHT LOSS
- BRAIN FOCUS
- NAD+

A quick web search shows multiple parties in my surrounding geographic location that appear to be willing to provide IV treatment of what appears to be the same type.

As some may know, I previously worked with the Pharmacy Quality Assurance Commission (PQAC). During that time, the aftereffects of the events with the New England Compounding Center were still fresh in everyone's minds. So, when something like the above crosses the transom, for me, my first question is about the who, what, how, and most importantly, the where of these medications.

1. Who is preparing the medication, i.e. compounding?
2. Who is administering the medication, i.e. running the IV?
3. Under whose prescriptive authority is the medication is being administered?

At the most recent annual meeting of the Federation of State Medical Boards, there was a presentation by two state boards and the United States Food and Drug Administration. While there were not specific cases discussed, some of the anecdotes related were concerning. Of course, they were just anecdotes and should not, in the absence of actual data, be the predominant factor in driving regulatory efforts around public health and safety.

In the wake of the FSMB meeting, the WMC chair, Dr. Domino, has formed an internal workgroup to delve deeper into issues surrounding these therapies. The workgroup's charter calls for it to look into what other states have done or considered and work with other healthcare licensing authorities like our colleagues with the Washington Board of Nursing and PQAC. There is an interagency group that has formed around aesthetic treatments and a subgroup there is also examining the issue of IV hydration treatment and mobile IV services.

Additionally, the WMC and our colleagues are not also mindful of other states that have also been looking into the proliferation of IV hydration services. At least four other states have adopted guidance and at least two others are at a similar point as the WMC. While it is too early in the WMC's review to say what may come of the workgroup's efforts, the WMC recognizes there are certainly advantages to treatment modalities that can be brought to patients.

What's In a Name?

Edw. C. Lopez, PA-C, C.P.M.M.

A title or a name may imply a specific rank, family, designation, or station and the implied information provided by that name may be correct and embraced at the time when assigned. Over time, a title may evolve and lose its identity.

In the 1960's as the United States of America was embroiled in a war in Southeast Asia that proved to be one of our least distinguished historical foreign policy moments. There was a group of young men returning home from that war, lucky enough to have survived but who's role while there was not to shoot and kill but to save lives. These young men carried out this mission by caring for those who were sick and injured during the dangerous and life-threatening ravages of jungle warfare as Army Medics and Navy Corpsman.

After returning home from that experience, these veterans wondered, what job could they pursue that could use that experience and training in the civilian world.

At the same time in North Carolina a physician and Chairman of the Department of Medicine at Duke University became keenly aware that a large population of that state's citizenry lived in rural areas throughout the state and had little access to care. The Duke Medical Center was experiencing an acute shortage of qualified clinical staff to run day to day clinical operations at the facility. Hearing of these veterans being discharged with exceptional experience in combat medical training and no way to use this experience but to possibly work as "orderlies" at the VA Hospitals, this physician came up with an idea that might serve everyone for the best.

And thus in 1965 Drs. Eugene Stead and Henry McIntosh, director of the Cardiac Care Unit at Duke Medical Center developed an abbreviated two-year medical school education. Four former military Corpsman were accepted to train on a parallel trac with the Duke University Medical students, building on their previous years of education, training and experience with the sole responsibility to fill the clinical staffing void at Duke. Eventually this training would help care for the rural underserved communities of North Carolina- resulting in the creation of a new U.S. profession. In his letter to the Duke Medical Center Board of Directors dated September 24, 1964, Dr. Stead announced, "The Department of Medicine of Duke University Medical Center is establishing a program to create a new position in the health field. We have chosen to call these individuals 'Physician Assistant'. They will be capable of extending the arms and brains of the physician, so that he can care for more people."

Today, 57 years after the first three graduating "PAs" put on their white lab coats and name tags, the U.S. has evolved into a very different place in many ways and while perhaps some would say we have changed for the better, others would say we still have many challenges and obstacles before us. But what is undeniable is that as of the latest 2023 census 207,000 PAs have earned National Board certification since 1975 with over 178,000 currently board certified. Today, 126,634 state licensed PAs are graduating from over 300 medical schools and university PA programs nationwide. PAs are working worldwide in every specialty and clinical role imaginable including primary care clinics in rural America, cardiac transplant centers in our major cities, in the U.S. State Dept., in the White House caring for presidential staff, as forensic medical investigators and as hospital department CEO's.

