Washington Medical Commission

UPDATE!

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

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wmc.wa.gov

In This Issue

Washington Medical Commission Update!

Message from the Chair

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Opioid Prescribing and Monitoring for Patients

Karen Domino, MD, MPH

The Washington Medical Commission (Commission) has modified its interpretive statement on opioid prescribing and monitoring for patients. The Commission is aware that some practitioners are refusing to treat patients who have taken or are currently prescribed opioids.

The Commission believes that appropriate management of pain is an important part of medical care. The diagnosis and treatment of pain is an integral part of the practice of medicine for all practitioners. The original versions of the opioid prescribing rules for physicians (WAC 246-919-850) and physician assistants (WAC 246-918-800) explicitly pointed out that lack of treatment of pain is a departure from appropriate care. Due to misunderstanding of the earlier rule, the revised interpretative statement explicitly highlights areas of prior misunderstanding. The areas of misunderstanding include:

1. Practitioners should avoid using rigid morphine equivalent dose (MED) that lead to undertreatment of pain or unnecessary tapering of patients who are stable in pain levels and functioning. There is no upper MED limit in Washington State or federal law.
2. The Commission evaluates the treatment of chronic pain based upon the documentation of the patient's overall well-being, including physical, psychological, social, and work-related factors, **not** MED. Documentation should include patient outcomes, medical reasoning, and discussions with the patient.
3. Opioid tapering of a patient below a certain MED is not required. Initiating a tapering schedule without receiving the patient's consent or considering the adverse effects on the patient's function and quality of life, is a violation of the Commission's opioid prescribing rules and represents substandard care.
4. Refusing to treat the patient with opioids if indicated or terminating a patient from practice because the patient's care involves opioid therapy are also examples of practicing below the standard of care.

Clinical Experience Assessment (CEA) Policy

The WMC has implemented the Clinical Experience Assessment (CEA) Policy, effective January 10, 2025, as outlined in policy number POL2025-01. This policy introduces the CEA form, designed to evaluate the readiness of International Medical Graduates (IMGs) for residency programs in Washington State, in accordance with RCW 18.71.472.

Purpose of the CEA Form: The CEA serves as a tool for physician assessors to prepare IMGs for residency by determining their overall readiness. It is important to note that the CEA is not a component of the residency application process nor a qualification for residency.

Assessment of Residency Preparedness: The form utilizes an "entrustment" scale to evaluate the IMG's competence in various clinical tasks, aiding both the assessor and the IMG in identifying areas of strength and those requiring improvement.

Frequency of Assessment: Assessors are encouraged to use the CEA quarterly throughout the training program until the IMG achieves a passing score in all competencies, indicating readiness for residency.

Monitoring and Retention: The WMC plans to develop a monitoring system to track the effectiveness of the CEA, identifying challenges and areas for improvement in IMG pre-residency training. Completed CEA forms should be retained for four years and made available upon request.

If you have any questions about this or any other WMC policy, you can contact medical.policy@wmc.wa.gov.

Executive Director Report

WASHINGTON Medical Commission
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Kyle Karinen, J.D., LL.M

Several years ago, my predecessor, Melanie DeLeon, did a series of articles for this newsletter that detailed the Commission's disciplinary process. Those four articles are still available on the Commission's website, and I commend those articles to all readers.

1. Someone Filed a Complaint Against Me – Now What? A Peek Behind the Curtain (WMC Update Spring 2021)

2. The Investigation Process (WMC Update Summer 2021)

3. Case Disposition: The Third Act in our Behind the Curtain Series (WMC Update Fall 2021)

4. Compliance – The Last Act in our Behind the Curtain Series (WMC Update Winter 2021)

These articles offer a broad outline of the processes behind the Commission's statutory mandates. These articles are particularly worthwhile considering the Commission's January adoption of a procedure for managing conflicts of interest.

Washington's law against conflicts of interest for state officers, like commission members, is fairly straightforward and mandatory. The laws highlighted concentrate a good deal on financial interests. As a professional licensing agency housed in a larger umbrella agency, for the members of the Commission, it's very rare to make decisions that involve their own financial interests, financial interests of a relative or business or professional associate. In a situation where those concerns are implicated, commission members must recuse themselves.

The other area where the procedure is applied is a little broader – appearance of fairness. As put forth in a relevant Washington Supreme Court decision, appearance of fairness applies over commission actions in order to ensure that "a reasonably prudent and disinterested observer would conclude that all parties obtained a fair, impartial, and neutral hearing." I invite you all to again reconsider Ms. DeLeon's series again at this point.

