UPDATE!

Vol.15 Fall 2025

Promoting Patient Safety and Enhancing the Integrity of the Profession Through Licensing, Discipline, Rule Making, and Education.

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

Message from the Chair

WASHINGTON Medical Commission
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It is an Honor to Serve as your Chair

Terry Murphy, MD

Hello to all Washington MD's, PA's, and Certified Anesthesiologist Assistants. I am Dr. Terry Murphy, the newly elected Chairperson of the Washington Medical Commission (the Commission). I am honored to serve in these challenging times to help licensees continue to provide the excellent care they give to patients in this great state of Washington. Washington has been my home since 2007, when after leaving a busy ER shift in an inner-city urban warfare town in California, seven bullets zoomed over my windshield as two black SUVs chased a third car with multiple shots being fired toward the third car. I was shaken and it wasn't the first time, as people had been shot in the parking lot of that hospital and even the waiting room! I called my longtime friend and mentor, who recommended I interview for a position in Washington and so began a much higher quality life for myself and my family in central Washington.

Caring for victims of stab wounds or gunshot wounds almost daily, was replaced with farm accidents, motor vehicle accidents, primary care type needs, and 1-2 hunting accidents per year. Stroke and heart attack patients had to be stabilized and transferred 80-120 miles away. Burn victims had to be stabilized and transferred to the only Level 1 trauma center in the state, almost 200 miles away. There was the ever-present problem of finding qualified professionals to staff the ER. I was blessed with friends and colleagues who would drive from the west side of the state or fly in from other states to help. I'm still in touch with many of these dedicated professionals. We continued to provide quality care to all patients until after five CEO's in almost six years, the contract was severed, and all the PAs and MDs were suddenly out of work.

I continued to work in emergency medicine, still living in Washington, but practicing out of state for several years in 150-500 bed hospitals. Finally, a job offer back in Washington at a critical access hospital in a small rural town became available and became my most challenging position ever. Care was single coverage, 12-hour shifts sometimes seeing two patients per hour, sometimes more depending on the need. A multi-vehicle accident with multiple injured would all be transported to the same hospital with the single provider.

I was Chief of Staff at this hospital, when I opened a letter with the Washington Medical Commission logo, thinking "What do they want?". The letter from the governor at the time invited me to apply to represent the MD's and PAs of District 4. I presented the letter to hospital administration and the Medical Executive Committee, asking if they were in support of the application. There was an enthusiastic "YES". In retrospect, I think there was the thought of staff MD's and PA's getting a free pass in the case of a complaint, but this is not the case. When we get a complaint against a colleague, coworker, or friend, we have a recusal policy to protect the sanctity of the process. After applying, being interviewed, and waiting, I was appointed by the Governor.

That was 6 ½ years ago. I continue to be grateful to serve on the Commission with colleagues committed to quality medical care and patient safety. At this stage of my career, after 46 years of serving in healthcare, I am honored to give back to the people of Washington and medical colleagues with fairness, equity, and education. The mission of the Commission is to "promote patient safety and enhance the integrity of the profession through licensing, discipline, rulemaking, and education". It is a challenge for the 21 commissioners who serve in a climate where the number of complaints are at an all-time high. Every complaint is taken seriously and weighed on its merits. System problems are labeled as such. We strive to identify "one-off" errors as such. When discipline is indicated, it is a panel decision with discussion of what is necessary for the provider to become the best version of themselves and put the problem behind them.

Dr. Karen Domino is a great example of the quality of person serving on the Commission. Her leadership over the past two years and service for several years prior, has strengthened the Commission and its mission. Her lifelong dedication to patient safety is world renown. Mr. Kyle Karenin, Executive Director, has also demonstrated great leadership and commitment to the mission. As I attend various conferences, meeting physicians from other state medical commissions, there's always an interest in what Washington is doing. We are recognized as a strong and effective board. The staff and commissioners are working harder than ever for you and I'm honored to be a part of this process.

Executive Director Report

WASHINGTON Medical Commission
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End of Summer Updates
Kyle Karinen, J.D., LL.M

The summer season is typically a slower time at the Commission. However, this past summer, things have been humming. This quarter, I am going to provide a couple of updates and include an ask of folks reading this entry in the Commission's newsletter.

HELMS Update

The Department of Health (the Department) implemented the first stage of the Healthcare Enforcement and Licensing Management System (HELMS) in 2024. This has been a project long in the works as the Department's then-current database was past its point of useful life and the vendor supporting the database indicated it would be ending its support. That first stage was a relatively minor improvement over an outward-facing portal. In April of this year, the first major phase of HELMS went live with the migration of all the licensing functions from the old database into HELMS. As one might expect with a database of hundreds of thousands of licenses, the past few months have not been without bumps in the road. The HELMS team, including members of the Commission staff, have been working every day since the end of April to address those bumps. We have heard a good deal of feedback from licensees, applicants, and other folks who assist those physicians (MD) and physician assistants (PA) and have taken that to heart. As the Department and the Commission continue to work out the rough spots with HELMS, please be assured that we are paying attention to this feedback and as the project concludes early next year, we look forward to refining the system.

Join the Commission

The Commission routinely receives complaints involving areas of clinical care where it does not have an PA or MD that practices in that specific area of care. For evaluation of complaints and, if authorized for investigation, the review of the completed investigations, the Commission has a number of options. The Commission can lean on members who have experience in adjacent fields of care, commission members who have experience in administrative roles involving that field of care, or it can hire a clinician from outside the Commission's ranks to review the investigative report and provide a recommendation.