PA News - What's in a Name

With the evolution of this profession has come a close self examination of its title and its name. As the profession has evolved, there has been a voice, soft and quiet at first and each year becoming louder that the name, "Physician Assistant" has outgrown itself, become outdated and clearly misrepresents what the profession is in the 21st Century while it is quickly evolving as it strives to help meet the healthcare manpower needs of America and beyond. And so, after many years of debate, self-examination and counsel, the AAPA in their 2021 annual House of Delegates conference voted 198 to 68 in favor of adopting a name change of the profession to "Physician Associate". Needless to say, this has made most PAs very happy as they believe that this "Name" of their profession more accurately describes, reflects and portrays who they are and what their role is in America's healthcare system without changing the "PA" moniker. However, what is also true is that like any cultural or professional changes in society, some will resist, deny or push back the tide of change for a variety of legitimate or even spurious reasons.

With this professional enthusiasm and excitement, many PAs around the country have decided to embrace this new "name" or "title" or "designation" including several states who have or are planning to submit new state legislation to change their designation of their professional title to "Physician Associate". Oregon, our neighbor to the south, has successfully agreed to make that legal name change. However, what must be remembered, is that while a professional organization may decide to change a title, professional designation or a profession's name, PAs by all 50 state licensing laws are not regulated by professional organizations, political action committees or social movements. PAs are defined and regulated by individual state laws and statutes, and this includes the professional designation which includes the name or title.

In the state of Washington that statute can be found in the Washington Administration Code WAC 246-918-130 as well as RCW 18.71A.010 (4). The WAC outlines requirements to initially license and maintain PA licensure while endorsing and supporting the current PA name and title.

At the same time, it has been and continues to be the role of the Washington Medical Commission (WMC) to "protect the public by ensuring quality healthcare is provided by physicians and physician assistants. The WMC establishes and enforces qualifications for licensure, consistent standards of practice and continuing competency. The WMC currently regulates about 34,000 licenses, more than 3,000 of which are PA's."

In conclusion, the WMC is aware of the evolution of healthcare practices and most professional decisions made by the Physician and Physician Assistant professions both in Washington state and nationally. We continue to closely monitor those decisions as they come up. However, the WMC recognizes that our statutory and legal responsibility and authority is to uphold and support the law as written in our state relating to our licensees while striving to protect the public health of our citizens. We will continue to do so until the law and regulations mandate us to do otherwise. Therefore, we currently take no position regarding the PA profession name change, reminding all Washington State PAs that the current professional licensed title and professional designation for PAs in Washington state is "Physician Assistant".

New Profession - Anesthesiologist Assistants

The WMC filed a CR-101, Preproposal Statement of Inquiry, to establish licensing regulations for anesthesiologist assistants in response to Senate Bill (SB) 5184 (Chapter 362, Laws of 2024) codified in chapter 18.71D RCW. The CR-101 was filed on August 28, 2024, as WSR #24-18-057. The WMC will hold workshops for this rulemaking in the coming months. To provide comments on this rulemaking, please visit the website linked here.

Sepsis Awareness Month: Addressing Health Disparities and Improving Outcomes

WASHINGTON **Medical Commission**
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Mahlet Zeru, MPH
Equity and Social Justice Manager

Since its designation in 2011, September has been recognized as Sepsis Awareness Month[1], a time when healthcare providers and institutions come together to increase awareness of sepsis - a leading cause of death in U.S. hospitals[2]. Sepsis is commonly defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection[3]. The implementation of facility based standardized protocols, monitoring policies and quality improvement in healthcare facilities has decreased the prevalence of sepsis[4,5], but minority populations continue to face disproportionately higher risk[6].

Understanding Sepsis Disparities Among Minority Populations
Although healthcare improvements have led to a reduction in sepsis prevalence, minority patients remain at greater risk due to a combination of socioeconomic factors, healthcare access barriers, and systemic discrimination[7]. These factors contribute to higher infection rates, delayed treatment, and poorer outcomes for minority groups7[8,9].

Higher Rates of Chronic Conditions
Chronic health conditions, such as diabetes[10], hypertension[11], and kidney disease[12], are more prevalent among African Americans, Hispanics, and Native Americans compared to their White counterparts. These conditions heighten the risk of infections that may lead to sepsis. For instance, a 2002 study of sepsis cases in New Jersey hospitals found that black patients with sepsis were more likely to have underlying conditions like HIV, diabetes, obesity, burns, and chronic renal failure than white patients[13]. These comorbidities increase susceptibility to infections and contribute to worse sepsis outcomes.