The disciplinary process set forth in Washington law requires commission member input at multiple points including, but not limited to:

1. Authorizing investigation of a complaint.

2. Directing an investigation as a Reviewing Commission Member (RCM).

3. Making a disposition decision on a completed investigation.

4. Serving on a hearing panel after formal charges are initiated.

5. Review and consider for approval a settlement agreement; and

6. Review and consider for approval a release from oversight.

There are a couple of additional considerations worth noting. At the Case Management Team (CMT) meetings where commission members decide whether to authorize an investigation, the materials they review are redacted and do not contain identifying information. Some of these measures were adopted for the purpose of reducing implicit bias, but to ensure that the Commission has reviewed complaint information with the identity of the physician or physician assistant redacted.

After that point, during the investigation and disposition decisions, the only commission member who knows the identity of a physician or physician assistant is the Reviewing Commission Member along with identifying information like educational background and the name of the facility where the allegations took place.

Practically, these measures support a decision-making process that supports the principles of fairness and neutrality on the part of commission members. The procedure contains additional measures and considerations beyond these highlights. The Commission adopted this policy after over a year of discussion between commission members and discussion with other interested parties during the Commission's Policy Committee. It was adopted with the goal of providing clarity and greater transparency and I hope readers will find it thoughtful and comprehensive. As always, please feel free to reach out to me directly at 360-236-4810 or kyle.karinen@wmc.wa.gov if you have comments or concerns.

"Medice, Cura Te Ipsum"

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

I remember a time over four decades ago when as a young man, after finishing college and my PA education, that I had hoped for a long lasting, fulfilling and rewarding career. A career that I would dedicate my talents, my energies and my life to serving the sick and injured and then look back some day on a meaningful life and career thereafter thinking that it was worth the sacrifice and the journey. And while in general, I cannot complain so far, but medicine for many, or dare I say most of my friends and colleagues working in medicine today, has not been so great. And so, I ask myself, "What happened to that dream, that hope and that naive ambition that we once clung to?" Was it progress, time, politics, corporate takeovers, population growth, rising costs and new paradigms that spoiled it all?

And while in the 1960's when Dr. Eugene Stead et al conceived and created the PA profession to work in North Carolina, who would have thought that today we have over 300 PA programs and over 160,000 practicing PAs in every specialty all over the world? And yes we can all agree that this can be considered progress, but with that progress has come a whole lot more.

According to several sources, today among the most important issues facing PAs are our unclear practice scope and roles, our increasing workload demands, the risk of burn out due to increasing stress levels, navigating the changing healthcare bureaucracy, the EMR robbing us of our face to face time with our patients, our limited opportunities for career advancement, challenges in our patient's understanding of who we are as well as healthcare payors and authorities and medical staff bylaws not understanding our roles and our responsibilities. All of this and more has contributed to our responding and ultimately behaving in the workplace and at home in ways that have been less than optimal or ideal.

And while you may have heard all of this before, I bring it up here yet again because I wish to sound the alarm that according to our Washington citizens, PAs are behaving in ways that are resulting in an increasing number of complaints by our Washington patients and their families to our Washington Medical Commission, not only about delivery of care, but many more complaints regarding behavior, attitude, personal communication issues, lack of empathy and compassion, racism, sexism and lack of self-care. Yes… Progress has been good for us all but "there is another side of that coin" that we must consider. With progress often follows the stress of adaptation, cooperation and implementation and sometimes we are just not ready for all of it.

To all of us I ask for you to consider the words in the Bible found in the book of Luke chapter 4 verse 23, "Medice, cura te ipsum" translated to English "Physician, heal thyself".

"I wish to sound the alarm that according to our Washington citizens, PAs are behaving in ways that are resulting in an increasing number of complaints by our Washington patients and their families"

While this is NOT intended to be a sermon, it is nevertheless a warning cry from one PA to another that we examine ourselves daily and properly prepare ourselves for the job that we do each day. That we take time to explore the elements of what constitutes the often over used comment of "find your work life balance". Examine the "why" you do what you do each day in your work and always consider, ourselves as "healers" and thus how we present ourselves to those needing our services often is as simple as sitting down and listening attentively to the physical and emotional pain that may be presented by that patient in our midst. And we should never forget that the healing process always begins the moment contact is initiated between the patient and the "healer".

