Washington Medical Commission

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UPDATE!

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

In This Issue

> Listening to patients, validating their experiences, and offering personalized pain management are not only markers of clinical quality standard but a core foundation of excellent patient-provider relationships"
>
> - Mahlet Zeru

Message from the Chair

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Thank you and Farewell

Karen Domino, MD, MPH

In the post-COVID era, the WMC observed many patient complaints related to communication and medical records.

My two years as Chair of the Washington Medical Commission (WMC) have passed very quickly! It has been an honor and privilege to serve and represent allopathic physicians and physician assistants (PAs) practicing in Washington State! Dr. Terry Murphy is moving up from the Vice Chair position and will be an outstanding Chair!

In my final newsletter message, I reflect upon issues and improvements in the core mission of the WMC since the time I was appointed as a commissioner. My tenure on the WMC has bridged the COVID years and current post-COVID era. When I first was appointed, I was inundated with complaints by physicians, departments, and hospital leadership over the prolonged time for licensing of new physicians. This complaint arose during the very busy February to June timeframe when residents, fellows and new attending physicians are seeking medical licensure. The WMC staff took these serious staffing/patient care concerns to heart and modified procedures to dramatically reduce time for licensure in Washington state!

Another important advance has been the increased recognition by WMC commissioners and staff of the massive importance of systems factors in medical error. Most physicians and PAs now work in large health care systems with team-based health care. Relatively few practitioners are involved in solo-practice. The National Academy of Medicine's "To Err is Human" 2000 report emphasized that medical error is a medical *system* problem, not an individual practitioner problem. As an example, wrong site surgery, a "never event", is not simply the fault of the surgeon. Instead, nursing and anesthesia practitioners play critical roles in pre-surgery time-out procedures to avoid medical errors. System factors are now incorporated into the WMC investigations of complaints. These include identification of systems factors involved in the adverse outcome, types of systems changes made to prevent future occurrences, and how staff are educated to recognize the contributors of medical error to improve patient safety in the future.

In the post-COVID era, the WMC observed many patient complaints related to communication and medical records. The vast majority do not rise to requiring discipline. As a result, the WMC has developed a physician support program where educational resources are sent to the practitioner to provide feedback and education concerning optimal communication strategies. We hope these resources will help avoid the need for future WMC actions.

The WMC has also recognized the unintended consequences of its previously adopted opioid rules involving legacy patients on long-term opioids. The WMC recently approved a guidance document and will be initiating rulemaking to update these rules. As Past-Chair, I will be chairing these sessions and look forward to feedback from patients, physicians, physician assistants, and the public.

As Past Chair, I look forward to seeing the implementation of Anesthesiologist Assistants into practice in Washington State. Dr. Murphy and I will also work with other groups within the Department of Health focused upon intravenous therapy clinics, ketamine clinics and hallucinogen clinics, such as psylocibin.

Executive Director Report

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Unlicensed Practice of Medicine
Kyle Karinen, J.D., LL.M

Over the past few months, the Commission has been approached on a number of occasions and asked, in essence, "Does a person need a MD or PA license in Washington in order to do X, Y, or Z?" While in theory, the answer is not complicated, in practice, it can be complex. In this article, I am going to run through a number of considerations that go into addressing the issue of the unlicensed practice of medicine in Washington.

1. **There are numerous exemptions from licensure.** The Medical Practice Act in Washington is relatively clear. "No person may practice or represent himself or herself as practicing medicine without first having a valid license to do so."[1] However, there are also no less than 15 exemptions from that requirement.[2] Whether or not an activity is exempt from the licensure requirement is inherently a legal question. Which leads us to . . .

2. **The Commission is not in a position to provide legal advice.** The Commission, as well as the Department of Health (the Department), are licensing and regulatory agencies. Neither the Commission nor the Department are authorized to provide ad hoc legal advice.