Barriers to Healthcare Access
Access to quality healthcare plays a critical role in the early detection and treatment of infections that can lead to sepsis. However, minority populations often face significant barriers to care, including lack of insurance, fewer healthcare facilities in their communities, and lower quality of care[13,14]. These factors contribute to delayed diagnoses and inadequate treatment, raising the risk of sepsis and its complications. Black patients are more likely to reside in areas with under-resourced hospitals[15], fewer specialists, and lower nurse-to-patient ratios[16,17], all of which can impact the quality of care they receive.

Impact of Implicit Bias and Systemic Racism
Implicit bias and systemic racism within healthcare settings also contribute to disparities in sepsis care[18]. Research shows that black patients are less likely to be admitted to the ICU for severe sepsis or septic shock compared to white patients[19]. Delayed recognition and treatment of sepsis in minority populations—both adults[20] and children[21] —have been documented, leading to worse outcomes and lower survival rates. These disparities underscore the need for addressing biases that affect clinical decision-making and care delivery.

Addressing Sepsis Disparities: A Path Forward
Efforts to reduce sepsis disparities must focus on several key areas:

- Improving Access to Healthcare: Ensuring minority communities have better access to quality healthcare services, including preventive care and timely treatment.
- Enhancing Quality of Care: Strengthening the resources and care provided in hospitals that predominantly serve minority populations.
- Addressing Implicit Bias: Implementing training programs for healthcare providers to recognize and mitigate the effects of implicit bias in clinical settings.
- Community Outreach: Increasing awareness and education about sepsis in minority communities to promote earlier recognition of symptoms and encourage timely medical intervention.
- Systemic Changes: Tackling the broader social determinants of health, such as poverty and housing, which contribute to disparities in infection rates and sepsis outcomes.

Get Involved in Sepsis Awareness Month
Providers are encouraged to participate in Sepsis Awareness Month activities throughout September by taking advantage of continuing medical education (CME) opportunities focused on sepsis care and management.

- Sepsis Alliance Institute
- Sepsis Core Elements: CDC Webinar Series
- American College of Physicians

By staying informed and engaged providers can help reduce the burden of sepsis and close the gaps in care affecting minority populations. Healthcare providers can ensure that all patients; regardless of race, ethnicity, or socioeconomic status can receive the timely, high-quality care they need to survive sepsis.

Endnotes can be found on page 20

Rulemaking Efforts

Amelia Boyd

Program Manager

Postgraduate Medical Training, WAC 246-919-330 via Standard Rulemaking
On April 26, 2024, the WMC adopted revisions to WAC 246-919-330. The revisions eliminate the outdated requirement for consecutive years of training in no more than two programs. The CR-103, Rulemaking Order, was filed on June 6, 2024, as WSR #24-13-019. The rules were effective July 9, 2024.

General Provisions for Opioid Prescribing for Physician Assistants and Allopathic Physicians
A CR-102, Proposed Rulemaking, was filed on March 20, 2024, as WSR #24-07-107 for both chapter 246-918 WAC (physician assistants) and chapter 246-919 WAC (allopathic physicians) to revise the opioid prescribing rules as follows:

1. Exempting patients with Sickle Cell Disease.
2. State in rule that not all chronic pain patients need to be tapered off opioids.
3. Clearer rules regarding biological specimen testing.

A hearing was held on April 26, 2024, during which these proposed rules were not adopted. At the hearing, concerns were raised about the proposed removal of "biological testing" from subsection (1) of both the Periodic Review—Chronic pain sections: WAC 246-918-870 and WAC 246-919-920. Due to these concerns, a follow-up workshop was held on June 4, 2024, to refine the draft language and the revised proposal now includes "biological testing" once again. A supplemental CR-102 was approved at the WMC's July 19, 2024, Business meeting. The supplemental CR-102 is in progress and the hearing is tentatively scheduled for October 11, 2024. Please visit our Rules in Progress page for the current schedule.

2SHB 1009 Military Spouse Temporary Practice Permits
Second Substitute House Bill (2SHB) 1009 Concerning military spouse employment was passed during the 2023 legislative session. The WMC has a section in both the physician's chapter, WAC 246-919-397, and the physician assistant's chapter, WAC 246-918-076, which address how a military spouse can obtain a temporary practice permit. Both WACs are identical except for references to physician or physician assistant in their respective chapters. 2SHB 1009 provides additional information for issuing this temporary permit, a different definition of military spouse, and other items that are not included in the WACs. The WMC will consider amending these WACs to align with the bill more closely. The CR-101 for this rulemaking was filed on September 12, 2023, as WSR #23-19-029.