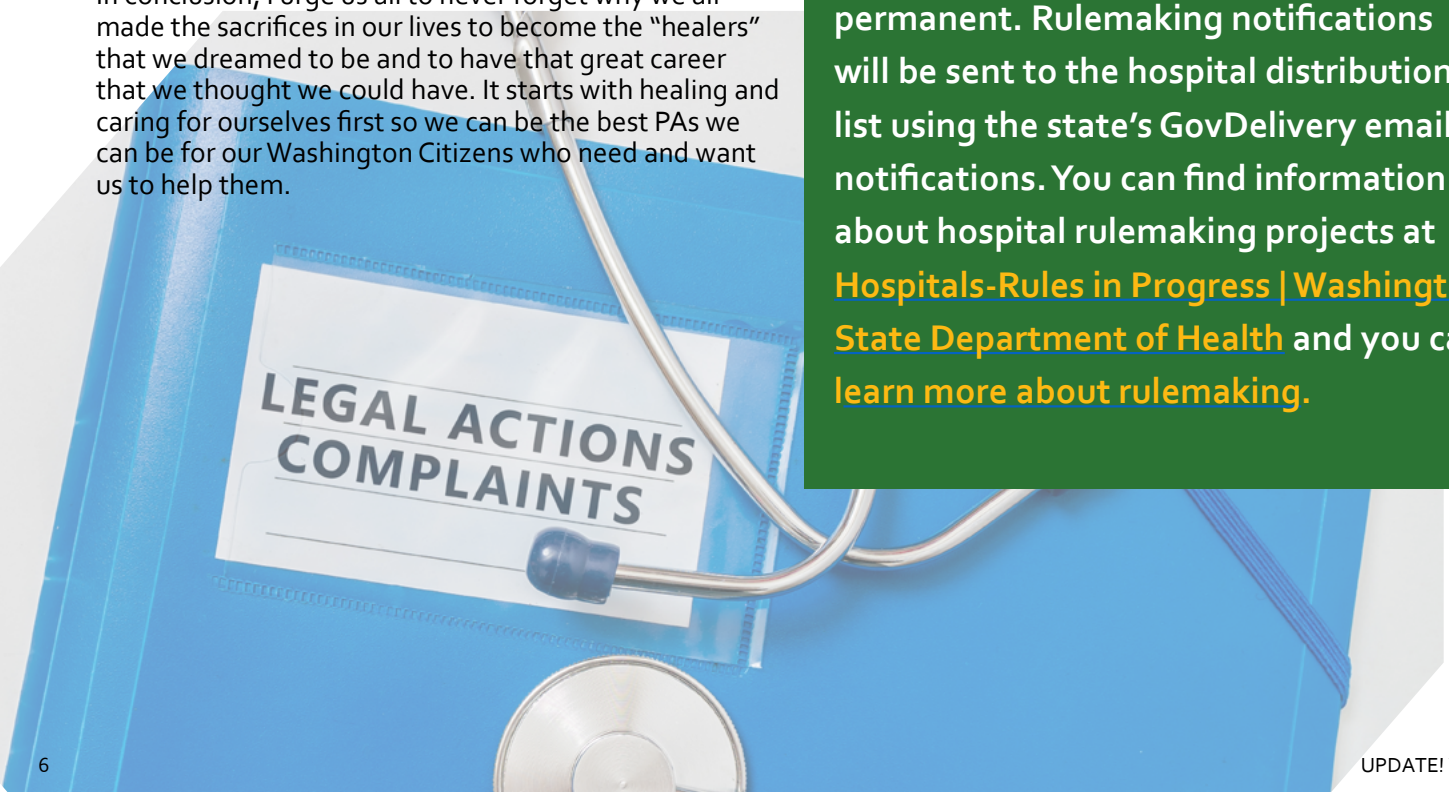
Let us remember that "Psychic Healers", "Curanderos", "Native American Medicine Men", "Shamans", "Druids", "Acupuncturist's", "Massage Therapists" "Homeopaths", and so many others, have provided a level of "healing" for many sufferers worldwide for centuries before allopathic medicine and physicians arrived on the scene and they did it all without MRI's, EMR's and CAT Scans but only with the common skill of demonstrating caring, empathy and the healing touch.

For PAs, we now have an opportunity to demonstrate the art of healing, despite the direction that medicine may be heading today. But we cannot do it if our lives and our own mental and physical health are impaired. I would ask you to please take a hard look at yourselves and your work and be more mindful of what you do and why you do it. Be more committed to demonstrating by your demeanor, your handshake, your face and your style toward your patients that they are the most important person in the world at that moment and that you will do what you can to help them through their medical journey at that time. I can still remember one of my professors saying to me decades ago, often because of my complaining that someone mistreated me because of my ethnicity and the color of my skin, he would calmly say to me, "Son, we are to gather warmth, from the coldness of others". While difficult to do, after 50 years of trying, while I'm better at it than I used to be, I'm still working on it.

Even the medical literature has demonstrated the pitfalls of poor Physician-Patient Communication as reported by Levinson, Roter and Mullooly et al in JAMA 1997; 277: 553-559 where it warned us back in 1997, "In examining this doctor-patient hypothesis, recent research has found that physicians who exhibit more negative communication behaviors are more likely to have been sued in the past for malpractice than those with more positive doctor-patient relations".