3. **Practice of medicine in Washington is broad.** The statutory definition includes instances where an individual:

    - Offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality.
    - Administers or prescribes drugs or medicinal preparations to be used by any other person.
    - Severs or penetrates the tissues of human beings;[3]

The takeaway here is that many things can be the practice of medicine. Every practice act for all 80+ healthcare-related professions have some accounting of what an individual is licensed to do.

4. **The Commission does not enforce laws that prohibit the unlicensed practice of medicine.** This is a central concern factor here. Even if the Commission were inclined to offer legal advice to any of the dozen inquiries a year about license requirements, the Commission does not have a regulatory role for unlicensed practice. Under the Uniform Disciplinary Act, primary authority over unlicensed practice is vested with the Secretary of Health.[4] The Commission maintains a supportive role as the Secretary investigates claims of unlicensed practice. For cases the Secretary designates as unlicensed practice of medicine, the Commission pays for the services of the Secretary's investigators, legal staff, and administrative staff. However, the Commission does not provide any substantive input. This enforcement structure has analogues in many states and, notably, attempts to steer clear of federal antitrust concerns.[5] The primary takeaway here is that while the Commission would almost certainly have a concern or two to offer, it is not the Commission's role or place to enforce the prohibition. That said, the Secretary does have a role. Which leads us to soccer.

The 2025 FIFA Club World Cup starts on June 14. In brief, it is a soccer tournament held every four years that involves club teams from all over the globe. It provides an example of how these issues come into play that's illustrative of the moving regulatory parts. Last December, the Commission was approached by FIFA and asked whether health care practitioners accompanying the teams would need to be licensed in Washington.

As you might expect, the clubs wish to have their own medical staff attend to their players while they are working in the U.S. Also, as you might expect, very few of their staff are licensed in the United States, let alone Washington. In discussions with FIFA staff, I was happy to point them to the statutory exemptions for licensure, explain the structure around who does what within the Department of Health, i.e. the Commission only regulates MDs and PAs, and reference the side issue of the state and federal controlled substances acts. The FIFA representatives were quick to stipulate that the medical staff would only be treating their respective club's players.

In this particular case, the Commission directed them to the Department and the concerns raised by the FIFA representatives were addressed. Please see the letter from the Interim Secretary of Health. While this is just one example of the sort of concerns that arise in this area, it's one of the most frequently misunderstood.

Endnotes are available on page 16

What happens when you get a letter from the Commission

Arlene Dorrough

If you are a practicing MD or Physician Assistant (PA) for long enough, there comes a time when you may receive notice that a complaint has been made against you. Do you know what this means? Do you know what your next steps are? Is this possibly the end of your career? This article will help you to know what to do should this occur and, hopefully, will slow your pulse and reassure you that the sky is not falling, it is not the end of your career, and it is even possible to use this event as a steppingstone to improve patient care and advocacy for the PA profession.

First things first. Understand that the Commission is there to help you find out what went wrong, correct the problem and resume your care of patients, all without making the issue a public one. Most providers are surprised when they find out a complaint has been made and are eager to clear up their record or make amends with the patient to avoid harsh feelings or any negative blowback in the future. This is often where things diverge. Complaints can include everything from perceived rudeness, poor technique to allegations of sexual assault. While our response to these different scenarios will depend on the complaint and the circumstances involved, one thing that seems to be common in ALL complaints is poor communication with the patient.

Many complaints may have been avoided by good communication with the patient. This can be communication about the billing process, appointment intervals, upcoming tests or labs and their results, and of course procedures or surgeries that are performed. Talking with the patient through any procedure is a good way to avoid imperceptions on the patient's behalf. Ensure that the patient understands what you are doing and allow the patient time to ask questions.

This is extremely important with any sensitive procedures being performed in the office. Sexual assault is, unfortunately common among many men, women and children in our country. Learning to perform a mindful examination that empowers the patient to feel free in communicating with you as the provider and allows the patient agency to stop the procedure, if it becomes too difficult for them to tolerate. Thinking that if you just perform the procedure quickly and completely to get it over with, is not a good approach and has often led to trauma for some patients, which can expose you to a valid complaint.