At their October 20, 2023, Business meeting, the Commissioners approved initiating the next step in the rulemaking process, CR-102, Proposed Rulemaking. The hearing for this rulemaking is tentatively scheduled for October 11, 2024. Please visit our Rules in Progress page for the current schedule.

Expedited Rulemakings (CR-105)

Physician Assistant Collaborative Practice
The CR-105 in response to ESHB 2041 Concerning physician assistant collaborative practice was filed on July 16, 2024, as WSR #24-15-055. The comment period for this rulemaking ends September 23, 2024. Comments regarding this rulemaking can be sent to amelia.boyd@wmc.wa.gov until that date.

Technical Edits to WAC 246-919-945 and WAC 246-918-895
The CR-105 was filed on July 16, 2024, as WSR #24-15-054. This rulemaking removes references to osteopathic physician assistants. The comment period for this rulemaking ends September 23, 2024. Comments regarding this rulemaking can be sent to amelia.boyd@wmc.wa.gov until that date.

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. The 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.

Establishing the use of nitrous oxide in office based surgical settings, WAC 246-919-601

The WMC is considering amending WAC 246-919-601 to exempt the use of nitrous oxide in office-based surgical settings under certain circumstances. Additionally, the WMC is considering adding a new subsection to further address the use of nitrous oxide in such settings. The CR-101, Preproposal Statement of Inquiry, for this rulemaking was filed on May 17, 2024, as WSR #24-11-104.

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

Upcoming Rulemakings

At their October 20, 2023, Business meeting, the Commissioners approved initiating rulemaking on the following:

- Regarding SSB 5389 – define "qualified physician"

The CR-101, Preproposal Statement of Inquiry, for this rulemaking is in progress. Once the CR-101 is filed, workshops will be held. Please visit our Rules in Progress page for the current schedule.

At their April 26, 2024, Business meeting, the Commissioners approved initiating rulemaking on the following:

- Standard rulemaking in response to SB 5184 Concerning licensure of certified anesthesiologist assistants

The CR-101, Preproposal Statement of Inquiry, for this rulemaking is in progress. Once the CR-101 is filed, workshops will be held. Please visit our Rules in Progress page for the current schedule.

At their July 19, 2024, Business meeting, the Commissioners approved initiating rulemaking on the following:

- Opioid prescribing for physician assistants and allopathic physicians.

The CR-101, Preproposal Statement of Inquiry, for this rulemaking will be in progress later this year. Once the CR-101 is filed, workshops will be held. Please visit our Rules in Progress page for the current schedule.

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. WMC rulemaking comments or questions may be emailed to medical.rules@wmc.wa.gov.

WPHP Report

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WPHP's Program Updates

Vanessa Bloy
Communications Manager, Washington Physicians Health Program

New Communications Efforts
This year, one of the primary initiatives for the Washington Physicians Health Program (WPHP) was launching a Strategic Communications Plan to continue to raise visibility about our program and services in the medical community. We added capacity for a more robust communication infrastructure providing increased communications, thought leadership, and external engagement support with key partners and stakeholders.

One of our first efforts was updating our mission, vision, and values statements with our team to embody the essence of the organization, align with its purpose, and provide a strong foundation for core messaging.
Mission: WPHP is Washington's trusted resource for restoring the health of medical professionals. Our confidential support and exceptional outcomes provide reassurance of safe practice and promote workforce sustainability.
Vision: Advancing the health and well-being of our medical community.

Values:

- Collaboration: We honor the role that each person plays in working together.
- Respect: We believe in the inherent worth of all people and foster a safe and affirming environment.
- Equity: We recognize diverse backgrounds and needs.
- Advocacy: We champion people and causes that further our mission.
- Transparency: We build trust through honesty and openness.
- Excellence: We are driven to be the best at what we do.
- Service: We are dedicated to providing outstanding support to all we serve.

We are also refining our external engagement strategy to tap into high-impact opportunities along with developing new resources to share information about our program. We've refreshed our website including adding additional content and tools along with revamping our quarterly Physician Health Focus newsletter.

Quality Assurance Team Development
WPHP continues to revolutionize and redesign systems to streamline workflows and efficiency while improving our program participant and staff experience. WPHP created our Quality Assurance team last year to reduce administrative burden to clinical staff, build resilience to clinical staff turnover, and strengthen our quality and performance program. Since then, the team has expanded and oversees program participant adherence and enrollments. The Quality Assurance team has also helped develop nationally recognized innovations in our toxicology testing system.