And even recently, those reportedly temperamental Cardio-Thoracic surgeons, at their most recent Society of Thoracic Surgeons meeting in L.A. this winter adopted their new "Policy for Respectful Scholarly Discourse to address the ongoing problem of unprofessional and disruptive behavior among members at conferences and events."

In conclusion, I urge us all to never forget why we all made the sacrifices in our lives to become the "healers" that we dreamed to be and to have that great career that we thought we could have. It starts with healing and caring for ourselves first so we can be the best PAs we can be for our Washington Citizens who need and want us to help them.



OCHS Facilities Program

On January 10, 2025, Governor Jay Inslee issued directive 25-01 which directs the Department of Health (the department) to adopt an emergency rule regarding emergency abortion care in Washington State. The department filed an amendment to existing rules to ensure access to treatment, including abortion care, for emergency medical conditions in hospital emergency departments and to protect a pregnant person's right to exercise informed consent in prioritizing their health and safety when receiving treatment for emergency medical conditions in hospital emergency departments. The emergency rule was filed on January 13, 2025, and went into effect immediately.

The department will also conduct rulemaking to make these requirements permanent. Rulemaking notifications will be sent to the hospital distribution list using the state's GovDelivery email notifications. You can find information about hospital rulemaking projects at Hospitals-Rules in Progress | Washington State Department of Health and you can learn more about rulemaking.

Cultural Beliefs and Health Practices Among Washington's Immigrant Communities: Guidance for Medical Providers

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Mahlet Zeru, MPH
Strategy Manager

Washington State is home to a diverse and rapidly growing immigrant population, with individuals from Mexico, India, and China representing the top three countries of birth for foreign-born residents.[1] Whether practicing in urban centers like Seattle, Spokane, and Tacoma or in rural communities across the state, medical providers are likely to care for patients from these diverse backgrounds.[2]

Understanding the cultural beliefs, health practices, and communication styles of these communities can help providers build trust, improve adherence to treatment plans, and ultimately achieve better health outcomes[3]. This resource highlights common cultural misunderstandings that arise in clinical settings and offers practical strategies to deliver culturally responsive care.

> **"Understanding the cultural beliefs, health practices, and communication styles of these communities can help providers build trust, improve adherence to treatment plans, and ultimately achieve better health outcomes"**

Cultural Beliefs and Practices: Mexican Patients

Among Mexican and Mexican American patients, health is often viewed through a holistic, family-centered lens. Health is seen not just as an individual concern, but a family responsibility, where elders, spouses, and extended family actively participate in decision-making[4]. Traditional remedies are frequently used alongside Western medicine, including herbal teas, religious or spiritual practices, and visits to curanderos (traditional healers)[5]. These remedies are deeply rooted in cultural identity and are often viewed as more natural, safe, and accessible[6,7]. Patients may not disclose their use of traditional healing practices unless providers explicitly inquire.[8]

Another important cultural theme is respect for authority, where patients may nod in agreement out of politeness, even if they do not fully understand the treatment plan or have lingering concerns[9]. This can lead to unintentional nonadherence if misunderstandings are not uncovered [10]. Teach-back methods, open-ended questions, and inviting family participation can help providers ensure treatment plans align with cultural values and that patients truly understand the recommended care.[11,12]

Cultural Beliefs and Practices: Indian Patients

For Indian and Indian American patients, health is frequently viewed through a holistic and integrative framework that blends Western medicine with Ayurveda, yoga, and dietary practices.[13] Family involvement is central, especially for older adults, where parents, grandparents, and senior relatives often have a strong voice in healthcare decisions.[14]

Mental health carries significant stigma in many Indian communities, leading patients to express emotional distress through physical symptoms such as headaches, fatigue, or stomachaches, rather than discussing mental health directly.[15] This somatization can lead to underdiagnosis of depression, anxiety, and other mental health conditions.[16] Providers can ask culturally sensitive questions and normalize discussions of emotional well-being.[17]

Additionally, Indian patients also frequently view providers as authoritative experts, expecting them to provide clear guidance rather than fostering collaborative decision-making[18]. To improve communication and care outcomes, providers can proactively invite questions, explore the use of traditional remedies, and frame mental health concerns in holistic terms, such as balance and well-being, which may be more culturally acceptable.[19]

Cultural Beliefs and Practices: Chinese Patients

Chinese and Chinese American patients often approach health through the framework of Traditional Chinese Medicine (TCM), which emphasizes balance, harmony, and the flow of qi (energy).[20] Many Chinese patients combine Western treatments with TCM practices such as acupuncture, herbal therapy, cupping, and dietary modifications.[21,22] Understanding and respecting these complementary approaches can strengthen trust between patient and provider.[23]