Even if the complaint is not related to a procedure, it is your responsibility to find out what actions may have put you in this position, if only to avoid similar complaints in the future. If the complaint stems from past experiences for the patient, was there something you may have been able to say or do to put that patient at ease, or encourage them to voice their concerns? Effective and empathetic communication can facilitate strong bonds with your patients, building trust going forward. I will say this once: a patient that trusts you will never file a complaint against you.

Timely documentation is another common complaint. If you have not documented the visit, it has not been done. It is as simple as that. Missing documentation slows billing, and the patient is not aware of the next steps if there is no record of what happened. Further, the longer it takes you to document the visit, the more information slipping from memory and eroding the accuracy of that information. Try to remember that you are making a scientific documentation of this patient's condition and detailed facts are imperative.

So, for whatever reason, you have received a complaint. Try to remember the encounter as best as you can and be honest with yourself about the interaction. If there was something you could have done better, it is in your best interest to address it. This is how good providers become great providers, through learning from their mistakes. You cannot learn from your mistakes if you don't recognize your role in the mistake.

The Commission has investigators who will utilize, among other things, documented patient information to support or invalidate the claim being made against you. This is yet another reason to keep your documentation accurate and timely. If you have made an error that is not a pattern, the Commission will likely send you a letter emphasizing where you could benefit from additional knowledge, they can also send you information on where to access additional courses to sharpen skills where needed.

Should the investigation show a pattern of behavior or skill deficiency, the commission will authorize a stipulation to informal disposition or STID. When a pattern of behavior is noted, or sometimes when an infraction is egregious (rare), the medical commissioners will talk amongst themselves to determine if this was an understandable mistake and what courses or additional knowledge is needed to prevent continued errors going forward. There may be fine associated with the infraction, and you may be required to attend classes or access an educational and write a scholarly paper about how this information can benefit you and your patients going forward.

Should you ever be notified of a complaint, you should do your best to gather as much information about the encounter as possible. Be honest about your role in the issue and be willing to take the needed steps to prevent similar events in the future. You will be allowed to explain your side of the story and we look carefully at the situation, the patient and any external circumstances that may have played a part in the incident.

As a medical commissioner, who has gone through this process myself, I can honestly say we want the process to be as quick and comfortable as possible and we concern ourselves with your opinion on the process, as we are constantly working to improve our process to better serve you.

This article is already long enough, but I also wanted to add that should you go through the disciplinary process, I encourage you to consider preparing a presentation about the nature of the complaint and what you learned. You will cement the learning into your practice and encourage others to avoid the same issue. You can turn this otherwise frightening event into a bedrock foundation for your continued practice. Think about it.

Scammers Continue to Impersonate the Medical Commission
Gina Fino, MD WMC Medical Consultant

Getting a phone call from the WMC, not anyone's idea of fun and may be a scam. As an active licensee who is on the staff of the WMC, I speak to other Commission staff every workday. I have direct knowledge and experience of how the WMC works. Yet, if I received a phone call about my license from someone claiming to be the WMC, I'm sure my stomach would start to churn. I share this to show that a quick, instinctual response to such a phone call can occur before any processing of the situation. Scammers are counting on this visceral reaction and will use it to their advantage.

The WMC is aware that scammers are still contacting practitioners using the WMC phone number and other contact information. The most important thing to know is that the WMC will never ask you to respond to an inquiry urgently.

Also, you can call the WMC at 360-236-2750 to confirm that the WMC has reached out to you. Visit our web page for more information on what you need to know to avoid scammers: Scammers Continue to Impersonate State Regulators: What You Need to Know.