All of these options can have drawbacks, so the Commission routinely brings on board pro tem commission members who have clinical experience in areas where it receives complaints and there is not necessarily an active commission member with extensive underlying experience. For example, over the past four years, the Commission has been fortunate to have an ophthalmologist in its pro tem ranks. As a result, the Commission members will hold off on opening complaints that come through until their pro tem colleague has an opportunity to review the complaint. There are several other areas of clinical care where it would be helpful to have clinicians, so if you are a urologist, radiologist, psychiatrist, general surgeon, or an orthopedic surgeon, please reach out to either myself or the Commission's program manager, Amelia Boyd (amelia.boyd@wmc.wa.gov). We would love to talk to you about working with the Commission.

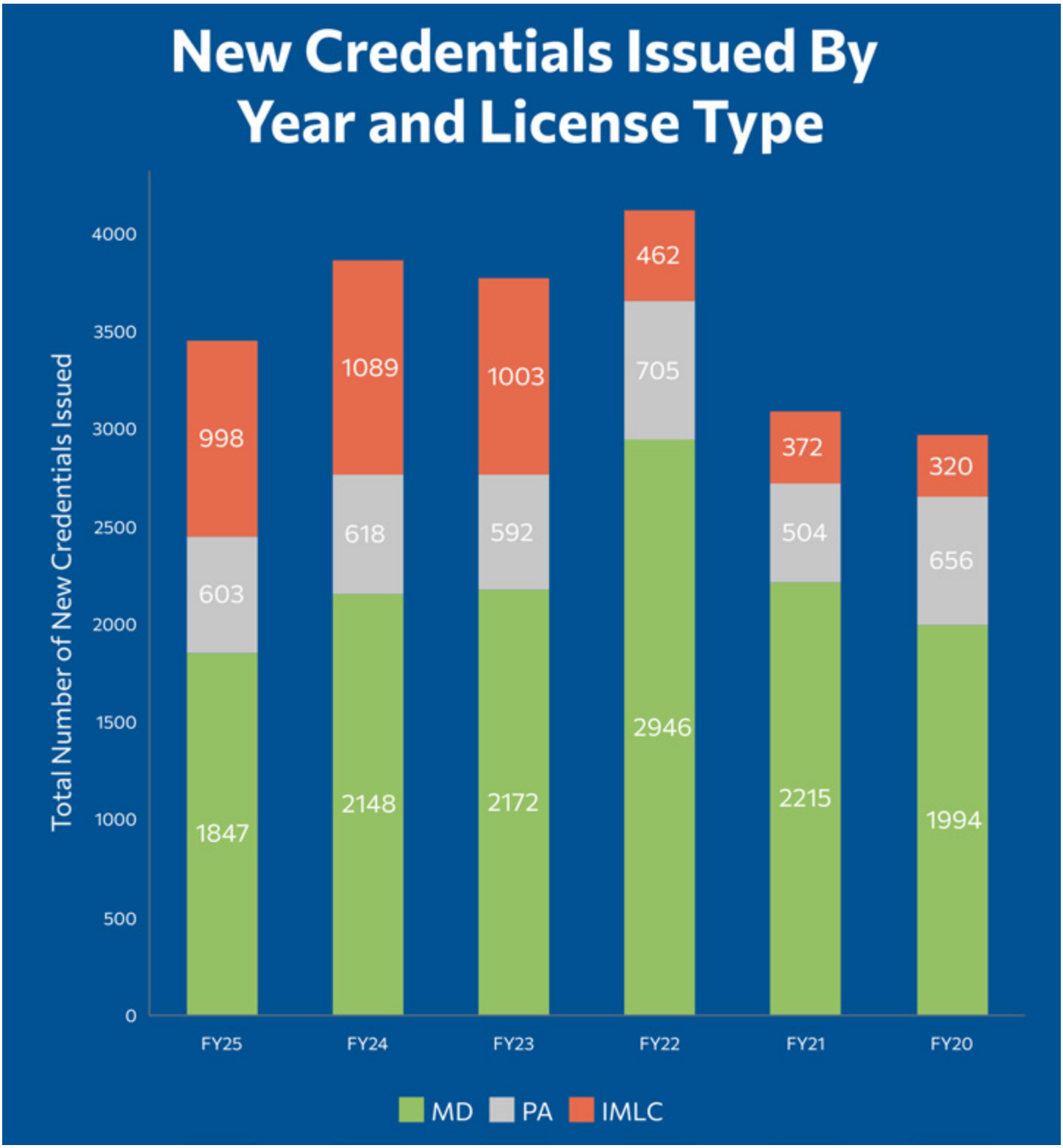
Ongoing Clinical Fraud

There was a recent article in the Washington Post that highlighted a troubling trend. In the September 5 online version of the New York Times and reprinted in the September 14 online edition of the Seattle Times, there was detailed account of a number of physicians who had their name attached to advertisements without their knowledge or consent. Several appeared on YouTube, but they also appeared in multiple other social media environments. Several used an AI-generated voice of the purported physician in pursuit of selling merchandise, nutritional supplements and even spinoff versions of books authored by physicians. Perhaps one of the most troubling aspects of the article was the relatively unsuccessful attempts by the actual physicians to have their names, images and likeness removed from the advertisements. As recounted previously, the Commission has had its own issues with individuals impersonating Commission staff in an effort to get physicians and physician assistants to wire them money. The article raises more issues than it does talk about a regulatory effort or even framework to address this sort of fraud, but it merits monitoring.