Family involvement is highly valued, especially in medical decision-making for older adults. Children or other relatives often serve as cultural bridges, translating medical information and influencing decisions.[24] Communication tends to be indirect, with some patients nodding politely to indicate respect, even if they do not fully understand the medical advice.[25] This can lead to misunderstandings, especially if providers assume agreement equals understanding.[26]

To improve culturally responsive care for Chinese patients, Providers can ask explicitly about traditional remedies, use teach-back techniques and encourage family participation where appropriate.[27] Recognizing and respecting TCM beliefs, while clearly explaining potential conflicts with Western treatments, can improve adherence and patient satisfaction.[28]

Cultural Competency References for WA Providers:

- Washington Medical Commission - Health Equity Training Requirements
- DOH Health Equity Resources
- National Standards for Culturally and Linguistically Appropriate Services (CLAS)

Cultural and Language Resources for Providers

Medical Interpretation Services:

- Universal Language Service: (425) 643-7416 - widely used in WA healthcare settings.
- DOH Language Access Services: (Search: Language Access Program)
- WA Medicaid Interpreter Services (DSHS)

Patient Education Materials in Multiple Languages:

- MedlinePlus Multilingual Health Information
- EthnoMed (WA-Based Resource from Harborview Medical Center)

WMC Public Meetings

May

- 01 - Policy Committee
- 07 - 2025 Legislative Session Wrap Up
- 08 - Personal Appearances
- 09 - WMC Business Meeting

June

- 26 - Policy: Interested Parties

July

- 10 - Personal Appearances
- 24 - Policy Committee

August

- 21 - Personal Appearances
- 22 - WMC Business Meeting

Full event details can be found on our event calendar

WPHP Report

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What is the Washington Physicians Health Program & How it Helps the Medical Community

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

In this article, we will look at the mission of the Washington Physicians Health Program (WPHP) and some of the common questions about it. An integral part of WPHP's mission is to inform and educate the medical community about physician health and impairment. Our goal is to empower physicians with accurate information so they may make informed decisions should they find themselves, or a colleague, in difficulty.

What is WPHP and who does it serve?

WPHP is the Washington Physicians Health Program. For more than 35 years, WPHP has earned a reputation as Washington's trusted resource for restoring the health of medical professionals. WPHP is an independent physician-led, nonprofit organization. We serve Osteopathic Physicians, Allopathic Physicians, Podiatric Physicians, Anesthesiology Assistants, Physician Assistants, Dentists, and Veterinarians as well as students and residents of these disciplines.

WPHP offers early intervention, assessment, treatment referral, and post-treatment health support for those in the medical workforce with conditions that may negatively impact practice performance. 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. Referral to WPHP protects the well-being of healthcare professionals and the patients they serve. Our confidential support and exceptional outcomes provide reassurance of safe practice and promote workforce sustainability.

What health conditions does WPHP help with?

WPHP assists healthcare professionals with any health condition that may impact clinical performance. Examples include mental health disorders, non-psychiatric health conditions, cognitive concerns, substance-related concerns, depression, anxiety, suicidal thinking and behavior, burnout, trauma, and stress.

How is WPHP funded?

WPHP is primarily funded by a special license surcharge that is paid by the license holders who are eligible to participate in WPHP. The program is not funded by taxpayer dollars or from regulatory program budgets. In this way, WPHP is truly a peer-to-peer assistance program that is funded by and for the license holders who are eligible for WPHP services. The license surcharge amounts are set by the legislature with the endorsement of the professional associations that represent the licensees served. WPHP also receives donations which help WPHP assist healthcare professionals, conduct research, and provide scholarships for those who could not otherwise afford treatment, and support education and outreach efforts in the community.

Is WPHP part of the Washington Medical Commission (WMC)?

No, and this is often an area of confusion. WPHP is an independent non-profit organization that is contracted by the Department of Health to assist physicians and physician assistants confidentially without the involvement of the WMC. Physicians and PAs are reluctant to seek help when they believe that a health condition may become known to medical regulators. Understanding that WPHP is completely separate from the WMC can provide reassurance that participation in WPHP will not somehow become known to the regulator.

How confidential is the program?

One of the reasons Physician Health Programs (PHPs) were developed was to provide confidentiality for healthcare professionals with stigmatized health conditions. Healthcare professionals are more likely to seek assistance if they believe their information will be kept confidential. Under these circumstances, they can participate in the PHP without involvement of state medical boards. Strong confidentiality protections encourage early intervention in the illness process before impairment occurs and when the prognosis for full recovery is most favorable. Confidential participation in WPHP begins at the initial assessment, following completion of a thorough informed consent procedure.