Remember to protect yourself by:

1. Never click on links or download suspicious attachments
2. Don't fall prey to a manufactured urgency. A vital component of this fraud is the urgency of request or demand. If you are contacted by a regulatory agency, you will have a legally protected amount of time to respond
3. If you suspect that you are being contacted by a fraudulent regulator, you can verify the request with the WMC by calling: (360) 236-2750
4. Restrict your personal information online. Scammers leverage personal information from social media accounts or other public forums

ACOG Releases Updated Guidelines for Pain Management

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Mahlet Zeru, MPH
Strategy Manager

Across Washington State, women have filed complaints with the Washington Medical Commission citing inadequate treatment of pain. These concerns are not isolated or anecdotal. A substantial and growing body of academic research confirms that women particularly Black, Indigenous, Latina/x, and other women of color routinely face bias and substandard care when reporting pain[6,7,8,9].This systemic issue extends across healthcare settings and specialties, resulting in women being underdiagnosed[10,11,12] undertreated[13], and ultimately harmed[14,15]. When patients feel unheard or dismissed[16], they are more likely to delay or avoid future care[17,18], including preventive service leading to worsening health outcomes[19] and further entrenching disparities[20] in health equity[21,22].

Numerous research studies have validated the extensive presence of pain bias against women. A 2024 study analyzing over 21,000 emergency department discharges in the U.S. and Israel found that women were significantly less likely than men to receive analgesics, even when reporting similar pain levels, and providers frequently failed to record their pain scores[23]. A foundational 2001 research titled, *The Girl Who Cried Pain*, revealed that women report more frequent and severe pain than men but are consistently treated less aggressively due to enduring stereotypes portraying them as overly emotional or exaggerating symptoms[24]. These biases are compounded by racial disparities: Black and Hispanic women face greater obstacles to receiving adequate pain relief. A 2019 study found that postpartum Black and Hispanic women were prescribed fewer opioids than their White counterparts, despite reporting higher pain levels[25]. Similarly, a retrospective study of over 81,000 childbirth admissions in New York found that Black and Hispanic women were less likely to receive epidural analgesia than White women, even after adjusting for clinical and insurance factors[26]. Collectively, these studies confirm that the dismissal of women's pain especially among women of color is not incidental, but systemic and persistent across clinical settings.

In response to these well-documented disparities, the American College of Obstetricians and Gynecologists (ACOG) released updated guidelines in 2025 for pain management in gynecologic ambulatory care.

These updates are especially critical for outpatient reproductive health and primary care providers. ACOG now explicitly recognizes that minimizing or dismissing procedural pain is not only clinically harmful but reflects implicit bias within healthcare systems. The organization calls for trauma-informed, equity-centered care, especially during procedures such as IUD insertion or removal, endometrial biopsy, cervical dilation, and colposcopy with biopsy.

ACOG recommends that providers proactively assess and validate patients' pain, offer a range of evidence-based and patient-centered pain management options, and use bias-aware, trauma-informed communication. Pain management strategies should include NSAIDs prior to procedures, topical anesthetics such as lidocaine, paracervical blocks, misoprostol for cervical softening, IV sedation or anesthesia when indicated, and non-pharmacologic supports such as support person or comfort measures. These practices must be accompanied by thorough documentation of patient preferences and pain management plans.

To address underlying bias, ACOG urges providers to engage in self-reflection to identify disparities in their own clinical decisions, utilize standardized pain assessment tools to reduce subjectivity, build time for patient questions and shared decision-making, and avoid assumptions about what pain patients should tolerate based on race, gender, age, or reproductive history.

Providers play a critical role in helping close the gap observed in pain management. Listening to patients, validating their experiences, and offering personalized pain management are not only markers of clinical quality standard but a core foundation of excellent patient-provider relationships[27]. Implementing these practices can directly reduce disparities and lead to improved outcomes for women across Washington.

Endnotes are available on page 16

> "When patients feel unheard or dismissed, they are more likely to delay or avoid future care including preventive service leading to worsening health outcomes and further entrenching disparities in health equity".