Fiscal Year 2025 (FY25) Licensing Trends

I wanted to also provide the briefest of overviews on the state of the MD and PA workforce from a numbers perspective. Some of this information can also be found on the Commission's website as part of our annual fiscal-year-end performance report. Included in this report is a snapshot of some demographic information that might be interesting (Page 15). The report breaks down the type of practice model that most physicians and physician assistants practice in and well as average age and top specialties.

On this note, here are the numbers from FY25 from a licensing perspective in terms of new licenses issued in Washington:



Healthcare Enforcement & Licensing Management System (HELMS)

HELMS is the new online portal available to healthcare providers for submitting applications, renewals, status changes, and account updates. All Washington state allopathic physicians and physician assistants need to create a HELMS portal account.

Create, Connect, and Use your HELMS Account

Step 1: Find your license number before you start
Use the Provider Credential Search to find your license number if you don't have it available.

Step 2: Use a desktop computer
Use a desktop computer – mobile and tablet users have experienced error messages.

Step 3: Access your SAW account
Create a Secure Access Washington (SAW) account or log into your existing account. Do not use the old DOH portal as it will no longer work. It is important that you do not create a new account if you already have a credential with the Department of Health. Creating a new account will not link your current account, applications, or credentials.

Need help? Download the How to Create a SAW Account for Online Application.

Step 4: Add HELMS to your portal (first time only)

- Click the "Add a New Service" button
- "I would like to browse a list of services by agency."
- Click "Department of Health"
- Add the "Health Professional and Facility Licensing (HELMS)" service to your SAW account

Step 5: Navigating HELMS
Download or print the complete Guide to Using Your HELMS Portal.

- For renewals, scroll down for the renewal button
- For new applications only, click on the top button

Step 6: Complete your demographic data survey
Submit your demographic data in compliance with state law.
Under RCW 18.130.042 all licensed health care professionals in Washington are required to provide demographic and workforce data during initial licensure and renewal.

Step 7: Do you need a receipt?

Navigate to your HELMS portal homepage and select "Payments," "History," and "Download Receipt."

Step 8: Renewal notices are now digital
Renewal notices will be emailed about 90 days prior to your renewal due date. Verify your email address in your HELMS portal to ensure that you receive your notice.

Step 9: Check the status of your application or renewal anytime
Log into your HELMS account through SAW and check the status column next to your credentials on the homepage.

Step 10: Print your credential
Log into your HELMS portal through SAW. On your portal homepage click "Download Credentials" under the "All Credentials" tab.

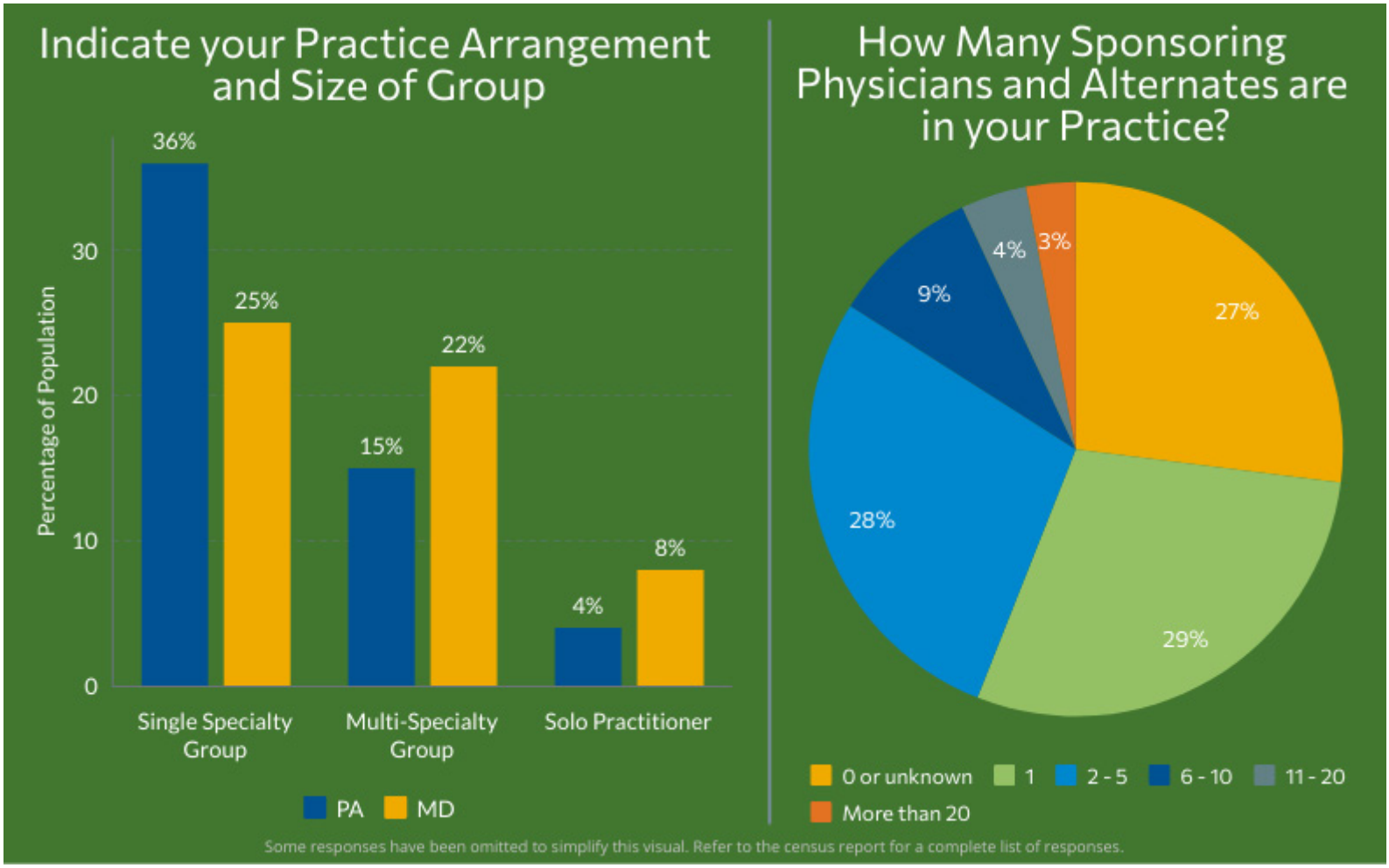
You Are Not Alone: Is There a Risk of Isolation in Medical Practice?