Dr. Chris Bundy Accepts Additional Role as FSPHP's First-Ever Chief Medical Officer
In addition to his role as WPHP's Executive Medical Director, Dr. Bundy, has been appointed to serve on the Federation of State Physician Health Programs (FSPHP) leadership team as the organization's first-ever Chief Medical Officer (CMO). This new role marks a significant milestone for FSPHP, reflecting its growth and commitment to sustained leadership in physician health. Dr. Bundy will be serving in a consulting capacity with FSPHP as he continues his full-time position as Executive Medical Director for WPHP. As CMO, Dr. Bundy will join FSPHP's elected physician leaders, who play crucial roles in cultivating partnerships, fostering relationship building, and institutional learning. The FSPHP CMO's responsibilities will include evaluating and addressing organizational matters that require medical expertise, representing FSPHP policy on physician health and well-being to both internal and external stakeholders, serving as a spokesperson for FSPHP in educational and outreach efforts when called upon by elected leaders, and collaborating with the FSPHP president and executive director to respond to media requests. Additionally, Dr. Bundy will provide expert guidance on emerging issues relevant to FSPHP's mission for which there is no existing policy guidance.

WPHP Education and Outreach Efforts
WPHP provides robust education and outreach to Washington's medical community. Last year, our organization provided 62 hours of educational presentations on topics related to physician health to medical students, trainees, practicing physicians, and healthcare leaders across the state and nation. In 2024, WPHP continues this tradition, presenting to residency programs, boards, commissions, and associations on the benefits of WPHP's program, outcomes, and physician well-being.

WPHP Advocacy
One of the focuses for WPHP this year is advocacy, and we are making tremendous strides advocating for license and credentialing question reforms and preserving WPHP protections in the public records act. To learn more about WPHP or make a referral, please call 800-552-7236 or visit our website.

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Preparing for the 2024-2025 Respiratory Virus Season

October 16th, 2024
12:00 – 1:00 PM PST
CME is Available
More Information

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Federation of State Medical Boards, the Washington Medical Commission, and the Washington State Department of Health. The Federation of State Medical Boards is accredited by the ACCME to provide continuing medical education for physicians. The Federation of State Medical Boards designates this live activity for a maximum of *1.0 AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Legal Actions

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May 1, 2024 – July 31, 2024

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				
Benson, David B., MD MD.MD.00040349 Skagit County	Ex Parte Order of Summary Suspension	6/11/24	Alleged repeated practice below the standard of care when treating pregnant patients and newborn infants.	Restricted from practicing obstetrics and newborn care.
Akers-White, La Tania M., MD.MD.61003240	Ex Parte Order of Summary Suspension	6/21/24	Revocation of license in Montana.	Indefinite suspension.
Formal Actions				
Alhafez, Fadi, MD MD.MD.60094946 Pierce County	Agreed Order	6/13/24	Negligent performance of cosmetic surgery on a patient; negligent testosterone replacement therapy on three patients.	Restricted from performing cosmetic surgery without oversight of a preceptor; retain physician to perform periodic reviews of respondent's hormone therapy practice; CME in record keeping, informed consent, testosterone replacement therapy; prior to practicing cosmetic surgery must complete CME on pre-operative evaluation of surgical patients; paper; personal appearances; fine. May petition to terminate in three years.
Ataee, Sean, MD MD.MD.00047909 Out of state	Final Order on Default	6/13/24	Revocation of licenses in California and New York	Denial of application to renew license.
Figueras, Dominic A., MD MD.MD.0038348 Out of state	Final Order on Default	5/9/24	Failure to comply with Commission Order.	Indefinite suspension.
Knox, David G., MD MD.MD.00018242 Out of state	Agreed Order	7/23/24	Surrender of license in Oregon.	Voluntary surrender of license.