Legal Actions

WASHINGTON Medical Commission
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February 1, 2025 – April 30, 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
Summary Actions				
Hedmann, Shaun MD MD.MD.00034892 Out of state	Order of Summary Suspension	4/11/25	Surrender of license in Oregon.	Indefinite suspension of license.
Mundall, Jon M.R., MD MD.MD.00023408 Spokane County	Order of Summary Restriction	2/12/25	Alleged negligent treatment of patients for hypothyroidism.	Restricted from diagnosing, managing, or treating thyroid disorders.
Varnell, Daniel D., MD MD.MD.00046806 Out of state	Order of Summary Suspension	4/11/25	Inability to practice safely due to a health condition.	Indefinite suspension of license.
Formal Actions				
Dagan, Benigno W.A., MD MD.MD.00036169 Pierce County	Agreed Order on Modification	3/19/25	Negligent treatment of a patient for hypothyroidism.	Reinstatement of license. Restricted from diagnosing, managing, or treating thyroid disorders; undergo clinical competency assessment; CME in management of thyroid disorders; paper; compliance audits; personal appearances; fine. May petition to terminate in three years.
Gao, Lu, MD MD.MD.60815256 King County	Final Order	3/24/25	Criminal conviction for fourth-degree assault-domestic violence with sexual motivation.	Suspension of license. May petition for reinstatement in eight years.
Healey, David S., MD MD.MD.60565218 Out of state	Waiver Order	3/13/25	Criminal conviction for second-degree child molestation; disciplinary action in Massachusetts.	Revocation of license.
Li, Frank D., MD MD.MD.00049251 Out of state	Order on Non-Compliance	2/28/25	Failure to comply with a Commission order.	Indefinite suspension of license.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions				
Patel, Yogesh, MD MD.MD.60309742 Out of state	Default Order	4/30/25	Disciplinary actions in the states of Colorado, Illinois, and Arkansas.	Indefinite suspension of license.
Vassall, Alford N., MD MD.MD.60062958 Thurston County	Agreed Order	3/13/25	Negligent pelvic examination.	CME in patient communication, boundaries, and trauma-informed care; paper; personal appearances; personal reports; fine. May petition to terminate in three years.
Webster, Thomas A., MD MD.MD.60851665 Thurston County	Default Order	3/26/25	Criminal conviction for conspiracy to accept kickbacks in connection with fraudulent telemarking and medical supply scheme.	Indefinite suspension of license.
Wright, Jonathan V., MD MD.MD.00011394 King County	Modified Agreed Order	4/14/25	Negligent management of patient's hypothyroidism.	Voluntary surrender of license.
Informal Actions				
Appelbaum, Andrew MD MD.MD.00033120 King County	STID	3/13/25	Alleged allowing untrained staff to administer vaccines and answer questions telephonically; staff recycle and handle dangerous materials; failure to notify patients of potential contamination; disruptive behavior. Respondent took remedial actions.	Review WMC policy on disruptive behavior; paper; develop protocol for employee injury reporting; notice of STID to employer; personal appearances; personal reports; costs. May petition to terminate in two years.
Blakenship, Beth L., PA PA.PA.10003496 Spokane County	STID	3/7/25	Alleged dating of patient.	Ethics course; costs.
Borgen, Matthew E., PA PA.PA.60736542 Pierce County	STID	3/13/25	Alleged failure to document reason for prescribing opioids, stimulants, and hormones to a patient; alleged failure to document a reason for prescribing opioids to a second patient; and alleged accessing a medical record of a colleague without authority.	Restricted from prescribing controlled substances; course in safe prescribing of controlled substances; paper; CME in confidentiality of personal health information; ethics course; WPHP assessment; personal appearances; costs. May petition upon completion of all terms.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Boyer, Marnie L., PA PA.PA.10004142 Grant County	STID	3/13/25	Alleged declaring patient dead without checking respiration, circulation, or pulse and without physically examining the patient.	CME in emergency medicine; course in communication and civility; paper; personal appearances; personal reports; costs. May petition to terminate in three years.
Buxbaum, Evan R., MD MD.MD.60027949 San Juan County	STID	3/13/25	Alleged disciplinary action in California for inappropriate submission of pediatric vaccine exemptions to California Department of Public Health; and allegedly recommending that a four-year-old child should receive only two of four childhood vaccines recommended by the CDC.	Compliance with California order; prohibition from completing Washington State Medical Certificates of Exemption and Health Care Practitioner Declaration on a Washington State Personal/Religious Certificate of Exemption; literature review of childhood vaccines; paper; compliance audits; personal appearances; costs. May petition to terminate in two years.
Flaming, Michael B., MD MD.MD.60415836 Clark County	STID	3/13/25	Alleged serving as a medical director for a clinic and failing to examine, assess, or create a treatment plan for a patient who underwent aesthetic procedures by a registered nurse.	CME in non-physician clinical supervision and timely documentation; ethics course; review WMC guidance on the duties of medical directors; personal appearances; personal reports; costs. May petition to terminate in one year.
Watts, Michael A., MD MD.MD.61337302 Pierce County	STID	3/13/25	Alleged disruptive behavior and excluding a patient's nurse case manager from attending an appointment.	Communications course; paper; personal appearances; costs. May petition to terminate in one year.