Ed Lopez PA-C

"*No man is an island, entire of itself…*" — so begins Meditation XVII from Devotions Upon Emergent Occasions by English poet and cleric John Donne (1572–1631). Composed in 1624 during a near-fatal illness, Donne's reflection on the interconnectedness of humanity remains deeply relevant nearly four centuries later. In the aftermath of the COVID-19 pandemic, with its widespread lockdowns, social distancing, and extended periods of isolation, it is my opinion that our collective need for human connection has become more evident than ever.

Today, this heightened need for connection is met with a troubling rise in isolation. Whether in our personal lives or professional environments, this disconnection is undermining the fabric of our relationships and communities. Mental health and social work literature increasingly supports what many of us already know intuitively: we are social beings who depend on one another to thrive. No one, physician, PA or otherwise, functions at their best in isolation. Remember… humanity started as tribes, later becoming communities in support of each other as a matter of survival.

While the effects of loneliness are often examined in the context of parenting, personal relationships, and the workplace, I have recently been considering its impact within the medical profession. In reviewing several complaints and disciplinary cases involving physicians and physician assistants, a striking pattern seems to have emerged: many of our colleagues who have been disciplined, appear to be practicing in isolation—outside the context of a group or of a collaborative setting. When we look at the available data collected through the self-reported Physician Assistant Demographic Census, we learn the following.



This observation raised an important question: Could the absence of a collaborative practice environment contribute to poor clinical decisions or unprofessional behavior? Might these outcomes have been avoided if the providers had worked alongside colleagues who could offer feedback, guidance, or simply just be a sounding board?

Although correlation does not imply causation, in my mind the question merits at least thoughtful consideration. Is it possible that isolation in medical practice increases the risk of diminished judgment, ethical missteps, or behavioral decline? I don't know! But....

In 2023, U.S. Surgeon General Dr. Vivek Murthy identified loneliness and isolation as a public health epidemic, citing research linking isolation to increased rates of anxiety, cardiovascular disease, dementia, stroke, and premature death. A 2017 study equated the health risks of chronic loneliness to smoking 15 cigarettes per day.

Beyond emotional well-being, collaborative work environments have been shown to improve performance. In their 2018 study published in the Proceedings of the National Academy of Sciences, Bernstein, Shore, and Lazer examined how intermittent collaboration among individuals of varying performance levels impacts outcomes. They found that both high and low performers benefited from working together: high performers improved by adopting useful ideas from their peers, while lower performers were elevated through exposure to higher standards and solutions.

While this evidence does not establish definitive causation between isolation and professional misconduct, I would suggest that environments lacking collaboration may create conditions that allow poor decision-making to go unchecked.

To that end, I want to emphasize an important point to any provider who finds themselves working in isolation, whether professionally or emotionally: that you are not alone.

> ***"I have recently been considering its isolation's impact within the medical profession. In reviewing several complaints and disciplinary cases involving physicians and physician assistants, a striking pattern seems to have emerged.***

Physician and YouTube educator Dr. Christopher Thompson echoed this concern in his video, "The Loneliness of Medicine", where he stated:
"The life of a doctor is a lonely one. Your friends have moved on. That tends to happen after you neglect them for four years of pre-med, four years of medical school, and four years of residency."

He observed that many physicians, having devoted so many years to training, find they have little in common with people outside the profession—and that loneliness is even more acute for those practicing alone.

Research supports these observations. A 2010 article in Occupational Medicine titled "Occupational Isolation Among General Practitioners in Finland" by Aira et al., identified key elements of professional isolation: making decisions independently, lacking collaboration with colleagues and specialists, absence of community within the workplace, and a lack of mentorship. The authors concluded that: *"Enabling flexible teamwork and social and professional support networks are the key issues in solving the problem of occupational isolation in general practice."*

The Washington Medical Commission is committed to its mission of promoting patient safety and upholding the integrity of the medical profession through licensing, discipline, rulemaking, and education. Equally important, however, is our commitment to supporting physicians and physician assistants in being the best versions of themselves, both professionally and personally.

We encourage all healthcare professionals to reflect on their own practice environments and emotional well-being. If you are struggling with feelings of isolation, burnout, or disconnection, we urge you to reach out—to a trusted colleague, to a professional organizations such as WAPA, WSMA, AMA, AAPA, WPHP, or PROBE, or to us directly.

Remember the wisdom of Donne's words: "No man is an island." In medicine, as in life, we are stronger, wiser, and more resilient together.