Existing state and federal laws allow WPHP to protect the identity of participants and referent(s) when they follow WPHP recommendations and do not pose a risk to themselves or their patients. In 90% of cases, WPHP participants' identities, circumstances, and participation remain confidential and do not involve disclosure to the applicable state regulatory entity. Most WPHP participants known to their regulator were involved prior to referral to WPHP. A small minority (2.5-5% per year) forfeit program confidentiality when risk of unsafe practice or program non-compliance require WPHP to notify the regulatory entity.

Washington state statutes and rules provide for a confidential physician health program and set out its definitions and requirements. RCW chapters 18-71 (Physicians) and 18-130.070 (especially 18-130-175) are the most relevant statutes. WPHP is a Part 2 program under 42 CFR Part 2 - Confidentiality of Substance Use Disorder Patient Records. Together these laws and regulations provide exceptional privacy protection and reassurance that participant records are safe from subpoena or disclosure in legal proceedings and will not be released without the participant's consent.

With limited exception, WPHP does not release its records to participants or third parties. This policy protects the identities of referral sources and prevents participants from being compelled to produce the WPHP record during discovery in a legal proceeding.

WPHP is not a HIPAA covered entity and its records are not subject to the HIPAA privacy rule. However, the legal protections noted above provide greater assurance of privacy than typically afforded under HIPAA.

WPHP's commitment to confidentiality and privacy is unwavering. That said, there are important practical and legal limitations to confidentiality that should be considered. WPHP participants may be asked to provide consent for WPHP to communicate with evaluation and treatment providers, key supports, or concerned others as a condition of program participation. Such communications are critical for WPHP to effectively carry out its mission and support the health and advocacy needs of program participants. WPHP makes every effort to limit disclosures to their intended purpose. For example, communications with healthcare providers would likely include protected health information, while verification of health status and safety to practice for employment or credentialing purposes would not.

WPHP has a statutory obligation to notify the applicable regulatory entity when a participant is unable to practice with reasonable skill or safety or fails to comply with program requirements (RCW 18.130.175). Such notifications are uncommon. In such cases, WPHP provides ample opportunity for remedy prior to notifying the regulator. Following notification, WPHP must release program records to the regulator if requested.

Danger to self or others, abuse of a child or vulnerable adult, and medical emergencies are other examples in which WPHP may have a legal reporting obligation that supersedes a participant's confidentiality protections.

Conclusion

In WPHP's more than 35-year history, we have facilitated the rehabilitation and successful return of health professionals to practice. In addition, we have provided support and resources to medical professionals who sought WPHP assistance but did not require our program. To learn more about WPHP and stay up to date on issues in physician health, please visit our website and or follow us on Facebook or LinkedIn.

Expansion of Buprenorphine Treatment via Telemedicine Encounter

The U.S. Drug Enforcement Administration (DEA) has issued a final rule to update and refine regulations surrounding the prescribing of controlled substances via telemedicine, with a particular focus on balancing public health needs and the prevention of substance misuse. This rule is part of an effort to clarify how the practice of telemedicine, which grew significantly during the COVID-19 pandemic, can continue to support patient access to necessary care without compromising the safety measures associated with controlled substances. Learn More