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.

WPHP Report

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Advancing Physician Mental Health Through Support and Advocacy

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

Physician mental health remains a critical issue in healthcare, with recent data revealing both persistent challenges and signs of progress. Nationwide, there is growing momentum to improve the mental health of healthcare workers. Institutions and organizations are increasingly recognizing that supporting employee well-being is not just ethical, it's a smart business strategy with measurable benefits.

Health Workforce Well-Being Day in March and Mental Health Awareness Month in May continue to shine a spotlight on the mental health struggles of healthcare professionals and encourages the removal of stigmatizing policies that prevent them from seeking the help they need. These efforts aim to ensure access to evidence based care and foster a culture of support within the healthcare system.

Physician Health Programs (PHPs), such as the Washington Physicians Health Program (WPHP), play a pivotal role in this movement. These programs provide confidential care protected by legislation, supporting physicians through health conditions while safeguarding patient safety and professional careers. Through PHPs, physicians restore their lives, often returning to their work, with renewed strength and purpose.

WPHP continues to lead on this front, partnering with local and national partners to address systemic barriers to mental health care and advocating for critical licensing and credentialing reforms.

Partnering for Change – ALL IN: Wellbeing First for Healthcare Campaign

A mental health crisis has been plaguing modern medicine for decades. According to the CDC, health workers' mental health is worse than any other segment of the U.S. workforce. Further, among health workers reporting mental distress severe enough to meet diagnostic criteria for a mental health condition, only 38% reported seeking care and 20% shared they did not need care, despite severe symptoms.

The Dr. Lorna Breen Heroes' Foundation is leading a coalition in the ALL IN: Wellbeing First for Healthcare. This effort empowers health workers to access the mental health care and support they may need, while equipping employers, policymakers, and other decision makers with resources to eliminate systemic barriers to mental health care.

The ALL IN coalition is dedicated to advancing a state where the healthcare workforce's well-being is prioritized, and health workers feel valued and supported so they can sustain their sense of purpose and meaning in their work. By making beneficial progress to support health workers' mental health and well-being, the coalition aims to strengthen our healthcare systems and secure a healthier future.

The initiative calls for six actions to improve access to mental health care for health workers - addressing unique stressors, eliminating stigma, and creating a system that supports professional well-being and safe, compassionate patient care. Two of these actions highlight the role of PHPs: strengthening access to confidential Professional or Physician Health Programs and advancing a supportive pathway for practice re-entry for health workers, ensuring a transparent, structured, and reasonable process to return to practice.