Legal Actions

WASHINGTON Medical Commission
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May 1, 2025 – July 31, 2025

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 not involving reinstatement, 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
Formal Actions				
Burke, M. Barbara, MD MD.MD.00042122 Out of state	Agreed Order	6/4/25	Suspension of license in Ohio.	Indefinite suspension. May petition for reinstatement after reinstatement of Ohio license.
Cahill, Deborah, MD MD.MD.00022279 Chelan County	Agreed Order on Reinstatement	5/8/25	Initial non-compliance with WPHP health agreement.	License reinstated with conditions: Compliance with WPHP; clinical supervisor required; practice site approval; report CME compliance; personal reports; personal appearances. May petition to terminate in 36 months.
Grosdidier, Shannon R. MD MD.MD.00043737 Chelan County	Final Order of Default	7/16/25	Failure to comply with Commission order to undergo examination.	Indefinite suspension.
Hedmann, Shaun, MD MD.MD.00034892 Out of state	Final Order-Waiver of Hearing	6/17/25	Surrender of license in Oregon.	Indefinite suspension.
Houtz, Jane M., MD MD.MD.00038185 Out of state	Agreed Order on Reinstatement	7/7/25	Failure to provide medical records to patients and failure to cooperate with investigation. Failure to respond to Statement of Charges resulting in default.	License reinstated with conditions: provide medical records to patients; medical record-keeping course; paper; personal appearances. May petition to terminate in one year.
Kohchet Chua, Claribel L, MD MD.MD.00035572 Out of state	Final Order of Default	6/4/25	Suspension of license in Alaska.	Indefinite suspension.

Formal Actions				
Practitioner Credential and County	**Order Type**	**Date**	**Cause of Action**	**WMC Action**
Parvataneni, Kesav C., MD MD.MD.60827451 Out of state	Agreed Order on Reinstatement	6/4/25	Sexual relationship with a patient and prescribing for people who were not patients.	License reinstated with conditions: maintain compliance with WPHP health agreement; restricted from night shifts, supervising, solo practice, treating patients outside of workplace, and treating himself or family members, friends or co-workers; must use electronic prescribing; register with PMP; abide by WMC opioid rules; complete professional enhancement program; personal appearances. May petition to terminate in two years.
Riyaz, Farhaad R., MD MD.MD.61103258 Out of state	Agreed Order of Reinstatement with Conditions	7/10/25	Suspension of license in Virginia.	License reinstated with conditions: compliance with WMC CME requirements; maintain certification with the American Board of Dermatology. May petition to terminate in two years.
Shibley, Eric R., MD MD.MD.60108064 King County	Final Order	5/15/25	Criminal conviction for bank fraud and money laundering regarding application for COVID-19 relief funds; substandard prescribing of opioids to patients; failure to comply with WMC order.	Revocation of license.
Stockin, Michael, MD MD.MD.61074871 Pierce County	Agreed Order	5/8/25	Military criminal conviction for abusive sexual contact and indecent viewing of disrobed patients.	Revocation of license.
Informal Actions				
Burkey, Adam R., MD MD.MD.60545557 King County	STID	7/10/25	Alleged diversion of controlled substances; poor documentation, prescribing for family member.	Comply with WPHP health support agreement; record-keeping course; communications course; paper; review policy on self-treatment and treatment of family members; personal appearances; costs. May petition to terminate in 3 years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Case, Daniel J., MD MD.MD.00028745 Spokane County	STID	5/8/25	Civil settlement with CMS regarding allegations of ordering medically unnecessary durable medical equipment.	CME in telemedicine best practices; CME in ethics; occupational medicine training; paper; personal appearances; personal reports; costs. May petition to terminate after completing the requirements.
Farook, Amber MD.MD.60408626 King County	STID	5/15/25	Alleged unauthorized accessing of health care information of two people who were not patients.	Boundaries course; CME in ethics and patient confidentiality; paper; personal appearances; personal reports; costs. May petition to terminate in two years.
Harris, Victor J., PA PA.PA.10004575 Pierce County	STID	5/8/25	Alleged inappropriate prescribing of alprazolam to a patient; failure to cooperate with investigation; failure to have a collaboration agreement in place.	CME in the detection of substance use disorders in patients; CME in prescribing opioids and benzodiazepines; CME in record keeping; paper; register with PMP; compliance audits; personal appearances; costs. May petition to terminate in two years.
Hubbell, Geoffrey A., MD MD.MD.60275124 Out of state	STID	7/10/25	Alleged failure to recognize shock and respiratory failure in patient in ED; failure to diagnose sepsis in a patient in the ED.	Clinical competency assessment; CME in recognizing and treating shock, and in recognizing and treating respiratory failure; paper; personal appearances; personal reports; costs. May petition to terminate in four years.
Lippman, Jonathan E., PA PA.PA.61098614 Spokane County	STID	7/10/25	Alleged failure to consider common causes of fever in postpartum patient in ED.	CME in management of postpartum patients in ED; CME in diagnostic decision-making in ED; CME in unconscious bias; CME in record keeping; paper; personal appearances; costs. May petition to terminate in one year.
Luu, Paul, MD MD.MD.00032942 King County	STID	6/4/25	Alleged failure to ensure that CRNA's license was current and failure to comply with WMC rule governing office-based surgery by operating in an accredited facility.	Comply with WMC rule; develop written office protocol for monitoring auxiliary health care staff; CME in treatment of lidocaine toxicity; paper; personal appearances; personal reports; costs. May petition to terminate in four years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Pastor, Claire J., MD MD.MD.00036617 King County	STID	5/22/25	Alleged prescribing of ketamine and armodafinil to a patient without documenting an examination of the patient.	Ethics and boundaries course; review WMC policy on treating family members and WMC guidance on record keeping; paper; personal appearances; costs. May petition to terminate in one year.
Pulliam, Thomas J., MD MD.MD.60730018 Out of state	STID	5/8/25	Alleged reprimand by the North Carolina Medical Board.	Voluntary surrender of license.
Raleigh, Todd M., MD MD.MD.60562855 Whatcom County	STID	5/22/25	Alleged health condition that may impair ability to practice safely.	Comply with WPHP health support agreement; personal appearances; costs. May petition to terminate when WPHP determines that monitoring is no longer necessary.
Ur, Rebecca J., MD MD.MD.60843920 Kitsap County	STID	5/8/25	Alleged performance of arteriogram on wrong leg.	CME on wrong site surgery and purpose of time out procedure; develop and implement protocol; review Joint Commission universal protocol; paper; personal appearances; costs. May petition to terminate in one year.
Wang, Chou R., MD MD.MD.00029068 King County	STID	5/22/25	Alleged inadequate documentation of prescribing controlled substances.	Ethics course; review of WMC guidance document on medical records; paper; personal appearances; costs. May petition to terminate in one year.