Legal Actions

WASHINGTON Medical Commission
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November 1, 2024 – January 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 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				
Kane, Sean, MD MD.MD.61108510 King County	Order of Summary Suspension	1/31/25	Alleged failure to comply with Commission order and criminal conviction.	Indefinite suspension of license.
Patel, Yogesh, MD MD.MD.60309742 Out of state	Order of Summary Suspension	1/15/25	Suspension of license in Illinois; and actions in Colorado, Arkansas, and New York.	Indefinite suspension of license.
Formal Actions				
Akers-White, La Tania, MD MD.MD.61003240 Out of state	Final Order on Default	12/3/24	Disciplinary action in Virginia, and other states; revocation of license in Montana.	Indefinite suspension of license.
Benson, David B., MD MD.MD.00040349 Skagit County	Agreed Order	12/3/24	Negligent obstetrical care to several patients and negligent pediatric care to patients.	Restricted from practicing in the areas of obstetrics and newborn care; clinical competency assessment; clinical monitoring program; personal appearances; fine. May petition to terminate or modify restriction after assessment. May petition to terminate after five years.
Blanchette, Anne B., PA PA.PA.10003288 Out of state	Agreed Order	12/3/24	Failure to cooperate with investigation and failure to have a collaboration agreement on file.	Reprimand; collaboration agreement on file with Commission; restriction from prescribing ivermectin for non-FDA-approved indications; review CDC web site and UpToDate website for current guidelines for the prevention, treatment, and management of COVID-19; CME in ethics; CME in record keeping; paper; compliance audits; personal appearances; fine. May petition to terminate in two years.
Dagan, Benigno W.A., MD MD.MD.00036169 Pierce County	Final Order on Default	1/29/25	Inappropriate prescribing of thyroid medication.	Indefinite suspension of license.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Lalaji, Anand P., MD MD.MD.00049379 Out of state	Final Order on Default	11/26/24	Suspension of license in Kentucky and Virginia. Practice restriction in Arizona.	Indefinite suspension of license.
Mack, William, J., MD MD.MD.60972485 Out of state	Final Order on Default	11/20/24	Suspension of license in Kansas.	Indefinite suspension of license.
Mohammed, Amr, MD IMLC.IMLC.61316264 Out of state	Order of Automatic Surrender of IMLC License	11/14/24	Surrender of license in Kentucky.	Surrender of license.
Pao, Dorothy M., MD MD.MD.00043353 Clark County	Agreed Order	1/9/25	Surrender of license in Oregon.	Voluntary surrender of license.
Washington, William J., MD MD.MD.00046967 King County	Final Order	11/26/24	Federal conviction for wire fraud, health care fraud, conspiring to commit wire fraud and health care fraud, and conspiracy to make false statements related to health care matters; negligent care to 33 patients; prescribing testosterone for self; misrepresentation; failure to cooperate with investigation.	Revocation of license.
Informal Actions				
Apter, Robert L., MD MD.MD.00014471 Out of state	Agreed Order	11/27/24	Alleged prescribing medication and providing vaccine exemptions based on internet questionnaires.	Voluntary surrender of license.
Asiamigbe, Nneka T., PA PA.PA.61220081 Out of state	STID	11/14/24	Alleged exceeding scope of supervising physician's education, training, and expertise; and alleged failure to follow instructions of supervising physician.	Paper on the role of PAs and importance of collaborative relationship with supervising physician; personal appearances; costs. May petition to terminate in two years.
Bloom, David, MD MD.MD.60588400 Out of state	STID	1/9/25	Disciplinary action in California.	Comply with California order; restricted from engaging in solo practice; personal appearances; costs. May petition to terminate after release from California order.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Dhaliwal, Hardeep S., MD MD.MD.60383921 King County	STID	11/14/24	Alleged providing ketamine treatments to patients without documenting an adequate physical examination and psychiatric history, appropriate safeguards were in place, obtaining adequate informed consent, and appropriate knowledge or training in the administration of ketamine therapy.	Outside of using ketamine for dental procedures, restricted from treating patients with ketamine, psilocybin, or other psychedelic or hallucinogenic medications; restricted from treating psychiatric illnesses or mental health conditions; course in ethics and professionalism; course in record keeping; paper; personal appearances; costs. May petition to terminate in two years.
Kelley, Audrey C. PA PA.PA.60944261 Out of state	STID	11/14/24	Consent Agreement with Alaska State Medical Board.	Compliance with Consent Order in Alaska; personal appearances; enroll in WPHP monitoring agreement; costs. May petition to terminate after released from Consent Order in Alaska.
Larhs, Anthony E., MD MD.MD.0038333 King County	STID	11/27/24	Stipulated Order in Oregon.	Compliance with Oregon Agreement; ethics course; paper; personal appearances. May petition to terminate after release from Oregon Order.
Larsen, Murray L., MD MD.MD.00029346 Asotin County	STID	1/9/25	Alleged performance of EGD on patient without knowledge or permission of the hospital and without adequate documentation.	Ethics and boundaries course; record keeping course; personal appearances; costs. May petition to terminate in one year.
Lloyd, Christine, MD MD.MD.60309651 Out of state	STID	11/14/24	Alleged failure to meet standard of care in conducting independent medical exams.	Voluntary surrender of license.
Lockwood, Matthew M., MD MD.MD.60636863 Grant County	STID	1/9/25	Alleged premature discharge from emergency department of patient in hyperosmolar state and hyperglycemia before onset of Lantus and before peak effect of second dose of regular insulin.	CME in adult hyperglycemia management in ED; literature review; personal appearances; costs. May petition to terminate in two years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Oh, Kyle MD MD.MD.00029616 King County	STID	11/14/24	Alleged failure to adequately treat a patient's severe pain, to make efforts to expedite the patient's care, and to explore other possible reasons for the patient's severe pain.	CME in managing pain; CME in communication; paper; personal appearances; costs. May petition to terminate in two years.
Olsen, Robert B., MD MD.MD.00016720 King County	STID	1/9/25	Alleged health condition that could affect ability to practice with reasonable skill and safety.	Permanent restriction from treating patients or engaging in direct patient care.
Omura, Travis A., MD MD.MD.60453867 King County	STID	11/14/24	Alleged failure to document comprehensive neurological exam and failure to diagnose patient with large left superior cerebellar infarct.	CME in neurological emergencies; paper; personal appearances; costs. May petition to terminate in one year.
Polin, Richard S., MD MD.MD.00045150 Out of state	STID	11/14/24	Alleged Corrective Action Agreement with Oregon Medical Board.	Comply with Corrective Action Agreement in Oregon; personal appearances; costs. May petition to terminate after release from Oregon Agreement.
Singh, Randip MD MD.MD.00045861 King County	STID	11/14/25	Alleged prescribing of ketamine for at-home use without appropriate patient screening, counseling, monitoring, or documentation.	Restricted from prescribing compounded ketamine or ketamine until successful completion of a clinical competency assessment; CME in prescribing controlled substances; CME in boundaries and ethics; CME in record keeping; personal appearances; costs. May petition to terminate in three years.
Smith, Stephen L., MD MD.MD.00019257 Benton County	STID	12/18/24	Alleged violation of Commission order; treatment of family members; negligent care to patients.	Voluntary surrender of license.
Wampach, John J., MD MDRE.ML.61167306 King County	STID	1/9/25	Alleged health condition that could affect ability to practice with reasonable skill and safety.	Contact WPHP to undergo assessment and follow recommendations for further assessment and treatment, including enrolling in a health support agreement if recommended; personal appearances. May petition to terminate after conditions are met.