Lin, Wei-Hsung MD MD.MD.60207016 Benton County	Agreed Order	5/2/24	Negligent management of patients with symptoms consistent with COVID-19 infections.	Restricted from prescribing ivermectin for non-FDA-approved indications; restricted from prescribing medication or providing care to patients without first establishing a physician-patient relationship by seeing the patient or via real-time video, taking a history and examining the patient before deciding on a course of treatment; review CDC web site and UpToDate web site for current guidelines on prevention, treatment, and management of COVID-19; paper on learning from web sites; CME on establishing the physician-patient relationship and maintaining a medical record; paper on physician-patient relationship; compliance audits; personal appearances; personal reports; fine. May petition to terminate in three years.
Nielson, Alex L., MD MD.MD.61130110 Clark County	Agreed Order	5/2/24	Inappropriate conduct with co-worker.	Compliance with WPHP contract; ethics and boundaries course; personal appearances; fine. May petition to terminate after completion of WPHP contract.
Oliver, Richard T., Jr., PA PA.PA.60271207 Walla Walla County	Agreed Order	7/11/24	Alleged negligent care of patients while working for the Department of Corrections.	Voluntary surrender of license.
Parvataneni, Kesav C., MD MD.MD.60827451 Our of state	Agreed Order	7/31/24	Inability to practice safely due to a health condition.	Indefinite suspension.
Pearson, Sean P., PA PA.PA.60610092 King County	Agreed Order	5/2/24	Violation of Commission order.	Indefinite suspension.
Tantuwaya, Lokesh MD MD.MD.60432704 Out of state	Final Order on Default	7/11/24	Suspension of license in California.	Indefinite suspension.
Turner, Michael K., MD MD.MD.60072206 Benton County	Final Order	6/21/24	Negligent prescribing of ivermectin including to several patients based on intake forms submitted via web site; without informed consent; and without getting more information about two patients' liver disease.	Restricted from prescribing ivermectin for the prevention or treatment of COVID-19 until such time as the FDA approves ivermectin for such indications; CME in record keeping, telehealth, and prevention and treatment of COVID-19; paper; and fine. May petition for modification in two years.

Informal Actions				
Ahmad, Nauman MD MD.MD.60926635 King County	STID	5/2/24	Alleged use of confrontational and unprofessional language with patients.	Course on communication; review Commission policy on disruptive behavior; paper; personal appearances; costs. May petition to terminated in one year.
Ankeney, Geoffrey A., MD MD.MD.60048348	STID	7/11/24	Alleged negligent documentation and monitoring of patients receiving transcranial magnetic imaging (TMS).	CME in treatment resistant depression, TMS; and ethics; paper; personal appearances; costs. May petition to terminate in two years.
Berry, Kevin A., MD MD.MD.60387536 King County	STID	5/2/24	Alleged negligent pain management treatment.	CME in controlled substance prescribing and treating insomnia; paper; register with PMP and query the PMP regularly; compliance audits; personal appearances; and costs. May petition to terminate in three years.
Dryland, David MD MD.MD.61199579 Out of state	STID	7/11/24	Disciplinary action against license in Oregon.	Compliance with Oregon order; prior to treating a patient in Washington, must retain practice mentor; if prescribing methotrexate to a patient in Washington, must document medical decision-making and evaluate each prescription every 3 months; costs. May petition to terminate when the Oregon order is terminated.
Griffin, Basil M., MD MD.MD.00049372 Spokane County	STID	5/2/24	Alleged self-prescribing and prescribing for family members without documentation.	CME in prescribing controlled substances, medical ethics, and record-keeping; paper; personal appearances; costs. May petition to terminated in two years.
Hardy, Kristen J., PA PA.PA.60247903 Spokane County	STID	5/2/24	Alleged misdiagnosis of abdominal pain in elderly patient.	CME in diagnosing acute abdominal pain in elderly patients; paper; personal appearances; costs. May petition to terminate in three years.
Hemmert, Jonathan W., MD MD.MD.60850584 Out of state	STID	7/11/24	Alleged failure to supervise estheticians in med spa who were using device that had not been submitted to FDA for clearance or approval..	Practice agreement not to serve as the medical director of any facility in which the Cryoskin device is being used unless or until it is approved or cleared by FDA; review Commission's guidance document on roles of medical directors; literature review of roles of medical directors; paper; compliance audit; costs. May petition to terminate after completing requirements.