Order Type Descriptions

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.

Order on Non-Compliance: An order issued after a health law judge has found a licensee has failed to comply with a Commission order.

Order of Reinstatement-An order reinstating a suspended license. It usually contains restrictions and conditions.

Digital Platforms as Emerging Sources of Medical Information

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Mahlet Zeru, MPH
Strategy Manager

Social media now drives health trends worldwide, with Tiktok and Instagram reaching millions each day and shaping how people seek medical information.[1,2,3,4] Medical information previously available via a clinical visit is now accessible within seconds through trending videos, influencer endorsements, and algorithm-driven recommendations.[5,6] While the accessibility of information has empowered patients to become more engaged in their health, it has also created significant exposure to misinformation, unregulated products, and unsafe practices.[7,8]

For Clinicians, this shift presents a dual challenge. On one hand, clinicians are encountering patients who arrive better informed, motivated, and eager to discuss new therapies.[9],[10] On the other, they must navigate a clinical environment where misinformation directly intersects with care decisions, particularly around highly publicized products such as GLP-1 receptor agonists for weight loss and counterfeit botulinum toxin marketed as low-cost cosmetic injectables.[11,12,13,14] By understanding the drivers of these trends and their clinical risks, clinicians can proactively guide patients toward safe, evidence-based care while addressing the equity barriers that shape access to treatment. [15]

GLP-1 Receptor Agonists (semaglutide, tirzepatide)
GLP-1 receptor agonists including semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro, Zepbound are among the most visible medications on social media because of their robust weight-reduction outcomes.[16],[17] The FDA has issued warnings about counterfeit and unapproved formulations marketed online, as well as safety concerns with compounded versions.[18] Some compounded products use semaglutide salt forms (e.g., sodium or acetate) that differ chemically from the FDA-approved active pharmaceutical ingredient, raising questions about potency and safety.[19] Reports of variable concentrations, inconsistent dosing, and impurities underscore the potential for underdosing, overdosing, or toxic reactions.[20],[21]

Clinicians should advise patients to obtain GLP-1 receptor agonists exclusively from licensed pharmacies and discourage use of compounded formulations unless a documented shortage exists and compounding complies with state and federal requirements.[22]

Suspected counterfeit or substandard products should be reported promptly to FDA MedWatch.[23]

Counterfeit Botulinum Toxin Products
Cosmetic injectables such as botulinum toxin are increasingly marketed via social media, where 'before and after' videos, influencer endorsements, and discount promotions normalize cosmetic procedures and downplay associated risks.[24] This environment has fueled demand for non-medical access, with patients seeking procedures at "Botox parties", unlicensed spas, or home settings.[25]

The CDC has reported multiple cases of systemic botulism-like illness associated with counterfeit botulinum toxin injections from nonmedical sources.[26] Patients developed symptoms such as ptosis, diplopia, dysphagia, dysphonia, and progressive muscle weakness, with some progressing to respiratory distress requiring hospitalization and antitoxin therapy.[27,28,29] These presentations are similar to those of foodborne or wound botulism and require early recognition by clinicians.[30] A retrospective analysis further noted that more than half of cosmetic iatrogenic botulism cases were classified as moderate to severe, with nearly half requiring inpatient care.[31]

Clinicians should emphasize to patients that counterfeit injectables pose life-threatening risks. Counseling points should include:

- Injections must be FDA-approved and obtained from legitimate distributors.
- Procedures should only be performed by licensed professionals in clinical settings. Suspiciously low prices or home-based services are strong indicators of counterfeit or diluted products.[32]

Providers are encouraged to ask directly about cosmetic procedures obtained outside of medical offices and report adverse events to WA state health department or FDA MedWatch.[33]

Equity Implications

Although social media has created a surge in demand for GLP-1 receptor agonists and cosmetic injectables, access is limited to those who can afford it and have the insurance to cover costs.[47] Patients with lower incomes, Medicaid coverage, or those from historically marginalized communities may have limited access to legitimate prescriptions, increasing the temptation to pursue unregulated compounded or counterfeit alternatives marketed online.[48,49] This creates disproportionate risks for populations already facing barriers to obesity care and chronic disease management.[50,51]

Similarly, counterfeit botulinum toxin is frequently advertised on platforms targeting younger and cost-conscious audiences, who may be unable to afford FDA-approved procedures from licensed professionals.[52] Women and communities of color are often targeted by beauty and body-enhancement marketing, compounding inequities in health risk exposure.[53]

These disparities highlight the importance of patient-centered and culturally responsive counseling. Providers should acknowledge cost barriers openly, connect patients with legitimate assistance programs when available, and caution against unsafe alternatives.[54] Emphasizing safety, while avoiding stigma, may encourage patients to disclose use of unregulated products, allowing for timely intervention and harm reduction.[55]