Rulemaking Efforts

WASHINGTON Medical Commission
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Amelia Boyd
Program Manager

In Progress

New Profession: Anesthesiologist Assistants, SB 5184
A CR-101, Preproposal Statement of Inquiry, was filed on August 28, 2024, as WSR #24-18-057. The WMC is developing a new chapter of rules under Title 246 WAC to establish licensing regulations for anesthesiologist assistants, in accordance with SB 5184.

Between October and December 2024, the WMC held four workshops, working with the public, associations, and other interested parties to draft the proposed language. The Commission approved this language at their January 10, 2025, Business Meeting. A CR-102, Proposed Rules, is currently in progress, with a rulemaking hearing tentatively scheduled for May 9, 2025. Please visit our Rules in Progress page for more information.

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 will take effect on March 21, 2025.

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. The panel at the final workshop on January 27, 2025, approved the draft language for presentation to the Commission at its March 14, 2025, Business Meeting for review and potential approval to advance to the next step in the rulemaking process, the CR-102 (Proposed Rules). A hearing is tentatively scheduled for August 22, 2025. Please visit our Rules in Progress page for more information.

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.

Upcoming Rulemakings

Regarding SSB 5389 – define "qualified physician"
At their October 20, 2023, business meeting, the Commissioners approved initiating rulemaking related to SSB 5389. 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.

Opioid Prescribing for Physician Assistants (PA) and Allopathic Physicians (MD)
At their July 19, 2024, business meeting, the Commissioners approved initiating rulemaking on the opioid prescribing WACs in both the MD chapter 246-919 WAC and PA chapter 246-918 WAC. 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.

Chapter 246-919 WAC, Allopathic Physicians (MD)
At their January 10, 2025, business meeting, the Commissioners approved initiating rulemaking on several sections of allopathic physician (MD) rules, chapter 246-919 WAC. The sections that will be addressed in this rulemaking are WAC 246-919-010 through WAC 246-919-520 and WAC 246-919-602 through WAC 246-919-700. The CR-101, Preproposal Statement of Inquiry, is in progress. Once the CR-101 is filed, workshops will be held. Please visit our Rules in Progress page for the current schedule.

Recently Completed

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 provided additional information for issuing this temporary permit, a different definition of military spouse, and other items that are not included in the WMC's WACs. The WMC adopted rules that fulfill the requirements of 2SHB 1009 on October 11, 2024. The CR-103, Permanent Rules, was filed on December 3, 2024, as WSR #24-24-098. The rules became effective on January 3, 2025.

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 rules were adopted on November 14, 2024, and became effective on December 15, 2024. The revised rules can be found in the CR-103 filed on November 14, 2024, as WSR #24-23-043. The rules became effective on December 15, 2024.

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 removed references to osteopathic physician assistants. The rules were adopted on November 14, 2024, and became effective on December 15, 2024. The revised rules can be found in the CR-103 filed on November 14, 2024, as WSR #24-23-042. The rules became effective on December 15, 2024.

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.

Know Your Rights – Information from the Washington State Attorney General's Office

- Reproductive Health Care
- Gender Affirming Care
- Reproductive & Gender Affirming Care: Shielding Providers, Seekers & Helpers from Out-of-State Legal Actions
- Protecting Washingtonian's Personal Health Data and Privacy

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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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