Johnson, Drew A., PA PA.PA.60457629 Out of state	STID	5/2/24	Disciplinary action against license in Idaho.	Comply with Idaho order; paper; notify Commission if he intends to renew license; personal appearances; personal reports. May petition to terminate in two years.
Laney, Thomas J., MD MD.MD.00024468 Grant County	STID	5/2/24	Alleged negligent care of elderly patient who developed sever hypoxemia during dental procedure.	Surrender of license.
Liebert, John A., MD MD.MD.0009587 Out of state	STID	6/13/24	Disciplinary action against license in Arizona.	Surrender of license.
Lundeby, John P., MD MD.MD.00033393 Spokane County	STID	7/11/24	Alleged failure to refer patient with complications and possible internal bleeding from lipoabdominoplasty to hospital.	CME in identification and management of acute blood loss and post-operative bleeding; paper; communication course or review 3 articles on communication; personal appearances; costs. May petition to terminate in one year.
Mohandessi, Soroush, MD MD.MD.61122713 Clark County	STID	6/13/24	Disciplinary action against license in Oregon.	Restricted from practicing psychotherapy; practice limited to forensic psychiatry, medication management, administrative medicine; comply with Oregon Order; personal appearances; costs. May petition to terminate when the Oregon Order is terminated.
Salvos, Timothy L., PA PA.PA.60785165	STID	7/11/24	Alleged disruptive behavior in the workplace.	Complete Understanding Disruption at Acumen Institute; paper; personal appearances; costs. May petition to terminate in one year.
Sheary, Conrad L., PA PA.PA.61013867 Snohomish County	STID	5/2/24	Alleged failure to provide necessary in-person care to geriatric patient following telemedicine visit.	CME in management of chronic conditions in geriatric patients; CME in wound care; CME in ethical obligations of primary care provider; paper; preceptor to monitor practice; personal appearances; quarterly personal reports; costs. May petition to terminate in three years.

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 on 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.

Statement of Compounding Semaglutide

Pharmacy Commission Approved Aug. 22, 2024

The compounding of semaglutide by pharmacies and FDA-registered outsourcing facilities has risen due to the FDA shortage status of Ozempic and Wegovy.

The federal Food Drug & Cosmetic Act (FD&C Act), prohibits compounding regularly, or in inordinate amounts, "any drug products that are essentially copies of a commercially available drug product." The FD&C Act and the FDA have recognized that a compounded drug will not be considered a copy of a commercially available drug product in the following three situations:

1. The drug has been discontinued and is no longer marketed.
2. The drug is not readily available and is listed on the FDA's drug shortage list.[1]
3. There is a specific change for an identified patient whose medical needs cannot be met by the commercially available product.

Compounding pharmacies are responsible for checking the FDA's website on a regular basis to determine whether Ozempic and Wegovy are on the FDA's drug shortage list. If a drug is listed on the FDA's drug shortage list as "currently in shortage" (and not in "resolved" status), then the drug is not considered by the FDA as a commercially available drug product, which means compounding pharmacies may be able to prepare a compounded version of that drug if they meet requirements of the FD&C Act. This includes, among other things, requirements of the FD&C Act related to bulk drug substances.

More specifically, the FD&C Act requires that bulk drug substances used to compound must:

1. comply with the standards of an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph, if a monograph exists, and the USP chapter on pharmacy compounding;
2. if such a monograph does not exist, be components of drugs approved by the FDA; or[2]
3. if such a monograph does not exist and the drug substance is not a component of a drug approved by the FDA, appear on the final or interim 503A or 503B bulk drug substances list published by the FDA.

With respect to semaglutide:

1. There is no USP or NF monograph for semaglutide.
2. Ozempic and Wegovy contain semaglutide base – not a salt form. Therefore, only the base is a component of an FDA-approved human drug product. The salt forms are different active ingredients than used in FDA-approved drugs, and do not meet FD&C Act requirements for compounding.
3. Semaglutide does not – in any form – appear on the FDA's "bulks list" for compounding. Therefore, no salt form of semaglutide may be used in a compounded drug product.

Even if a compounding pharmacy or FDA-registered outsourcing facility obtained semaglutide base for potential compounding use, the compounding pharmacy or FDA-registered outsourcing facility must also ensure that the active pharmaceutical ingredient (API) received is a pharmaceutical grade product (not "research use only"), accompanied by a valid certificate of analysis, and is sourced from an establishment registered with the FDA and licensed in Washington state and its resident state.

The commission has determined that a failure of licensees to comply with the requirements of the FD&C Act when compounding a semaglutide drug product may result in disciplinary or enforcement action by the commission and/or the FDA (e.g. RCW 18.64.026(1) and RCW 18.130.180(7)). In addition, pharmacies and pharmacists that dispense semaglutide drug products that have been compounded in a manner that is not compliant with the FD&C Act's requirements may also be subject to disciplinary or enforcement action by the commission and/or the FDA (e.g. WAC 246-945-305(2) and WAC 246-945-415(1)).