Like Washington, almost every state has a recognized PHP. These programs provide confidential assessment, referral to treatment, resources, and health support agreements for healthcare professionals and those in training when there is a concern that a health condition may be negatively affecting their ability to provide safe, effective care. So long as no patient harm occurred, health workers participation in a PHP provides an alternative to credentialing or regulatory action.

WPHP and the Dr. Lorna Breen Heroes' Foundation are united in advocating for a system where seeking mental health support is not a risk, but a right. As part of this mission, I recently co-presented with Dr. Stefanie Simmons, Chief Medical Officer of the Dr. Lorna Breen Heroes' Foundation, for the Washington State Medical Association's Physician and Practitioner Wellness Webinar series on the topic of "Advocacy as Wellness: Navigating the Path to Reform and Resilience." Dr. Simmons will also be speaking at WPHP's 30th Annual Reunion on advocacy efforts to support mental health of the healthcare workforce.

Barriers and the Need for Support

Reducing barriers for healthcare professionals seeking help remains essential along with providing greater financial support. A 2023 article that I co-authored in The American Journal on Addictions, titled "Barriers to Recovery for Medical Professionals" highlighted, "There is increasing focus on physician burnout, psychiatric problems, and substance use disorders."

And that "PHPs are vital to physicians, especially physicians-in-training, as 'safe haven programs.'"

Given the rates of burnout, mental health issues, and substance use disorders in the medical profession, it's imperative that access to PHPs be expanded, destigmatized, and financially supported.

"Meaning in Medicine" and "Well-Being" in Graduate Medical Education

Earlier in the year I attended the 2025 Accreditation Council for Graduate Medical Education (ACGME) Annual Educational Conference "Meaning in Medicine." This is the world's largest Graduate Medical Education (GME) conference and highlighted the importance of aligning personal and professional values, promoting well-being, and fostering collaboration within the healthcare community.

In a session titled "Physician Health Programs and GME: A Candid Conversation," I joined panelists including Dr. Courtney Barrows McKeown, a surgeon and physician in recovery, and Cindy Hamra, JD, MA, Associate Dean at the University of Washington. We discussed best practices, real-life experiences, and how GME and PHPs can collaborate to support trainees in crisis while mitigating the risk of adverse professional consequences that can discourage residents from seeking and accepting help when needed.

I also took part in the ACGME "2024 Well-Being Symposium: Charting New Directions for GME." One key outcome was the formation of several Well-Being Affinity Groups that will convene throughout the year to identify resources to support resident well-being. As part of this initiative, I will be leading the Access the Mental Health Care Affinity Group.

Credentialing Reform: A Model for Change

WPHP also collaborated on a groundbreaking development in healthcare credentialing, led by Dr. Brian Johnston of UW Medicine. This landmark reform has set a new standard for credentialing processes, placing a strong emphasis on the well-being and mental health of healthcare professionals.

WPHP played a critical role in providing consultation and technical assistance throughout this initiative, helping UW Medicine align credentialing procedures with best practices that support the health and sustainability of their workforce. By integrating comprehensive well-being measures into the credentialing process, UW Medicine has demonstrated a deep commitment to the mental health of their physicians and healthcare teams. Some of the key tools involved in this reform include the Peer Reference Form, the Washington Practitioner Application, and the Medical Staff Reappointment Application, all designed to streamline the credentialing process while focusing on practitioner well-being.

This reform serves as a model for other healthcare institutions, not just within Washington but across the country. It highlights how a thoughtful, well-supported credentialing process can promote the long-term wellness and success of healthcare professionals.

Advancing the Health and Well-Being of Our Medical Community

For more than 35 years, WPHP has been Washington's trusted resource for restoring the health of medical professionals. Our confidential and support and exceptional outcomes provide reassurance of safe practice and promote workforce sustainability. If you or a colleague need help, please do not hesitate to reach out to us at wphp.org or 800-552-7236.