Clinicians can safeguard patients, promote equitable care, and strengthen trust by staying abreast of new social media trends, being ready to offer clear and evidence-based guidance and address the equity barriers that shape access to safe healthcare.[56,57,58] Evidence indicates that when accurate information is provided by healthcare professionals through social media channels, patient adherence and treatment outcomes improve significantly.[59]

Endnotes for this artical can be found on page 18

Additional Resources

- FDA MedWatch & Safety Reporting Portal: For reporting adverse drug or supplement events; educational webinars on counterfeit drugs (fda.gov/medwatch).
- Washington Poison Center: 24/7 consultation line (1-800-222-1222) and clinician/patient resources (wapc.org).
- Washington State Department of Health (DOH): Offers integrative health guidance, medication safety alerts, and continuing education (doh.wa.gov).
- Washington Medical Commission (WMC): Provides CME on safe prescribing, patient safety, and equity; reporting tools for unsafe practices (wmc.wa.gov).
- University of Washington School of Medicine – CME: Accredited CME offerings in integrative medicine, toxicology, and prescribing (uwcme.org).
- Northwest Center for Public Health Practice (NWCPHP): Training in health equity, public health law, and emerging clinical issues (nwpublichealth.org).

New Educational Video Series on Physician Professional Boundaries Offers Free CME

The FSMB, the FSMB Foundation, and the AIM Foundation are proud to announce the release of a new, free educational video series designed to promote professionalism and ethical standards in medicine by exploring the critical topic of physician professional boundaries.

This innovative series, now available online, features concise, scenario-based videos depicting real-world challenges physicians may face in maintaining appropriate boundaries with patients. The series guides viewers through three common situations where boundaries may become blurred:

- Writing prescriptions for friends and family
- Pursuing inappropriate romantic relationships with patients, their guardians, or key third parties
- Conducting intimate examinations without clear communication and patient consent

More information about CME accreditation and this series can be found on the FSMB website.

WPHP Report

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Strengthening Workforce Resilience and Patient Care Through Support for Health Professionals

Chris Bundy, MD, MPH
Executive Medical Director, Washington Physicians Health Program

For more than 35 years, the Washington Physicians Health Program (WPHP) has been Washington's trusted resource for restoring the health of medical professionals. Our program is designed to provide confidential, therapeutic support for health professionals facing mental health conditions, substance use disorders, and other medical conditions that could adversely impact safe practice. In some cases, brief assessment and referral to services are all that is needed to support health and put concerns at rest. In other cases, more help is needed and WPHP is ready to assist.

WPHP recently published our 2024 Annual Report which highlights the impact and vital work we are doing to support health professionals in our medical community while honoring our valued partners.[1]

WPHP continues to earn consistently high ratings for program services and satisfaction from stakeholders and program participants. In fact, 92% of colleagues view WPHP as a valuable resource to the medical community, with 88% reporting they would refer a colleague in need to WPHP. Among program participants, 84% describe their WPHP experience as helpful with one in five reporting that WPHP saved their life.

WPHP and Physician Health Programs (PHPs) nationwide play a critical role in the health and well-being of health professionals while safeguarding patient care. These programs have demonstrated measurable success in promoting physician health, enhancing patient safety, and fostering a more resilient and sustainable healthcare workforce. The following illustrates some of the ways WPHP and PHPs contribute to a stronger and safer healthcare system overall.

1. Enhancing Patient Safety and Care Quality

   - Early intervention and referral to WPHP gives health professionals the opportunity to receive necessary treatment before a health condition negatively impacts patient care.
   - Structured PHP health support is associated with decreased professional liability risks and exceptional health outcomes for program participants and graduates.[2]
   - Multiple studies have demonstrated healthy physicians provide better care.

2. **Mitigating Physician Burnout and Supporting Physician Well-Being**

   - Physician burnout remains a critical issue nationwide. While rates of burnout appear to be improving, physicians remain at higher risk than other professions with 45.2% reporting at least one symptom of burnout.[3]
   - WPHP participants have consistently reported substantially lower rates of burnout than national averages. In 2024, 17% of WPHP program participants reported experiencing burnout at less than half the national average, underscoring the program's meaningful impact on physician well-being.

3. **Reducing Professional Liability Risk & Proven Success in Outcomes and Recovery**
   - Participation in a PHP program supports health while also reducing the likelihood of professional liability claims. One peer-reviewed study has demonstrated that physicians who complete a PHP program have lower professional liability risk than their peers who have never participated in PHP monitoring.[2]
   - WPHP's outcomes prove the program's effectiveness in supporting sustained recovery and professional reintegration among participants. According to data from the 2024 WPHP Annual Report, 85% of WPHP program participants are working in their professional field at the time of program discharge. Additionally, 86% of program participants diagnosed with a substance use disorder remain abstinent at five years.
   - WPHP exit survey data shows that 75% of program participants report full remission of symptoms of their health condition at program discharge, with 98% in full or partial remission. In that same survey, 66% of WPHP participants also reported improved quality of life as a result of the program.