Statement of Compounding Semaglutide

Notice to Consumers/Patients
Consumers should be reminded that these medications are legitimately available by prescription only, and should only be prescribed in direct consultation with, and under the supervision of, a licensed healthcare professional.[3]

From the FDA's webpage, Medications Containing Semaglutide Marketed for Type 2 Diabetes or Weight Loss | FDA:

FDA has received adverse event reports after patients used compounded semaglutide. Patients should not use a compounded drug if an approved drug is available to treat a patient. Patients and health care professionals should understand that the [FDA] does not review compounded versions of these drugs for safety, effectiveness, or quality.

Patients should be aware that some products sold as 'semaglutide' may not contain the same active ingredient as FDA-approved semaglutide products and may be the salt formulations. Products containing these salts, such as semaglutide sodium and semaglutide acetate, have not been shown to be safe and effective.

Patients should only obtain drugs containing semaglutide with a prescription from a licensed health care provider, and only obtain medicines from Washington state-licensed pharmacies or outsourcing facilities registered with FDA.

References (not an exhaustive list):

- Chapter 18.64 RCW
- RCW 18.130.180
- Chapter 246-945 WAC
- FD&C Act § 503A(b)(1)(A)(i)-(iii), (b)(1)(D), (b)(2)
- Product Under Section 503A of the Federal Food, Drug, and Cosmetic Act Guidance for Industry (fda.gov)
- Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act Guidance for Industry (fda.gov)
- Interim Policy on Compounding Using Bulk Drug Substances Under Section 503A of the Federal Food, Drug, and Cosmetic Act Guidance for Industry (fda.gov)
- Interim Policy on Compounding Using Bulk Drug Substances Under Section 503B of the Federal Food, Drug, and Cosmetic Act Guidance for Industry (fda.gov)

[1]Please note that, at the time of publication, the FDA has stated it "does not intend to take action against an outsourcing facility for filling orders that it received for a compounded drug that is identical, or nearly identical, to an approved drug that was on FDA's drug shortage list at the time that the outsourcing facility received the order, provided the drug also appeared on the FDA drug shortage list within 60 days of the outsourcing facility distributing or dispensing the drug" (Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act Guidance for Industry (fda.gov)). FDA-registered outsourcing facilities should consult with the FDA to confirm the future status of this enforcement policy.

[2] The Food, Drug, and Cosmetic Act (FD&C Act) references the Secretary of the U.S. Department of Health and Human Services (HHS). The FDA is an agency within the U.S. Department of Health and Human Services (HHS Organizational Charts Office of Secretary and Divisions | HHS.gov).

[3] FDA alerts health care providers, compounders and patients of dosing errors associated with compounded injectable semaglutide products | FDA

WMC Public Meetings

September - 2024

26 - Policy Committee

October - 2024

11 - Business Meeting

16 - Preparing for the 2024- 2025 Respiratory Virus Season*

30 - Addressing Vaccine Hesitancy in Rural Communities: Part One*

November - 2024

11 - WMC Offices Closed

28 to 29 - WMC Offices Closed

December - 2024

05 - Policy: Interested Parties

25 - WMC Offices Closed

January - 2025

02 - Policy Committee

09 - Personal Appearances

10 - WMC Business Meeting

30 - Policy: Interested Parties

More Information can be found on our Event Calendar

*Accreditation Statement - This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Federation of State Medical Boards, the Washington Medical Commission, and the Washington State Department of Health. The Federation of State Medical Boards is accredited by the ACCME to provide continuing medical education for physicians. The Federation of State Medical Boards designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The WMC will hold two Rules Hearings on Friday, October 11, 2024:

1. Regarding military spouse temporary practice permits, WAC 246-918-076 (physician assistants) and WAC 246-919-397 (physicians). Begins at 9:15 am. The CR-102, Proposed Rulemaking, filed as WSR #24-18-041 on August 27, 2024, includes the proposed language.
2. Regarding general provisions for opioid prescribing and tapering rules for allopathic physicians and physician assistants. Begins at 9:45 am (CORRECTED TIME). The Supplemental CR-102, Proposed Rulemaking, filed as WSR #24-18-091 on August 30, 2024, includes the proposed language.

The comment period for both rules will expire on October 4, 2024, at 11:59 pm. If you would like to provide comments, you may do so here. These hearings will be held in conjunction with the WMC's Business meeting, which will begin after the last hearing is adjourned or 10:15 am, whichever is later. These meetings will be held virtually via Teams.

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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.

Endnotes

1 https://www.sepsis.org/get-involved/sepsis-awareness-month/#:~:text=In%202011%2C%20Sepsis%20Alliance%20designated,death%20in%20U.S.%20hospitals%20%E2%80%93%20sepsis. Accessed August 2024

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