References:

1. Centers for Disease Control and Prevention. "Health Workers Face a Mental Health Crisis." *Centers for Disease Control and Prevention*, 24 Oct. 2023, https://www.cdc.gov/vitalsigns/health-worker-mental-health/index.html.

2. Centers for Disease Control and Prevention. "Gaps in Mental Health Care–Seeking Among Health Care Providers During the COVID-19 Pandemic — United States, September 2022–May 2023." *Morbidity and Mortality Weekly Report*, vol. 74, no. 2, 16 Jan. 2025, pp. 19–25, https://www.cdc.gov/mmwr/volumes/74/wr/mm7402a1.htm.

3. Weinhouse, Samuel, et al. "Barriers to Recovery for Medical Professionals: Assessing Financial Support through a Survey of Physician Health Programs." *The American Journal on Addictions*, vol. 32, no. 4, July 2023, pp. 385–392.

Employers Can Now Pay Licensing Fees with Payment Pin

We are excited to introduce a new feature in the DOH / HELMS licensing portal. This feature will be more efficient for licensed professionals whose employers pay renewal fees. Payment Pin is a bulk payment feature that allows employers to pay application or renewal fees for their employees. It is convenient and secure through the HELMS portal. Learn more about how it works and how to set up your payment pin.

Rulemaking Efforts

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Amelia Boyd
Program Manager

In Progress

New Profession: Anesthesiologist Assistants SB 5184
A CR-102, Proposed Rules, was filed on March 25, 2025, as WSR #25-08-028. The Commission has developed a new chapter of rules under Title 246 WAC which establishes licensing regulations for anesthesiologist assistants, in accordance with SB 5184.

Between October and December 2024, the Commission 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 rules hearing was held on May 9, 2025, where the proposed language was adopted. A CR-103, Permanent Rules, is currently in progress, with a projected effective date sometime in September. Please visit our Rules in Progress page for more information.

Establishing the use of nitrous oxide in office based surgical settings, WAC 246-919-601
The Commission is considering amending WAC 246-919-601 to exempt the use of nitrous oxide in office-based surgical settings under certain circumstances. Additionally, the Commission 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 Commission 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 Commission at its March 14, 2025, Business Meeting. During that meeting, the Commission authorized moving forward with the next step in the rulemaking process, the CR-102, or Proposed Rules. The CR-102 is currently in progress, with a hearing tentatively scheduled for August 22, 2025. 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 Commission 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 will be held 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 Commission'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 Commission 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 that 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.

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.

Chapter 246-919 WAC, Allopathic Physicians (MD)
At their January 10, 2025, Business meeting, the Commission 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

General Provisions for Opioid Prescribing for Physician Assistants (PA) and Allopathic Physicians (MD)
The Commission 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.

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 Commission 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 Commission's WACs. The Commission 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 Commission's rules GovDelivery. Commission 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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Promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education.

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ED Report : Unlicensed Practice of Medicine

1 RCW 18.71.021.

2 Included are exemptions for licensed of dentistry, osteopathic medicine, nursing, and podiatric medicine, among others where there is a separate practice act and license requirement.

3 RCW 18.71.011.

4 RCW 18.130.190. There is a porton of this statute that also allows other bodies and individuals to maintain a civil action for injunctive relief that has rarely, if ever, been relied upon to address the issue of unlicensed practice.

5 In 2015, the United States Supreme Court entered a decision in a case involving the Federal Trade Commission and the North Carolina Board of Dental Examiners. While the ruling might actually be somewhat different if it were argued now, the majority based part of its ruling on a legal doctrine called the state action doctrine. A detailed discussion of the majority and dissent reasoning would be lengthy. This is not the right venue for the Commission to do anything other than recognize the factors present in the majority's opinion and be mindful of them.

ACOG Releases Updated Guidelines for Pain Management

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