4. Strengthening Workforce Resilience and Sustainability

- By addressing health issues early on, PHPs reduce expenses related to turnover, training new physicians, and medical malpractice claims.
- A strong support system provided by PHPs can enhance physician retention rates. By normalizing help-seeking through PHPs and reducing the stigma associated with mental health and substance use disorders, these programs help the workforce overcome personal challenges while providing ongoing support.[4-5]

5. Providing Confidential Help and Trusted Advocacy

- One of the reasons the PHP model was developed was to provide confidentiality for health professionals with stigmatized health conditions as they are more likely to seek assistance when their information is kept private.
- WPHP provides participants with trusted, credible verification of health status and program adherence to support continuation or re-entry to practice. Many find this essential with 87% of program participants report needing and benefiting from WPHP's advocacy.
- Through strong confidentiality protections, 90% of WPHP's program participants receive help without ever being known to their licensing board.
- WPHP continues to make tremendous strides in advocating for license and credentialing question reforms and addressing other systemic barriers for health professionals locally and nationally. Recently, WPHP was consulted for the article "Reducing Barriers to Mental Health Care for Physicians: an Overview and Strategic Recommendations" in JAMA, underscoring the recognition that our advocacy efforts are receiving.[6] The article highlights the life-saving impact of PHP programs and the importance of confidential help for physicians experiencing mental health conditions.

Looking ahead, WPHP remains committed to advancing the health and well-being of health professionals through our program as well as by providing ongoing education and outreach. To learn more about WPHP, view the annual report in its entirety, or make a referral, please visit our website or call 800-552-7236. Follow us on Facebook and LinkedIn.

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Rulemaking Efforts

WASHINGTON Medical Commission
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Amelia Boyd
Program Manager

In Progress

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.

Between July 2024 and January 2025, the WMC held three workshops, collaborating with the public, associations, and other interested parties to develop the draft language. At the final workshop held on January 27, 2025, the panel approved the draft language for presentation to the WMC at its March 14, 2025, Business Meeting. During that meeting, the Commissioners authorized moving forward with the next step in the rulemaking process, the CR-102, or Proposed Rules. The CR-102 was filed June 30, 2025, under WSR #25-14-080. On August 22, 2025, a hearing was held, and based on the testimony presented, the Commissioners voted to return to the CR-101 phase of rulemaking. Workshops will be scheduled soon. Please visit our Rules in Progress page for more information.

Opioid Prescribing for Physician Assistants (PA) and Allopathic Physicians (MD)
A CR-101, Preproposal Statement of Inquiry, was filed on April 30, 2025, as WSR #25-10-039. The WMC is considering amending the following opioid prescribing rules to modernize the language, add clarity, and bring the rules more in line with current practice: MD, WAC 246-919-850 through 246-919-985; and PA, WAC 246-918-800 through 246-918-935. Workshops are ongoing. Please visit our Rules in Progress page for the current schedule.

Chapter 246-919 WAC, Allopathic Physicians (MD)
A CR-101, Preproposal Statement of Inquiry, was filed on rulemaking on May 22, 2025, under WSR #25-12-014. The WMC is considering amending WAC 246-919-010 through WAC 246-919-520 and WAC 246-919-602 through WAC 246-919-700 to modernize language, add clarity, and bring the rules more in line with current practice. Workshops will be scheduled soon. Please visit our Rules in Progress page for the current schedule.

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 on hold pending the outcome of the Department of Health's ongoing Sunrise Review of the Pharmacist Scope of Practice. Please visit our Rules in Progress page for the current schedule and draft language.

Recently Completed

New Profession: Anesthesiologist Assistants, SB 5184
The CR-103, Permanent Rules, was filed June 26, 2025, under WSR #25-14-053. The WMC has developed a new chapter of rules under Title 246 WAC which establishes licensing regulations for anesthesiologist assistants, in accordance with SB 5184. The effective date for these rules was July 27, 2025.

The Secretary of the Department of Health has the authority to establish fees for healthcare professions. As such, the rulemaking process for establishing fees for this new profession is being handled by that office. A CR-102, Proposed Rules, was filed July 22, 2025, under WSR #25-15-148. The hearing for the fees was held on August 26, 2025. The CR-103, Permanent Rules, is in progress.

General Provisions for Opioid Prescribing for Physician Assistants (PA) and Allopathic Physicians (MD)
The WMC has adopted amendments to their opioid prescribing rules to exclude patients with sickle cell disease, to clarify tapering considerations, and to clarify the use of biological specimen testing. The rules amend WAC 246-918-801 Exclusions, WAC 246-918-870 Periodic Review—Chronic pain, and WAC 246-918-900 Tapering considerations—Chronic pain for physician assistants, as well as WAC 246-919-851 Exclusions, WAC 246-919-920 Periodic Review—Chronic pain, and WAC 246-919-950 Tapering considerations—Chronic pain for allopathic physicians.

The rules add sickle cell disease to the list of exemptions from opioid prescribing limits. To prevent harm from abrupt opioid discontinuation, the rules clarify that not all chronic pain patients need tapering. The rules also state that a single abnormal biological test result should not be the sole basis for discontinuing opioid treatment. The CR-103 for Permanent Rulemaking was filed on February 18, 2025, as WSR #25-05-091. The WSR document contains the adopted rule language, which took effect on March 21, 2025.

Cancelled Rulemaking

Regarding SSB 5389 – define "qualified physician"
At their October 20, 2023, Business meeting, the Commissioners approved initiating rulemaking related to SSB 5389. However, a CR-101, Preproposal Statement of Inquiry, was never filed. On May 14, 2025, an interpretive statement titled "'Qualified Physician' Under Optometry Law" was filed under WSR #25-11-037 which relates to this rulemaking request. The WMC routinely incorporates their interpretive statements into WAC. Since multiple sections of chapter 246-919 WAC (physicians/MDs) are already open for rulemaking, the WMC plans to incorporate the interpretive statement into those rules. As such, at their August 22, 2025, Business Meeting, the Commissioners voted to rescind their earlier approval of this rulemaking.

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.

All Upcoming hearings, stakeholder meetings and other events can be found on the WMC Event Page

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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

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